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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

LETRINH HOANG, D.O., PHYSICIANS FOR INFORMED CONSENT, a not-for-profit organization, and CHILDREN'S HEALTH DEFENSE, CALIFORNIA CHAPTER, a California Nonprofit Corporation

Plaintiffs,

v.

ROB BONTA, in his official capacity as Attorney General of California and
ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California ("OMBC")

Defendants.

Case No: 2:22-cv-02147-DAD-AC

NOTICE OF MOTION AND MOTION FOR PRELIMINARY INJUNCTION AND MEMORANDUM OF LAW

Date: January 17, 2023
Time: 1:30 PM
Courtroom: 5, 14th floor (via Zoom)
Judge: Hon: Dale A. Drozd

Action Commenced: December 1, 2022

TO DEFENDANTS AND THEIR COUNSEL OF RECORD:

PLEASE TAKE NOTICE THAT on January 17, 2023, at 1:30 p.m. or as soon thereafter as the matter may be heard, at the United States District Court for the Eastern District of California, in

courtroom number 4, 15th Floor (via Zoom), 501 I Street, Sacramento, California, the Plaintiffs will move for an order granting preliminary injunctive relief.

Pursuant to Federal Rules of Civil Procedure 65, Plaintiffs seek a preliminary injunction to enjoin Defendants ROB BONTA and ERIKA CALDERON from investigating, filing an accusation against, or disciplining any osteopathic physician for violating Business and Professions Code Section 2270.

This motion is based on Plaintiffs' Notice of Motion and Motion, the Declarations of Plaintiff LeTrinh Hoang, D.O., Shira Miller, M.D., Debbie Hobel, Jamie Coker-Robertson, Shannen Pousada, and Sanjay Verma, M.D., and all papers and records on file with the Court or which may be submitted prior to the time of the hearing, any oral argument and any further evidence which may be offered.

Dated: December 6, 2022

Respectfully submitted,

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I. INTRODUCTION AND SUMMARY OF ARGUMENT

This lawsuit challenges the constitutionality of AB 2098, which becomes effective January 1, 2023 as Business and Professions Code Section 2270, under the First Amendment free speech clause and as being void for vagueness under the Fifth Amendment Due Process clause. This Motion for Preliminary Injunction seeks to stop the Osteopathic Medical Board of California (the "Board") from investigating, filing charges against, or disciplining osteopathic physicians under Section 2270 pending the final judgment of this Court.

AB 2098 prohibits physicians from conveying information and advice to their patients about COVID-19, which the State of California believes to be inconsistent with the prevailing opinions of the U.S. public health authorities and the majority of the medical community. However, if the pandemic has taught the world anything, it teaches that the views and edicts of the U.S. public health and medical authorities have changed, sometimes quickly, dramatically, and often inconsistently.

This is neither surprising nor fault-worthy considering the rapidity with which the virus has evolved, and the fact that other countries have employed different public health policies, frequently with better outcomes than in the U.S. And that is said acknowledging the fact that the United States is by far the leader in Covid vaccine and treatment development.

The AB 2098-created "contemporary scientific consensus" is surely a moving target, but is often quite blurry, and sometimes even completely false –but only in hindsight. This is explained in the detailed declaration of Sanjay Verma, M.D., which presents a meticulously sourced chronology of the changing, contradictory and often wishful-thinking basis of the U.S. public health authorities' response to the pandemic.[1]

[1] The most obvious example of the false (and dangerous) "scientific consensus" was the purported safety of the J&J vaccine, after what critics viewed as the inadequacy of testing. Initial reports of an association between the vaccine and serious clotting adverse events would have been considered under AB 2098 "Covid misinformation" if these reported risks were conveyed to patients. The spread of this "Covid misinformation" which at the time was against both the "scientific consensus" and the "standard of care", caused the public health authorities to take a closer look. Eventually and after countless deaths and hospitalizations from side effects (and it is literally "countless" because there is still is no good data about how many people died from the J&J vaccine), the same public health and

Even though AB 2098 will only take effect on January 1st, the declarations of patients Debbie Hobel and Jamie Coker-Robertson explain how the new law has already made them question whether their osteopathic physicians will give them candid opinions and honestly answer specific questions, because to do so might put these physicians at risk for investigation and sanction by the Board.

Despite all the generalities and argument by medical organizational authority about the need to protect the public from so-called "Covid misinformation" and "disinformation," the idea that the government can limit, on pain of professional discipline, the information and opinions that patients can receive from their physicians is constitutionally appalling. The Supreme Court has expressed the highest degree of skepticism and contempt towards such government efforts, likening them to the state-mandated directives of the most repressive authoritarian and fascist regimes of the 20th century.[2]

For purposes of this motion, there are two critical definitions in the new law. First, "disseminate" (Section 2270 (b)(3)) means "the conveyance of information from a licensee to a patient under the licensee's care in the form of treatment or advice." It is indisputable that speech by health care professionals to patients is constitutionally protected and subject to some form of heightened scrutiny (almost certainly strict scrutiny), unless the speech is an incidental part of some separate medical procedure (or more vaguely denominated as "professional conduct").

The second important definition in the challenged statute is "misinformation" meaning "false information that is contradicted by contemporary scientific consensus contrary to the standard of care." *Id.* at subsection (b)(4). The legal implications of this definition are that the law is both content based (Covid specifically) and viewpoint restrictive (i.e., making sanctionable conveying information with a particular viewpoint inconsistent with what the State considers true scientific information). Content and viewpoint based First Amendment restrictions are, according to the Supreme Court, subject to strict

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scientific consensus authorities which recommended it, rescinded its use as a first line vaccine. *See* the Verma Declaration at page 7, para 24. Another prominent example is the questionable and misleadingly general claim that the "unvaccinated" have an eleven times greater risk of death than the vaccinated. (Stated as a legislative fact in AB 2098 1 (b), and shown to be based on a flawed analysis of the data (explained in the Verma Decl. at page 13 para. 44 to page 15 para. 54, sourced in Appendix 6, page 34).

[2] *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S.Ct. 2361, 2374-2375 (2018) ("*NIFLA*"), the language is quoted in full in the Complaint at pages 18 and 19.

scrutiny, and that would include restrictions on professional speech. *NIFLA*, 138 S.Ct. at 2371, *citing Reed v. Town of Gilbert,* 576 U.S. 155 (2015).

Furthermore, the Supreme Court has specifically rejected the notion that physicians' communications to patients are a separate category of speech entitled to less protection than the same speech by non-professionals. *NIFLA*, 138 S.Ct. at 2371 (rejecting *Pickup v. Brown*, 740 F.3d 1208 (9th 2012) which asserted that a professional's speech to a patient was less than fully First Amendment protected and subject to some kind of intermediate scrutiny).

AB 2098 certainly fails strict scrutiny, as do almost all laws adjudged under this standard. We submit that there cannot be a compelling interest to prohibit California patients from receiving information from their physicians just because the State and professional organizations disagree, especially since such information is available to patients in almost every place else in this country. However, due to the bill's profound intrusion into the physician-patient relationship, the bill violates even the lesser heightened standard of intermediate scrutiny. There is no evidence in the legislative record that what California osteopathic physicians tell their patients (or would tell their patients) has caused any public harm, any harm to patients—or would do so. Nor does the record give any other rationale why silencing osteopathic physicians is a reasonable fit to foster the general public interest asserted, or that it would meaningfully contribute a solution to the perceived problem that the bill seeks to address. (Other reasons the law fails either level of scrutiny are set out at pages 18-21 *infra.*)

AB 2098 is also unconstitutionally vague under the heightened specificity requirement of the Due Process vagueness standard because of the inherent ambiguity of the definition of "Covid misinformation." The definition does not provide a reasonable physician with sufficient information to know whether his or her communications about Covid vaccines or other treatments are disciplinable or not. There is no clarity in the relationship between "false information" and the two subsequent terms "contemporary scientific community" and "the standard of care." When truthful and accurate information is contradicted by the "contemporary scientific consensus" and "standard of care", is the truth "Covid misinformation"?

Even if this Court found that truth can *never* be "Covid misinformation", the bill would still be unconstitutionally vague on its face because the bill makes unelected government officials the arbiters

of "truth" upon their changing whims. As indicated, experience during the pandemic has already shown "government truth" changes fast, changes with personas, and is inconsistent from one jurisdiction to the next (i.e., Florida is different than California). AB 2098 is so vague that physicians cannot even discern whether writing truthful but cutting-edge newsletters to patients constitutes sanctionable "advice". Government officials often claim that true information is actually false unless the "right" context is given simultaneously. This absurd law allows government officials to control not only what is considered "true" but even the *context* in which such "truth" may be spoken. This overreach shocks the conscience.

Because details matter, (especially to establish standing), Plaintiff LeTrinh Hoang's Declaration (pages 2-3, and the Complaint at page 4 para. 11 to page 7, para 20, to which she attested, per her Declaration page 4 para. 17) explains some of the questions she is asked by patients and the information she wants to provide. This information is supported by the medical literature and some of it paints a more nuanced and personalized picture for her patients than if she were merely to robotically repeat the mainstream public health talking points that do not reflect a true evidence-based "scientific consensus."

Despite all the references to science and "contemporary scientific consensus", AB 2098 is a deeply unscientific law. It impermissibly interferes with physicians' free speech rights and their patients' rights to receive important information, even though the State of California and public health authorities disagree with the content and viewpoint of these communications. If First Amendment free speech means anything, it means that "the majority preferences must be expressed in some fashion other than silencing speech based on its content." *R.A.V. v. City of St Paul,* 505 U.S. 377, 392 (1992).

II. STATEMENT OF MATERIAL FACTS

A. The Challenged Law

On September 30, 2022, Governor Newsom signed AB 2098 into law. The newly created Business and Professions Code Section 2270 provides in relevant part:

> "(a) It shall constitute unprofessional conduct for a physician and surgeon to disseminate misinformation or disinformation related to COVID-19, including false or misleading information regarding the nature and risks of the virus, its prevention and treatment; and the development, safety, and effectiveness of COVID-19 vaccines.
> (b) For purposes of this section, the following definitions shall apply:
> (1) "Board" means the Medical Board of California or the Osteopathic Medical Board of California, as applicable.

> (2) "Disinformation" means misinformation that the licensee deliberately disseminated with malicious intent or an intent to mislead.
> (3) "Disseminate" means the conveyance of information from the licensee to a patient under the licensee's care in the form of treatment or advice.
> (4) "Misinformation" means false information that is contradicted by contemporary scientific consensus contrary to the standard of care.
> (5) "Physician and surgeon" means a person licensed by the Medical Board of California or the Osteopathic Medical Board of California under Chapter 5 (commencing with Section 2000)."

AB 2098 California Legislative Information, Bill Text, https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB2098.

The new law is based on a July 29, 2021 press release by the Federation of State Medical Boards asking that its member state boards to investigate and sanction physicians for spreading Covid misinformation.[3]

B. The Plaintiffs' Direct and Deep Interest in Challenging AB 2098

The individual Plaintiff and two organizational Plaintiffs have a deep and direct connection to AB 2098, and a strong interest in challenging its constitutionality.

Plaintiff LeTrinh Hoang, D.O. has been a California licensed osteopathic physician for more than 25 years (Hoang Declaration at page 2 para. 2). She treats pediatric and adult patients. *Id*. A part of her practice is advising patients (and their families) about issues relating to Covid, and that includes providing information about the risks and benefits of the vaccine, as well as labeled and off-label treatments for Covid. The level of specificity of the information she provides depends on the particular patient and her past experience with that person. Some patients receive information about the latest studies as a complete and detailed answer to their questions about vaccines and boosters *Id*. at page 2, para. 3 to page 3, paras. 13, and the Complaint at page 4, para. 12 to page 6 para. 16)

One of the most important things many patients want to discuss with Plaintiff Hoang is the current Pfizer vaccine booster and whether they should take it. In addition to advising patients that the booster has been authorized for use in some ages by the FDA (but not fully approved), she thinks it is necessary to advise them: (1) The data supporting the use of the booster were not reviewed by the FDA's scientific vaccine advisory committee; and (2) Paul Offit M.D., a prominent committee member, does not

[3] *See* the Complaint at page 13, para. 58 for the text of this press release.

recommend that children take the booster. Hoang Declaration at page 2, para. 4, Complaint at page 5 para. 13. The data supporting the booster consisted of a study of eight mice, clinical and pre-clinical data from the prior booster, clinical trial data from the original mRNA vaccine, and other facts relating thereto. Complaint at page 5 para. 13. However, it is unclear whether speaking facts like these puts Dr. Hoang at risk for professional discipline under the new law. *Id*. at page 6, para. 17-19. Dr. Hoang's Declaration (and the Complaint) contains other specific information she would like to provide to patients contemplating taking the vaccine or the boosters, but she is similarly concerned that she may be putting her license at risk (Declaration at pages 3-4 and Complaint at page 5, para. 14 to page 5 para. 16.)[4]

Plaintiff Physicians for Informed Consent ("PIC") is a California-based nonprofit group consisting of physicians, other health care practitioners and laymen whose mission includes advocating for physicians' rights to provide true and evidence-based information to patients concerning the risks and benefits of vaccines. Complaint at page 7 para. 21 A core PIC function is collecting and analyzing the evolving *worldwide* scientific literature on vaccine safety and efficacy and providing this information to its members and the public at large. *Id*. at para. 22. The scientific evidence presented by PIC is sometimes at odds with, what is at any given time, the view of U.S. health authorities and what may be assumed to be the U.S. scientific consensus, but all information PIC's physicians currently provide is based on the best available worldwide evidence. *Id.* at para. 23. Frequently PIC's written summaries have foreshadowed changes subsequently made to the "scientific consensus." *Id.*

Many of PIC's osteopathic physician members are faced with choosing between what they reason is providing accurate and complete information about the risks of the vaccine and the different Covid treatments, which will put them in possible violation of the new law, or keeping silent. Moreover, due to the Board's broad power to investigate physicians, many of its members are afraid to speak in public or even to publicly support this case for fear of triggering a Covid misinformation investigation and prosecution. *Id*. at page 8 paras. 25-26.

PIC has associational standing to represent its osteopathic physicians and its lay members because (1) both sets of PIC's members would have the right to assert these claims, (2) their rights are

[4] Dr. Hoang attests to these facts in her Declaration. (Page 3, para. 17).

germane to PIC's educational purpose, and neither the claims nor the relief require the participation of PIC's members individually Complaint at page 8 paras. 27-30.

Plaintiff Children's Health Defense, California Chapter ("CHD-CA") California Chapter is a 501(c)(3) non-profit corporation whose mission is to end childhood health epidemics by working aggressively to eliminate harmful exposures, hold those responsible accountable, and to establish safeguards to prevent future harm. Complaint at page 9 para. 31.

In the vaccine space, CHD-CA educates and advocates concerning the negative risk-benefit profile of the Covid vaccines for California children and is deeply involved in educating about Covid vaccine and treatment issues. CHD-CA's members include thousands of California parents of children who want to receive objective, non-coerced information from California physicians about the risk profile of the Covid vaccines, as well as off-label Covid treatments versus standard-of-care treatments if their children contract Covid. *Id.* at para. 32-33.

Under AB 2098, however, physicians who provide information that is not within the "scientific consensus" and designated "standard of care" risk board prosecution and discipline. AB 2098 will have a chilling effect on physicians as they will have to decide between providing accurate but non-conforming information to parents at the risk of professional investigation and discipline or just reciting by rote their educated guess at so-called scientific consensus that day. This creates a risk of self-censorship, which will significantly impair the ability of CHD-CA's parent members to receive such nonconforming opinions from their osteopathic physicians. An actual and justiciable controversy exists between Plaintiffs and Defendants. *Id.* at page 9-10, para 34-39.

Plaintiff CHD-CA sues in its own capacity and on behalf of its constituent members who have been adversely affected by Defendants' actions. AB 2098 affects children whose parents will be unable to receive accurate information from their doctors. *Id.* CHD-CA has the requisite associational standing. *Id*. at page 10, para. 38.

III. REQUIREMENTS FOR A PRELIMINARY INJUNCTION IN A FIRST AMENDMENT CASE

The standard four-part test for a plaintiff to obtain a preliminary injunction is: 1. Likelihood of success on the merits; 2. Irreparable injury in the absence of relief; 3. The balance of equities tips in plaintiff's favor; and, 4. Showing the public interest favors granting the injunction. *Winter v. Natural Res. Def. Council, Inc*. 555 U.S. 7, 20 (2008); *Flexible Lifeline Sys. Inc. v. Precision Lift, Inc*. 654 F.3d 989, 994 (9th Cir. 2001).[5]

However, in a First Amendment free speech preliminary injunction motion, there are three significant modifications to the general test which greatly relax the general preliminary injunction standards because of the jurisprudential policy of protecting First Amendment rights as quickly as possible.

First, the plaintiff only needs to prove a colorable First Amendment violation or threatened violation. *Thalheimer v. City of San Diego*, 645 F.3d 1109 (9th Cir. 2011) *overruled on other grounds by Bd. of Trs. of the Glazing Health & Welfare Trust v. Chambers*, 941 F.3d 1195, 1199 (9th Cir. 2019).

Second, if the speech is found to be protected, meaning some form of heightened scrutiny is applicable (either strict or intermediate scrutiny), the burden is on the defendant to show that the challenged statute satisfies that level of scrutiny, which would include proof that less restrictive alternatives were considered and found to be less effective than the statutory solution, *Ashcroft v. ACLU,* 542 U.S. 656, 666 (2004), and that is because "the burdens at the preliminary injunction stage track the burdens at trial*." Id.*; *see also Gonzalez v. O Centro Espirita Beneficent Uniao do Vegetal,* 546 U.S. 418, 429 (2006).

Third, in a preliminary injunction seeking to temporarily stop the enforcement of a likely or colorable claim of unconstitutionality, the three latter preliminary injunction elements are either

[5] When the State is the defendant, the last two factors merge (balance of equities and public interest merge as the government's interest is the public interest. *Nken v. Holder*, 556 U.S. 418, 435, (2009). *See also Am. Bev. Ass'n v. City & Cty. of San Francisco*, 916 F.3d 749, 758 (9th Cir. 2019), ("[T]he fact that [Plaintiffs] have raised serious First Amendment questions compels a finding that . . . the balance of hardships tips sharply in [Plaintiffs'] favor," and "we have consistently recognized the significant public interest in upholding First Amendment principles." (internal quotation marks and citations omitted)).

presumed or carry less importance. Thus, for irreparable injury, "'[t]he loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury' for purposes of the issuance of a preliminary injunction." *Elrod v. Burns*, 427 U.S. 347, 373 (1976); *see also S.O.C., Inc. v. County of Clark*, 152 F.3d. 1136, 1148 (9th Cir. 1998) (establishing "probable success on the merits" of a First Amendment claim itself demonstrates irreparable harm).

