No. 24-

In the Supreme Court of the United States

PIERRE KORY, M.D., LE TRINH HOANG, D.O., BRIAN TYSON, M.D., PHYSICIANS FOR INFORMED CONSENT, a not-for-profit corporation, and CHILDREN'S HEALTH DEFENSE, a not-for-profit corporation,

Applicants,

v.

ROB BONTA, in his official capacity as Attorney General of California, REJI VARGHESE, in his official capacity as Executive Director of the Medical Board of California, ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California

Respondents

To the Honorable Elena Kagan, Associate Justice of the United States Supreme Court and Circuit Justice for the Ninth Circuit

This Application Raises First Amendment Issues Similar/Complementary to *Stockton v. Ferguson*, 24A440, Set for Conference on January 10, 2025

Application for Injunction

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QUESTIONS PRESENTED

1. According to the district court and the Ninth Circuit, all speech between a doctor and a patient is unprotected by the First Amendment because it is all medical conduct or incidental to medical care or treatment. Is that correct under *Nat'l Inst. of Fam. & Life Advocs. v. Becerra*, 585 U.S. 755 (2018) ("*NIFLA*")?

2. If not, are the information, opinions, and recommendations made by physicians to patients about Covid to be analyzed by content and viewpoint analysis and authority which has held that this type of speech is fully First Amendment protected?

3. If strict scrutiny applies to Respondents' enforcement program of threatening to investigate and sanction California physicians for such speech, have the Applicants established the modified *Winter* factors for obtaining a preliminary injunction based on the preliminary injunction record?

4. Specifically, does the absence of any evidence in the preliminary injunction record that less restrictive means were considered and rejected require a finding that Respondents failed to meet their strict scrutiny burden of proof?

5. Were the lower courts incorrect in characterizing this lawsuit as making a facial challenge to the words of the California disciplinary statute or an

"as applied" challenge, as opposed to a challenge to a multi-year, executive and legislative enforcement policy of threatening physicians with sanctions for providing information and recommendations contrary to the mainstream Covid narrative?

6. As a matter of law, based on the record, and *de novo* review, have Applicant physicians established their standing to challenge the Respondents' enforcement policy, and/or have the Applicant organizations established standing to assert the right of patients to hear the information targeted by the Respondents under *Murthy v. Missouri*, 603 U.S. 43 (2024)?

7. Given the nationwide scope of efforts to discipline physicians for protected speech, the media's cajoling the medical boards to sanction more physicians for their protected speech, and the impact of such efforts on the publics and patients' right to hear divergent viewpoints, should this Court intervene now and in the related case of *Stockton v. Ferguson*, 24A440, and enter an injunction, or a stay and convert this Application into a petition for certiorari and decide this case and *Stockton* at the same time or as consolidated cases?

PARTIES TO THE ACTION AND RULE 29.6 STATEMENT

Applicants in this proceeding were the plaintiffs in the California district court case, and the appellants in the Ninth Circuit appeal. They are individuals Pierre Kory, M.D., Le Trinh Hoang, D.O., Brian Tyson, M.D, Physicians for Informed Consent ("PIC"), a not-for-profit corporation without a parent corporation, and Children's Health Defense, ("CHD") a domestic not-for-profit corporation incorporated under the laws of the State of California (which does not have a parent corporation, or issue stock).

Respondents were the defendants in the district court case and the appellees in the Ninth Circuit appeal. They are Rob Bonta in his official capacity as the California Attorney General, and Kyle S. Karinen, in his official capacity as Executive Director of the Medical Board of California and Erika Calderon, Executive Director of the Osteopathic Board of California. All three Defendants/ Respondents are jointly represented.

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APPLICATION

TO THE HONORABLE ELENA KAGAN, ASSOCIATE JUSTICE OF THE SUPREME COURT AND CIRCUIT JUSTICE FOR THE NINTH CIRCUIT:

Pursuant to Rules 20, 22 and 23 of the Rules of this Court, and 28 U.S.C. section 1651, Applicants are submitting this request for an injunction stopping Respondents from continuing their enforcement program targeting the information, opinions, and recommendations on Covid-19 which California licensed physicians may provide to patients.

Applicants are requesting that this Honorable Justice refer this matter to the entire court, so that it can reiterate its prior rejection of the professional speech doctrine in *NIFLA,* which both the district court and the Ninth Circuit are attempting to reestablish.

Furthermore, this application is closely related to an application Applicants' counsel have filed in *Stockton v. Ferguson*, 24A440 (and which has one common applicant, CHD). *Stockton* is scheduled for conference on January 10, 2025. This case (*Kory*) deals with physician speech to patients, whereas *Stockton* deals with physicians' public speech.

The case law is the same, as are the principle constitutional tools of content and viewpoint analysis, and both cases focus on the speech versus conduct dichotomy.

Further, the lower courts in both cases have under read *NIFLA* in the same way, that all physician speech is unprotected because it is regulatable conduct or incidental to regulable conduct, and hence purportedly excepted from *NIFLA*'s

rejection of the professional speech doctrine.

In addition, the judges in both cases have mischaracterized Applicants' case as asserting an as applied challenge to the medical boards'/commission's primary disciplinary statute. In actuality, both cases are constitutional challenges to each board's enforcement policy and practice of sanctioning physicians for their protected speech, which is neither a facial challenge to the words of the statute nor an applied statutory challenge to only the named applicants. The challenge to the specific statutes were limited to overbreadth, or closely related concepts like vagueness.

By deciding the cases together, the Court can articulate clear and comprehensive guidelines on governmental restrictions and oversight of speech by professionals to the public and to patients/clients. This is much needed given the widespread national campaign by private actors and the media that the government has the unfettered right to censor physicians' speech when it disagrees with the expressed viewpoint.

Applicants are requesting that the Court issue a stay of all proceedings in this case, and all cases before both California medical boards predicated on the protected speech of California licensed physicians, and convert this application into a petition for a writ of certiorari.

DECISIONS BELOW

The decisions below are styled as *Pierre Kory, M.D. et al. v. Rob Bonta, et al.*

On Apil 23, 2024, the U.S. District Court for the Eastern District of California denied Applicants' motion for a preliminary injunction, and held that

plaintiffs lacked standing to make an as applied challenge to Business and Professions Code Section 2234 (c). Case No. 2:24-cv-00001-WBS, reproduced at 6a-32a.

Applicants' interlocutory appeal to the Ninth Circuit (Case No. 24-2946) was denied by unpublished memorandum decision dated November 27, 2024, reproduced at 1a-5a.

RULE 23.3 STATEMENT

Applicants did not move for a stay in the Ninth Circuit, but seek review under Supreme Court Rule 23.3 "extraordinary circumstances" based upon a showing "with particularity why the relief sought is not available in any other court," *In re United States*, 138 S. Ct. 371, 375 (2017). The extraordinary circumstances justifying not requesting relief below arose after the Ninth Circuit denied the *Stockton* Applicants' Rule 8(a)(2) motion whereupon it became clear that the lower court was not following *NIFLA,* and content and viewpoint analysis. That plus that the Court is reviewing *Stockton* on January 10, 2025, and is thus in a position to rule on both the public speech of physicians (*Stockton*) and speech to patients (this Application).

This Court has accepted important related constitutional cases together in order to ensure the law is consistent throughout the country. *Cf. Brown v. Board of Education*, 347 U.S. 483 (1954) (consolidating multiple cases challenging school segregation to address nationwide constitutional issues comprehensively); *Obergefell v. Hodges*, 576 U.S. 644 (2015) (resolving related cases across multiple

states regarding same-sex marriage to ensure uniform application of constitutional principles).

Moreover, bypassing a stay in the Ninth Circuit is justified due to the futility of seeking relief below. Between this case and *Stockton*, the Ninth Circuit has reestablished the professional speech exception despite *NIFLA*. *cf McCarthy v. Madigan*, 503 U.S. 140 (1992), (discussing futility to justify not exhausting state administrative remedies).

Finally, the urgency of these constitutional issues further supports immediate Supreme Court intervention. *See Roman Catholic Diocese of Brooklyn v. Cuomo*, 592 U.S. 14 (2020), (expedited review of First Amendment claims during the pandemic, emphasizing the irreparable harm caused by even temporary infringements on constitutional rights. The same applies here.

JURISDICTION

This Court has jurisdiction to issue an injunction pursuant to 28 U.S.C. § 1651 (the All-Writs Act) and 28 U.S.C. § 1254(1). Applicants timely filed their appeal in the Ninth Circuit under 28 U.S.C. § 1291, challenging the district court's denial of a preliminary injunction.

THE RELEVANT STATUTE

United States Constitution, First Amendment

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.

California Business and Professions Code Section 2234 provides in relevant part:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> ….
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
>> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>>
>> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> ….

THE STANDARD OF REVIEW

Different justices have articulated different formulations of what is required to issue an injunction pending appellate court review under the All-Writs Act, 28 U.S.C. § 1651(a). However, the common elements seem to be that the legal rights are "indisputably clear" (*Ohio Citizens for Responsible Energy, Inc. v. NRC*, 479 U.S. 1312 (1986) (Scalia, J., in chambers) (citations and alterations omitted)), and that the *Winter* factors are satisfied. *Roman Catholic Diocese of Brooklyn v. Cuomo*, 592 U.S. at 16, *citing Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7, 20 (2008).

