

From: \_\_\_\_\_

**Re: COVID Vaccine Mandate**

DATE

As a \_\_\_\_\_ (type of health care provider) with over \_\_\_ years of clinical practice, I have dedicated my life to providing the highest quality healthcare possible and advocating for those with whom I serve in delivering that care.

At the beginning of the pandemic I saw this as a time to put the needs of others ahead of the wellbeing of myself and family and consider it an honor to have worked alongside countless others willing to make a similar sacrifice.

It is for these reasons I feel compelled to make an appeal to hospital leadership for reconsideration of a vaccine mandate as terms of ongoing employment that could result in losing up to 20% of your workforce.

**The following information is not intended as an argument against vaccination per se, but against a policy mandating these vaccines as terms of employment.**

The current vaccines created under the WARP SPEED initiative and approved for emergency use authorization (EUA) deserve close scrutiny from a safety and efficacy perspective if such a mandate should be enacted.

### **Vaccine Safety**

Data reported by the Vaccine Adverse Event Reporting System (VAERS) show that between Dec. 14, 2020 and Sept. 3, 2021, a total of [675,593 adverse events](#) following COVID vaccines were reported to the Vaccine Adverse Event Reporting System (VAERS). The data included a total of [14,506 reports of deaths](#) — an increase of 595 over the previous week.

The VAERS reporting system includes reports from outside the US. Under FDA regulations, if a manufacturer is notified of a foreign case report that describes an event that is both serious and unexpected they are required to submit it to VAERS.

It is well documented that VAERS is passive reporting system and only captures a small fraction of actual vaccine adverse events. A federal study performed by Harvard consultants on behalf of the Agency for Healthcare Research and Quality (AHRQ) found that "[fewer than 1% of vaccine adverse events](#)" are ever reported to VAERS. Given the gross under-reporting by VAERS, the numbers cited above represent just the tip of the iceberg for COVID vaccine injuries.

Potential for COVID-19 vaccines to trigger aberrant immune responses resulting in antibodies to human tissue through a process called [molecular mimicry](#). This occurs when antibodies developed against the vaccine spike protein cross-react with human proteins that share the same peptide sequences capable of triggering autoimmune pathologies that may not be immediately apparent or associated with the vaccine. [Vaccine-induced autoimmunity](#) from autoimmune cross-reactivity is associated with narcolepsy, Guillain-Barré syndrome, multiple sclerosis, demyelinating neuropathies, systemic lupus erythematosus, and postural orthostatic tachycardia syndromes.

Another potential outcome from these novel vaccines is the risk of exacerbating COVID-19 severity via [antibody-dependent enhancement](#) (ADE). An article published in Nature states *“Antibody -based drugs and vaccines against severe acute respiratory syndrome coronavirus (SARS-CoV-2) are being expedited through preclinical and clinical development. Data from the study of SARS-CoV and other respiratory viruses suggest that anti-SARS-COV-2 antibodies could exacerbate COVID-19 infection through antibody-dependent enhancement (ADE). Previous respiratory syncytial virus and dengue virus vaccine studies revealed human clinical safety risks related to ADE, resulting in failed vaccine trials.”* <https://www.nature.com/articles/s41564-020-00789-5>

The lack of redress should injury or death occur to a recipient of a vaccine is undeniable given the indemnification of vaccine manufacturers provided by the [PREP Act](#). The Act provides immunity from tort liability claims through the Countermeasure Injury Compensation Program, or CICIP, run by the Health Resources and Services Administration (HRSA) .

Since the newly licensed Comirnaty vaccine is not yet available, the FDA [decrees](#) that the Pfizer-BioNTech vaccine under the EUA should remain unlicensed but can be used “interchangeably” ([page 2, footnote 8](#)) with the newly licensed Comirnaty product. Despite the fact that FDA considers these two vaccines interchangeable, there is a very significant legal distinction between vaccine products used under an EUA compared with those that FDA has fully licensed. EUA products are [experimental](#) under U.S law with liability protections provided by the PREP Act.