Third, focusing on balancing the interests, the Supreme Court has expressed reluctance to balance the equities when the government is attempting to suppress content-based speech. *See United States v. Alvarez,* 567 U.S. 709, 717 (2012) ("In light of the substantial and expansive threats to free expression posed by content-based restrictions, this court has rejected as 'startling and dangerous' a 'free floating test for First Amendment coverage … [based on] an *ad hoc* balancing of relative social costs and benefits.'") quoting *United States v. Stevens*, 559 U.S. 460, 470 (2010). *See also*, *Am. Bev. Ass'n v. City & Cty. of San Francisco*, 916 F.3d 749, 758 (9th Cir. 2019). Shifting the focus to the public's interest, there is no public "interest in the enforcement of an unconstitutional law." *ACLU v. Ashcroft*, 322 F.3d 240, 251 n. 11 (3rd Cir. 2003). "By protecting those who wish to enter the marketplace of ideas from government attack, the First Amendment protects the public's interest in receiving information." *Pac. Gas & Elec. Co. v. Pub. Utils. Comm'n*, 475 U.S. 1, 8 (1986).

IV. ARGUMENT

A. Plaintiffs can Demonstrate a Likelihood of Success on the Merits of the First Amendment Free Speech Claim

A reasonable methodology to demonstrate likelihood of success (or lack thereof) on a First Amendment free speech claim is to utilize a decision tree consisting of three questions: 1. Is the speech targeted by the law protected or unprotected? (If unprotected, then the court uses the rational relationship test, which means the law or regulation is (almost always) upheld). 2. If the speech is protected, what level of heightened scrutiny applies? (Either strict or intermediate scrutiny). 3. Can the government meet its burden of proof that the statute satisfies the applicable level of scrutiny? If so, the statute is constitutional and there is no colorable claim, meaning no likelihood of success. If the government cannot meet its burden, the claim is colorable and there is a likelihood of success on the merits. Under the modification to the *Winter* test, the preliminary injunction should be granted.

In short: 1. Heightened scrutiny applies because AB 2098 unquestionably targets information conveyed to patients with a specific content and viewpoint; 2. Based on Supreme Court precedent (and a Ninth Circuit decision directly on point) the strictest of strict scrutiny applies; and, 3. AB 2098 fails under both strict and intermediate scrutiny.

By contrast, here is what is *not* the law: The Ninth Circuit (and other Circuits) had floated the notion that professional speech is less protected because it involves professionals, even if the speech is content and viewpoint based, and despite the fact that the Supreme Court had previously held that content and viewpoint-based restrictions to free speech are adjudged under strict scrutiny. (*See* discussion of *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2014), starting on page 11, i*nfra*.) The Ninth Circuit's position was in no small part based on the Supreme Court allowing states to regulate information to be given to pregnant women seeking abortion as part of informed consent in *Planned Parenthood of Southeastern Pennsylvania v. Casey,* 505 U.S. 833, 884 (1992) ("*Casey*").

Current law is the Supreme Court precedent *NIFLA*. The Ninth Circuit's professional speech doctrine was cited and rejected by the Supreme Court in *NIFLA*, 138 S.Ct. 2361. S*ee* pages 13-16 *infra.* And in yet another death-blow to *Pickup, Casey* (the key Supreme Court authority supporting *Pickup*'s professional speech doctrine) was recently overturned by *Dobbs v. Jackson Women's Health Org.*, 142 S.Ct. 2228 (2022) ("*Dobbs*").[6]

The following discussion of the relevant case law shows that almost certainly, strict scrutiny applies to AB 2098 and that any argument to the contrary by Defendants would have to be based on a legal argument not already presented in *Pickup* or in the Ninth Circuit's decision that was reversed by the Supreme Court in *NIFLA*. Defendants' task is all the harder in light of *Dobbs'* overturning *Casey*.

1. *Conant v. Walters*, 309 F.3d. 629 (9th Cir. 2002)

Conant is the most on-point authority and strongly supports strict scrutiny for AB 2098. It also directly supports Plaintiffs' standing to bring this pre-enforcement case.

Conant involved a challenge brought by physicians, a physician group and a patient group to the Drug Enforcement Agency's (DEA) announced policy that it would investigate and deregister physicians

[6] "And they [*Roe v. Wade* and *Planned Parenthood v. Casey*] have distorted First Amendment doctrines." *Dobbs v. Jackson Women's Health Org.*, 142 S.Ct. at 2276.

(i.e., revoke their DEA registration to write controlled substance prescriptions) for "recommending" medical marijuana to patients.[7] This, despite the fact that California had passed a referendum allowing physicians to recommend (but not prescribe) the drug. However, under federal law, *and under the then national "contemporary scientific consensus,*" the drug had no legitimate medical use. This is reflected in the fact that marijuana was a Schedule 1 drug, which by definition means the drug has no national, scientifically recognized medical use.

The Plaintiffs argued that physicians had a First Amendment free speech right to make the recommendation. The district court applied strict scrutiny and granted a preliminary injunction. After trial, another district court judge issued a permanent injunction which was affirmed on appeal by the Ninth Circuit.

Conant distinguished the fully protected speech of a physician's "recommendation" of the drug from writing a prescription, which all parties conceded would not be protected by the First Amendment because it was professional conduct (and a violation of federal law).

Conant strongly supports the Plaintiffs' position in this case, as it is based on the difference between the fully protected speech of making a recommendation (or giving the physician's opinion) from potentially regulatable professional conduct (rational relationship test) of issuing prescriptions. Plaintiffs' First Amendment challenge to AB 2098 involves the former and not the latter.[8]

2. *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2014)

As indicated, the professional speech doctrine articulated in *Pickup* is no longer good law. However, a detailed discussion of *Pickup* is instructive and indeed necessary for two reasons. First, and to reiterate, *Pickup*'s First Amendment analysis and doctrine were specifically cited, discussed and rejected by the Supreme Court in *NIFLA*. Therefore, this Court and should reject Defendants' arguments here that were made in *Pickup* to support the continuum-based First Amendment doctrine.

[7] Because of the similarities in the make-up of the plaintiffs in *Conant* to this case, *i.e.,* physicians, affected by the law or policy, a doctors' group and a patients' group, and because it was a pre-enforcement case, *Conant* strongly supports Plaintiffs' standing.

[8] As set out in the Complaint, page 3 end of footnote 1 and in Dr. Hoang's Declaration, page 4 para. 16, there is no such thing as Covid treatment consisting solely of speech.

Second, despite being abrogated by the Supreme Court, and its *Casey* underpinning being overruled by *Dobbs*, the Ninth Circuit has recently (and perhaps inexplicably) revived *Pickup* (or at least *Pickup*'s holding) in *Tingley v. Ferguson*, 47 F.4th 1055 (9th Cir. 2022) (discussed on page 17-18 *infra*.).

Pickup involved two groups of mental health professionals who filed separate lawsuits challenging the constitutionality of SB 1172, which made it a board disciplinable offense to provide sexual orientation change therapy to minors. One district court used strict scrutiny and issued a preliminary injunction against the law (*Welch v. Brown*, 907 F. Supp. 2d 1102 (E.D. Cal. 2012), (decision by Shubb, J.). The other district court denied the preliminary injunction applying a rational relationship standard because the law targeted therapy which is professional conduct, not speech, (i.e., facts and opinions about the therapy) and thus does not call for heightened scrutiny.

On the combined appeal, the Ninth Circuit affirmed *Pickup's* denial of the preliminary injunction and reversed this the *Welch* court's granting of a preliminary injunction. The *Pickup* panel acknowledged its earlier decision in *Conant,* but held that more regulation is possible for "conduct necessary to administer treatment itself." *Pickup*, 740 F.3d at 1227 (and that sounds much like speech incidental to conduct).

The court also found that "a professional's speech to patients is somewhat diminished." *Id*. at 1228 *citing Casey*, 505 U.S. at 884 (which upheld a state statute requiring certain "non-controversial" information about abortions be made part of the formal informed consent process which is required prior to a patient receiving the abortion medical procedure). Conceptually, the *Pickup* panel viewed professional speech as on a "continuum". Fully protected speech would encompass a physician's "soapbox" speech to the public. At the other end would be professional speech which performs, in effect, double duty as professional conduct (like the sexual orientation conversion therapy at issue in that case). In the middle was professional speech directed to a patient. That middle of the continuum received lesser protection than soapbox speech, but more than professional speech which is conduct, (presumably intermediate scrutiny).

The *Pickup* panel specifically stated that since the statute

> "regulates only treatment while leaving mental health practitioners free to discuss and recommend, or recommend against, SOCE we conclude that any effect it may have on free speech interests is incidental. Therefore, we hold that SB 1172 is subject to only

> rational basis review and must be upheld if it bears a rational relationship to a legitimate government interest."

Id. at 1231 (*citing Casey v. Planned Parenthood* above).

To further explain its continuum professional speech approach, the *Pickup* court gave other examples of less or unprotected professional speech, like the fact that physicians can be held civilly liable for giving negligent advice or sanctioning professional conduct if there is speech associated with and inseparable from the negligent conduct, or even giving bad advice about quack medicine. *Id.* at 1228. These examples were meant to demonstrate the State's long history of restricting professional speech, presumably to justify its ability to regulate protected speech in support of the Ninth Circuit's view that professional speech directed towards patients is not fully protected.

However, as stated above and demonstrated below, *Pickup* (or at least its professional speech analysis and continuum framework) is no longer good law in light of *NIFLA* and *Dobbs*.

3. *Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S.Ct. 2361 (2018)

NIFLA is the leading and most recent Supreme Court precedent on professional speech. Its close review shows where the *Pickup* and *NIFLA* panels went wrong and how this Court can avoid those errors by applying strict scrutiny to AB 2098.

The issue in the case was the constitutionality of a California statute that required pro-life pregnancy clinics to post notices to patients containing information about how the patients could get publicly funded (i.e., free) women's health care, including abortions.

The plaintiffs were several affiliated pro-life pregnancy care clinics, the purpose and function of which was to talk pregnant women out of having an abortion and to provide pregnancy care. Obviously, the last thing these clinics wanted to do was to be forced by the State to provide their patients with government-authored information about pregnant women's right and ability to obtain free abortions. The clinics sued to strike the law down under the First Amendment and argued that strict scrutiny applied.

The California district court refused to apply strict scrutiny and held, *inter alia*, that state mandated content notices were either professional conduct subject to the rational relationship test or professional speech subject to intermediate scrutiny, and that the law survived under both. As a result, the district court denied the requested preliminary injunction. (As set out in *Nat'l Inst. Of Family & Life*

Advocates v. Harris, 839 F.3d 823, 832 (9th Cir. 2016) *rev. Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S.Ct. 2361.)

The Ninth Circuit affirmed. It found that the mandated notices were content based but refused to follow the Supreme Court's recently decided *Reed v. Town of Gilbert,* 576 U.S. at 163, wherein the Supreme Court held that content based First Amendment restrictions are presumptively unconstitutional and are adjudged under strict scrutiny.

The Ninth Circuit gave two reasons for not following *Reed*'s mandate for strict scrutiny. First, it noted that it had already held that content-based restrictions do not always require strict scrutiny. *Nat'l Inst. Of Family & Life Advocates v. Harris,* 839 F.3d at 836-837, *citing United States v. Swisher*, 811 F.3d 299, 311-313 (9th Cir. 2016) (*en banc*). Second, it noted that the Supreme Court had recognized the right of states to regulate the content of physicians' speech on abortion issues in *Casey,* 505 U.S. at 884.

The *NIFLA* Circuit panel also extensively discussed *Pickup,* and consistent with that decision, held that the mandatory information about abortion in the challenged law was subject to intermediate scrutiny because it was physician speech directed to patients and thus fell in the middle of the *Pickup* "continuum." *NIFLA,* 839 F.3d at 838-841. The court then held that the law survived *intermediate scrutiny* (*Id.* at 841-844), and accordingly, it affirmed the district court's denial of the preliminary injunction.[9]

The Ninth Circuit's *NIFLA* opinion would require that AB 2098 be subjected to intermediate scrutiny, but for the fact that the Supreme Court reversed and very specifically criticized *Pickup's* First Amendment analysis as well as other parts of the Ninth Circuit's reasoning in its *NIFLA* opinion.

For example, as indicated a few paragraphs above, the Ninth Circuit decided that it did not have to apply *Reed v. Town of Gilbert*'s presumptively unconstitutional strict scrutiny test to the California statute even though it was content based. How did the Supreme Court start its First Amendment analysis of the California statute? By citing *Reed v. Town of Gilbert,* and quoting the very language that the Ninth Circuit said it did not have to follow. *See NIFLA*, 138 S.Ct. at 2371.

[9] The case actually involved two kinds of pregnancy clinics which were analyzed differently, but that is not material to this analysis.

This is a direct rejection of the Ninth Circuit's position that strict scrutiny does not apply to content-based First Amendment restrictions in professional speech to patients. The Supreme Court has thus shown that lower courts are not free to disregard *Reed v. Town of Gilbert*.

The Supreme Court stated that the reason strict scrutiny was not applied by the lower California courts was because "Some Courts of Appeals have recognized 'professional speech' that is subject to different rules." *Id*. *citing, inter alia, Pickup v. Brown,* 740 F.3d at 1227-1229. But as the Supreme Court declared "this Court has not recognized 'professional speech' as a separate category of speech. Speech is not unprotected merely because it is uttered by 'professionals. … This Court's precedents do not permit governments to impose content-based restrictions without 'persuasive evidence. … of a long (if heretofore unrecognized) tradition' to that effect.'" (Citation omitted). *NIFLA,* 138 S.Ct. at 2371-2372.

But while the Supreme Court did *not* recognize professional speech as a separate "category," it did acknowledge that speech uttered by professionals is less protected "in two circumstances—neither of which turned on the fact that professionals were speaking," *Id*. at 2372, those being commercial speech (i.e., advertising, which is accorded much less First Amendment protection, whether or not the advertiser is a professional) and the regulation of "professional conduct, even though that conduct incidentally involves speech." *citing Casey v. Planned Parenthood, Id.* at 2372.

The Supreme Court then discussed *Casey*, viewing abortion like any other medical procedure performed on a patient that requires informed consent. *Id*. at 2373. The operative point being that if there is a separate and distinct medical procedure, the speech providing the required informed consent for that procedure is incidental to the procedure, is not fully protected, and not subject to strict scrutiny. The converse also seems the likely implication of the Supreme Court's reading of *Casey*, namely, that if the speech is not incidental to a separate and distinct medical procedure, then it is fully protected, i.e., strict scrutiny applies.

At the end of the day, however, the *NIFLA* Supreme Court did not specifically hold that strict scrutiny applied to compelled speech because it found that the statute failed even intermediate scrutiny. And in fairness, the Court did not completely foreclose the possibility that there might be some persuasive reason to treat professional speech as a unique category exempt from ordinary First Amendment principles. *NIFLA*, 138 S.Ct. at 2375. However, having reviewed the Ninth Circuit's

opinion in *NIFLA,* and having considered (and rejected) *Pickup*'s rationale for treating physician speech to patients differently from general content and viewpoint strict scrutiny, the Supreme Court remained unconvinced. (And as per page 13 above, *Pickup* referenced other examples where the California courts gave speech by professionals less protection, such as negligent advice and still, the Supreme Court was unconvinced by *Pickup*'s continuum professional speech framework analysis, and rejected *Pickup*'s call for less scrutiny.)

The takeaway from *NIFLA* is that for anything less than the *Reed* required strict scrutiny to apply to this case, the Defendants would have to make some argument about why professional speech to a patient should be treated as a separate, less protected category that has not already been made (and rejected) in *Pickup* or the Ninth Circuit's NIFLA decision.[10] And again, there is the not-so-small jurisprudential fact that *Pickup*'s underpinning from *Casey* was expressly overturned by *Dobbs.*[11] Based on *NIFLA*, (and *Dobbs*), strict scrutiny should be used on AB 2098.

4. *Otto v. City of Boca Raton,* 981 F.3d 854 (11th Cir. 2020)

This Eleventh Circuit case is highly instructive on numerous specific issues in this motion, and also because it is the clearest application of *NIFLA* to date. *Otto* involved the same sexual conversion therapy as in *Pickup* (and in *Tingley* discussed below).

After allowing limited discovery and an extensive hearing with witnesses, the district court applied intermediate scrutiny and denied the motion for a preliminary injunction in a long but muddled opinion. The Eleventh Circuit held that strict scrutiny applied, reversed, and ordered the district court to grant the preliminary injunction.

The Eleventh Circuit rejected the city's attempt to evade the presumption against content-based restrictions by claiming that the speech was conduct. It was skeptical and dismissive of the government's attempt to "relabel" speech as conduct. *Otto,* 981 F.3d at 861. This is consistent with *NIFLA's*

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[10] And to reiterate once again, that would include *Pickup*'s rationale for lesser heightened First Amendment protection because physicians can be held liable and sanctioned for negligent advice. *See Pickup v. Brown.* 740 F.2d at 1228. That ship has sailed and should be resting silently on the bottom of the deep blue sea.

[11] *See* footnote 6 on page 10 *supra*.

reassertion of *Reed v. Town of Gilbert* after the Ninth Circuit's refusal to apply the presumption of unconstitutionality and strict scrutiny in its overturned *NIFLA* opinion.

The *Otto* panel also found the ordinance was viewpoint based which is "an egregious form of content discrimination." *Id.* at 864, *citing Rosenberger v. Rector & Visitors of Univ. of Virginia*, 515 U.S. 819, 829 (1995), and noted that there is an argument to be made that the Supreme Court implied that viewpoint regulation is a *per se* violation of the First Amendment.

Arguably, the most important part of *Otto* for this case is its discussion of the parameters of fully regulatable (i.e., rational relationship test) incidental speech to professional conduct. As suggested above, *NIFLA* more or less found that incidental speech had to be a required part of some separate medical procedure. However, the *Otto* panel made this point crystal clear by stating that the challenged ordinances are "direct, not incidental regulations of speech. Moreover, they are not connected to any regulation of *separately identifiable conduct*." *Otto,* 981 F.3d at 865. (Emphasis added). Because the talk conversion therapy was not part of separately identifiable conduct, the Eleventh Circuit used the strictest of strict scrutiny ("least-restrictive means of furthering a compelling government interest"), *Id*. at 875*, citing, inter alia, Williams-Yulee v. Fla. Bar*, 575 U.S. 433, 444 (2015).