STATEMENT OF THE CASE

A. The Origins of California's Covid Misinformation Threat and Disciplinary Campaign

California's combined executive and legislative branch campaign threatening California physicians with professional discipline for their viewpoint speech contrary to the mainstream Covid narrative was precipitated by a short press release issued by the Federation of State Medical Boards (the "Federation") on July 29, 2021. The press release invited its member medical boards throughout the country to sanction physicians for spreading "Covid misinformation" and "disinformation" to the public and patients. Verified Complaint, hereinafter "Complaint" at Appendix 110a-111a, para. 63 (hereinafter just the page reference will be provided as all references are to the Appendix unless otherwise stated).

The opening salvo came from Medical Board President Kristina Lawson's announcement at the Board's February 10-12, 2022 public meeting that the board would be implementing the Federation's press release, and would sanction physicians for "Covid misinformation." *Id.* at 111a, para. 64-65.[1]

A few days later, the California Legislature opened the second front by introducing AB 2098, adding a new board provision specifically making disseminating Covid "misinformation" to the public and patients a board disciplinable offense. *Id*. at 112a, para. 66.[2] AB 2098 references the Federation's

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[1] The complaint alleges that Ms. Lawson was the Chairman of the Federation's Ethics Committee. *Id*. at 111a, para. 64.

[2] We ask the Court's indulgence as Applicants provide a detailed history of AB 2098. Although it is not the statutory basis of the boards' current Covid misinformation

press release as a rationale (*id.)* and was effective on January 1, 2023 as Business and Professions Code Section 2270 (i*d*. at para. 68) for speech to patients.[3]

B. Legal Challenges to AB 2098/Section 2270

Prior to its effective date, four federal challenges were filed against the bill. *Id.* at para. 70 and n.10. *Hoang v. Bonta*, one of the four cases, was filed by Applicants' counsel, and had three of the five Applicants herein as plaintiffs (Dr. Hoang, Physicians for Informed Consent ("PIC") and Children's Health Defense ("CHD"). Two of the three Respondents herein were defendants in *Hoang*. *Id.* at para. 70.

In the first filed case, a central district judge denied a preliminary injunction on both First and Fifth Amendment grounds. *Id*. at footnote 10 and *McDonald v. Lawson,* 2022 WL 18145254 (C.D. Cal. 2022). In the second and third filed cases however, by order dated January 23, 2023, Eastern District Judge William B. Shubb issued a preliminary injunction against Section 2270 on Fifth Amendment vagueness grounds in the two related cases, *Hoang v. Bonta* and *Hoeg v. Newsom*. *Id*. para. 70, and 652 F. Supp. 3d 1172 (E.D. Cal. 2023).

Of significance to the standing issue in this Application, Judge Shubb engaged in an extensive standing analysis (on his own for the *Hoang* plaintiffs,

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policy, it is a part of Respondents' three-year program to suppress physician speech, and provides the necessary context for Applicants' standing argument.

[3] That public speech was not included in the final bill is more related to *Stockton* than this case. The Stockton record sets out the California Legislature's reasoning why it did not think physicians' public speech could be constitutionally regulated. *See Stockton* Appendix, at pages 131-132.

since although the Attorney General's office challenged the *Hoeg* Plaintiffs' standing (and the standing of the plaintiffs in the other two lawsuits), it did not challenge the *Hoang* Plaintiffs' standing). *Hoeg v. Newsom,* 652 F. Supp. 3d at 1182-84. Judge Shubb ruled that all plaintiffs in both related cases had met the relaxed pre-enforcement standing requirements. *Id*. This is important to this Application because the standing allegations of the three common plaintiffs in *Hoang* are virtually identical to the standing allegations in the complaint in this case for the three common Applicants.

Further, the same speech was targeted by the Defendants/Respondents and sought to be protected by the plaintiffs in both *Hoang* and this case, to wit, so-called "Covid misinformation" to patients. The only difference between the four prior cases and this case is the Respondents' statutory basis/assertion of authority, AB2098/Section 2270 which specifically targeted "Covid misinformation" in the former, versus the general standard of care provision in Section 2234(c) in this case. Complaint, 98a, paras. 3-4.

C. The Legislature Makes a Tactical Retreat and the Medical Board Pivots

In September 2023, the Legislature passed SB 815 which, *inter alia*, repealed Section 2270, effective January 1, 2024. *Id*. at 112a, para. 71. However, the initial reporting of the repeal quoted Section 2270's sponsor's spokesman as stating that "Fortunately, with this update, the Medical Board of California will continue to maintain the authority to hold medical licensees accountable for deviating from the standard of care and misinforming their patients about COVID-19 treatments." *Id*.

at 113a, paras. 72-73. (A copy of the article in which the statement was reported is attached at 113a.) In addition, by December 2023, the medical board had disciplined at least one physician for Covid misinformation under its standard of care authority. *Id*. at 113a, para. 74, and 102a para. 21 to 103a. (A copy of the statement of charges and the final disposition of that case is attached as 139a and 140a.)

The announcement of Section 2270's upcoming repeal prompted the Ninth Circuit to order the parties in the *McDonald v. Lawson* and *Couris v. Lawson* consolidated appeals (Nos. 22-56220, 23-55069) to brief the issue of mootness. Judge Shubb did the same in *Hoeg* and *Hoang*. Subsequently, the Attorney General's office moved to dismiss *Hoeg* and *Hoang* on mootness grounds.

The Ninth Circuit dismissed on mootness grounds the *McDonald* and *Couris* appeals. *McDonald v. Lawson*, 94 F.4th 864 (9th Cir. 2024).[4] Judge Shubb dismissed *Hoeg* and *Hoang* by order dated April 2, 2024. *Hoeg v. Newsom*, 728 F. Supp.3d 1152 (E.D. Cal. 2024).

D. Applicants' "Follow-up" lawsuit

Because it was clear that the repeal of Section 2270 was not stopping the Respondents from targeting protected physician speech, on January 2, 2024 (and

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[4] It is noteworthy that the Ninth Circuit's mootness finding was in part based on a declaration by the medical board's executive director that the medical board was no longer enforcing Section 2270 because of its upcoming repeal. *Id.* at 869-70. Not disclosed was that the board had simply pivoted back to using its general statutory powers of enforcing the standard of care to achieve the same goal of targeting physicians' communications to patients about Covid, as evidenced by the Accusation against Dr. Reyna filed in the summer of 2023.148a-153a.

instead of opposing the Attorney General's motion to dismiss), the three *Hoang* plaintiffs together with two medical doctors (Pierre Kory MD and Brian Tyson MD) filed a new "follow-up action" (Complaint, 98a, para. 3) to *Hoang* and *Hoeg,* which was accepted as a related case by Judge Shubb. 130a, Dkt. Entry 4.

Instead of the *Hoang* challenge to a bill/new statute, this lawsuit challenges the Respondents' "practice and policy" of investigating and sanctioning physicians for their protected speech to patients. It also asserts the right of patients (via organizational Applicants Physicians for Informed Consent ("PIC") and Children's Health Defense ("CHD")) to hear this speech. Complaint, 118a para. 89-119a, para. 95.

In addition, it is alleged that if the Respondents assert their statutory powers to enforce the "standard of care" as a defense, then such defense would render the statute overbroad. *Id*. at 119a, para. 96. Contrary to the findings of both the district and appellate court, Applicants have not alleged that the words of the standard of care statute (Bus. & Prof. Code Section 2234(c)) are facially unconstitutional, or that the statute as applied to the specific Applicants are unconstitutional. Again, the challenge is to the practice and policy of threatening and targeting physicians with discipline for providing information and recommendations contrary to the mainstream Covid narrative. This critical misreading of the Complaint by both courts is a fatal flaw in both opinions.

Finally, this lawsuit does not allege or seek to establish that the medical act of prescribing Ivermectin or any other off-label drug for Covid is protected speech.

Rather, it is principally about information and the Respondents' constitutional lack of authority to sanction physicians for the information provided to patients based on their characterizing speech as Covid misinformation in violation of the standard of care.

E. Applicants/Plaintiffs

1. Pierre Kory, M.D.

Applicant Pierre Kory, MD is a critical care doctor and at all relevant times, has a telehealth medical practice providing information and advice to patients, including California patients under his California medical license. Complaint, 100a, para. 13, 102a, para. 18. As a leading expert on Ivermectin, Dr. Kory's consulting practice includes dealing with patients with questions about Ivermectin, and whether he recommends its use. *Id.* at para. 19. Dr. Kory has understandable concerns that the information and recommendations he provides to California patients could trigger a medical board disciplinary action. Complaint, 102a at para. 21.[5]

2. Le Trinh Hoag, D.O.

Dr. Hoang is a licensed pediatric osteopathic physician whose practice includes advising patients (and their families) about the risks versus benefits for

[5] Dr. Kory's concerns may have increased recently arising from the fact in mid-August 2024, the private certifying organization, American Board of Internal Medicine revoked his board certification arising out of his public advocacy of Ivermectin as a treatment for Covid. *See, e.g.*, *Doctors accused of spreading misinformation lose certifications*, Washington Post (Aug. 13, 2024), https://www.washingtonpost.com/politics/2024/08/13/doctors-accused-spreading-misinformation-lose-certifications/?utm_source=chatgpt.com.