Congress [created a fund](#) specifically to help cover lost wages and out-of-pocket medical expenses for people who have been irreparably harmed by a "covered countermeasure," such as a vaccine. But according to [CNBC](#) it is difficult to use and rarely pays. Attorneys say it has compensated less than 6% of the claims filed in the last decade. If a case for compensation through the CICIP is successful, the program only provides [up to \\$50,000 per year](#) in unreimbursed lost wages and out-of-pocket medical expenses and it won't cover legal fees or anything to compensate for pain and suffering.

The only exception to the PREP Act's blanket liability protection for industry is when a victim can show evidence of a manufacturer's “willful misconduct.” According to a recent

[Emory Law Review](#) to be held liable the defendant must have committed an act or omission that it undertook: “(i) intentionally to achieve a wrongful purpose; (ii) knowingly without legal or factual justification; and (iii) in disregard of a known or obvious risk that is so great as to make it highly probable that the harm will outweigh the misconduct,” which is a defined term in the statute.

Defendants also cannot be liable for willful misconduct if the person in question “acted consistent with applicable directions, guidelines, or recommendations” of the HHS Secretary. Furthermore, unless the HHS Secretary or the Attorney General has initiated an enforcement action regarding the alleged willful misconduct, the act or omission cannot constitute willful misconduct under the PREP Act.

With access only to an administrative tribunal, with a one-year statute of limitations, and with no opportunity for appeal or review in any court, consumers have exceptionally limited recourse under the PREP Act.

### **Vaccine Efficacy**

An excellent review of the vaccine’s efficacy against the now predominant delta strain was released September 9<sup>th</sup> by Nina Pierpont, MD PhD. Dr. Piermont is a graduate from Yale University with a BA in Biology, an MA PhD from Princeton in population biology/evolutionary biology and ecology and an MD degree from Johns Hopkins. The article is entitled “[COVID-19 Vaccine Mandates Are Now Pointless: COVID-19 vaccines do not keep people from catching the prevailing Delta variant and passing it to others](#)”. [September 9, 2021 Nina Pierpont, MD, PhD.](#)

The article summarizes findings from Massachusetts to Vietnam to the UK comparing the vaccine’s promising efficacy against the original SARS-CoV-2 strain in contrast to the vaccine’s inability to prevent infection with delta variant and also reviews the Israeli findings regarding acquired immunity from infection vs vaccine induced immunity which showed that vaccination without prior infection was associated with 13 times greater probability of becoming infected compared to previously infected. <https://theexpose.uk/wp-content/uploads/2021/09/Pierpont-Why-mandated-vaccines-are-pointless-final-1.pdf>

Furthermore, on August 6<sup>th</sup> [Public Health England reported](#) 742 deaths from the Delta COVID variant. Out of the 742 deaths, 402 were fully vaccinated and 79 had received one COVID vaccine injection. Only 254 of the deaths occurred in those unvaccinated. To break the data down further, there were 402 deaths out of 47,008 cases in the vaccinated and 253 deaths out of 151,054 in those unvaccinated.

**Table 5. Attendance to emergency care and deaths of confirmed and provisional Delta cases in England by vaccination status (1 February 2021 to 2 August 2021)**

Variant	Age group (years)**	Total	Cases with specimen date in past 28 days	Unlinked	<21 days post dose 1	≥21 days post dose 1	Received 2 doses	Unvaccinated
Delta cases	<50	265,749	84,772	28,330	23,822	40,449	25,536	147,612
	≥50	33,736	13,803	2,989	195	5,640	21,472	3,440
	All cases	300,010	98,722	31,841	24,018	46,089	47,008	151,054
Cases with an emergency care visit§ (exclusion‡)	<50	8,449	N/A	70	756	1,127	694	5,802
	≥50	1,940	N/A	10	15	326	1,098	491
	All cases	10,391	N/A	82	771	1,453	1,792	6,293
Cases with an emergency care visit§ (inclusion#)	<50	10,975	N/A	119	953	1,368	864	7,671
	≥50	3,342	N/A	24	30	486	1,815	987
	All cases	14,319	N/A	145	983	1,854	2,679	8,658
Cases where presentation to emergency care resulted in overnight inpatient admission§ ((exclusion‡)	<50	1,970	N/A	35	136	203	153	1,443
	≥50	1,059	N/A	7	12	125	620	295
	All cases	3,030	N/A	43	148	328	773	1,738
Cases where presentation to emergency care resulted in overnight inpatient admission§ (inclusion#)	<50	3,084	N/A	61	211	298	224	2,290
	≥50	2,074	N/A	20	23	230	1,131	670
	All cases	5,159	N/A	82	234	528	1,355	2,960
Deaths within 28 days of positive specimen date	<50	71	N/A	2	4	4	13	48
	≥50	670	N/A	5	6	65	389	205