If therapy consisting solely of speech is adjudged under the strictest scrutiny, *a fortiori,* the purely informational (viewpoint discriminatory) speech here should be subjected to the strictest scrutiny.[12]

5. *Tingley v. Ferguson*, 47 F.4th 1055 (9th Cir. 2022)

Tingley involved the same First Amendment challenge to a Washington sexual orientation conversion therapy prohibition for minors that was rejected by the Ninth Circuit in *Pickup v. Brown* for a California statute (and which was successful in *Otto*). Most of the reported case involves the plaintiffs' standing. The law recited therein, the analogous facts, and the result strongly support Plaintiffs' standing in this case.

On the professional speech issue, the *Tingley* court very narrowly read *NIFLA* (compared to *Otto*) as abrogating "only the part of *Pickup* relating to the professional speech doctrine, and not its central holding that California's conversion therapy was a regulation of conduct that incidentally

[12] Other important lessons from *Otto* are discussed in page 18-20 *infra*.

burdened speech." *Id*. at 1077. The panel then held, "*Pickup* remains binding law and controls the outcome of this case." *Id*. As the court poetically said: "States do not lose the power to regulate the safety of medical treatment performed under the authority of a state license merely because those treatments are implemented through speech rather than through a scalpel." *Id*. at 1064.

While *Tingley's* overly narrow reading of *NIFLA* might be questionable, as well as its resulting reaffirmation of the twice death-by-the-Supreme Court *Pickup* conceptual edifice, at least the Ninth Circuit acknowledged that *Pickup's* professional speech doctrine had been abrogated by the Supreme Court in *NIFLA*. That abrogation includes the Ninth Circuit's misguided idea in its *NIFLA* opinion that lower courts can choose to ignore *Reed v. Town of Gilbert's* (and *R.A.V. v. City of St. Paul's*) requirement that content-based restrictions are presumptively unconstitutional and require strict scrutiny.

Based on the above case analysis, AB 2098's restriction of physicians conveying information and opinions to patients is presumptively unconstitutional and subject to the *strictest* of strict scrutiny.

B. AB 2098 fails under Strict Scrutiny or Even Intermediate Scrutiny

1. AB 2098 Fails Strict Scrutiny

Since this case involves a fundamental right, strict scrutiny means that the Defendants must *prove* a compelling state interest, and they also must *prove* that the means chosen were narrowly tailored such that the least restrictive means possible were used. *South Bay Pentecostal Church v. Newsom,* 141 S. Ct 716, 718-719 (2021)[13]; *Williams-Yulee v. Fla. Bar*, 575 U.S. at 444.

Defendants will maintain the Legislature has a strong and compelling state interest to protect the public from COVID-19. However, the state's legitimate authority to protect does not include the "free-

[13] "In cases implicating this form of 'strict scrutiny,' courts nearly always face an individual's claim of constitutional right pitted against the government's claim of special expertise in a matter of high importance involving public health or safety. It has never been enough for the State to insist on deference or demand that individual rights give way to collective interests. Of course, we are not scientists, but neither may we abandon the field when government officials with experts in tow seek to infringe a constitutionally protected liberty. The whole point of strict scrutiny is to test the government's assertions, and our precedents make plain that it has always been a demanding and rarely satisfied standard. *See Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 546, 113 S.Ct. 2217 (1993). Even in times of crisis—perhaps especially in times of crisis—we have a duty to hold governments to the Constitution." *South Bay Pentecostal,* 141 S.Ct. at 718.

floating power to restrict the ideas to which children [people of all ages in our case] may be exposed." *Otto,* 981 F.3d at 869 (while protecting children is a crucial government interest "speech cannot be suppressed solely to protect the young from ideas . . . that a legislative body thinks unsuitable for them"), *quoting Erznoznik v. City of Jacksonville*, 422 U.S. 205, 212-214 (1975). *Otto* thus suggests the government's assertion of a *generalized* compelling interest does not justify shielding patients from ideas with which the legislature (and even experts) do not agree.

Otto is also highly instructive on the quality of the expert evidence necessary to sustain a restriction to professional free speech under any heightened scrutiny standard. In reviewing the city's evidence to justify the banning of sexual orientation conversion therapy, the panel found that it consisted of "assertions rather than evidence." *Otto, supra,* 981 F.3d at 868 (11th Cir. 2020).

More specifically, the city argued, and the district court accepted, that it would be "futile" for the city to have to produce actual evidence of harm from the talk therapy "when so many professional organizations have declared their opposition to SOCE [the talk therapy]." Or, as the *Otto* panel characterized the argument, "In other words, evidence is not necessary when the relevant professional organizations are united." *Id*. at 869.

> "But that is, really, just another way of arguing that majority preference can justify a speech restriction. The 'point of the First Amendment' however, 'is that majority preference must be expressed in some fashion other than silencing speech on the basis of its content. *R.A.V. v. City of St. Paul*, 505 U.S. at 392 (1992). Strict scrutiny cannot be satisfied by professional societies' opposition to speech. Although we have no reason to doubt that these groups are composed of educated men and women acting in good faith, their institutional positions cannot define the boundaries of constitutional rights. They may hit the right mark – but they may also miss it.
> Sometimes by a wide margin, too. It is not uncommon for professional organizations to do an about-face in response to new evidence or new attitudes…."

Id.[14]

This language from *Otto* is on point and hits the bullseye for several reasons. As alleged in the complaint, there is no actual evidence in the Legislative record that what California osteopaths tell their patients has caused any harm to them or that they are negatively affecting public health because of viral

[14] The Declaration of Sanjay Verma, M.D. contains 18 pages of discussion showing the about-facing by the public health authorities, and another 20 single-spaced pages of the sources proving same.

infections, transmissions, hospitalizations or deaths. Complaint page 12 para. 54-57. (The same might be said about medical doctors).

As evidenced by the findings, the object of the bill as originally filed was the public dissemination of Covid "misinformation" by doctors, not what they tell their patients in response to specific questions and the advice they give patients. Therefore, there was no consideration given to what questions patients have, or what information physicians think needs to be given. The Complaint sets out some detailed true and accurate information which Plaintiff Dr. Hoang and PIC's osteopathic physicians want to convey to patients. Complaint page 4 para. 12 to page 6 para. 16, and page 7 para. 23 to page 8, para. 24.

This itself is fatal to AB 2098, because strict scrutiny requires evidence that the other alternatives would not have been effective. (*See United States v. Playboy Ent Grp. Inc*. 529 U.S. 803, 817 (2000)). In this case, the Defendants would be hard-pressed to point to evidence of an alternative that the Legislature considered, because the purpose of the bill was to stop physicians from speaking out in public against the Covid narrative for fear of increasing the public's vaccine hesitancy. However, the passed version of the bill limited its application to communications between physicians and patients for treatment or advice. In any event, where in the Legislative record is there any evidence that less restrictive measures would not have been effective—including social media advertising of the efficacy and benefit of the vaccines and boosters, advertising about the efficacy of the FDA approved drugs for COVID-19, or a public statement by the Board conveying its opinion on these issues? And, perhaps more transparency and honesty about the potential dangers of the vaccines, rather than all the efforts at vaccine-injury denialism, might also be a better solution. (*See* the declaration of nurse Shannen Pousada who details how that after she suffered a heart attack after receiving the J&J vaccine, her doctors were initially reluctant to acknowledge that it was likely caused by the vaccine for worker's compensation purposes, and how the State treated the finding like "Covid misinformation.")

Finally, the *Otto* panel's reference to experts and professional societies missing the mark is amply demonstrated by Dr. Verma's Declaration that shows how on almost every major issue related to Covid, the scientific consensus changed, was more aspirational/wishful thinking than evidence based, or was just proven to be plain wrong.

2. AB 2098 does not even survive intermediate scrutiny

To survive intermediate scrutiny:

"The State must show ... that the statute directly advances a substantial governmental interest and that the measure is drawn to achieve that interest." *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 572, 131 S.Ct. 2653 (2011). Intermediate scrutiny is "demanding" but requires less than strict scrutiny. *Retail Digital Network, LLC v. Appelsmith*, 810 F.3d 638, 648 (9th Cir. 2016). "What is required is 'a fit that is not necessarily perfect, but reasonable; that represents not necessarily the single best disposition but one whose scope is in proportion to the interest served; that employs not necessarily the least restrictive means but ... a means narrowly tailored to achieve the desired objective.'" *Id.* at 649 (quoting *Bd. of Trustees of the State Univ. of N.Y. v. Fox*, 492 U.S. 469, 480, (1989)); *NIFLA*, 839 F.3d 823 (9th Cir. 2016), *rev. on other grounds NIFLA,* 138 S.Ct. 2361 (2018); See *also Jones v. Bonta*, 34 F.4th 704 (9th Cir. 2022). Furthermore, "The existence of 'numerous and obvious less-burdensome alternatives' is relevant to assessing whether the restriction on speech reasonably fits the interest asserted." *Klein v. City of San Clemente*, 584 F.3d 1196 (9th Cir. 2009), citing *City of Cincinnati v. Discovery Network, Inc*., 507 U.S. 410, 417 n.13 (1993).

The lesser burdensome alternatives (which were not proven to be less effective than the statutory restriction to protected free speech) demonstrate that the AB 2098 "solution" was not a reasonable fit. The other facts and arguments in the strict scrutiny analysis apply with equal force here, and show that there is no evidentiary basis to satisfy the Defendants' burden of proof that the means were narrowly tailored to achieve the desired objective.

The government is literally limiting the information that patients are allowed to hear from their physicians. Such extreme government censorship of ideas is exactly what the Supreme Court and the Eleventh Circuit were appalled by in their likening the government's restrictions to free speech to what the Soviets, Communist China and Nazis did. See *NIFLA*, 138 S.Ct. at 2374-2375 (quoted in full in the Complaint at page 18-19).

In short, it does not matter what level of heightened scrutiny is used, the State of California cannot be allowed to stop patients of osteopathic physicians from receiving truthful information about any aspect of the pandemic simply by declaring the information to be false and inconsistent with what the

Board may deem to be the scientific consensus at any given point in time and with what the Board might determine to be the standard of care months or years after the advice is given.

V. AB 2098 FAILS THE HEIGHTENED SPECIFICITY REQUIREMENT OF THE DUE PROCESS CLAUSE

It is black letter constitutional law that "perhaps the most important factor affecting the clarity that the Constitution demands of a law is whether it threatens to inhibit the exercise of constitutionally protected rights. If, for example, the law interferes with the right of free speech or of association, a more stringent vagueness test should apply." *Village of Hoffman Estates v. Flipside, Hoffman, Estates,* 455 U.S. 489, 499 (1982).

As set out in the Complaint, the vagueness of the new law is primarily the result of the definition of "Covid misinformation" as "false information that is contradicted by contemporary scientific consensus contrary to the standard of care" and the relationship between the three clauses. Is the information that Dr. Hoang wishes to provide Covid misinformation? (*See* the Complaint at pages 4-6). How about truthful information about the studies that show Ivermectin to be an effective treatment for Covid, together with the disclaimer that the FDA does not consider any of these studies alone or together as authoritative or of the same quality as studies that show no efficacy? There are no principled answers to these questions because of the inherent vagueness of the definition of "Covid misinformation." Is proof of the falsity of the information a separate elemental requirement, or is information deemed "false" just because it is not consistent with the "scientific consensus and the standard of care"?

The complaint sets out many specific questions that are unanswerable under the law on anything other than an unprincipled, ad hoc, arbitrary basis. (*See* the Complaint at pages 4-6, page 7, para. 24, and the Second Claim at pages 15 para. 67 to page 17 para. 74). Because there is no obvious statutory answer to these questions, any attempt to apply this vague definition would be unprincipled, arbitrary and capricious, meaning that there are no rules or guidelines by which a decision by the Board can be made. Any decision will be *ad hoc* and not based on any pre-existing, articulated or ascertainable standard. And that means reasonable osteopathic physicians cannot know from the law what they can say and what information they must withhold from their patients on penalty of Board's investigation and discipline.

And that makes AB 2098 unconstitutional under the heightened specificity required by Due Process case law cited above.

VI. PLAINTIFFS HAVE SATISFIED THE REMAINING ELEMENTS FOR A PRELIMINARY INJUNCTION

A. Irreparable Injury

As indicated in Section III above, irreparable injury is presumed if there is strong evidence of a First Amendment freedom of speech violation, as there is in this case. However, the Complaint and Declarations of Plaintiff Hoang and PIC President Shira Miller demonstrate that physician speech is and will be chilled by the new law in large part because of the statute's vagueness and uncertainty about how undefined terms may apply to information physicians want to convey to patients.

Further, the Declarations of Debbie Hobel, and Jamie Coker-Robertson show that even though the law is not yet in effect, it is already having an actual negative impact in the doctor-patient relationship due to the conflict between providing truthful information that may or may not be consistent with the prevailing medical consensus and withholding information to the possible detriment of the patient. Such damage to the trust between physicians and patients is irreparable and can lead to patients simply not consulting with physicians on these important matters, as shown by patients such as Ms. Hobel and Ms. Coker-Robertson who question whether their doctors will tell the truth. This is actual injury.

B. Balancing the Equities and The Public Interest

As indicated, when the state is the defendant, the last two *Winter* preliminary injunction factors merge. The balance of equities favors protected free speech, favoring the free marketplace of ideas, and it also favors recognition that patients have a fundamental right to receive information from their physicians even if government authorities and professional organizations do not agree with it. The Board cannot demonstrate that investigation or even sanctioning a few or even many California osteopathic physicians would have a meaningful impact on the public health discussion of the government's pandemic response. Thus, AB 2098's investigative and sanctioning authority targeting protected speech is not only unconstitutional, it is futile.

The public has no interest in the Board acting in violation of the constitutional rights of its licensees and their patients. In an evolving pandemic, the public's interest is best served by having

medically trained people speak candidly to their patients, even if all the information they convey is not in accord with government views.

Dr. Verma's expert declaration presents numerous examples where the public health authorities had to walk back their recommendations. As wisely stated by the *Otto* panel, sometimes experts and professional associations get it wrong. That is the fundamental truth of this case and why the Court should stop the Board from targeting viewpoint speech between a doctor and a patient during an evolving pandemic.

VII. REQUEST THAT NO BOND BE REQUIRED

This case seeks to protect the First Amendment rights of physicians and their patients. The Defendants will suffer no monetary harm if the temporary relief is granted. See *Jorgensen v. Cassiday*, 320 F.3d 906, 919 (9th Cir. 1997). Plaintiffs have a strong likelihood of success on the merits, see *Scherr v. Volpe*, 466 F.2d 1027, 1035 (7th Cir. 1972), and the "equities of potential hardships to the parties" weigh in favor of Plaintiffs. See *Temple Univ. v. White*, 941 F.2d 201, 220 (3rd Cir. 1991). Therefore, Plaintiffs request that no bond be required.

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For the foregoing reasons, Plaintiffs respectfully request that the Motion for Preliminary Injunction be granted and that the Osteopathic Medical Board of California be prohibited from investigating or sanctioning any osteopathic physician under Bus. & Prof. Code Section 2270 pending the final judgment in this case.

Dated: December 6, 2022

Respectfully submitted,

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LOCAL RULE 231 (D)(3) STATEMENT

1. Plaintiffs request an evidentiary hearing and would call Sanjay Verma, MD and the Board's Executive Officer, Defendant Erika Calderon.
2. Plaintiffs anticipate that the hearing will take two hours.

Richard Jaffe, Esq.

CERTIFICATE OF SERVICE

I, Richard Jaffe affirm as follows:

1. I am an attorney at law admitted to practice in this court. I am not a party to this action and am over the age of 18. I am counsel of record for the Plaintiffs in this case. I submit this Certificate of Service under penalties of perjury.
2. This Motion and all the declarations are being served on the Defendants together with the summons, complaint and the various court documents in this matter. A proof of service from the process server will be separately filed.

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

LETRINH HOANG, D.O., PHYSICIANS FOR INFORMED CONSENT, a not-for-profit organization, and CHILDREN'S HEALTH DEFENSE, CALIFORNIA CHAPTER, a California Nonprofit Corporation Plaintiffs, v. ROB BONTA, in his official capacity as Attorney General of California and, ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California ("OMBC"), Defendants.	**Case No: 2:22-cv-02147-DAD-AC** [proposed] ORDER GRANTING PRELIMINARY INJUNCTION

Plaintiffs' Motion for Preliminary Injunction came for hearing before the Court on January 17, 2022. Having given full consideration to Plaintiffs' papers, evidence, relevant authorities, and Defendants' responses thereto, as well as the oral presentations of counsel; for good cause appearing and in accordance with Fed. R. Civ. P. 65(b), the Court finds that Plaintiffs have demonstrated they are likely to succeed on the merits, likely to suffer irreparable harm in the absence of preliminary relief,

that the balance of equities tips in Plaintiffs' favor, and that an injunction is in the public interest. *See Winter v. Natural Res. Def. Council,* 555 U.S. 7, 20 (2008).

The Court makes the following findings:

1. Substantial and irreparable injuries to Plaintiffs' constitutional speech rights are occurring and will continue to occur in the absence of immediate injunctive relief.
2. Plaintiff has no adequate remedy of law.
3. An injunction serves the public interest by upholding the Constitution. Denial of preliminary relief would allow continued injury to Plaintiffs. Granting of preliminary relief causes no injury to Defendants.

IT IS HEREBY ORDERED that Plaintiffs' Motion for Preliminary Injunction is **GRANTED**. Defendants Attorney General Rob Bonta, and Erika Calderon, Executive Officer of the Osteopathic Medical Board of California, and all employees who report directly or indirectly to the Defendants, or act in concert with them are hereby preliminarily restrained and enjoined, pending a final determination on the merits, from commencing or continuing any investigation of California licensed osteopathic physicians on the grounds that such physicians have or might have violated Bus. & Prof. Code Section 2270.

IT IS FURTHER ORDERED THAT Defendant Erika Calderon cause to be posted on OMBC's web site that enforcement of Bus. & Prof. Code Section 2270 is being stayed pending the final disposition of this action; and,

IT IS FURTHER ORDERED THAT Defendant Erika Calderon cause a notice to be sent to all physicians who are currently under investigation for "misinformation" relating to COVID-19 that such investigations are abated pending the final disposition of this case.

The Court finds that no bond is necessary in this case because Defendants' compliance with the preliminary injunction would create no risk of monetary loss.

IT IS SO ORDERED

_____

Dale A. Drozd
United States District Judge

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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

LETRINH HOANG, D.O., PHYSICIANS FOR INFORMED CONSENT, a not-for profit organization, and CHILDREN'S HEALTH DEFENSE, CALIFORNIA CHAPTER, a California Nonprofit Corporation

Plaintiffs,

v.