Covid vaccines and continued boostering. *Id*. at 103a, para. 12-24. The Complaint and her declaration provide context and details about the information she may convey to the families, including some of the observations she has made since treating patients with Covid and those who have taken the vaccine. *Id*. at para. 24 to 104a, para. 26, Hoang Declaration, 85a-87a. As of the date of the complaint, she intended to provide such information to families, regardless of whether her board might view this as Covid misinformation and subject her to board investigation and prosecution. Complaint, 104a at para. 27-28.

Finally, Applicant Hoang is a member of Applicant PIC (Hoang Declaration, 85a para. 2, lns. 7-9) which membership may satisfy the required standing connection between her as a speaker and PIC members as listeners under *Kleindienst v. Mandel*, 408 U.S. 753, 762 (1972).

3. Brian Tyson, M.D.

Applicant Brian Tyson is a California licensed physician who owns a large urgent care clinic which has treated 20,000 plus Covid patients. Complaint, 104a para. 29, Tyson Declaration, 89a, para. 2. The Complaint and his Declaration details his observations made as a result of his clinic's experience, and sets out some of the information he tells patients and will continue to tell patients even if it may subject him to investigation and disciplinary proceedings. Complaint, 104a, para. 30 to 105a, para. 36. Declaration, 89-90. Applicant Tyson was previously investigated for over a year for alleged Covid misinformation to the public (*id*., para. 35, and thus has a reasonable concern or fear about further board action against him. Complaint, *id*., para. 36.

4. Physicians for Informed Consent

Applicant Physicians for Informed Consent is a California not for profit corporation which advocates for the rights of physicians to provide evidence-based information concerning the risks and benefits of vaccines (Complaint, 105a para. 37) and to do so, it collects data from around the world, which information is sometimes at odds with the U.S. scientific consensus. *Id*. at para 38 to 106a, para. 39. Many of its physician members are afraid to speak out against what the Covid narrative and CDC pronounces and what they believe to be an accurate risk profile from the vaccines and the boosters, as well as other issues, like the potential benefit of repurposed drugs like Ivermectin. *Id.* at 106a, para. 40 to 107a, para. 43. PIC asserts that their physician members' speech is being chilled by the Respondents' ongoing Covid misinformation censorship campaign. *Id.* at 43. The rights of PIC members are germane to its purpose, and such members (like Applicant Hoang) would have standing to assert their individual rights. *Id.* at 107a, para. 43-46.

PIC also asserts the rights of its lay California members to hear the speech of Applicant and other California physicians which could involve the physicians in disciplinable conduct. *Id.* para. 47, continuing to 108a.

5. Children's Health Defense

Applicant Children's Health Defense is an education and advocacy not for profit whose mission is to end childhood health epidemics and which supports medical freedom, bodily autonomy and protect individuals' rights to receive the best information available based on the physician's best judgment. *Id.* at 108a. para. 48. CHD's members include California physicians who wish to provide information

about booster shots and off-label drugs like Ivermectin, which information is or could be viewed as inconsistent with the mainstream Covid narrative. *Id*. at para. 50, continuing to 109a.

CHD has non-physician parent members who want to receive information like the information contained in the Complaint. *Id*. at para. 50 lns. 21-23. The Respondents' Covid misinformation enforcement program chills CHD's physician members and impairs its lay members from receiving such information. *Id*. at para. 51, continuing to 109a. CHD sues in its own capacity and on behalf of its constituent members who have been and will continue to be adversely affected by Respondents' actions (*id*. at 109a, para. 52), and CHD satisfies the other requirements for associational standing. *Id*. at para. 53. As with Applicants Hoang and PIC, Judge Shubb found these allegations sufficient for standing purposes in *Hoeg v. Newsom,* 652 F. Supp. 3d at 1182-84.

F. Applicants' Evidence

Applicants submitted declarations from the three physician Applicants (Kory, 79a-83a, Hoang, 84a-87a, Tyson, 88a-91a), the purpose of which is to give their perspective, and relate some of the information they wish to share with their patients, which information and perspective is at odds with what conventional medical authorities would like the public and patients to know.

The record also includes declarations from patients from Applicant Hoang and Kory. Debbie Hobel expresses concerns (as she did in her declaration in the *Hoang* case) about patients not trusting their physicians if they can be subjected to

board sanction for providing information and opinions contrary to the public health authorities' dictates. Hobel Declaration, 92a, para. 2 to 93a, para. 7. Neil Selfinger explains how he had been advised to take a second dose of the Covid shot after experiencing significant and continuing side effects from the first shot. Once Dr. Kory explained some of the underreported side effects, Mr. Selfinger was able to make a more informed decision, and he also obtained relief based on Dr. Kory's recommendations. Selfinger Declaration, 95a, para. 1 to 96a, para. 8.

Finally, Applicants submitted an extensive medical expert declaration (Verma Declaration, 42a-78a), which sets out many pages of sourced information which Applicant physicians and other like-minded physicians might discuss with California patients. This declaration also presents the changes and problems with the consensus' thinking about Covid.[6] Most importantly for this Application, Dr Verma relates that people do not have to pay for a medical visit to get a Covid vaccine, but rather seek out their doctors because

> …they have questions and concerns about the safety and efficacy of the COVID-19 vaccines despite the public health media campaign extolling the benefits of the vaccines and their 'exceeding rare' side effect. … [and other issues which are not widely publicized.]
> [M]ost of my patients with cardiac complications after COVID-19 vaccination had not previously been educated on these risks underscores the material and sometimes fatal consequences of silencing doctors who engage in an ethically transparent and comprehensive risk-benefit analysis.

Id. at 43a, para. 4, ln. 27 to 44a, ln 12.

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[6] Applicants submitted a substantially similar declaration in *Hoang v. Bonta* and *Stockton v. Ferguson*.

This supports Applicants' core contention that this case is about information, opinions, and general recommendations, not about the delivery of a medical intervention or treatment. It also shows the district court's error in trying to transform the case into sanctioning medical interventions.

It is for these limited purposes that these declarations are included in this Application (in addition to the fact that the entire record is before the Court in the Appendix, except for the briefing).

G. Respondents' Evidence

For the purposes of this Application, Respondents' evidence in the preliminary injunction record may be more important than Applicants' evidence, if strict scrutiny applies and as Applicants argue, Respondents have the burden of proving that they considered and rejected lesser intrusive measures than restricting protected speech.

Respondents' evidence consists of two essentially identical declarations from the executive directors of the medical board and the osteopathic medical board. 33a-37a and 38a-41a respectively. There was no medical or scientific substantive response to any of the studies, opinions or clinical observations, or patient information presented in the declarations submitted by the Applicants. The two executive directors mostly just related the boards' disciplinary process.

There is a discussion about the California Right to Try Act. Varghese Declaration at 41a, para. 12. However, the relevance of a state right to try investigational medical treatments is unclear to this case which involves whether

physicians' speech to patients is constitutionally protected.

The only other relevant evidence comes from the Federation's press release and the Board President's adoption statement quoted in the Complaint. 110a-111a, para. 63 and 111a, para. 65.

SUMMARY OF ARGUMENT

This Application raises three substantive issues: The First Amendment, standing, and whether the Applicants have satisfied the modified *Winter* preliminary injunction requirements as a matter of law based on the preliminary injunction record before this Court. The other issue is whether the Court should take the case at this time.

A. The First Amendment Issue

This Court in *NIFLA* has expressly rejected the notion promoted by some circuits, including the Ninth Circuit, that the category of physician speech to patients is *ipso facto* unprotected. And yet, that is exactly what both the district and circuit courts decided in this case below, namely that all speech by a physician to a patient is part of medical treatment governed by the standard of care.

Beyond the conflict with *NIFLA*, both lower courts' decisions contradict what prior Ninth Circuit authority has held for over twenty years. More disturbingly, there is now a class of government operators who are exempt from the First Amendment, so long as they couch their restrictions or declare the speech to be covered by the standard of care, or part of medical care and treatment. The Court should find that strict scrutiny applies to the viewpoint discrimination employed by

Respondents, find that they did not meet their heavy burden of proof, and conclude that the other *Winter* factors have been satisfied.

B. Standing and Why These Cases Should be Taken Up Now and Decided Together

Both the district and appellate court erred by misconstruing this case as a facial or as applied challenged to Section 2234 (c). It does no such thing. Rather, this case challenges a non-state national actor's (the Federation) initiation of a California government's multi-year, multi-pronged policy and program of threatening to sanction physicians for information and recommendations about Covid that conflict with the mainstream Covid narrative. The program encompasses both the board's announced policy, and specific legislation passed but then repealed by the Legislature, after it had been enjoined. There is a long history of this Court finding standing for challenges to government policies, despite the fact that the statutory bases of the challenged policy are neutral and even if the policy has not yet been applied to the plaintiffs.