SARS-CoV-2 variants of concern and variants under investigation

Variant	Age group (years)**	Total	Cases with specimen date in past 28 days	Unlinked	<21 days post dose 1	≥21 days post dose 1	Received 2 doses	Unvaccinated
	All cases	742	N/A	8	10	69	402	253

Data sources: Emergency care attendance and admissions from ECDS, deaths from PHE daily death data series (deaths within 28 days). NHS trusts are required to submit emergency care attendances by the 21<sup>st</sup> of each month. As a result, the number of cases with attendances may show substantial increases in technical briefs prepared after the monthly cut-off, compared with other briefs from the same month.

As months pass since vaccinations, countries from around the world are experiencing a surge in vaccinated deaths and hospitalizations. 60% of hospitalizations in Israel are fully vaccinated patients. (Hence the rush for boosters.)

Associate Editor of the British Medical Journal (BMJ) [Peter Doshi](#), voiced numerous reservations in November of 2020, comments which now seem prescient.

*“First, a relative risk reduction is being reported, not absolute risk reduction, which appears to be less than 1%. Second, these results refer to the trials’ primary endpoint of covid-19 of essentially any severity, and importantly [not the vaccine’s ability to save lives](#), nor the [ability to prevent infection](#), nor the efficacy in important subgroups (e.g. frail elderly). Third, these results reflect a time point relatively soon after vaccination, and we know nothing about vaccine performance at 3, 6, or 12 months...”*

In an August 25<sup>th</sup> article published by [Newsweek](#), COVID case data from Israel suggests that vaccination alone is not enough to completely halt the pandemic.

*“Scientists around the world have closely watched Israel to see how vaccinations could affect the pandemic, since the country launched a rapid vaccination campaign in*

*December 2020. This saw more than half of its population fully vaccinated as early as March this year. Yet Israel currently has one of the worst rates of biweekly COVID cases per million people in the world as the country battles the delta variant, according to figures collected by [OurWorldInData](#) as of August 24.”*

To summarize, there is mounting evidence that these products are failing to prevent infection among the vaccinated or prevention of disease transmission from the vaccinated to the unvaccinated. Perhaps the most illogical aspect of this blanket policy is the requirement that those with prior infection and therefore lasting immunity are not exempt from this mandate which runs counter to basic immunology. All of this would suggest that the stated goal of the mandate, i.e., to prevent disease transmission from HCW to patient, cannot be accomplished via vaccines alone. Put another way, we cannot vaccinate ourselves out of this pandemic.

### **Ethical Considerations**

If the aforementioned concerns regarding safety and efficacy fail to persuade leadership to seek a change in course, then one should consider this action an affront to basic human rights and a violation of the Nuremberg code by coercing employees under threat of termination of employment to take vaccines that are still under EUA classification, Pfizer being the noted exception (see above comments regarding Comirnaty).

The demographic most likely to refuse to comply with this mandate are nurses of child bearing age due to concerns these vaccines could have on reproductive health. Leadership should be cautious in disregarding these concerns given [NIH has recently allocated \\$1.67 million](#) to five institutions to explore potential links between COVID-19 vaccination and menstrual changes.

<https://www.nichd.nih.gov/newsroom/news/083021-COVID-19-vaccination-menstruation>

I do not request exemption based on religious beliefs or a pre-existing medical condition, but on the verifiable information provided which I hope you will find time to review. One size does NOT fit all. Vaccination, history of prior infection, or weekly/bi-weekly consent to testing seems a commonsense solution to this issue. I do, however, request exemption from this vaccine mandate for myself and countless others, who from day one, have been willing to risk their lives to answer the call of serving others in times of unparalleled need and will continue to do so should this mandate be reversed.

Respectfully submitted,

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