ROB BONTA, in his official capacity as Attorney General of California
ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California ("OMBC")

Defendants.

Case No. 2:22-cv-02147-DAD-AC

DECLARATION OF SANJAY VERMA, M.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Date: January 17, 2023
Time: 1:30 PM
Courtroom: 5, 14th floor (via Zoom)
Judge: Hon: Dale A. Drozd

Action Commenced: December 1, 2022

I, SANJAY VERMA, M.D., hereby declare:

1. I have personal knowledge of the facts set forth herein. I submit this Declaration in support of Plaintiffs' Motion for a Preliminary Injunction. If called to testify I could competently testify as follows.

EXPERT BACKGROUND

2. I am a California licensed medical doctor having practiced medicine for 12 years. I am Board Certified in Internal Medicine with sub-specialties in cardiovascular disease and Interventional Cardiology. My CV is attached hereto as Exhibit A.

3. I am a member of Physicians for Informed Consent. I have provided the group with information and analyses of various aspects of the scientific evidence (or lack thereof) for COVID-19 vaccination and treatments, as well as the public health response to the pandemic such as masking, school closures and lockdowns.

4. During the pandemic, I have been involved in the treatment of COVID-19, in particular patients who presented to me with various cardiac manifestations. I have also treated numerous patients with cardiomyopathy and other inflammatory cardiac conditions temporally associated with them having received a COVID-19 vaccine (cardiac complications which more likely than not was a consequent to the COVID-19 vaccine).

5. My experience dealing with these cardiac patients has compelled me to closely follow the evolving approaches to management of COVID-19 patients, as well as the changing public health measures to contain the spread of the virus. Because COVID-19 is a pandemic, it is reasonable and necessary to extensively examine the medical and public health responses in different parts of the world. This enables a scientist to identify the differences in approaches in medical and public health interventions and preventatives to determine which have been successful or less effective. Critical analysis of data, evidence and studies beyond the US is routinely undertaken by scientists and physicians. However, non-US information seems to be often neglected and ignored in individual or public health recommendations for COVID-19 pandemic response.

6. On the most general level, it is fair to say that different countries have taken quite different approaches to vaccination and booster recommendations, as well as public health measures (masking, lockdowns and school closures) than the United States. These differing approaches appear to have led to quite different outcomes in terms of some of the key outcome parameters such as deaths, excess deaths, infection rate, hospitalizations and adverse events associated with the COVID-19 vaccines.

7. While it is beyond the scope of this declaration to give a comprehensive comparative analysis, on a general level, I think it is fair to say that in most significant parameters measuring the success of government response to the pandemic, the United States has been far less successful than other developed countries. The specific topics I will address include a small portion of the literature supporting this general opinion.

PROFESSIONAL CONCERNS WITH AB 2098

8. My main concern with AB 2098 is that the phrase "contemporary scientific consensus" is vague and illusory as it applies to the information which physicians may need to convey to patients about the pandemic and how they should respond to it. In some instances, there is no actual evidence-based scientific consensus. Rather, there are public health officials expressing their hopes and wishes wrapped up in some minimal and wholly inadequate alleged scientific justification which masquerades as scientific consensus. An obvious example of this is the often asserted but unproven public health assertion that the COVID-19 vaccines could stop or reduce transmission of the disease, or prevent infection.

9. Another type of vagueness occurs when there is a difference between the government's recommendation and the lack of formal consensus. Perhaps the best example of this would be the fact that the current COVID-19 vaccine booster is still authorized only under Emergency Use Authorization (EUA) by the FDA and was not endorsed by the FDA's own vaccine advisory committee. One of the leading members of the committee does even not recommend its use. Is FDA authorization under EUA sufficient to allow the Osteopathic Board to investigate and sanction a physician for "COVID misinformation" for not recommending a patient to take the booster? Although I am quite familiar with the scientific evidence (or rather

the lack thereof) behind the booster shot (and there is almost none as I will explain), I cannot ascertain from the statute if a physician could recommend against the booster without risking board investigation and sanction.

10. Another aspect of the vagueness (or problematic use of this undefined term) is that the evolving nature of the virus has caused scientific opinion to shift so frequently and so quickly such that it is no longer meaningful to call any given expression of the prevailing scientific view a "contemporary scientific consensus". Such apparent consensus lasts only until the next contrary article is published with momentum. However, the momentum is observed more in retrospect over months than in real-time. Examples of this are detailed below, especially via the appendices. Given the volume of material presented in the appendices, I request the opportunity to testify at the preliminary injunction hearing so I can answer questions for counsel and the Court.

11. To demonstrate these points of vagueness and the general unsuitability of using "contemporary scientific consensus" as a disciplinary criterion, I have prepared a detailed overview of the public health response to the pandemic, broken down into Masks and Vaccines (transmission, safety, efficacy natural immunity). I have also included evidence of what would be considered misinformation promulgated by the CDC, as well as its withholding of information which led to the then "contemporary scientific consensus" eventually being proven wrong.

12. In addition, my summary includes the reasons why I think the California medical boards are ill equipped to adjudicate interpretations of rapidly evolving pandemic science. Finally, I have included historical examples of the changing medical science on some important medical treatments such as aspirin and prior vaccines.

I. MASKS (for citations, see Appendix I)

13. Initially in the pandemic, cloth masks (even gaiters and bandanas) were considered acceptable to prevent infection and transmission. "Masks saves lives" was often reported in media based upon unproven presumptions in 'models' that masks (even cloth masks) reduce deaths "by at least one third" (IHME model). Dr. Atlas' tweet stating that cloth

masks do not work was deleted in 2020 (according to a statement from Twitter to CNN, "the message was removed for violating the company's policy for sharing 'false or misleading content related to COVID-19 that could lead to harm.'")

14. In 2021, more research data began to surface that mask mandates in schools did not prevent transmission in children. Likewise, published research demonstrated that mitigation efforts on college campuses also did not prevent transmission. In December, 2021, Dr. Leana Wen (during a CNN interview) emphatically declared that cloth masks do not prevent spread of an airborne virus regardless of variant. Subsequently, there was a push to increase quality of masks, emphasizing three-ply procedure (surgical) masks or N95 / KN95 masks.

15. In California, data revealed that counties with mask mandates fared no better than counties without mask mandates during Delta wave. Likewise, a study in Europe found no benefit of mask mandates. Los Angeles County has had among the most stringent mitigation efforts throughout the pandemic and still had the highest per capita COVID-19 hospitalizations during winter of 2020-2021. Most recently, CDC lifted mask mandates in health care settings; however, California stands apart in continuing to mandate masks in health care settings.

16. The details of these changes sourced by URL reference is attached hereto as Appendix 1 and incorporated herein.

17. AB 2098 provides that "It shall constitute unprofessional conduct for a physician and surgeon to disseminate misinformation or disinformation related to COVID-19, including false or misleading information regarding the nature and risks of the virus, its prevention and treatment; and the development, safety, and effectiveness of COVID-19 vaccines".

18. However, CDC's own recommendation evolved regarding the benefit of cloth masks, not because there was new scientific data, but because existing scientific data were finally accepted. Had physicians and scientists been prohibited or self-censored from sharing this data in 2020 and 2021, the evolving stance on cloth masks might have been further delayed, to the material detriment of public health.

II. COVID-19 Vaccines (preventing transmission) (citations in App. II)

19. Early in the rollout of COVID-19 vaccines, numerous public health experts

touted the benefit of vaccines to prevent transmission. CDC Director Dr. Rochelle Walensky (during interview with Rachel Maddow on MSNBC) declared the COVID-19 vaccines prevent transmission. POTUS Biden, Pfizer CEO Albert Bourla, and numerous mainstream media articles emphatically declared that the COVID-19 vaccines prevent transmission to others.

20. Preventing transmission was precisely the basis of employer mandates and health care worker COVID-19 vaccine mandates (to protect coworkers and patients, respectively). During SCOTUS oral arguments in January 2022, Justice Elana Kagan stated "we know that the best way to prevent spread is to get vaccinated." However, the Phase III trials (whose data was used for EUA in Dec 2020) was never designed to test for transmission. CDC Director Dr. Rochelle Walensky, Dr. Deborah Birx, and Pfizer CEO Albert Bourla all recently acknowledged there never was any scientific evidence to support these original claims. Studies as early as summer of 2021 demonstrated that the vaccinated can spread as much as the unvaccinated. In its recent updated guidance on COVID-19, CDC finally stated "CDC's COVID-19 prevention recommendations no longer differentiate based on a person's vaccination status." However, there never was any scientific justification for differentiating based upon vaccination status in the first place.

21. Attached and incorporated herein as Appendix 2 are the URL references to the changing views of the benefit of the vaccine in preventing transmission of the virus.

22. AB 2098 states "It shall constitute unprofessional conduct for a physician and surgeon to disseminate misinformation or disinformation related to COVID-19, including false or misleading information regarding the nature and risks of the virus, its prevention and treatment; and the development, safety, and effectiveness of COVID-19 vaccines".

23. However, initial claims that vaccines prevent transmission were unfounded. Nevertheless, such claims were considered to reflect the "contemporary scientific consensus." Scientists and physicians who challenged these unsubstantiated claims were the ones who were actually promoting scientifically justified interpretations of the data. Furthermore, the entire shift in apparent "contemporary scientific consensus" occurred in a relatively short timeframe, shorter than the amount of time the Osteopathic Board would need to investigate, prosecute

through hearing , and discipline a physician. Indeed, the expert testimony in such a disciplinary action could be revised, outdated, and revised again before conclusion of the administrative proceeding. Expert testimony could then be revised still further after the proceedings, thereby making a complete mockery of the administrative process while depriving physicians of due process of law.

III. The Safety of COVID-19 Vaccines (citations in App. III)

24. As early as spring 2021, reports started to surface regarding very serious severe adverse events: VITT-TTS (vaccine-induced immune thrombotic thrombocytopenia), CVST, (Cerebral Venous Sinus Thrombosis), myocarditis, neurological complications like GBS (Guillain-Barre Syndrome), Bell's Palsy, and even fatalities. CDC's initial response has repeatedly been dismissive, suggesting such reports were merely random statistical coincidence (i.e., were not occurring more frequently than the background rate in the general population). Janssen's COVID-19 vaccine was repeatedly deemed "safe and effective". However, later data proved that there was considerable increased risk of VITT and GBS, which were sometimes fatal. Ultimately, the use of Janssen's COVID-19 vaccination was significantly restricted by the FDA and CDC; however, during the delay in acknowledging this increased risk, many suffered irreparable harm (including death). Myocarditis was also initially dismissed by CDC as being within the background rate in general population. Subsequent research has repeatedly confirmed increased risk of myocarditis with mRNA COVID-19 vaccines, especially for younger males. CDC did finally acknowledge this increased risk of myocarditis after COVID-19 vaccination, but continues to insist such cases are "rare" and "generally mild".

25. This assessment is based upon VAERS (Vaccine Adverse Reporting System) data alone, despite VAERS data having been repeatedly shown to underestimate the rate of vaccine associated myocarditis by three to four times. CDC's own Vaccine Safety Datalink (VSD) reports rates twice that of VAERS. Numerous international studies published in reputed scientific journals demonstrate rates three to four times that of VAERS. CDC's own MMWR (Morbidity and Mortality Weekly Report) in April 2022 (using 40 insurance databases) confirms the three to four-fold increased rates of myocarditis compared to data of VAERS

(when using health care databases rather than the passive surveillance data in VAERS). For anaphylaxis, VAERS data underestimates the risk after COVID-19 vaccination by up to twenty-two times. Prior to COVID-19, estimates of severe adverse reactions using VAERS data are even more dismal.

26. However, CDC continues to use VAERS for all its risk-benefit analysis to erroneously conclude the "benefits outweigh the risks". In its most recent publication on intermediate follow-up (minimum 90 days) of myocarditis cases in VAERS, 47% were lost to follow-up (no follow-up data on almost half the victims), about 50% still had residual symptoms of myocarditis (i.e., had not fully recovered), and about a third still had activity restrictions (i.e., were deemed to still be unsafe to resume physical exertion due to increased risk of sudden cardiac death). Thus, CDC's own data contradict the repeated claim that these myocarditis cases are "generally mild".

27. Attached and incorporated herein as Appendix 3 are the URL references to the changing and contradictory views on this subject.

28. AB 2098 states, "The safety and efficacy of COVID-19 vaccines have been confirmed through evaluation by the federal Food and Drug Administration (FDA) and the vaccines continue to undergo intensive safety monitoring by the CDC."

29. However, the safety of COVID-19 vaccines, especially the boosters, was *not* adequately evaluated in children prior to approval. The sample size was too small in the studies to assess for severe adverse events. During the ACIP meeting, officials acknowledged the only way to know what those severe adverse reactions would be is to monitor during post market surveillance (to have adequate sample size).

30. The most recent bivalent booster was added to the children's vaccine schedule without any clinical data from that bivalent booster. CDC's safety monitoring lags 6-18 months from initial reports. By the time the FDA fact sheet is modified (or CDC's recommendations are adjusted), many have already suffered irreparable harm (and even fatalities). CDC relies heavily on passive surveillance with VAERS (and to some extent VSD). Longitudinal active surveillance (i.e., actively soliciting data and comparing to unvaccinated) was rendered virtually

impossible when the control group was eliminated early in 2021. This precluded any systematic post market longitudinal follow-up for severe adverse events.

31. The federal agencies such as the FDA and CDC continue to promulgate the idea that the COVID-19 vaccines (including the boosters) are proven safe and effective, and that side effects are exceedingly rare. However, the over reliance upon VAERS database (despite it having been proven to considerably under estimate the risks) has caused at least the cardiology community to temper recommendation for vaccines in some population subsets. As discussed below, several countries have also changed their recommendations for COVID-19 vaccines in healthy children and young adults. This undermines miscellaneous government and the infectious disease expert positions that side effects are too rare to impact recommendations refuting any notion of a "scientific consensus".

32. Although CA AB 2098 presumes or asserts without proof that the "vaccines continue to undergo intensive safety monitoring by the CDC", there is increasing evidence in CDC's failure to do so. Despite CDC Director Dr. Rochelle Walensky assuring Congress that "all [deaths] are adjudicated", CDC has thus far never published any formal analysis of the 32,220 deaths reported in VAERS. Indeed, CDC and FDA have refused to release autopsy reports despite a Freedom of Information Act (FOIA) request. With respect to the myocarditis reports in VAERS, CDC's most recent publication on intermediate term follow-up (minimum 90 days) reveals that a staggering 47% were lost to follow-up (i.e., could not be reached on follow-up to assess their clinical condition). CDC Director Dr. Rochelle Walensky admitted the agency made some "pretty dramatic, pretty public" mistakes. As reported in New York Times (February 2022), CDC has only published a fraction of the data it collected about COVID-19 pandemic, apparently "because basically, at the end of the day, it's not yet ready for prime time." More recently, CDC erroneously reported higher pediatric COVID-19 deaths (during ACIP presentation), but refused to correct the number even when presented with the corrected information (they initially reported at least 1,433 deaths among people 19 and younger in the United States were attributed to COVID-19, but acknowledged in the updated version that the number was just 1,088).

33. CA AB 2098 states **"**The safety and efficacy of COVID-19 vaccines have been confirmed through evaluation by the federal Food and Drug Administration (FDA) and the vaccines continue to undergo intensive safety monitoring by the CDC." Furthermore, AB 2098 states, "It shall constitute unprofessional conduct for a physician and surgeon to disseminate misinformation or disinformation related to COVID-19, including false or misleading information regarding the nature and risks of the virus, its prevention and treatment; and the development, safety, and effectiveness of COVID-19 vaccines."

34. However, CDC appears to have been withholding important information, delaying release of information, and using erroneous inflated numbers in their presentations (for vaccine approval in children). The COVID-19 vaccines do not in fact "continue to undergo intensive safety monitoring by the CDC.". Therefore, it seems scientifically and professionally reckless (for public safety) to investigate and sanction physicians who are upholding the highest standards of advising patients about the risks versus benefits of the COVID-19 vaccines in providing information about the deficits in CDC's safety monitoring of the COVID-19 vaccines.

35. According to CDC, "V-safe is a safety monitoring system that lets you share with CDC how you, or your dependent, feel after getting a COVID-19 vaccine". However, CDC was reticent in releasing data from V-Safe, acquiescing only after 463 days of legal action by Informed Consent Action Network (ICAN) which entailed two lawsuits culminating in court order to release that data. ICAN's V-Safe data analysis reveals a staggering 7.7% of the ten million V-safe users required medical attention after vaccination. This data ought to have been made public to enable responsible informed consent discussions between physicians and patients. As reported in New York Times earlier this year, CDC was intentionally withholding data that might lead to vaccine hesitancy.

36. AB 2098 sates, "The safety and efficacy of COVID-19 vaccines have been confirmed through evaluation by the federal Food and Drug Administration (FDA) and the vaccines continue to undergo intensive safety monitoring by the CDC". That it necessitated legal action over 463 days undermines the claim by AB 2098 that the vaccines continue to

undergo intensive safety monitoring by the CDC. CDC was either not undertaking intensive safety monitoring of V-Safe data, or it was doing so but withholding the information from the public.

37. Additionally, most of CDC analysis of severe adverse reactions after COVID-19 vaccination is based upon the false presumption that the effects of mRNA vaccination (and the consequent spike protein synthesized) last only a few days to weeks after injection. CDC's own web site has changed throughout the pandemic: initially indicating the mRNA is broken down within a few days and spike protein may persist up to a few weeks. That messaging has now been deleted from their website. Several scientific studies demonstrate spike protein can be found even four months after injection. Not only does this suggest that CDC's initial presumption was wrong, but it also seriously undermines the limitation of side effects to within a few weeks after injection (i.e., if spike protein persists for many months after injection, then the analysis for potential causation needs to be extended beyond the few weeks to which CDC limits its analysis).

IV. The Efficacy of Vaccines (citations in App. IV)

38. When mRNA COVID-19 vaccines were granted EUA in Dec 2020, there were repeated claims of "95% effective" (against symptomatic infection) and "100% effective against severe disease". However, these claims of Vaccine Efficacy (VE) were based upon *interim analysis* of Phase III trial data (i.e., *interim* because original Phase III protocols stipulated the trial would continue for about 26 months but the results released in December 2020 were based only upon minimum 60-days' follow-up). However, as noted by Peter Doshi (editor of BMJ), efficacy of a vaccine for respiratory illness is best assessed throughout the respiratory virus season (i.e., minimum 4-6 months' follow-up) and not with only 60 days' follow-up data. Indeed, in summer 2020, UCSF abandoned its COVID-19 vaccine development precisely because their research demonstrated dramatically waning antibody levels within a couple months. Numerous post-market studies have demonstrated waning immunity from COVID-19 vaccination after only a few months (as early as 2-4 months but definitely after 4-6 months).