In addition, both lower courts also failed to recognize that Applicants demonstrated the standing for the organizational Applicants to hear the speech of physicians like Applicant physicians. Specifically, the organizational Applicants have standing on the asserted claim under both *Virginia Bd. of Pharmacy v. Virginia Citizens Consumer Council*, 425 U.S. 748 (1976) and *Kleindienst v. Mandel*, 408 U.S. 753 (1972) as recognized recently in *Murthy v. Missouri*, 603 U.S. 43 (2024).

Finally, this case is unlike most of the cases which reject standing; the state's program is part of a non-state actor's national campaign to cajole its state board members throughout the country to disregard the First Amendment protections long accorded to professional speech. Another part of this nationwide campaign is presently before this Court in *Stockton.* The broader context and the nationwide scope of the physician censorship programs like California's present a *sui generis* and extraordinary circumstance which speaks to the standing issue, as well as establishing a compelling reason why this Court should take up both this case and *Stockton*.

That is in addition to the fact that the conflict between the Ninth and Eleventh Circuits on professional speech not only continues, but as a result of this case and *Stockton*, is now even bigger.

Win or lose, the country, state medical boards, physicians, their patients, and the public need guidance from this Court about the limitations, if any, on the government's power to control the information physicians may share with patients and the public.

REASONS FOR GRANTING THIS APPLICATION

I. PHYSICIANS' SPEECH IS PROTECTED AND RELIEF SHOULD BE GRANTED

A. Both Lower Court Decisions are Inconsistent with *NIFLA*

The starting point on physician speech to patients is this Court's discussion of professional speech in *NIFLA*:

> Some Courts of Appeals have recognized "professional speech" as a separate category of speech that is subject to different rules. *See, e.g.*, *King v. Governor of New Jersey,* 767 F.3d 216, 232 (C.A.3 2014); *Pickup v. Brown,* 740 F.3d 1208, 1227–1229 (C.A.9 2014); *Moore–King v. County of Chesterfield,* 708 F.3d 560, 568–570 (C.A.4 2013). These courts define "professionals" as individuals who provide personalized services to clients and who are subject to "a generally applicable licensing and regulatory regime. [citations omitted.] "Professional speech" is then defined as any speech by these individuals that is based on "[their] expert knowledge and judgment," *King, supra,* at 232, *or that is "within the confines of* [*the*] *professional relationship,"* *Pickup, supra,* at 1228. So defined, these courts except professional speech from the rule that content-based regulations of speech are subject to strict scrutiny. See *King, supra,* at 232; *Pickup, supra,* at 1253–1256; *Moore–King, supra,* at 569.
>
> But this Court has not recognized "professional speech" as a separate category of speech. Speech is not unprotected merely because it is uttered by "professionals."

Nat'l Inst. of Fam. & Life Advocs. v. Becerra, 585 U.S. 755, 767 (2018) (emphasis added).

Contrary to this explicit language, the district court decided that all speech between a doctor and patient is excluded from First Amendment protection because "… when a doctor speaks in his capacity as the patient's treating physician and incident to his provision of medical care, the physician's words constitute medical care." Decision, 15a, ln. 27 to 16a ln. 2 (underscore in the original). There is no way to reconcile the district court's words and *NIFLA.* Therefore, the district court's decision is in essence an invitation to this Court to disavow or reconsider *NIFLA*.

The Ninth Circuit agreed with the district court's view by tersely stating that Section 2234 (c) "does not purport to regulate speech unrelated to treating patients…." 2a. Then, with equal terseness, it limits *NIFLA* to the "required

communication of a particular message" (*id.* at 3a), *i.e.*, limiting *NIFLA* to compelled speech.

This is unsatisfactory because while *NIFLA* was a compelled speech case, the prior cases *NIFLA* criticized for creating the exclusion from First Amendment protection (including *Pickup*), were not. Nor were the other cases *NIFLA* relied upon by this Court, like *Reed v. Town of Gilbert*, 576 U.S. 155 (2015). Thus, contrary to the Ninth Circuit's opinion, *NIFLA*'s rejection of the professional speech doctrine includes the *expressive* speech which is the subject of this action,

Unless this Court decides to now recognize a long-standing exception to Free Speech that it failed to recognize in 2018 – the last time the California Attorney General argued that all physician speech is unprotected – it should reverse both lower courts on this point.

However, and finally, there is one significant constitutional distinction between *NIFLA* and this case. *NIFLA* involved content only restrictions. This case involves viewpoint restrictions, which this Court has held to be the most egregious form of content discrimination. *Rosenberg v. Visitors of Univ. of Va.*, 515 U.S. 819, 829-30 (1995), and *Matal v. Tam,* 137 S. Ct. 1744, 1763 (2017). The Eleventh Circuit noted that there is an argument to be made that this Court implied that viewpoint regulation is a *per se* violation of the First Amendment. *Otto v. City of Boca Ratan,* 981 F.3d 854, 864 (11th Cir. 2020).

Of more direct note, according to the Ninth Circuit's *NIFLA* opinion, the only reason it did not apply strict scrutiny was because the compelled speech was

not viewpoint based. *See Nat'l Inst. of Fam. & Life Advocs. v. Harris,* 839 F.3d 823, 836 (9th Cir. 2016). Accordingly, unless this Court disavows *NIFLA*, because Respondents' actions are both content and viewpoint based, strict scrutiny should apply to the Respondents' enforcement policy against so-called Covid misinformation.

B. Even Under Ninth Circuit Precedent, Information and Recommendations by Physicians to Patients are First Amendment Protected

The decisions by both lower courts are also inconsistent with Ninth Circuit precedent, namely, *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002), *Pickup v. Brown*, 740 F.3d 1208 (9th Cir. 2014), *abrogated on other grounds by Nat'l Inst. of Family & Life Advocates v. Becerra*, 585 U.S. 755, and *Tingley v. Ferguson*, 47 F.4th 1055 (9th Cir. 2022).[7]

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 for "recommending" medical marijuana to patients.[8] Under federal law, the drug had no legitimate medical use and most doctors thought it had no medical benefit.

The plaintiffs argued that physicians had a First Amendment free speech right to make the recommendation. The district court agreed, applied strict

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[7] And lest we forget that the Ninth Circuit's decisions in *Pickup* and *Tingley* are inconsistent with *Otto v. City of Boca Ratan*, 981 F.3d 854 (11th Cir. 2020), which Applicants maintain correctly applied *NIFLA*.

[8] *Conant* also directly supports Applicants' standing, and that administrative policies can be unconstitutional even if their statutory basis is neutral on its face.

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 Applicants' position, as it is based on the difference between the fully protected speech of making a recommendation (or giving the physician's opinion) from regulatable professional conduct (rational relationship test) of issuing prescriptions. Applicants' First Amendment challenge in this case involves the former and not the latter. There is no argument or claim that Applicant physicians or any physicians have a First Amendment right to prescribe Ivermectin or any other off-label drug to Covid patients.

Pickup's principal specific holding is the state can constitutionally make sexual orientation change therapy a disciplinable offense, *i.e.*, make administering the talk therapy a violation of the standard of care, because the professional's speech is the actual medical/mental health treatment, and medical treatment is regulatable by the state government. That the treatment is delivered by speech does make the speech protected because speech which is "incidental to" medical treatment is unprotected (subject to the rational relationship test). *Pickup*, 740 F.3d at 1229.

However, the important part of *Pickup* for this Application is its articulation of the "continuum" of professional speech, and specifically, the middle of the continuum (between fully protected public speech and unprotected therapy delivered by speech). Information and recommendations about sexual orientation therapy were in the middle of the "continuum" as "a professional's speech to patients is somewhat diminished." In short, *Pickup* changed the protected status of information and recommendation from *Conant*'s fully protected/strict scrutiny status into intermediately protected speech.

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* for a similar California statute. The Ninth Circuit reached the same result as it did in *Pickup* because it read *NIFLA* as allowing the government to regulate speech incidental to conduct. "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." *Tingley,* 47 F.4th at 1064.

However, the holding and result are not important since our case involves physicians conveying information, opinions, and recommendations – not treatment – and does not involve the medical act of issuing a prescription. What is important for this Application is that *Tingley* reads *NIFLA* as abrogating the "midpoint" of *Pickup*'s continuum. *Tingley*, 47 F.4th at 1074 & 1075. Applicants read this *Tingley* language as reverting the information/recommendation speech back to the *Conant*

rule of full protection/strict scrutiny. It cannot be otherwise, since recategorizing these physician communications to patients as unprotected would violate *NIFLA,* and *Tingley,* which purports to follow *NIFLA*.

Accordingly, under *Conant* and *Tingley*, the district court and the Ninth Circuit should have found that strict scrutiny applies to California's effort to regulate so-called Covid misinformation to patients. But they did not do so, and examining the district court's analysis shows its deep confusion, and basically a rejection of *NIFLA*.

C. The District Court's Confusion

The district court attempted to distinguish *Conant* by pointing out that the prescribing of medical marijuana would be illegal, so it was easy for the *Conant* panel to protect the speech recommending it, since the speech was thus "untethered from treatment" (13a-14a). The district court tried to differentiate "untethered from treatment" speech by stating that:

> Most situations in medical practice are not so clear-cut. Within the same patient conversation, a doctor could go from (1) speaking about his views on a particular treatment based on his experience and expertise, to (2) prescribing the use of that treatment for the patient's care. The former would be speech, while the latter would be conduct. This is because the "the 'key component' of a doctor's prescription of a drug is the provision of the drug not the speech itself *See NAAP* [*National Ass'n for the Advancement of Psychoanalysis v. California Bd. of Psychology*], 228 F.3d [1043] at 1053 [(9th Cir. 2000)]. And 'the First Amendment does not prevent a state from regulating treatment even when that treatment is performed through speech alone. *Pickup*, 740 F.3d at 1230. Thus, when a doctor speaks in his capacity as the patient's <u>treating</u> physician <u>and incident to his provision of medical care</u>, the physician's words constitute medical care."

Id. at 15a lns. 17 to 16a ln. 2 (underscore in the original, but case names underscored in the original are modified to italics for consistency with the brief's citations).

Now we get to the heart of the district court's confusion. It uses *Pickup*'s that when the speech is the treatment, it is unprotected conduct, to make the illogical and legally unsupported leap that when a physician speaks as a "treating physician" and is providing medical care, "the physician's words constitute medical care."

It is illogical because the fact that speech which is therapy is unprotected in the Ninth Circuit does not logically entail that speech which is not therapy is unprotected. It is legally unsupported because *Pickup* held that speech involving information and recommendations about a treatment is in the middle of the continuum, while *Tingley* moved that speech back to *Conant*'s fully protected status.

Further, it is constitutionally irrelevant whether the treatment which is the subject of the speech is illegal (*Conant*), made disciplinable by legislative enactment modifying the standard of care (*Pickup, Tingley* and AB 2098), or is deemed to be a violation of the standard of care enforceable under Section 2234 (c), as set out by a board policy resulting from the pandemic (this case).

From the physicians' point of view (and the Constitution's), the source of the medical board's disciplinary action does not matter one whit. Providing information and recommendations about Ivermectin or other off-label drugs is just as "untethered" as the speech about medical marijuana or sexual orientation therapy

because it can lead to the same result, board investigation and sanction.

This case asks whether the First Amendment protects physicians' communications to patients about controversial topics (or during a public health crises) when the communications is not related to the administration or prescribing of a medical treatment? *Conant*, *Pickup* and *Tingley* all say such speech is protected. Content and viewpoint analysis require that any such government restrictions are subject to a strict scrutiny analysis. And *NIFLA* teaches that courts cannot declare *ipso facto* and *de jure* that such speech is categorically unprotected just because it is uttered by a doctor in a doctor-patient encounter.

D. The Respondents' Have Not Satisfied Their Strict Scrutiny Burden of Proof

Strict scrutiny means that the Respondents 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, 718-19 (2021)[9]; *Williams-Yulee v. Fla. Bar*, 575

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[9] "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 (Opinion of Justice Gorsuch with whom Justice and Thomas and Justice Alioto join).

U.S. 433, 444 (2015).

Strict scrutiny requires that the government provide evidence that other alternatives that do not involve restricting protected speech would not have been effective to achieve the compelling state interest. *See United States v. Playboy Ent. Grp. Inc.* 529 U.S. 803, 817 (2000). Where is the evidence that suppressing dissenting views about Covid is a compelling state interest? More importantly, where is the evidence that other less restrictive measures than sanctioning physicians for their dissenting viewpoint speech would not have been effective to achieve the compelling state interest? Perhaps greater transparency and honesty about the short-term benefits of the shots, and the potential dangers of the vaccines to some patient subsets, might have been a better solution.

Consider Respondents' strict scrutiny burden through the lens of *Brown v. Entm't Merchants Ass'n*, 564 U.S. 786, 799 (2011), wherein this Court stated that to satisfy strict scrutiny "[the] State must specifically identify an 'actual problem' in need of solving, and the curtailment of free speech must be necessary to the solution." The *Brown* court said that under strict scrutiny the state "bears the risk of uncertainty" and "ambiguous proof will not suffice," as well as a "direct causal link" between the targeted information and the harm. *Id.*

Where is the actual evidence that restricting the protected speech of California physicians to their patients (or to the public if that is also what Defendants intend to do) will directly benefit public health more than lesser restrictive measures could have? The only actual evidence proffered by the

Respondents comes from the declarations of the two executive directors, and they are silent on other means considered and rejected, and do not provide a cogent and specific explanation of the compelling state interest. Accordingly, this Court should conclude that the Respondent have failed to meet their strict scrutiny burden of proof.

E. Applicants Have Satisfied the Modified *Winter* Test

1. The Modified *Winter* Test

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). *Elrod* was recently applied during Covid in *Roman Catholic Diocese v. Cuomo*, 592 U.S. at 19.

When the state is the defendant, the last two factors merge because in the balance of equities, the government's interest is the public interest. *Nken v. Holder*, 556 U.S. 418, 435 (2009). As to these merged elements, there is not public interest in the enforcement of an unconstitutional law. *ACLU v. Ashcroft*, 322 F.3d 240, 251 n.11 (3d Cir. 2003). In short, "[B]y establishing a likelihood that [the challenged law] violates the U.S. Constitution, [p]laintiffs have also established that both the public interest and the balance of the equities favor a preliminary injunction." *Ariz. Dream Act Coal. v. Brewer*, 757 F.3d 1053, 1069 (9th Cir. 2014).

In short, in this type of fundamental constitutional challenge, the courts focus on the likelihood of success on the merits, which has been demonstrated

above. That all being said, the public has a strong interest in permitting physicians to speak their mind and disagree with the prevailing medical view, in general, but more so during the pandemic.

2. Trust in Medical Professionals and the Chilling Effect of Respondents' Program of Threats and Intimidation

As shown by the Declaration of Debbie Hobel (91a-93a), patients' trust in physicians can be undermined if patients think the government compels physicians to only recite government approved information and opinions. The Declaration of Neil Selfinger (94a-96a) illustrates the benefit to patients to allow physicians to provide information and recommendations even if it is against the mainstream Covid narrative. His declaration also shows the dangers to patients of requiring all physicians to mindlessly mimic the prevailing medical views.

The importance that the First Amendment protection provides to physicians to speak freely to patients without fear of government reprisal was specifically recognized by Judge Kozinski in his concurring opinion in *Conant,* 309 F.3d at 640-41.[10] Judge Kozinski's statement is also directly relevant to standing insofar as it shows the chilling effect of the threats made by California officials.

But the strongest negative judicial reaction to government programs like

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[10] "… doctors are particularly vulnerable to intimidation; with little to gain and much to lose, only the most foolish or committed of doctors will defy the federal government's policy [of prohibiting the use of marijuana for medical purposes] and continue to give candid advice about the medical use of marijuana."

The same can be said for physicians who dare to tell patients something other than the Covid narrative of accepting every booster, and only taking on-label Covid medications.

what the Respondents are doing in California is found *in NIFLA*'s extensive quote from *Wollschlaeger v. Governor of Florida,* 848 F.3d 1293, 1328 (11th Cir. 2017) (*en banc*) (W. Pryor, J. concurring):

> "Doctors help patients make deeply personal decisions, and their candor is crucial." Throughout history, governments have "manipulat[ed] the content of doctor-patient discourse" to increase state power and suppress minorities.
>
> *** [examples taken for Communist China, the Soviet Union, and the Third Reich omitted]
>
> Further, when the government polices the content of professional speech, it can fail to " 'preserve an uninhibited marketplace of ideas in which truth will ultimately prevail.' " *McCullen v. Coakley,* 573 U.S. ——, —— – ——, 134 S.Ct. 2518, 2529, 189 L.Ed.2d 502 (2014).

NIFLA, 585 U.S. at 771.

Respondents' attempt to transform all communications between physicians and patients into regulatable conduct negatively impacts the doctor-patient relationship, as it erodes trust by raising questions as to whether physicians are speaking their truth, or just conveying the party line to protect their license and livelihood. Hence, the public's interest weighs in favor of ensuring that physicians will continue to speak candidly to patients.

II. ALL OF THE APPLICANTS HAVE STANDING

Both lower courts held that the Applicants did not have standing to bring what they mischaracterize as an "as applied" challenge to Section 2234(c). They are incorrect for multiple reasons. Applicants would point out that they only need to

show that one of them has standing to have the case go forward.[11]

A. The Organizational Applicants Have Standing

PIC and CHD have standing to assert their right to hear the protected speech of Applicant and other physicians, because they have the same kind of concrete injury as the plaintiff organization had in *Virginia Bd. of Pharmacy v. Virginia Citizens Consumer Council*, 425 U.S. 748, as related in *Murthy*, 603 U.S. at 75. There was no finding that any member of the plaintiff's group had contact with any specific pharmacy. Standing was based on plaintiff's interest in the information or content of pharmacists' message of prescription drug prices. That was sufficient for the consumer organization to have a "concrete, specific connection to the speaker" and hence a "cognizable injury" according to *Murthy,* 603 U.S. at 75.