39. Some recent studies even suggest that after a few months there is negative efficacy (i.e., increased risk of infection) for those who have received two or three doses of COVID-19 vaccination. However, until these studies repeatedly confirmed the waning vaccine immunity, CDC continued to insist that vaccine immunity was better than immunity from natural infection. CDC's risk-benefit analysis (i.e., number of COVID-19 hospitalizations and deaths averted by vaccination) is based upon the initial higher estimates of VE (i.e., CDC extrapolated the initial VE as if it would be sustained without any waning) and has not adjusted its vaccine efficacy risk-benefit calculations despite the mounting evidence of waning immunity over time. Other national societies (e.g., American College of Cardiology) use CDC's calculations from summer 2021 to justify their own recommendations in support of the claim that benefits outweigh the risks. CDC Director Dr. Rochelle Walensky repeatedly claims that the benefits outweigh the risk. None of the risk-benefit calculations by any government agency or professional medical society has adjusted its risk-benefit calculation with the known and proven waning immunity.

40. Attached and incorporated herein as Appendix 4 are the URL references to the changing views of vaccine efficacy.

41. AB 2098**:** states "The safety and efficacy of COVID-19 vaccines have been confirmed through evaluation by the federal Food and Drug Administration (FDA) and the vaccines continue to undergo intensive safety monitoring by the CDC."

42. However, repeated studies have demonstrated the initial high efficacy touted by CDC and FDA has rapidly diminished (even negligible after a few months in children). Most recently, the bivalent booster was added to the children's vaccine schedule *without any clinical data from that booster.* At no point has there been an emphasis by FDA or CDC to assess efficacy over 4-6 months *prior to approval and recommendations* despite increasing evidence that 60-day follow-up efficacy data is often subsequently refuted by longer term follow-up (i.e., rapidly waning immunity after 2-4 months)

V. The Disparagement of Natural immunity (citations in App. V)

43. From the beginning of the COVID-19 pandemic, the public health authorities have dismissed the value or effect natural immunity has on the prevention of hospitalization and death from COVID-19 reinfection. Supported by CDC recommendations, employers, universities, and health care facilities have mandated the COVID-19 vaccines *regardless of immunity from prior infection*. This is contrary to the long-standing accepted practice in medicine which accepts serology (i.e., proof of antibodies) as a valid exemption for vaccination proof (e.g., MMR serology precludes need to provide vaccination proof for health care facilities). However, many studies have shown that for some variants, natural immunity is more effective than immunity conferred by vaccination (in preventing severe disease over many months). There was never any valid scientific evidence for the disparagement of natural immunity, despite the widely quoted statements of public health authorities and prominent members of the infectious disease academic community. Attached to this Declaration as Appendix 5 are the URL's supporting these statements.

VI. Unvaccinated dying at 11 times greater than fully vaccinated? (citations in App. VI)

44. AB 2098**:** states "Data from the federal Centers for Disease Control and Prevention (CDC) shows that unvaccinated individuals are at a risk of dying from COVID-19 that is 11 times greater than those who are fully vaccinated." AB 2098 Section 1 (b).

45. The CDC repeatedly claims that unvaccinated are being hospitalized at rates much higher than those fully vaccinated. Claims have been made that unvaccinated are dying at rates 11 times greater than those fully vaccinated and being hospitalized 10-17 times more than fully vaccinated. However, such analysis is deeply flawed for several reasons.

46. First, it does not adjust for the estimated 40% of hospitalizations and deaths that may have been over counted (when differentiating those 'with COVID' versus 'from COVID').

47. Second, this analysis is not static over time (the benefit decreases over time as is evidenced by the studies on waning immunity).

48. Third, this analysis varies by age group (there is considerably lower benefit in healthy children and young adults than in seniors over 65 years old). There are no clinical trials

that prove reduced COVID-19 mortality in pediatric population in those who are vaccinated (because mortality is so rare in children, the sample size of all the trials is too small to detect any difference).

49. Fourth, there is suggestion that CDC's analysis skews the results by including all other causes of death for the unvaccinated but not for the vaccinated (i.e., biased analysis by using different inclusion criteria for deaths in unvaccinated versus vaccinated).

50. Fifth, the definition of "unvaccinated" was altered in 2021 to include: (a) vaccinated patients where the injury or death occurred within the first two weeks after vaccination, (b) vaccinated patients who were simply not up-to-date on recommended boosters, and (c) vaccinated patients lacking a vaccination record at that facility. The data on the so-called "unvaccinated" included a systemic problem of hospital error where a vaccinated patient presented at the hospital without a vaccination record and was therefore labeled "unvaccinated". Throughout the pandemic, it has been observed that healthcare workers do not always thoroughly and objectively verify vaccination status. Furthermore, the administrative burden of reporting adverse reactions to VAERS is quite cumbersome. These factors have contributed toward flawed data and misplaced blame targeting the genuinely unvaccinated compared to the falsely labeled unvaccinated.

51. Sixth, this analysis does not distinguish the unvaccinated who have immunity from prior infection. As discussed above, those who have immunity from prior infection have strong protection against hospitalization and death from COVID-19 reinfection. CDC's own seroprevalence estimates indicate that 86% of all children have already been infected by SARS-CoV2. Thus, neglecting prior infection in their claims of unvaccinated dying and being hospitalized from COVID-19 at much higher rates than the vaccinated is a misrepresentation of the comparative risk.

52. Finally, the CDC analysis excludes (without justification or explanation) those who may have died after the vaccination (i.e., from causes other than COVID-19, but likely post vaccination cardiovascular mortality linked to the COVID-19 vaccination). There are currently about 32,220 reported deaths in VAERS. While CDC assures the public that "all

[deaths] are adjudicated" thus far no formal analysis has been published on these deaths after vaccination (whether they are causally related).

53. One recent study from Southern California actually found no mortality benefit amongst the vaccinated.

54. White House COVID advisor Dr. Ashish Jha recently stated that "we can prevent essentially every COVID death in America" through updated vaccination and treatment. This is readily contradicted by recent analysis in the Washington Post which demonstrates that 58% of all COVID deaths are amongst the vaccinated (compared to 42% amongst the unvaccinated). Additionally, nearly 90% of all COVID deaths are now in those over 64 years old (the highest ever throughout the pandemic).

55. Attached and incorporated herein as Appendix 6 are the URL references for this section.

VII. Other examples of medical science changing over time (citations in App. VII)

56. AB 2098 states "Misinformation" means false information that is contradicted by contemporary scientific consensus contrary to the standard of care." However, in a rapidly evolving pandemic with new research every month, what is defined as "standard of care" changes fast. Cloth masks, steroids, early ventilation, risk of COVID-19 to children, duration of vaccine immunity, and risks of vaccine complications to healthy children and young adults have evolved with respect to acceptable scientific narrative and recommendations. Furthermore, there is no actual *consensus,* but rather there is strong evidence of suppression of contrarian views to give the pretense of consensus.

57. Many major scientific societies simply repeat CDC's analysis and recommendations without performing independent critical analysis of the available data. Mainstream media runs with and repeats the CDC sanctioned studies, further augmenting the appearance of consensus. Internationally, there are countries that significantly disagree with CDC's recommendations, especially regarding healthy children and young adults.

58. Throughout the history of medicine, there are examples of evolving standard of care: what was once the standard of care is subsequently replaced with diametrically opposed

recommendations. If at any point in the evolution of scientific knowledge and 'consensus', contrarian views were legally culpable with disciplinary action, we would not have continued to progress with more scientifically accurate conclusions and recommendations. Aspirin, clopidogrel, and beta blockers are examples of medications that have undergone dramatic revision in their indications. Several vaccines have been withdrawn after post market safety concerns demonstrated unacceptable harm. Thalidomide was once hailed internationally as a great therapeutic for morning sickness in pregnant women, until countless cases of phocomelia were documented (leading to its withdrawal). Scientists should be able to self-govern with an ongoing process of reflecting, evaluating, testing, analyzing, and challenging data from various perspectives without fear of losing their professional credentials.

59. Attached and incorporated herein as Appendix 7 are the URL references to the other examples of medical science changing over time.

VIII. Countries that have Different Vaccine Recommendations (citations in App. VIII)

60. As I stated in the beginning of this declaration, some European and other developed countries have different vaccine recommendations from the recommendations of the CDC. Attached hereto as Appendix 8 is a noncomprehensive list of some of these countries with different vaccination recommendations.

IX. Over estimating deaths and hospitalizations attributed to COVID-19 (citations in App. IX)

61. AB 2098 states "The global spread of the SARS-CoV-2 coronavirus, or COVID-19, has claimed the lives of over 6,000,000 people worldwide, including nearly 90,000 Californians." These data are deeply flawed since they do not adjust for over counting. 40% of COVID hospitalizations were likely in those 'with COVID' rather than 'from COVID' (two studies from CA pediatric hospitals confirm this). Additionally, approximately 30% of COVID+ deaths occurred in persons from long term care facilities, who have a median life expectancy of five months even before the pandemic. After adjusting for these, the actual number of deaths attributed to COVID-19 is considerably lower than current CDC estimates.

62. Attached and incorporated herein as Appendix 9 are the URL references to data and studies showing that the number of deaths and hospitalizations caused by COVID-19 has been substantially over estimated.

63. CDC repeatedly states that COVID-19 vaccines save lives and that the benefits outweigh the risks. Throughout the COVID-19 vaccine rollout, despite increasing evidence for waning immunity across all ages and increased risk of myocarditis for younger people (especially males), and no proven mortality benefit in children, CDC continues to recommend COVID-19 vaccination (and boosters) for all ages regardless of individual risk stratification and regardless of immunity from prior infection. In their risk-benefit calculations and analysis of COVID-19 vaccinations, CDC does not appear to account for the increased all-cause mortality which *may* be associated with COVID-19 vaccination. Data from CDC reveal that for 18-64-year-olds there were about 56,015 and 66,392 in September 2019 and September 2020, respectively (average 61,203 for September during these two years). However, during September 2021 there were 92,917 deaths amongst 18-64-year-olds. This represents an increase by over thirty thousand (50%) in *one month*. Additionally, data from life insurance claims reveal that for those under thirty-five years old, there were more non-COVID deaths than COVID deaths during the pandemic (March 2020 to April 20222) compared to the preceding three years. Since over 75% of all COVID-19 deaths in the USA have been amongst those over 65 years-old, this increase in all-cause mortality amongst younger adults is deeply troublesome and warrants formal analysis.

64. The official narrative by public health experts is that increased all-cause mortality is attributed to delayed medical care during 2020 and early 2021 community wide shutdowns and hospitals overwhelmed with COVID patients leading to inadequate access to health care (especially elective cardiac procedures and cancer screening). Additional explanations offered by public health experts include lifestyle changes (poor eating habits, inadequate physical activity, and even 'stress') consequent to 'shelter in place' (i.e., stay at home) orders by public health officials. However, CDC has still not revealed autopsy reports of the thirty-two thousand deaths in VAERS (despite a FOIA request by Epoch Times). CDC also has never published any

formal analysis of the thirty-two thousand deaths in VAERS or the increased deaths in 2021 and 2022. Although definitive causation with COVID-19 vaccination has not yet been proven, the lack access to autopsy findings and formal analysis of these deaths is contrary to the presumption of thorough post-market pharmacovigilance that is presumably occurring to protect the public from preventable harm.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: December 5, 2022

SANJAY VERMA, M.D.

APPENDICES

Appendix 1
The Evolving and Contradictory Mask Consensus

Appendix 2
The Changing and Contradictory Statements About the Ability of The Vaccines to Prevent Infection.

Appendix 3
Vaccine Safety

Appendix 4
Vaccine Efficacy

Appendix 5
Disparaging or Underestimating Natural Immunity

Appendix 6
Unvaccinated dying at 11 times greater than fully vaccinated?

Appendix 7
Examples of changes to the scientific consensus

Appendix 8
Countries with different vaccine recommendations

Appendix 9
Covid-19 deaths and hospitalizations have been overestimated.

Appendix 1
The Evolving and Contradictory Mask Consensus

- Twitter removed Dr. Atlas' tweet saying cloth masks don't work
  - https://nymag.com/intelligencer/2020/10/twitter-removes-scott-atlass-tweet-saying-masks-dont-work.html
  - CDC Oct 2020 cloth masks recommended for community
    - https://wwwnc.cdc.gov/eid/article/26/10/20-0948_article
- Unsubstantiated claims that masks save lives (based upon IHME unproven *presumption* that masks, even cloth masks in community, reduce deaths by "at least one third")
  - https://cepr.org/voxeu/columns/mask-mandates-save-lives
  - https://www.statnews.com/2020/10/23/universal-mask-use-could-save-130000-lives-by-the-end-of-february-new-modeling-study-says/
  - https://www.npr.org/sections/coronavirus-live-updates/2020/10/24/927472457/universal-mask-wearing-could-save-some-130-000-u-s-lives-study-suggests
- 2020: CDC recommends community mask adoption
  - https://www.cdc.gov/media/releases/2020/p0714-americans-to-wear-masks.html
- CDC's own data showing poor efficacy of anything other than N95
  - https://www.cdc.gov/library/covid19/pdf/2020-08-18-Science-Update_FINAL_public.pdf
- Gaiters and bandanas:
  - "As a last resort, the agency said that health care providers could consider using "homemade masks" – such as bandanas or scarves – to care for coronavirus patients, ideally in combination with a face shield."
  - https://www.cnn.com/2020/03/19/health/hospital-coronavirus-shortages-preparedness/index.html
  - https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html
  - https://www.bostonherald.com/2020/03/23/bandanas-can-substitute-as-coronavirus-masks-as-a-last-resort-says-cdc/
- Single layer masks (e.g., Gaiters and bandanas) no longer recommended
  - https://www.cdc.gov/library/covid19/pdf/2020-08-18-Science-Update_FINAL_public.pdf
  - https://bestlifeonline.com/cdc-face-masks-news/
- CDC concedes cloth masks not as effective (NYT)
  - https://www.nytimes.com/2022/01/14/health/cloth-masks-covid-cdc.html
- Dec 2020 Military grade camera shows risk of airborne spread
  - https://www.washingtonpost.com/investigations/2020/12/11/coronavirus-airborne-video-infrared-spread/

- "Wearing cloth masks will not have much effect"
  - https://www.sciencedirect.com/science/article/pii/S2452199X20301481
- "The homemade cloth masks again yielded either no change or a significant increase in emission rate during speech compared to no mask"
  - https://www.nature.com/articles/s41598-020-72798-7
- "A rigorous study finds that surgical masks are highly protective, but cloth masks fall short."
  - https://www.nature.com/articles/d41586-021-02457-y
    - *Note:* the study found NO benefit of cloth masks, and surgical masks had some benefit in those >50 yr., but no benefit in <50 yr
- Even surgical masks not effective in high-risk settings
  - https://www.science.org/doi/10.1126/science.abg6296
  - https://pubmed.ncbi.nlm.nih.gov/34016743/
- Bacterial and fungal isolation from face masks
  - https://www.nature.com/articles/s41598-022-15409-x
- Dec 2021 onwards Dr Leana Wen: cloth masks not effective against airborne virus
  - https://twitter.com/drleanawen/status/1473083590707662850
  - https://twitter.com/drleanawen/status/1517235792787251206
  - https://reason.com/2021/12/21/leana-wen-cloth-mask-facial-decorations-covid-cdc-guidance/ (has actual video)
- CDC mask study (expanded reanalysis by Dr. Høeg showing no benefit of school mandate)
  - https://www.journalofinfection.com/article/S0163-4453(22)00550-3/fulltext
  - https://www.the74million.org/article/study-masking-in-school-had-little-or-no-effect-on-student-covid-cases/
- CDC updates mask recommendations
  - https://www.washingtonpost.com/health/2022/01/10/cdc-weighs-n95-kn95-masks-guidance-omicron/
  - https://www.webmd.com/lung/news/20220115/cdc-updates-mask-guidelines-cloth-masks--least-effective
  - https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html
- Even in 2020 we had data showing that surgical masks were minimally effective and some cloth masks were ineffective
  - https://www.health.harvard.edu/blog/masks-save-lives-heres-what-you-need-to-know-2020111921466
  - https://www.cato.org/working-paper/evidence-community-cloth-face-masking-limit-spread-sars-cov-2-critical-review
  - Dr. Osterholm (commentary that cloth masks provide very limited protection)

- https://www.cidrap.umn.edu/news-perspective/2020/07/commentary-my-views-cloth-face-coverings-public-preventing-covid-19

- Case against mask for children
  - https://www.wsj.com/articles/masks-children-parenting-schools-mandates-covid-19-coronavirus-pandemic-biden-administration-cdc-11628432716
- Studies that suggest low quality masks *increase* risk of spread
  - https://www.nature.com/articles/s41598-020-72798-7
  - https://aip.scitation.org/doi/10.1063/5.0034580
- CA counties with mask mandate fared *no better* than those without
  - https://www.sfgate.com/coronavirus/article/California-mask-mandates-delta-COVID-19-data-works-16502191.php
- CDC drops mask requirement in health care settings 2022
  - https://www.webmd.com/lung/news/20220928/cdc:-masking-no-longer-required-in-health-care-settings
  - However, CA continues mask mandate for health care settings
- Analysis of mask compliance in Europe fails to find benefit
  - https://www.cureus.com/articles/93826-correlation-between-mask-compliance-and-covid-19-outcomes-in-europe

Appendix 2
The Changing and Contradictory Statements About the Ability of The Vaccines to Prevent Infection

Vaccines prevent transmission /infection

- https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html
- https://www.cnn.com/2021/08/05/health/us-coronavirus-thursday/index.html
- https://www.msnbc.com/transcripts/transcript-rachel-maddow-show-3-29-21-n1262442
- https://www.businessinsider.com/cdc-director-data-vaccinated-people-do-not-carry-covid-19-2021-3
- https://www.cnbc.com/2021/03/01/dr-scott-gottlieb-says-data-shows-covid-vaccines-reduces-transmission.html
- https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html
- https://twitter.com/albertbourla/status/1402240820120592393
- https://twitter.com/albertbourla/status/1468596735115247618
- https://twitter.com/fortunemagazine/status/1377810547035488266?lang=en
- https://twitter.com/CDCDirector/status/1583563153547603969
- https://twitter.com/DrEliDavid/status/1582256734264926208
- https://twitter.com/drelidavid/status/1582256734264926208 (Pfizer interview)
- https://twitter.com/pfizer/status/1349421959222853633
    - "gain herd immunity and stop transmission"
        - Pfizer Tweet Jan 2021