PIC and CHD's organizations' standing allegations are similar to the plaintiff's standing facts in *Virginia Bd. of Pharmacy.* Both cases have organization plaintiffs consisting of consumers of content specific information (and in our case viewpoint specific information). In both cases, the consumer organizations are suing a health care board for rendering content speech sanctionable as unprofessional conduct. Examples of the viewpoint speech which is the target of Respondents' program is set out in detail in the Complaint and the declarations.[12] Accordingly,

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[11] "A proper case or controversy exists only when at least one plaintiff "establish[es] that [she] ha[s] standing to sue.;" (citations omitted). *Murthy,* 603 U.S. at 57.

[12] *See* the Verma Declaration 42a-77a which contains an abundance of viewpoint information which Applicant physicians and like-minded physicians wish to share. *See also* the allegations of organizational Applicant PIC at 105a, para. 37 to 106a, para. 41, and CHD's member physicians at 108a, para. 50. The information which the organizational Applicants' consumer members want to hear is provided in the

Murthy and *Virginia Bd. of Pharmacy* support PIC and CHD's standing.[13]

In addition, Applicant Hoang is a member of Applicant PIC (Hoang Declaration, 85a para. 2 lns. 7-8), which is more of a "connection" between the speaker and listener than the invited foreign speaker and the university professor listeners in *Kleindienst v. Mandel*, 408 U.S. at 762. Hoang's connection to PIC thus should satisfy the *Mandel* connection requirement mentioned in *Murthy*.

B. Both Decisions are Based on a Flawed First Amendment Theory that all Physician Speech to Patients is Unprotected

Both lower court decisions have misread First Amendment law as holding that all communications between physicians and patients are unprotected conduct. Specifically, the district court concluded that the record is "devoid of any evidence that the Boards have or may use their authority under Section 2234(c) to do anything other than regulate physician conduct, let alone discipline doctors for their protected speech in the manner plaintiffs suggest." *Id.* at 21a, lns 24-28. The district court also specifically held that there is no physician protected speech to patients ("… when a doctor speaks in his capacity as the patient's treating physician and incident to his provision of medical care, the physician's words constitute medical care." Decision, 15a, ln. 27 to 16a ln. 2 (underscore in the original). The Ninth Circuit adopted the district court's position by tersely stating

Complaint and declarations. *See, e.g.*, 106a, para. 47, to 108a (PIC) and 108a, para 48-51 (CHD). Other specific viewpoint information from Applicant physicians is found in their declarations (Kory, 79a-82a, Hoang,84a-87a, and Tyson, 88a-90a). *See also* the declaration of Neil Selfinger, 94a-97a, and Debbie Hobel, 91a-93a.

[13] Applicants raised *Murthy* and the organizational Applicants' standing thereunder below, but the Ninth Circuit addressed neither.

that Section 2234 (c) "does not purport to regulate speech unrelated to treating patients…." 2a. Thus, both courts use the lack of First Amendment violations as a basis for their no standing determination. This is a misstatement of the law per *NIFLA, Conant, Tingley* and even *Pickup*. (*See* pages 18-24 *supra.*)

C. The Lower Courts Erred in Requiring Applicants to Conform to a Facial or As-Applied Statutory Challenge Which Led it to Erroneously Conclude There was No Standing

Both lower courts misconstrued this case as either a facial or as applied challenge to Section 2234 (c). It is not. It is a challenge to California's three-year enforcement policy and program threatening physicians for the protected speech. The program was precipitated by the non-governmental agency Federation's call to its member boards throughout the country to sanction physicians for Covid misinformation (*see* pages 4 to 9 *supra*) and has involved the medical boards and the Legislature via AB 2098/Section 2270, which after its repeal, led to this "follow up" lawsuit. *Id.*

There is ample precedent for challenges to enforcement policies despite the facial neutrality of the statutory basis of the policy, or whether or not the policy has been applied to or threatened to be applied to the plaintiffs. *See, e.g.*, *Conant v. Walters*, 309 F.3d. 629 (discussed in detail *supra,* pages 21-22.) *See also NWDC Resistance & Coal. Whites v. Immigration & Customs Enf't*, 493 F. Supp. 3d 1003 (W.D. Wash. 2020) (Standing motion to dismiss denied against claim that ICE's policies and practice interfered with the plaintiffs' First Amendment rights). There are many challenges to the practices and policies of the military. *E.g., Wilkins v. United States*, 279 F.3d 782, 787 (9th Cir. 2002), citing numerous cases; *Rostker v.*

Goldberg, 453 U.S. 57 (1981) (Equal Protection challenge to male-only draft registration). Applicants have as much standing to challenge California's multi-year policy and program as any of the plaintiffs in these cases.

Based on the foregoing, the Court should reject the lower courts' attempt to pigeonhole this case as either a facial or as applied challenge to Section 2234 (c) as a way of supporting its lack of standing finding.[14]

But why is rejecting the facial versus as applied dichotomy important to standing? Focusing on what is just one of the proffered statutory bases of the Federation inspired enforcement program forecloses consideration that for much of 2022 and 2023 the program was focused on and implemented/grounded on a different and more specific statute, Section 2270.

Why is that important? Both decisions focus on the threat of enforcement of Section 2234(c) for protected speech which considers whether there is 1) a concrete plan to violate the law; 2) Whether defendants have communicated a specific warning to initiate proceedings against them; and 3) Whether there is a history of past prosecutions. (9th Circuit decision at 3a, district court's opinion at 20a, lns. 11-19.) The Ninth Circuit agreed with the lower court that Applicants showed none of those three circumstances in their "as applied" challenged to Section 2234 (c). 4a.

Au contraire: As previously stated (page 11 *supra*), Applicant Hoang plans on continuing to advise patients in a manner which would trigger a Covid

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[14] The Complaint does raise overbreadth. Complaint, 119a, para 96. This point was argued to both courts, but addressed by neither.

misinformation investigation (citing the Complaint, the relevant portions of which are verified by her verification (123a) and by her declaration. 85a). The same for Applicant Tyson who makes the same concrete plan representations. Page 12, *supra* referencing the Complaint at 104a, para. 30 to 105a, para. 36, verified at 124a and in his declaration, 89a, para. 1 and 90a.[15] Applicants have therefore established a concrete plan.

But both decisions primarily focus on the threat of enforcement, and here is where the forced dichotomy straightjackets this case. Applicants framed this case as a combined executive and legislative program to be implemented by the medical boards, which program had been precipitated, if not directed by the private Federation of State Medical Boards' directive to all of its member medical boards throughout the country.

Applicants' case therefore is more than just the medical board's random isolated decision to use its general standard of care statute to threaten physicians. It implicates the Legislature in the program, via the enacted and repealed AB 2098/Section 2270. It also includes the Federation's national program to censor physician public speech as well as speech to patients, as the Court is now aware. The Federation and their member boards are making direct threats of government action based on the content and viewpoint of physicians' speech. That is the essence of this case (and *Stockton*).

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[15] Applicant Kory's verified allegations also show a concrete plan and standing. Complaint, 100a to 107a, and Declaration, 79a-83a.

This expanded frame fits in with this Court's recent decision in *NRA v. Vullo*, 602 U.S. 175 (2024), which although dealing with a Fed. R. Civ. Proc. 12(b)(6) motion, has on-point language about government coercion, threats and actions creating a substantial and imminent risk of harm to constitutionally protected speech. Heavily relying on *Bantam Books, Inc. v. Sullivan*, 372 U.S. 58 (1963), in *NRA v. Vullo*, the Court unanimously held that statements by a government official threatening private entities with adverse regulatory action if they failed to disassociate from a disfavored group constituted a sufficient basis for a First Amendment claim.

The threats in this case are direct, not third-party threats like in *NRA* and *Bantam Books*. That makes the coercion more compelling for redress than in *NRA* or *Bantam Books*.[16] Medical board president (and Federation official) Lawson made a published formal threat of disciplinary action (page 6 *supra*), and a similar informal threat was made by AB 2098's sponsor's spokesman to the California public (pages 8-9 *supra*).

And once again, this is all part of a nationwide campaign to restrict physician speech precipitated by a non-state actor, acting in consort with these California medical boards. Under *NRA*, these threats are more than enough to satisfy the threat of enforcement requirement. Further, this enlarged frame should greatly diminish or eliminate the (presently known) limited prior enforcement history.

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[16] And unlike in *Murthy*, here, the Court has the power to grant meaningful relief because the Respondents are directly threatening the Applicant physicians and other physicians.

Indeed, in the enlarged frame of the Federation's program with the two most active participant member boards being California and Washington, there is an argument to be made that Washington's Covid disciplinary cases, as well as the other cases throughout the country, can be considered in the prior history of enforcement. (as described in *Stockton* Application at pages 5 and 8-9).

III. SUPREME COURT INTERVENTION IS WARRANTED TO ADDRESS NATIONAL MISCONCEPTIONS ABOUT CONSTITUTIONAL PROTECTIONS FOR PHYSICIANS' SPEECH AND THE INTENSIFYING CONFLICT BETWEEN THE CIRCUITS

There is a growing misconception, promoted by non-state actors and the media, that physicians' dissenting speech on Covid can be punished to protect public health, and censorship of the information which patients receive is constitutionally permissible *See*, *e.g.*, the Washington Post's report titled "*Doctors Who Put Lives at Risk with COVID Misinformation Rarely Punished*" on July 26, 2023 https://www.washingtonpost.com/health/2023/07/26/covid-misinformation-doctor-discipline/ (article included in the *Stockton* Application at 240), as well as the other articles set forth at pages 8-9 in the *Stockton* Application. These articles show the public interest in this issue, and the need for the Court to set out the limitations, if any, the First Amendment places on governmental efforts to restrict the viewpoint speech of physicians.

Moreover, the conflict between the Circuits is growing, even since this Court denied certiorari in *Tingley* in December 2023. Between the two district court opinions and the Ninth Circuit's opinions in *Kory* and *Stockton,* physicians'

protected speech no longer exists in the Ninth Circuit. For, if neither the public speech of physicians nor speech to patients is protected, what's left?

The Ninth Circuit rule of law is that in pandemic times (and afterwards), the First Amendment does not apply to anything that comes out of a physician's mouth, pen, computer, or microphone, whomever the listener. That is because of the claimed but unproven danger dissident speech may cause to the public and patients.

Creating a pandemic exception to the First Amendment is inconsistent with the views of at least some members of this Court. (*See* Justice's Gorsuch's statement in *South Bay Pentecostal Church,* quoted on page 27, footnote 9 *supra*). Applicants hope that all other members of the Court agree that "Even in times of crisis—perhaps especially in times of crisis—we have a duty to hold governments to the Constitution." *Id*.

In the shifting winds of time, science and politics, what is reviled and ridiculed may become accepted, and that which had been accepted may become disfavored. By reaffirming the First Amendment's protection of speech in these two cases, the Court protects current and future disfavored speech, making the country better for it.

CONCLUSION

For the foregoing reasons, Applicants request that the Court issue the requested injunction or stay, and accept this case for full review by the Court, together with *Stockton v. Ferguson.*

RESPECTFULLY SUBMITTED

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NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

FILED

NOV 27 2024

MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

PIERRE KORY, M.D.; LE TRINH HOANG, D.O.; BRIAN TYSON, M.D.; PHYSICIANS FOR INFORMED CONSENT; CHILDREN'S HEALTH DEFENSE,

Plaintiffs - Appellants,

v.

ROB BONTA, in his official capacity as Attorney General of California; REJI VARGHESE, in his official capacity as Executive Director of the Medical Board of California; ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California,

Defendants - Appellees.

No. 24-2946

D.C. No.
2:24-cv-00001-WBS-AC

MEMORANDUM*

Appeal from the United States District Court
for the Eastern District of California
William B. Shubb, District Judge, Presiding

Argued and Submitted November 4, 2024
Pasadena, California

Before: SCHROEDER, W. FLETCHER, and CALLAHAN, Circuit Judges.
Concurrence by Judge CALLAHAN

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* This disposition is not appropriate for publication and is not precedent except as provided by Ninth Circuit Rule 36-3.

Plaintiffs-Appellants are California physicians and non-profit organizations with which they are affiliated. They filed this 42 U.S.C. § 1983 action against the California Attorney General and the executive officers of the boards that regulate the medical profession in California. Pursuant to California Business & Professions Code § 2234(c), the boards are to take disciplinary action against physicians who engage in "unprofessional conduct" by deviating from the "standard of care." Plaintiffs raised First Amendment challenges to prevent any enforcement that might arise from Plaintiffs' expression of views regarding Covid-19 treatment and vaccination. The district court denied a preliminary injunction because Plaintiffs failed to establish a likelihood of success on either a facial challenge or a challenge to the statute as applied to Plaintiffs.

To the extent that Plaintiffs on appeal seek to maintain a facial challenge, we must affirm, because the statute regulates conduct, not speech. *See Tingley v. Ferguson*, 47 F.4th 1055, 1072, 1074 (9th Cir. 2022), *cert. denied*, 144 S. Ct. 33 (2023). It provides for enforcement of the standard of care, which is the standard for physicians' treatment of patients. *See Flowers v. Torrance Mem'l Hosp. Med. Ctr.*, 884 P.2d 142, 145 (Cal. 1994) (explaining that the standard of care creates requirements for "treatment of [the] patient" (citation omitted)). The statute does not purport to regulate speech unrelated to treating patients or require any particular communication. It is therefore unlike the statute in *National Institute of*

Family and Life Advocates v. Becerra, which required communication of a particular message "regardless of whether a medical procedure [wa]s ever sought, offered, or performed." *See* 585 U.S. 755, 770 (2018). Plaintiffs have not established any likelihood of success on a facial challenge, and in their reply brief and at oral argument, they have disclaimed pursuing one.

To establish standing for their as-applied challenge, Plaintiffs must show a credible threat that the Defendants will prosecute them under the statute. *See* *Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 159 (2014). None of the Plaintiffs have been prosecuted under the statute, and Defendants have not threatened enforcement against them. So far as the record discloses, the only disciplinary proceedings against a physician related to Covid-19 communications or treatment involved a physician encouraging her patient to use veterinary ivermectin and resulted in the stipulated surrender of her license.

Plaintiffs nonetheless contend there is a threat that Defendants may prosecute them under the statute for making protected speech. To determine whether a purported threat is sufficient to establish an injury for Article III standing, we consider three factors: (1) whether Plaintiffs have a "'concrete plan' to violate the law"; (2) whether Defendants have "communicated a specific warning or threat to initiate proceedings" against them; and (3) whether there is a "history of past prosecution or enforcement." *See Tingley*, 47 F.4th at 1067

(quoting *Thomas v. Anchorage Equal Rights Comm'n*, 220 F.3d 1134, 1139 (9th Cir. 2000) (en banc)). Plaintiffs have not shown that any of these factors are present here. The district court therefore correctly ruled Plaintiffs lack standing to bring an as-applied challenge to § 2234(c).

AFFIRMED.

FILED

NOV 27 2024

MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

CALLAHAN, Circuit Judge, Concurring in the Judgment:

I believe Plaintiffs have standing to bring an as-applied challenge, but concur in the judgment because Plaintiffs have not established a likelihood of success on the merits at this stage of the proceedings.

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

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PIERRE KORY, M.D., LE TRINH HOANG, D.O., BRIAN TYSON, M.D., PHYSICIANS FOR INFORMED CONSENT, a not-for-profit corporation, and CHILDREN'S HEALTH DEFENSE, a not-for-profit corporation, Plaintiffs, v. ROB BONTA, in his official capacity as Attorney General of California, REJI VARGHESE, in his official capacity as Executive Director of the Medical Board of California, and ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California, Defendants.	No. 2:24-cv-00001 WBS AC MEMORANDUM AND ORDER RE: PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

----oo0oo----

Plaintiffs Pierre Kory, Le Trinh Hoang, Brian Tyson, Physicians for Informed Consent, and Children's Health Defense brought this § 1983 action against defendants Rob Bonta, in his

official capacity as Attorney General of California, and Reji Varghese and Erika Calderon, in their official capacity as Executive Director and Executive Officer of the Medical Board of California and the Osteopathic Medical Board of California, respectively (the "Boards"). (Docket No. 1.) Plaintiffs Kory, Hoang, and Tyson are physicians licensed by the Boards. The remaining two plaintiffs are organizations representing the interests of doctors and patients.

Plaintiffs challenge the constitutionality of the Boards' powers to discipline physicians under Cal. Bus. & Prof. Code § 2234 for conveying COVID-19-related information to their patients.

I. Factual and Procedural Background

The court previously related this case to two cases that challenged the constitutionality of California's Assembly Bill ("AB") 2098: Høeg v. Newsom, 2:22-cv-1980 WBS AC, and Hoang v. Bonta, 2:22-cv-2147 WBS AC. (Docket No. 5.)

AB 2098, then codified at Cal. Bus. & Prof. Code § 2270 but since repealed, took effect on January 1, 2023. The statute provided that "[i]t shall constitute unprofessional conduct for a physician and surgeon to disseminate misinformation . . . 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." Cal. Bus. & Prof. Code § 2270(a) (repealed 2024). The statute defined "misinformation" as "false information that is contradicted by contemporary scientific consensus contrary to the standard of care." Id. § 2270(b)(4). The statute augmented

the definition of "unprofessional conduct," id. § 2270(a), which is a pre-existing basis for disciplinary action by the Boards, see id. § 2234.

This court preliminarily enjoined enforcement of AB 2098 against the Høeg and Hoang plaintiffs on January 25, 2023, on the ground that the law was unconstitutionally vague under the Fourteenth Amendment. See Høeg v. Newsom, 652 F. Supp. 3d 1172 (E.D. Cal. 2023).