Vaccines do not prevent transmission (vaccinated can spread)

- https://www.cdc.gov/media/releases/2021/s0730-mmwr-covid-19.html
- https://www.audacy.com/kmox/news/national/cdc-director-says-vaccines-are-not-preventing-transmission
- https://www.washingtonpost.com/politics/2022/01/10/rochelle-walensky-is-not-good-this/
- https://www.cdc.gov/mmwr/volumes/71/wr/mm7133e1.htm
- https://www.scientificamerican.com/article/the-risk-of-vaccinated-covid-transmission-is-not-low/
- https://www.npr.org/sections/coronavirus-live-updates/2021/07/30/1022867219/cdc-study-provincetown-delta-vaccinated-breakthrough-mask-guidance
- Latest / updated CDC guidance (no difference in treatment of unvaccinated for prevention) https://www.cdc.gov/mmwr/volumes/71/wr/mm7133e1.htm

Possible INCREASED secondary attack rate (transmission) the more vaccination doses a person has

- https://www.nature.com/articles/s41467-022-33328-3

Vaccines never tested for transmission

- https://lynnwoodtimes.com/2022/10/11/covid-transmission-221011/
- https://twitter.com/rob_roos/status/1579759795225198593
- https://youtu.be/DD4TWEy8I6Y
- Dr. Deborah Birx: "I think it was hope that the vaccine would work that way."
    - In response to Rep Jim Jordan (Congress) [at 3 min 45 sec]
    - https://www.c-span.org/video/?c5021092/dr-birx-knew-natural-covid-19-reinfections-early-december-2020

Appendix 3
Vaccine Safety

- Janssen VITT-TTS
  - Rare, no cause for concern (Joint CDC / FDA statement)
    - https://www.cdc.gov/media/releases/2021/s0413-JJ-vaccine.html
    - https://youtu.be/kvLEJbbF3Tk (video of ACIP meeting 4/23/20221)
    - https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-04-23/06-COVID-Oliver-508.pdf (slides from ACIP meeting 4/23/2021)
    - Lift Pause of Janssen COVID-19 vaccine
      - https://www.fda.gov/news-events/press-announcements/fda-and-cdc-lift-recommended-pause-johnson-johnson-janssen-covid-19-vaccine-use-following-thorough
      - https://www.cdc.gov/mmwr/volumes/70/wr/mm7017e4.htm
  - Dec 2021: CDC limits Janssen due to concerns of TTS and GBS (use only under very specific circumstances)
    - https://www.cdc.gov/mmwr/volumes/71/wr/mm7103a4.htm
    - Note: June 2021 CDC found no cause for halting: https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-07/02-covid-alimchandani-508.pdf
  - April 2022: JAMA article demonstrating incidence of GBS 20x in Janssen compared to mRNA COVID-19 vaccines
    - https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2791533
  - May 2022: Restricted Access by FDA (despite initially stating not a concern)
    - https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-limits-use-janssen-covid-19-vaccine-certain-individuals
    - https://www.cnn.com/2022/05/05/health/fda-johnson-johnson-vaccine-eua/index.html
- mRNA Vaccines and myocarditis
  - April 2021 reports surfaced from Israel
    - https://www.reuters.com/world/middle-east/israel-examining-heart-inflammation-cases-people-who-received-pfizer-covid-shot-2021-04-25/
  - May 2021 (VAST work group was dismissive). https://www.cdc.gov/vaccines/acip/work-groups-vast/report-2021-05-17.html
    - "Within CDC safety monitoring systems, rates of myocarditis reports in the window following COVID-19 vaccination have not differed from expected baseline rates." (i.e., CDC dismissed initial claims

stating it was 'random statistical coincidence' and within the 'background rate occurring in general population')

- June 23, 2021 Emergency ACIP meeting (concludes safe to proceed despite reports of myocarditis)
  - https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-06/05-COVID-Wallace-508.pdf
- FDA summary briefing document. https://www.fda.gov/media/155931/download
  - Data from Insurance datasets reveal myocarditis rates are 3.7x GREATER than rates noted in VAERS
- Published studies showing increased rates of myocarditis (compared to VAERS)
  - https://www.nejm.org/doi/full/10.1056/NEJMoa2110737
  - https://www.nejm.org/doi/full/10.1056/NEJMc2207270
  - https://www.medpagetoday.com/infectiousdisease/covid19vaccine/94892
  - https://onlinelibrary.wiley.com/doi/epdf/10.1111/eci.13759
- April 2022 CDC MMWR (40 insurance databases)
  - Rate of myocarditis is 267/million (not 80 / million using VAERS alone) https://www.cdc.gov/mmwr/volumes/71/wr/mm7114e1.htm
- Sept 2022 CDC intermediate (90 day minimum) follow-up data on VAERS myocarditis reports (published in Lancet)
  - https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(22)00244-9/fulltext
    - Highlights
      - 47% lost to follow-up (why is CDC not tracking these cases down more aggressively?)
      - 50% still had residual symptoms
      - 25% were in ICU (contrary to CDC claims of "generally mild")
      - 48% of those not fully recovered and 28% of those fully or probably fully recovered *continued to have activity restrictions at median follow-up of 98 days*
- Myocarditis after Booster may be under reported. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8957365/
- Latest statement from American College of Cardiology seems to allow for nuanced individualized risk-benefit analysis. https://www.acc.org/Latest-in-Cardiology/Articles/2022/10/14/15/13/ACC-Underscores-Safety-of-COVID-19-Vaccine
  - "Stecker notes that it is reasonable for adolescent and young males to *consult with a physician prior to receiving additional mRNA boosters*, given the small but elevated risk of myocarditis in this group"

- VAERS vs VSD vs Electronic Medical Record (EMR) / Insurance databases
  - Anaphylaxis
    - The risk of anaphylaxis is also underestimated by 22 times according to this study using active surveillance after COVID vaccination.
      - https://jamanetwork.com/journals/jama/fullarticle/2777417
  - VSD 2:1 with VAERS (i.e., rates of myocarditis)
    - ACIP Presentation slides
      - https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2022-06-22-23/03-COVID-Shimabukuro-508.pdf
    - Myocarditis rates derived from VAERS vs VSD (VSD demonstrates about 2x VAERS but CDC continues to use VAERS data for its risk-benefit calculations)
  - EMR / insurance 3-4x vs VAERS
    - VAERS rates
      - https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2022-06-22-23/03-COVID-Shimabukuro-508.pdf
    - Rates of Vaccine myocarditis from Insurance data (CDC and FDA's own documents)
      - FDA summary briefing for BLA approval
        i. "Analysis of VAERS data from passive surveillance indicated a reporting rate of 40 cases per 1 million second doses administered to males 18 to 24 years of age, while an FDA meta-analysis of four healthcare claims databases in CBER's Biologics Effectiveness and Safety System estimated a rate of 148 cases per 1 million males 18 to 25 years of age vaccinated with the 2-dose primary series."
        ii. https://www.fda.gov/media/155931/download
    - CDC MMWR on myocarditis
      - "This study used EHR data from 40 health care systems* participating in PCORnet, the National Patient-Centered Clinical Research Network (7), during January 1, 2021–January 31, 2022. "
      - https://www.cdc.gov/mmwr/volumes/71/wr/mm7114e1.htm
    - Approximate numbers for comparing myocarditis rates
      - VAERS 80 / million
      - VSD 150 / million
      - Insurance / hospital database 250-300 / million

- So, why does CDC continue to use VAERS data alone in its risk-benefit calculations?

- FL Recommends AGAINST mRNA Vx for 18-38-year-olds (84% increased risk of death). https://floridahealthcovid19.gov/wp-content/uploads/2022/10/20221007-guidance-mrna-covid19-vaccines-analysis.pdf
- Dr. Paul Offit recommends young healthy kids NOT get Booster
  - https://news.yahoo.com/young-healthy-people-may-not-need-bivalent-boosters-offit-155018744.html
- Israel study: increased cardiac arrest associated with Vx. https://www.nature.com/articles/s41598-022-10928-z
- Preprint from Japan (increased CV mortality with mRNA Vx). https://www.medrxiv.org/content/10.1101/2022.10.13.22281036v1.full.pdf
- Safety in toddlers (1 in 200 had severe adverse reactions)
  - https://twitter.com/FLSurgeonGen/status/1586327074578497536
  - https://www.nejm.org/doi/full/10.1056/NEJMoa2209367
- Australian government offering compensation for COVID Vx deaths. https://www.servicesaustralia.gov.au/deceased-covid-19-vaccine-recipient-payments-and-funeral-costs-you-can-claim-through-covid-19?context=55953
- Need for active longitudinal surveillance with control group. https://www.nature.com/articles/d41586-021-00880-9
  - "This kind of surveillance can detect signs of rare adverse events, but most systems are not designed to determine their exact cause, says Black. That is because they only contain data for events that have been reported, and lack a comparison group to track adverse events that occur in unvaccinated populations."
  - "A more complete understanding of vaccine safety could be garnered from active surveillance systems that collect adverse event data — both background rates and after a vaccine — from electronic health records without relying on people reporting them directly. For example, the US Centers for Disease Control and Prevention collects data from nine health-care organizations across the country in the Vaccine Safety Datalink. In the consensus report from the 2018 IABS meeting, researchers called for an international network of active surveillance systems, which would allow public-health agencies to share data more easily, and hopefully determine the causes of adverse reactions quickly and definitively."
- CDC caught in lies, withholding information, spreading misinformation?
  - https://www.theepochtimes.com/exclusive-cdc-officials-told-they-spread-misinformation-but-still-didnt-issue-correction-emails_4826960.html
- CDC / FDA withholding autopsy reports despite FOIA request by Epoch Times

- https://www.theepochtimes.com/exclusive-fda-withholding-autopsy-results-from-people-who-died-after-getting-covid-19-vaccines_4763765.html
- CDC Director Rochelle Walensky admits pandemic response mistakes
  - "pretty dramatic, pretty public mistakes"
  - https://www.ft.com/content/d482491f-ed0b-41fd-ab63-195cd195b082
- "The C.D.C. Isn't Publishing Large Portions of the Covid Data It Collects"
  - https://www.nytimes.com/2022/02/20/health/covid-cdc-data.html
- CDC site on V-Safe
  - https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafe.html
- CDC V-safe data released pursuant to court order
  - https://www.prnewswire.com/news-releases/cdcs-covid-19-vaccine-v-safe-data-released-pursuant-to-court-order-301639584.html
  - https://www.foxnews.com/video/6313218294112
- ICAN's V-Safe data analysis (7.7% of 10M users required medical attention)
  - https://icandecide.org/v-safe-data/
- Duration of mRNA and Spike protein after injection
  - CDC originally (Oct 2021) stated "Our cells break down mRNA and get rid of it within a few days after vaccination" and that "Scientists estimate that the spike protein, like other proteins our bodies create, may stay in the body up to a few weeks."
    - https://web.archive.org/web/20211031174254/https:/www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/mrna.html
  - July 2022 it was modified
    - https://web.archive.org/web/20220716011916/https:/www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/mrna.html
  - But in Sept 2022 that section (both sentences above) was deleted without explanation
    - https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/how-they-work.html
  - Several studies demonstrate persistence of mRNA and / or spike protein longer than CDC's original (unsubstantiated) claims:
    - https://www.cell.com/cell/fulltext/S0092-8674(22)00076-9
    - https://pubmed.ncbi.nlm.nih.gov/35884842/
    - https://academic.oup.com/cid/article/74/4/715/6279075
    - https://pubmed.ncbi.nlm.nih.gov/34654691/

Appendix 4
Vaccine Efficacy

90-95% effective (initial promise)

- https://www.cdc.gov/mmwr/volumes/70/wr/mm7018e1.htm
- https://www.cdc.gov/mmwr/volumes/71/wr/mm7112e1.htm

100% effective against severe disease (initial promise)

- https://twitter.com/pfizer/status/1377578737680711691?lang=en
- https://www.pfizer.com/news/press-release/press-release-detail/pfizer-and-biontech-confirm-high-efficacy-and-no-serious
- https://www.science.org/content/article/absolutely-remarkable-no-one-who-got-modernas-vaccine-trial-developed-severe-covid-19
- https://www.cdc.gov/mmwr/volumes/70/wr/mm7042e1.htm

Waning immunity

- https://www.cdc.gov/mmwr/volumes/71/wr/mm7107e2.htm
- https://www.nejm.org/doi/pdf/10.1056/NEJMoa2119451?articleTools=true
- https://www.nejm.org/doi/full/10.1056/NEJMoa2115481
- https://www.nejm.org/doi/pdf/10.1056/NEJMoa2205011?articleTools=true
- https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)01185-0/fulltext
- https://www.cdc.gov/mmwr/volumes/71/wr/mm7107e2.htm?s_cid=mm7107e2_w
- https://www.nejm.org/doi/full/10.1056/NEJMoa2114228
- https://www.nejm.org/doi/pdf/10.1056/NEJMoa2210058?articleTools=true
- https://www.mdpi.com/1999-4915/14/8/1642
- https://www.frontiersin.org/articles/10.3389/fimmu.2022.919408/full
- https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2795654
- "Three-dose monovalent mRNA VE against COVID-19 -associated hospitalization decreased with time since vaccination. Three-dose VE during BA.1/BA.2 and BA.4/BA.5 periods was 79% and 60%, respectively, during the initial 120 days after the third dose and decreased to 41% and 29%, respectively, after 120 days from vaccination." https://www.cdc.gov/mmwr/volumes/71/wr/mm7142a3.htm?s_cid=mm7142a3_w
- https://pubmed.ncbi.nlm.nih.gov/36322837/
    - "Our findings suggest the need to reconsider the value and strategies of vaccinating healthy children in the omicron era with the use of currently available vaccines"
    - "Among children, the overall effectiveness of the 10-µg primary vaccine series against infection with the omicron variant was 25.7% (95% confidence interval [CI], 10.0 to 38.6). Effectiveness was highest (49.6%;

95% CI, 28.5 to 64.5) right after receipt of the second dose but waned rapidly thereafter and was negligible after 3 months"

- https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4224504
  - "but showed clear waning during the Omicron period, although VE estimates were substantially higher (above 80% to week 25, dropping to 40% by week 40) than against infection"
- https://pubmed.ncbi.nlm.nih.gov/35675841/
  - Key findings:
    - COVID mortality less than flu
    - No protection against hospitalizations
    - No protection against mortality
    - Vaccinated had increased risk of being on mechanical ventilation
- https://pubmed.ncbi.nlm.nih.gov/35675841/ ("By analyzing results of more than 460,000 individuals, we show that while recent vaccination reduces Omicron viral load, its effect wanes rapidly. In contrast, a significantly slower waning rate is demonstrated for recovered COVID-19 individuals.")
- Possible negative efficacy
  - https://www.medrxiv.org/content/10.1101/2022.09.30.22280573v1.full.pdf (preprint)
    - https://www.medrxiv.org/content/10.1101/2022.09.30.22280573v1
  - https://pubmed.ncbi.nlm.nih.gov/36151099/
    - This one takes some time to analyze
    - " For Omicron, the odds of infection were 1.10 (95%-CI: 1.00-1.21) times higher for unvaccinated, 2.38 (95%-CI: 2.23-2.54) times higher for fully vaccinated and 3.20 (95%-CI: 2.67-3.83) times higher for booster-vaccinated contacts compared to Delta. "
    - Note that for unvaccinated, Omicron and Delta were almost the same (1.1x higher). But for fully vaccinated Omicron was 2.38x higher, and for booster-vaccinated Omicron was 3.2x higher than Delta. So, prima facie it *appears* as if each successive vaccination dose made it worse for secondary attack rate during Omicron compared to Delta.
  - https://pubmed.ncbi.nlm.nih.gov/34384810/
    - Infection-enhancing antibodies have been detected in symptomatic Covid-19
    - Antibody dependent enhancement (ADE) is a potential concern for vaccines
    - Enhancing antibodies recognize both the Wuhan strain and delta variants
    - ADE of delta variants is a potential risk for current vaccines
    - Vaccine formulations lacking ADE epitope are suggested
- CDC Director Walensky: "too much optimism"

- "When the CNN feed came that it was 95% effective, the vaccine, so many of us wanted it to be helpful, so many of us wanted to say, 'Ok this is our ticket out.' So, I think we had perhaps too little caution and too much optimism for good things that came our way. I really do. I think all of us wanted this to be done. Nobody said waning, when, of these vaccines don't work. Oh well maybe they don't work at all, it'll wear off. Nobody said that if the next variant it doesn't, it's not as potent against the next variant.
- https://livestream.com/accounts/7945443/events/10161457/videos/229680766?fbclid=IwAR3qV7glhmwq9v9lnT3wPRp08oQ9rCcIoBFNaYZLfg4E2r3AdsEllHcLi84
- From July 2020:
  - https://www.sfchronicle.com/health/article/With-coronavirus-antibodies-fading-fast-focus-15414533.php
  - UCSF drops out of vaccine development due to rapidly waning antibodies

Appendix 5
Disparaging or Underestimating Natural Immunity

Disparaging natural immunity

- https://www.wsj.com/articles/the-high-cost-of-disparaging-natural-immunity-to-covid-vaccine-mandates-protests-fire-rehire-employment-11643214336
- https://www.cdc.gov/coronavirus/2019-ncov/vaccines/expect.html

No difference (i.e., natural immunity is equal or better than vaccine immunity)

- https://www.nejm.org/doi/full/10.1056/NEJMoa2118946
- https://www.nejm.org/doi/pdf/10.1056/NEJMoa2203965
- https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-022-02570-3
- Even WHO in 2021 stated natural immunity may be similar in protection. https://apps.who.int/iris/handle/10665/341241 ("To conclude, available tests and current knowledge do not tell us about the duration of immunity and protection against reinfection, but recent evidence suggests that natural infection may provide similar protection against symptomatic disease as vaccination, at least for the available follow up period")

Brownstone anthology of over 150 studies

- https://brownstone.org/articles/79-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted/

https://pubmed.ncbi.nlm.nih.gov/36224590/

- "In the 2020-2021 period indicate long-lasting and largely variant-transcending humoral immunity in the initial 20.5 months of the pandemic, in the absence of vaccination."

https://pubmed.ncbi.nlm.nih.gov/35549891/

- "Independently, we found no re-infection among those with prior COVID-19, contributing to 74,557 re-infection-free person-days, adding to the evidence base for the robustness of naturally acquired immunity."

APPENDIX 6
Unvaccinated dying at 11 times greater than fully vaccinated?

Who are the unvaccinated

- https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7034e5-H.pdf ("unvaccinated <14 (less than 14) days receipt of the first dose of a 2-dose series or 1 dose of the single-dose vaccine or if no vaccination registry data were available.)

Unvaccinated 17x more likely to be hospitalized

- https://twitter.com/cdcdirector/status/1440024215818756096
- https://twitter.com/cdcgov/status/1441115218562535432
- https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2796235

Unvaccinated 10x more likely to be hospitalized during Omicron

- https://www.medpagetoday.com/infectiousdisease/covid19vaccine/100596
- https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2796235

Washington Post Analysis (58% of all COVID deaths are now amongst the vaccinated)

- https://www.business-standard.com/article/international/vaccinated-people-now-make-majority-of-covid-deaths-in-us-report-122112400391_1.html
- https://www.washingtonpost.com/politics/2022/11/23/vaccinated-people-now-make-up-majority-covid-deaths/

CDC Data: Nearly 90% of all COVID deaths are now amongst those over 65 years old (highest ever throughout the pandemic). Washington Post Analysis

- https://twitter.com/washingtonpost/status/1597311932985667584?s=20&t=1dBFziP699CXIohv-O1rAA
- https://www.washingtonpost.com/health/2022/11/28/covid-who-is-dying/

APPENDIX 7
Examples of changes to the scientific consensus

- Aspirin is no longer recommended for primary prevention of heart attacks due to emerging evidence of increased risk of gastrointestinal hemorrhage (still recommended for secondary prevention)
  - https://connect.uclahealth.org/2022/04/26/daily-aspirin-no-longer-recommended-to-prevent-heart-disease/
  - https://www.webmd.com/heart-disease/news/20220427/aspirin-no-longer-recommended-prevent-heart-attack-stroke
  - https://www.bmj.com/content/375/bmj.n2521
- Several medications have been recalled in recent years due to concerns of carcinogenic effects not previously known
  - Ranitidine withdrawn from market
    - https://www.fda.gov/news-events/press-announcements/fda-requests-removal-all-ranitidine-products-zantac-market
    - https://journals.lww.com/ajnonline/Abstract/2020/08000/Ranitidine_Withdrawn_From_the_Market.16.aspx
  - ARB's recalled from market (ARB's are common BP medications)
    - https://www.fda.gov/drugs/drug-safety-and-availability/recalls-angiotensin-ii-receptor-blockers-arbs-including-valsartan-losartan-and-irbesartan
  - FDA's own list of recalls (371 entries)
    - https://www.fda.gov/drugs/drug-safety-and-availability/drug-recalls
- RotaShield vaccine was pulled from market in 1999 (association with fatal intussusception)
  - https://www.cdc.gov/vaccines/vpd-vac/rotavirus/vac-rotashield-historical.htm
  - https://www.reuters.com/article/rotavirus-vaccine/update-3-glaxos-rotavirus-vaccine-use-suspended-us-idUSN2221966720100322
  - https://www.wsj.com/articles/SB940801692891105660
- Swine flu vaccine halted
  - https://www.bbc.com/future/article/20200918-the-fiasco-of-the-us-swine-flu-affair-of-1976
  - https://www.history.com/news/swine-flu-rush-vaccine-election-year-1976
  - https://www.nytimes.com/1976/10/13/archives/swine-flu-progrram-is-halted-in-9-states-as-3-die-after-shots.html
  - https://www.latimes.com/archives/la-xpm-2009-apr-27-sci-swine-history27-story.html
- Recent published data confirms the benefits of statin medications in preventing heart disease may have been over stated

- https://www.healio.com/news/cardiology/20220314/metaanalysis-questions-strength-of-ties-between-statininduced-ldl-lowering-cv-outcomes
- https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2790055
  - "The study results suggest that the absolute benefits of statins are modest, may not be strongly mediated through the degree of LDL-C reduction, and should be communicated to patients as part of informed clinical decision-making as well as to inform clinical guidelines and policy."

- Thalidomide
  - "Sixty years ago (2 December 1961) the sedative drug thalidomide was withdrawn from use in the UK. After being on the market for five years as a treatment for morning sickness in pregnant women, it had finally been established that the medicine was responsible for babies being born with underdeveloped arms and legs and other malformations."
    - https://www.understandinganimalresearch.org.uk/news/sixty-years-on-the-history-of-the-thalidomide-tragedy
  - US FDA Frances Oldham is now hailed for her bravery in refusing to approve thalidomide in the US
    - https://www.fda.gov/about-fda/fda-history-exhibits/frances-oldham-kelsey-medical-reviewer-famous-averting-public-health-tragedy
    - https://www.uchicagomedicine.org/forefront/biological-sciences-articles/courageous-physician-scientist-saved-the-us-from-a-birth-defects-catastrophe
    - https://www.washingtonpost.com/national/health-science/frances-oldham-kelsey-heroine-of-thalidomide-tragedy-dies-at-101/2015/08/07/ae57335e-c5da-11df-94e1-c5afa35a9e59_story.html
      a. "In the annals of modern medicine, it was a horror story of international scope: thousands of babies dead in the womb and at least 10,000 others in 46 countries born with severe deformities."
- Beta blockers were initially not recommended in heart failure but are now standard of care
  - https://pubmed.ncbi.nlm.nih.gov/31370960/
  - https://pubmed.ncbi.nlm.nih.gov/28874420/
- Clopidogrel was previously recommended for patients with STEMI (particular type of heart attack) but this indication was subsequently removed
  - https://www.hcplive.com/view/evolving-evidence-prompts-changes-in-treatment-paradigm-for-acs

Appendix 8
Countries with different vaccine recommendations

- Denmark (under 50 years old only if higher risk)
  - https://sst.dk/en/English/Corona-eng/Vaccination-against-covid-19
- UK
  - Seasonal booster only for >50 years old and higher risk
    - https://www.nhs.uk/conditions/coronavirus-covid-19/coronavirus-vaccination/coronavirus-vaccine/
- Sweden
  - From Nov 1 onwards, only children with high risk
    - https://www.krisinformation.se/en/hazards-and-risks/disasters-and-incidents/2020/official-information-on-the-new-coronavirus/vaccination-against-covid-19/when-is-it-my-turn
- European Medicines Agency (EMA) recommends COVID-19 vaccine only for children with underlying medical conditions (not healthy children)
  - https://twitter.com/EMA_News/status/1585196429639036929

Countries that suspended Moderna mRNA COVID-19 vaccine for people under 30 years-old

- Germany, France, Denmark, Norway, Sweden, Finland
- https://www.bmj.com/content/375/bmj.n2477
- https://www.cnbc.com/2021/10/08/nordic-countries-are-restricting-the-use-of-modernas-covid-vaccine.html

Appendix 9
Covid-19 deaths and hospitalizations have been overestimated

- 40% of pediatric hospitalizations are 'with' COVID and not 'from' COVID (two California-based pediatric studies)
  - https://pubmed.ncbi.nlm.nih.gov/34011567/
  - https://pubmed.ncbi.nlm.nih.gov/34011566/
- NY: About 50% of people hospitalized 'with' COVID and not 'from' COVID
  - https://www.governor.ny.gov/news/governor-hochul-updates-new-yorkers-states-progress-combating-covid-19-131
  - https://www.healthline.com/health-news/the-difference-between-being-hospitalized-for-covid-and-with-covid
  - https://www.washingtonpost.com/outlook/2022/01/07/hospitalization-covid-statistics-incidental/
  - https://www.foxnews.com/health/almost-half-reported-ny-covid-19-hospitalizations-not-due-covid-19
  - https://www.beckershospitalreview.com/patient-safety-outcomes/hospitals-see-more-patients-with-covid-19-vs-for-covid-19.html
- Scotland: 36% hospitalized 'with' COVID (i.e., for other causes)
  - "Findings from this report concluded that 64% of patients were in hospital 'because of' COVID-19 during the period December 2021 to January 2022, as opposed to 'with' a Covid-19 diagnosis"
  - https://www.gov.scot/publications/coronavirus-covid-19-state-epidemic-04-february-2022/pages/4/
- New Study suggests almost half are hospitalized 'with' COVID
  - https://www.theatlantic.com/health/archive/2021/09/covid-hospitalization-numbers-can-be-misleading/620062/
- Orange County, CA 'with' COVID-19 increasing (many COVID-19 hospitalizations are not 'from COVID-19')
  - https://www.ocregister.com/2022/01/21/number-of-patients-hospitalized-with-covid-vs-for-covid-is-shifting/
- Median life expectancy in long term care facilities 5 months
  - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2945440/
- Nursing home deaths after vaccination
  - https://pubmed.ncbi.nlm.nih.gov/34018389/

Excess deaths (especially cardiovascular deaths)

- https://pubmed.ncbi.nlm.nih.gov/36176195/
  - "The trend of mortality suggests that age and sex disparities have persisted even through the recent Omicron surge, with excess AMI-associated mortality being most pronounced in younger-aged adults"

- Norway raises concerns about jabs for elderly
  - https://www.bloomberg.com/news/articles/2021-01-16/norway-vaccine-fatalities-among-people-75-and-older-rise-to-29
- Nursing home deaths after vaccination
  - https://pubmed.ncbi.nlm.nih.gov/34018389/
- Recent preprint study from JAPAN
  - https://www.medrxiv.org/content/10.1101/2022.10.13.22281036v1.full.pdf
  - "Myocarditis mortality rate ratios (MMRRs) and their 95% confidence intervals (95% CIs) after receiving SARS-CoV-2 vaccine compared with that in the reference population (previous 3 years) were significantly higher not only in young adults (highest in the 30s with MMRR of 6.69) but also in the elderly."
- Florida now recommends against mRNA COVID-19 for young males due to increased mortality
  - https://floridahealthcovid19.gov/wp-content/uploads/2022/10/20221007-guidance-mrna-covid19-vaccines-doc.pdf
  - "This analysis found there is an 84% increase in the relative incidence of cardiac-related death among males 18-39 years old within 28 days following mRNA vaccination" reports the updated Guidance for mRNA COVID-19 Vaccines (October 7, 2022).
- Israel: increased EMS calls for ACS and cardiac arrest associated with vaccination
  - https://pubmed.ncbi.nlm.nih.gov/35484304/
  - "the weekly emergency call counts were significantly associated with the rates of 1st and 2nd vaccine doses administered to this age group but were not with COVID-19 infection rates."

All Cause Mortality

- CDC data on mortality (cause of death) by age and year
  - https://data.cdc.gov/d/65mz-jvh5/visualization
- Society of Actuaries Research Institute Data
  - https://www.soa.org/4a368a/globalassets/assets/files/resources/research-report/2022/group-life-covid-19-mortality-03-2022-report.pdf
  - https://www.soa.org/research/research-institute/
- Younger adults dying at higher than expected rates
  - https://www.theepochtimes.com/adults-aged-35-44-died-at-twice-the-expected-rate-last-summer-life-insurance-data-suggests_4711510.html
  - https://www.theepochtimes.com/life-insurance-ceo-reveals-deaths-are-up-40-among-working-people-just-unheard-of-facts-matter_4567602.html

- Increase in all-cause mortality may be linked to vaccination
  - https://healthfeedback.org/what-can-explain-the-excess-mortality-in-the-u-s-and-europe-in-2022/

Exhibit A

SANJAY VERMA, MD FACC

Desert Care Multi-Specialty Clinic
47647 Caleo Bay Dr. Suite 210
La Quinta, CA 92253
sanjayverma@mac.com

PROFESSIONAL EXPERIENCE (Medical)

2020 – present	Desert Care Network, JFK Memorial Hospital, Indio, CA Interventional Cardiologist and Medical Director
2018 – 2020	Bay Area Hospital, Coos Bay OR Medical Director, Ambulatory Services and Cardiac Rehab Interventional Cardiologist [complex PCI, mechanical atherectomy, mechanical support (IABP, Impella), EKOS, TEE, PVI including CLI, TTE, MPI, ILR]
2016 - 2018	Pueblo Cardiology Parkview Medical Center, Pueblo CO Interventional Cardiologist
2010 - 2012	Riverside County Regional Medical Center, Moreno Valley CA Loma Linda Internal Medicine Residency Program Internal Medicine Physician (Internal Medicine Faculty and Hospitalist)

EDUCATION

2015 – 2016	Henry Ford Hospital, Detroit MI Interventional Cardiology Fellow
2012 – 2015	Henry Ford Hospital, Detroit MI General Cardiology Fellow
2009 - 2010	Riverside County Regional Medical Center (affiliated with LLUMC) Chief Medical Resident
2006 - 2009	Loma Linda University Medical Center (LLUMC), Loma Linda CA Internal Medicine Resident
1999 – 2005	Kasturba Medical College, Manipal, India M.B., B.S., *First Class*
1997 – 1999	University of California, Berkeley, Berkeley CA B.A., South Asian Studies with Philosophy minor *magna cum laude* Departmental Honors, Golden Key Honor Society
1986 – 1990	California State Polytechnic University, Pomona CA Electrical and Computer Engineering major

MEDICAL LICENSURE AND BOARD CERTIFICATIONS

American Board of Internal Medicine: Interventional Cardiology: 10/2016
American Board of Internal Medicine: Cardiovascular Disease: 10/2015
National Board of Echocardiography: Adult echocardiography: 7/2015
American Board of Internal Medicine Certification: 8/2010

Medical Board of California: License A105189 exp: 6/2024
Oregon Medical Board: License MD 186631 exp: 12/2023
Colorado Medical Board: Dr.0056532 exp: 4/2024

OR DEA Registration Number: FV1088310 Exp: 5/2022
CA DEA Registration Number: FV8944616 Exp: 5/2022

ACLS Certification: Exp: 3/2024
BLS Certification: Exp: 3/2024

PUBLICATIONS

Verma S, Burkhoff D, O'neill WW. Avoiding hemodynamic collapse during high-risk percutaneous coronary intervention: Advanced hemodynamics of Impella support. Catheterization and Cardiovascular Interventions. 2017 Mar 1;89(4):672-5.

Krishnan, S., **Verma, S.**, Cheng, M., Krishnan, R. and Pai, R.G., 2015. Left Ventricular Septolateral Mechanical Delay Is Associated with Reduced Long-Term Survival in Systolic Heart Failure with Narrow QRS Duration: Nine-Year Outcome in 109 Patients. *Echocardiography*, *32*(10), pp.1515-1519.

Naqvi TZ, Rafique AM, **Verma S**, Peter CT. AV and VV Optimization Causes Incremental Improvement in Cardiac Output and Synchrony Post Cardiac Resynchronization Treatment. Circulation 2006; 114(18): E-.

Rafique AM, **Verma S**, Peter CT, Naqvi TZ. A novel method for Non-Invasive programming of Atrioventricular and Ventriculo-Ventricular delays of Cardiac Resynchronization Devices. Circulation 2006; 114(18): E-.

Naqvi TZ, Rafique AM, Swerdlow CD, **Verma S**, Siegel RJ, Tolstrup K, Kerwin WF, Goodman JS, Gallik D, Gang ES, Peter CT. Predictors of Reduction in Mitral Regurgitation in Patients Undergoing Cardiac Resynchronization Treatment. Heart. 2008 May; Epub ahead of print. Cited in PubMed; PMID: 18467354.

POSTERS AND PRESENTATIONS

"Does Visual Grading of Myocardial Perfusion During Standard Resting Contrast Echocardiography Predict Extent of ST Segment Resolution or Lack Thereof and Angiographic No Re-Flow in Patients Presenting With ST Elevation Myocardial Infarction?" **Verma S,** Kanasagara J, Frank J, Parikh S, Ananthasubramaniam K. Henry Ford Hospital. Presented at NASCI, Scientific Sessions, New Orleans LA, 2014

"Beta Blockers Confer a Survival Benefit in Patients with Myocardial Infarction". **Verma S**, Wells K, Peterson EL, Surjanhata B, Williams LK, Lanfear DE. Henry Ford Hospital. Presented at AHA Scientific Sessions, Dallas TX, 2013

"Left Ventricular Septolateral Delay Affects Survival Independent of QRS Duration in Patients With Systolic Heart Failure: Nine Year Outcome in 119 Patients." **Verma S**, Cheng M, Krishnan S, Krishnan R, Pai RG. Presented at AHA Scientific Sessions Orlando FL, 2011

PROFESSIONAL SOCIETY MEMBERSHIPS

Fellow of the American College of Cardiology

PROFESSIONAL EXPERIENCE (other)

1991 – 1997	Project Manager, Systems Integration Projects and Industrial Engineering Various companies in Silicon Valley CA
1987 – 1990	Department Manager Bank of America, Brea, CA

PERSONAL

Languages: English, Hindi, German

Hobbies: photography, hiking, classical music, audiophile

Citizenship: USA

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

LETRINH HOANG, D.O., PHYSICIANS FOR INFORMED CONSENT, a not-for profit organization, and CHILDREN'S HEALTH DEFENSE, CALIFORNIA CHAPTER, a non-profit children's health organization

Plaintiffs,

v.

ROB BONTA, in his official capacity as Attorney General of California and, ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California ("OMBC"),

Defendants.

Case No: 2:22-cv-02147-DAD-AC

DECLARATION OF LETRINH HOANG, D.O.

Date: January 17, 2023
Time: 1:30 PM
Courtroom: 5, 14th floor (via Zoom)
Judge: Hon: Dale A. Drozd

Action Commenced: December 1, 2022

LeTrinh Hoang, D.O. declares as follows:

1. I am over the age of 18, and I have personal knowledge of the facts set forth herein. I am a plaintiff in this case, and I submit this declaration under penalty of perjury in support of our motion for a preliminary injunction. If called to testify, I would truthfully testify

as follows:

2. I am a pediatric osteopathic physician. I have been licensed by the Osteopathic Medical Board of California for more than twenty-five years. I treat children and see adults for osteopathic muscular treatments. My practice includes advising patients (and their families) about the risk versus benefits of the Covid vaccine and boosters based on the patient's medical condition and other circumstances such as age and general health status. My patients also solicit my advice regarding treatments for Covid-19, including the use of FDA approved on-label (Paxlovid), as well as off-label drugs like Ivermectin and HCQ.

3. Oftentimes, my discussions with patients and their families involve my summarizing recent studies from the U.S. and abroad. Many of these studies are not consistent with the U.S. "scientific consensus" or at least the public health authorities' pronouncements. However, these studies are consistent the public health recommendations in states like Florida and other countries –many of which have achieved far better outcomes in the prevention of Covid 19 deaths or reduction Covid 19 serious illnesses.

4. One of the things many patients want to discuss is the current vaccine booster and whether they should take it. In addition to advising patients that the booster has been authorized for use by the FDA, I advise patients that it has only been tested in less than a dozen mice, 2. The data supporting the use of booster was not reviewed by the FDA's scientific vaccine advisory committee and that Paul Offit M.D., a prominent committee member, does not recommend that children take the booster.

5. I have reviewed AB 2098 and I cannot tell from the law whether providing these facts to patients is "Covid misinformation." I discuss with them the risk factors of taking and not taking the booster based on my review of the medical literature.

6. I also routinely discuss vaccine safety with my male patients between the ages of 17 and 39, and give them accurate information about the well documented increase risk of cardiomyopathy and other cardiac serious adverse events of the mRNA shots to them.

7. Of course, I advise these patients that the mRNA Covid vaccines are fully approved by the FDA and that as such, they are considered by the contemporary scientific

consensus to be safe and effective, and the risk of serious side effects (including the above cardiac side effects) are small.

8. In addition, in my view, in order to provide patients with complete information, I think it is necessary for physicians to consider studies from around the world which reflect a different "scientific consensus" than what is the case in the United States. In addition, there is an enormous difference between vaccine rates in countries which provides important information to patients.

9. I have reviewed the Declaration of Sanjay Verma, M.D. and I am familiar with most of the scientific references referred to in it. In general, that is the kind of evidence-based information I would like the option of presenting to my patients.

10. However once Section 2270 takes effect, I cannot tell from the law if I can do so without risking being investigated for Covid misinformation. Although what I am saying is true and accurate, some of content may not be consistent with the "contemporary scientific consensus" and it might not be in accordance the Osteopathic Board's view of the standard of care. I am unaware of any guidance provided by my Board on these issues.

11. I feel as though it would be a risk to my license to provide this kind of arguably non-US scientific consensus-based information to patients.

12. To put it simply, to me and many other osteopathic physicians, the new law is unclear as to what I can and cannot tell to patients. Specifically, are physicians allowed to present any truthful, factually accurate information from the scientific literature which challenges the public health narrative that vaccine is safe and effective for everyone, and that side effects are so rare as to be of no concern to anyone contemplating the initial vaccine or boosters.

13. I have the same issues regarding patients who seek out information or advice from me about the off-label Covid treatments. Am I required to only relate the FDA's position (and the FDA has recently been revising its position on these drugs, and it is now at most just a recommendation against them.) Am I permitted to discuss the many published scientific studies supporting their use, so long as I advise patients that these studies do not represent the

consensus opinion of the FDA and the mainstream scientific community? And then can I let the patient (or parent) decide? Or do I have to limit my discussions to what the FDA says and disregard the many published studies showing a benefit.

14. I have seen up close what happens to physicians who are investigated by the California medical boards. It is a very stressful and expensive process, and it is something that I would like to avoid. I know many physicians who feel the same way I do. Some will self-censor and simply refuse to give any advice to their patients about Covid vaccines and treatments. Others will risk board investigation and discipline despite the risk and lack of clarity in the law.

15. However, my intention and plan is to provide what I know to be true and accurate information about the Covid vaccines and Covid treatments regardless of whether this accurate information is inconsistent with the contemporary scientific consensus and/or a future determination by my board that relaying accurate information to my patients can be a violation of the standard of care under the new law.

16. For the Court's information, as far as I know, there is no such thing as a Covid treatment which consists solely of a physician's speech.

17. Finally, I have reviewed the factual information about me in the Complaint and it is true and correct.

December 5, 2022

Le Trinh Hoang, D.O.

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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

LE TRINH HOANG, D.O., PHYSICIANS FOR INFORMED CONSENT, a not-for-profit organization, and CHILDREN'S HEALTH DEFENSE, CALIFORNIA CHAPTER, a California Nonprofit Corporation

Plaintiffs,

v.

ROB BONTA, in his official capacity as Attorney General of California and, ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California ("OMBC"),

Defendants.

Case No: 2:22-cv-02147-DAD-AC

DECLARATION OF SHIRA MILLER, M.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Date: January 17, 2023
Time: 1:30 PM
Courtroom: 5, 14th floor (via Zoom)
Judge: Hon: Dale A. Drozd

Action Commenced: December 1, 2022

SHIRA MILLER, M.D. declares as follows:

1. I am over the age of 18, and I have personal knowledge of the facts set forth herein. I am the Founder and President of Physicians for Informed Consent ("PIC") which is a

Plaintiff in this case. I submit this declaration under penalty of perjury in support of our motion for a preliminary injunction. If called to testify, I would truthfully testify as follows:

2. First, I have reviewed the factual allegations in the Complaint concerning PIC, and I can attest that the information is true and correct.

3. PIC is a 501(c)(3) nonprofit educational organization whose mission is, among other things, to deliver data on infectious diseases and vaccines, and unite doctors, scientists, healthcare professionals, attorneys, and families who support voluntary vaccination. The vision of PIC is that doctors and the public are able to evaluate the data on infectious diseases and vaccines objectively, and voluntarily engage in informed decision-making about vaccination.

4. PIC produces educational materials on infectious diseases and vaccines, with a focus on science and statistics. During the pandemic, PIC has produced COVID-19 Disease Information Statements (DIS) and COVID-19 Vaccine Risk Statements (VRS) and public service announcements, which contain data collated from peer-reviewed published medical literature from the U.S. and around the world but may or may not be contrary to the "contemporary scientific consensus" in California at a particular moment. It is not clear if under AB 2098 it will be illegal for physicians in California to distribute PIC's educational documents regarding COVID-19 to their patients.

5. Assembly Bill 2098, due to its lack of clarity and censorship of physician speech, has alienated and outraged physicians in our group and already some PIC physicians have moved out of state, or are thinking about moving out of state if the law goes into effect.

6. As president of PIC, I am privy to both confidential and public communications to the organization from the general public, from inquiries through our website and social media to inquiries at our events. I am also privy to communications with our physicians, both individually and in our confidential and private web forum. There is no question in my mind based on these conversations that AB 2098 will cause a chilling effect on some physicians, while other physicians will continue to educate their patients and express their medical opinion—even if they have to move and obtain a medical license in another state. Additionally, PIC has received threats that its doctors will lose their medical licenses

unless we remove our COVID-19 educational documents from the PIC website, as it is presumed that our doctors will be discussing the documents with their patients. Although the names of nearly all of our physician members are confidential, information about our leadership and founding members is public.

7. For the Court's information, as far as I know, there is no such thing as a Covid treatment which consists solely of a physician's speech.

8. Notably, there is an inadvertent conflation in paragraph 73 of the Complaint that I would like to clarify. The risk to young males of a cardiac adverse event due to mRNA vaccination (such as the Pfizer vaccine) is different than the risk to young females of a clotting adverse event due to the adenovirus vector vaccine by Janssen (Johnson & Johnson). As the CDC stated: "On April 13, 2021, CDC and FDA recommended a pause in the use of Janssen COVID-19 vaccine after reports of thrombosis with thrombocytopenia syndrome (TTS), a rare condition characterized by low platelets and thrombosis, including at unusual sites such as the cerebral venous sinus (cerebral venous sinus thrombosis [CVST]), after receipt of the vaccine.* ACIP rapidly convened two emergency meetings to review reported cases of TTS, and 10 days after the pause commenced, ACIP reaffirmed its interim recommendation for use of the Janssen COVID-19 vaccine in persons aged ≥18 years, but included a warning regarding rare clotting events after vaccination, primarily among women aged 18–49 years (3)." https://www.cdc.gov/mmwr/volumes/71/wr/mm7103a4.htm. See also the declaration of Sanjay Verma, M.D., page 7, section III ("The Safety of COVID-19 Vaccines"), in support of preliminary injunction.

December 6, 2022

Shira Miller, M.D.

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

LETRINH HOANG, D.O., PHYSICIANS FOR INFORMED CONSENT, a not-for-profit organization, and CHILDREN'S HEALTH DEFENSE, CALIFORNIA CHAPTER, a California Nonprofit Corporation,

Plaintiffs,

v.

ROB BONTA, in his official capacity as Attorney General of California and, ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California ("OMBC"),

Defendants.

Case No: 2:22-cv-02147-DAD-AC

DECLARATION OF DEBBIE HOBEL IN SUPPORT PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Date: January 17, 2023
Time: 1:30 PM
Courtroom: 5, 14th floor (via Zoom)
Judge: Hon: Dale A. Drozd

Action Commenced: December 1, 2022

I, Debbie Hobel, declare as follows:

1. My family currently lives in Ventura County. My son M.H. is a 16-year-old who attends school in Oxnard Union High School District. He is in his junior year.

2. We are former patients of Dr. Hoang and would gladly make an appointment to see her again to discuss Covid-19. We currently see an Osteopath in our County who is very conventional in his advice and recommendations – he is recommending the Covid-19 boosters, but we want a second opinion from Dr. Hoang. We like our local osteopath a lot (he has a good rapport with my son), but we do want a second opinion.

3. In our family we are not against Covid-19 vaccination. Each member of our family received Covid-19 vaccinations last year. We are pro informed consent, and I am a health freedom member of the group Physicians for Informed Consent. M.H. received two doses of the Pfizer vaccine. However, after my husband received a Covid-19 vaccine in October 2021, he immediately suffered a sore arm, which then became inflammation throughout his arm and hand. He is a musician so he had to stop playing piano professionally for a while because the adverse reaction has been so bad. He needs to wear splints on his fingers every day. It has been over one year and his fingers still do not function properly. He can now play some piano again but with diminished capacity. It's been really difficult for us.

4. M.H. has had intermittent breathing problems that have been difficult to diagnose and treat. Our osteopath sent us to a specialist (pediatric pulmonologist), who suggested it could be stress-related but he didn't know.

5. I am filing this declaration because I want Dr. Hoang to be free to speak candidly with me about her recommendations and how she may see things differently than our local osteopath. In the past, we found Dr. Hoang to be knowledgeable and we trust her. At this point the only thing that stands in the way for us is AB 2098. We're anticipating multiple appointments with Dr. Hoang and our local osteopath and we don't want AB 2098 interfering with our first opinion (local osteopath) or second opinion (Dr. Hoang).

6. I think our local osteopath is only telling me the CDC's recommendations, so I feel his advice is incomplete for the kind of informed consent that I'm looking for. I fear he

might just tell us to take the boosters for fear of board investigation. Either way, it seems like AB 2098 is already stressing out my relationships with doctors. For example, how can I be sure that our osteopath will put my family's health interests above his personal interests so he can stay out of trouble with the board? It's not an unrealistic concern on his part. I sympathize with his situation, and Dr. Hoang's.

7. My plan at this point is just to wait to make future medical appointments on Covid-19 vaccines with our osteopath and Dr. Hoang until I know whether AB 2098 is considered unconstitutional in court. If the law is constitutional, I figure there is really no point in me going to Dr. Hoang for a second opinion because I would just get her in trouble asking her for candid advice. I suppose one option would be to travel out of State for a second opinion, but that just seems outrageous. I am hoping a court can fix this for families like mine.

I declare under penalty of perjury that the above information is true and correct. Signed this 1st day of December 2022, in Oxnard, California.

Debbie Hobel

Debbie Hobel

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

LETRINH HOANG, D.O., PHYSICIANS FOR INFORMED CONSENT, a not-for profit organization, and CHILDREN'S HEALTH DEFENSE, CALIFORNIA CHAPTER, a California Nonprofit Corporation,

Plaintiffs,

v.

ROB BONTA, in his official capacity as Attorney General of California and, ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California ("OMBC"),

Defendants.

Case No: 2:22-cv-02147-DAD-AC

DECLARATION OF JAMIE COKER-ROBERTSON IN SUPPORT PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Date: January 17, 2023
Time: 1:30 PM
Courtroom: 5, 14th floor (via Zoom)
Judge: Hon. Dale A. Drozd

Action Commenced: December 1, 2022

1. I, Jamie Coker-Robertson, am the mother of a 14-year-old child (SS). I am making this declaration from my personal experience. SS has been a patient of Dr. Hoang her whole life, since birth. SS is healthy and unvaccinated for Covid-19.

2. SS has a routine medical appointment with Dr. Hoang in February 2023, where I know we'll discuss Covid-19 and vaccination because of the pandemic. I will be present during the appointment, and I have lots of questions for Dr. Hoang, some of which are detailed because I want to get her honest opinion on scientific developments, such as risk of myocarditis.

3. Dr. Hoang advised us that she is a plaintiff in this case, and that she has a plan to provide our family with independent advice and treatment from her integrative medicine perspective, but also she will let us know conventional information from the CDC.

4. In preparation for the appointment, Dr. Hoang shared with me two declarations in support of a motion for preliminary injunction in this case: her own declaration and the declaration of Sanjay Verma, MD.

5. I want to be assured that my daughter's appointment in February (and any future appointment) is free from undue influence by the osteopathic medical board. As long as AB2098 is a law in California, I will never be able to trust that my physician patient relationship is truly sacrosanct. I feel violated by AB2098.

6. AB2098 forces me into a predicament regardless of the outcome of our appointment, meaning that in February either (1) Dr. Hoang will violate AB2098 by providing me candid information outside "contemporary scientific consensus" exactly like the preliminary injunction declarations say will happen, or (2) Dr. Hoang will self-censor herself to my family's detriment.

7. But as long as AB2098 is the law, how am I *really* supposed to know there is no self-censorship? AB2098 is an outrageous intrusion to our doctor-patient relationship.

8. I have asked Dr. Hoang to file this declaration in court in the hopes that AB2098 can be enjoined before I'm forced into this predicament at our next doctor appointment.

I declare under penalty of perjury that the above information is true and correct.

Signed on December 2, 2022, at Fountain Valley, California.

Jamie Coker-Robertson

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

LETRINH HOANG, D.O., PHYSICIANS FOR INFORMED CONSENT, a not-for profit organization, and CHILDREN'S HEALTH DEFENSE, CALIFORNIA CHAPTER, a California Nonprofit Corporation,

Plaintiffs,

v.

ROB BONTA, in his official capacity as Attorney General of California and,
ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California ("OMBC"),

Defendants.

Case No. 2:22-cv-02147-DAD-AC

DECLARATION OF SHANNEN POUSADA IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Date: January 17, 2023
Time: 1:30 PM
Courtroom: 5, 14th floor (via Zoom)
Judge: Hon: Dale A. Drozd

Action Commenced: December 1, 2022

I, Shannen Pousada, declare as follows:

1. I am a Licensed Vocational Nurse in California, and I am providing this declaration from my personal experience.

2. I work per diem work locations for Kaiser Permanente in Walnut Creek, California. I have worked for Kaiser for 29 years.

3. Throughout the pandemic, Kaiser has required COVID-19 vaccination for employees. So I was COVID-19 vaccinated on 9/10/21.

4. Ten days after my 9/10/21 COVID-19 vaccination, I suffered a heart attack. Before the COVID-19 vaccination I was in excellent health. As I will explain below, my physicians concluded that other than my COVID-19 vaccination, there was no reasonable explanation for my heart attack. I was (at the time) 50-years old and had no history (and no family history) of heart problems before COVID-19 vaccination. The admitting hospital also reported my case to VAERS, as a likely vaccine related injury.

5. After you suffer a heart attack following a COVID-19 vaccination, you go through many physician appointments. You see specialists, many tests. It's a laborious process involving lots of physician-patient interaction.

6. During my physician appointments, Kaiser physicians repeatedly told me that it was wrong (misinformation) that the COVID-19 vaccine could cause my heart attack. Accordingly, my physicians gave me lots of tests in their hopes of finding something else wrong with me (so they could ascribe the heart attack to something other than my COVID-19 vaccine). Every test showed I was otherwise healthy, save for this one heart attack 10-days post vaccination. Eventually my physicians were forced to admit the misinformation - the COVID-19 vaccination was the likely cause of my heart attack. The State of California, by contrast, never examined me but summarily disagreed with my physicians' conclusion that the COVID-19 vaccine caused my heart attack (primarily because the cardiologist could not find like cases to compare, as I personally observed doctors censoring vaccine injury for fear of being labeled misinformation spreaders). Apparently, the State of California considers my health experience to be misinformation.

7. If this had happened to me after AB 2098, during the months' long process of appointments and tests and legal paperwork, it would have been *impossible* for me to receive a diagnosis and for my employment claims to be processed. And I had major issues finding a physician

to sign my exemption, as I was in true fear of being vaccinated again for COVID-19. No physician in California would sign.

8. My experience shows how AB 2098 will interfere with more than just garden-variety patient appointments. AB 2098 disrupts legal processes such as workers' compensation claims. Indeed, as a registered nurse, I observe many medico-legal issues where physicians must be free to discuss COVID-19, such as medical exemptions required for employment (which is a form of disability accommodation).

9. My experience also shows the legal predicament caused by AB 2098, even before it has become law, in the employment law context. Kaiser is both my employer and my healthcare provider. They originally tried to deny my COVID-19 vaccine likely caused my heart attack, but ultimately a Kaiser MD admitted it. If AB 2098 had been the law, they would have been prohibited from engaging in multiple legal processes: such as disability accommodation and legal claims processing. It is obvious the conflicts of interest that are exacerbated by AB 2098 as my employer mandates a vaccine they are not free to discuss, and then treats a vaccine injury they are not free to discuss, and then processes employment claims they are not free to discuss. If AB 2098 is upheld, it will deny procedural due process for employees/patients like me.

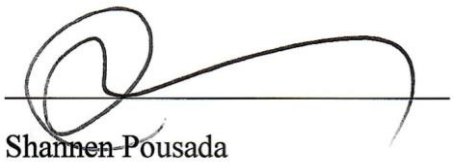
10. I am a member of the group Physicians for Informed Consent. I am providing this declaration because I think it's the right thing to do. I never asked Kaiser for any money for my vaccine injury. I just wanted them to continue covering my health insurance for my heart injury, which I think is reasonable. As long as AB 2098 is the law, I don't know what to expect with my legal claims process in the future, and because the vaccine is live in my system, I could have another heart attack at any time. It's very scary, and unfair.

11. My experience shows that even before AB 2098, my Kaiser physicians were unwilling to participate in reporting negative information about the COVID-19 vaccine. That they originally denied the obvious causation of my heart attack is emblematic of how negative information is suppressed for fear of increasing vaccine hesitancy. While there is a possibility my medical and legal situation can improve in 2023, if AB 2098 is deemed constitutional, that possibility is significantly diminished for me. And it would be even worse for people suffering COVID-19 vaccine injury in 2023

and beyond, because their physicians will not be willing to document their observation of so-called "misinformation" necessary to resolution of legal claims.

I declare under penalty of perjury that the above information is true and correct.

Signed this 5TH day of December 2022.



Shannen Pousada