The California Legislature subsequently repealed AB 2098, effective January 1, 2024. See Cal. Senate Bill 815 (Sept. 30, 2023). Both the Ninth Circuit and this court determined that the repeal of AB 2098 mooted actions challenging the statute. See McDonald v. Lawson, 94 F.4th 864, 870 (9th Cir. 2024); Høeg, 2024 WL 1406591, at *1-2 (E.D. Cal. Apr. 2, 2024). This court therefore dismissed the Høeg and Hoang actions. See id. at *3. Plaintiffs filed this action, making similar First Amendment arguments to those raised (but not addressed by the court) in the Høeg and Hoang matters. While the Høeg and Hoang matters involved First and Fourteenth Amendment challenges to AB 2098, the plaintiffs here bring a First Amendment challenge to the Boards' longstanding authority to discipline doctors under Business & Professions Code § 2234.

Plaintiffs now move for a preliminary injunction. (Docket No. 14.)

III. Preliminary Injunction Standard

To succeed on a motion for a preliminary injunction, plaintiffs must establish that (1) they are likely to succeed on the merits; (2) they are likely to suffer irreparable harm in the

absence of preliminary relief; (3) the balance of equities tips in their favor; and (4) an injunction is in the public interest. Winter v. Nat. Res. Def. Council, Inc., 555 U.S. 7, 20 (2008); Perfect 10, Inc. v. Google, Inc., 653 F.3d 976, 979 (9th Cir. 2011). "[I]njunctive relief [i]s an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief." Winter, 555 U.S. at 22.

III. Discussion

A. Regulation of Physicians and the First Amendment

"[R]egulating the content of professionals' speech 'pose[s] the inherent risk that the Government seeks not to advance a legitimate regulatory goal, but to suppress unpopular ideas or information.'" Nat'l Inst. of Fam. & Life Advocs. v. Becerra, 585 U.S. 755, 771 (2018) ("NIFLA") (quoting Turner Broad. Sys., Inc. v. F.C.C., 512 U.S. 622, 641 (1994)). "[P]hysician speech is entitled to First Amendment protection because of the significance of the doctor-patient relationship." Conant v. Walters, 309 F.3d 629, 636 (9th Cir. 2002). Physicians "must be able to speak frankly and openly to patients," in part because "barriers to full disclosure would impair diagnosis and treatment." Id.

However, under longstanding Supreme Court precedent, "[s]tates may regulate professional conduct, even though that conduct incidentally involves speech." See NIFLA, 585 U.S. at 768; see also Sorrell v. IMS Health Inc., 564 U.S. 552, 567 (2011) ("the First Amendment does not prevent restrictions directed at . . . conduct from imposing incidental burdens on speech"); R.A.V. v. City of St. Paul, 505 U.S. 377, 389 (1992)

1 ("words can in some circumstances violate laws directed not
2 against speech but against conduct"). "'[I]t has never been
3 deemed an abridgement of freedom of speech or press to make a
4 course of conduct illegal merely because the conduct was in part
5 initiated, evidenced, or carried out by means of language, either
6 spoken, written, or printed.'" Nat'l Ass'n for Advancement of
7 Psychoanalysis v. Cal. Bd. of Psych., 228 F.3d 1043, 1053 (9th
8 Cir. 2000) ("NAAP") (quoting Giboney v. Empire Storage & Ice Co.,
9 336 U.S. 490, 502 (1949)).

10 Physician conduct is no exception to this rule.
11 Accordingly, the Supreme Court has explained that there is "no
12 constitutional infirmity" where a law "implicate[s]" a
13 physician's First Amendment rights "only as part of the practice
14 of medicine, [which is] subject to reasonable licensing and
15 regulation by the State." See Planned Parenthood of Se. Pa. v.
16 Casey, 505 U.S. 833, 884 (1992), overruled on other grounds by
17 Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022) (cited
18 with approval in NIFLA, 585 U.S. at 769-70). "When a drug is
19 banned, for example, a doctor who treats patients with that drug
20 does not have a First Amendment right to speak the words
21 necessary to provide or administer the banned drug." Pickup v.
22 Brown, 740 F.3d 1208, 1229 (9th Cir. 2014), abrogated on other
23 grounds by NIFLA, 585 U.S. 755. Indeed, "[m]ost, if not all,
24 medical . . . treatments require speech, but that fact does not
25 give rise to a First Amendment claim." Id.; see also Robert
26 Post, Informed Consent to Abortion: A First Amendment Analysis of
27 Compelled Physician Speech, 2007 U. Ill. L. Rev. 939, 950 (2007)
28 ("The practice of medicine, like all human behavior, transpires

1 through the medium of speech. In regulating the practice,
2 therefore, the state must necessarily also regulate" the speech
3 of physicians.).

4 1. Overview of Recent Cases

5 In Pickup, the Ninth Circuit analyzed the speech-
6 conduct distinction in a case challenging Washington's law
7 banning the practice of sexual orientation conversation therapy
8 on children. The court stated that laws regulating the speech of
9 health care professionals could be placed along a "continuum."
10 See 740 F.3d at 1227. "At one end of the continuum, where a
11 professional is engaged in a public dialogue, First Amendment
12 protection is at its greatest." Id. "At the other end of the
13 continuum . . . is the regulation of professional conduct, where
14 the state's power is great, even though such regulation may have
15 an incidental effect on speech." Id. at 1229 (emphasis added).

16 "At the midpoint of the continuum, within the confines
17 of a professional relationship, First Amendment protection of a
18 professional's speech is somewhat diminished." Id. at 1228. As
19 such, the Ninth Circuit explained, in that midpoint category of
20 "professional speech," "the First Amendment tolerates a
21 substantial amount of speech regulation within the professional-
22 client relationship that it would not tolerate outside of it."
23 See id. at 1229.

24 Applying these principles to the Washington law, the
25 Pickup court concluded that the challenged law fell at the
26 "conduct" end of the spectrum because it regulated a "form of
27 treatment" and "[did] nothing to prevent licensed therapists from
28 discussed the pros and cons of [conversion therapy] with their

1 patients." See id. That "speech may be used to carry out"
2 conversion therapy "[did] not turn the regulation of conduct into
3 a regulation of speech." Id.

4 Four years later, in NIFLA, the Supreme Court
5 considered a California law requiring so-called "crisis pregnancy
6 centers" to make certain compelled disclosures. See 585 U.S. at
7 763-64. In analyzing the constitutionality of the law, the NIFLA
8 court explicitly rejected Pickup's continuum approach and
9 delineation of "'professional speech' as a separate category of
10 speech that is subject to different rules." See id. at 767. The
11 Court stated that its "precedents do not recognize [a tradition
12 of allowing content-based restrictions] for a category called
13 'professional speech,'" but reiterated the longstanding rule --
14 relied upon by the Pickup court -- that "States may regulate
15 professional conduct, even though that conduct incidentally
16 involves speech." See id. at 768.

17 In Tingley v. Ferguson, 47 F.4th 1055 (9th Cir. 2022),
18 cert. denied, 144 S. Ct. 33 (2023), the Ninth Circuit considered
19 a challenge to a California law banning conversion therapy that
20 was functionally identical to the one considered in Pickup. The
21 case gave the Ninth Circuit occasion to consider what effect
22 NIFLA had on Pickup. The court concluded that "NIFLA abrogated
23 only the 'professional speech' doctrine -- the part of Pickup in
24 which we determined that speech within the confines of a
25 professional relationship" (the "theoretical 'midpoint' of the
26 continuum") receives decreased scrutiny. See id. at 1073, 1075.

27 However, the Tingley court determined that "the
28 conduct-versus-speech distinction from Pickup remains intact"

1 post-NIFLA. See id. at 1055. NIFLA therefore did not abrogate
2 Pickup's analysis of the Washington conversion therapy law, which
3 fell within the category of professional conduct. See id. at
4 1077.
5 Following NIFLA and Tingley, then, a court's task in
6 analyzing a regulation of physicians under the First Amendment is
7 to determine whether the law at issue regulates physician speech,
8 in which case it is subject to strict scrutiny; or regulates
9 physician conduct, in which case it is not constitutionally
10 suspect and subject to rational basis review. See NIFLA, 585
11 U.S. at 767; Tingley, 47 F.4th at 1072, 1078.
12 2. Physician Conduct Versus Physician Speech
13 As a representative example, Dr. Kory avers that he
14 provides consultations during which he addresses patient
15 "questions and concerns" about ivermectin for the treatment of
16 COVID-19, including "whether he recommends its use." (Verified
17 Compl. (Docket No. 9) ¶ 19.)[1] Relying on Conant, plaintiffs
18 argue that this type of consultation is protected physician
19 speech.
20 In Conant, the Ninth Circuit addressed the
21 constitutionality of a federal policy of "investigating doctors
22 or initiating proceedings against doctors only because they
23 'recommend' the use of marijuana." 309 F.3d at 634. This policy
24 was grounded in marijuana's classification as a controlled
25 substance, which barred doctors from prescribing marijuana in any
26
27 [1] While plaintiffs make numerous contentions concerning
the efficacy of ivermectin in treating COVID-19, the court's task
28 here is not to determine the legitimacy of any medical treatment.

circumstance. See id. at 632-34. The Ninth Circuit concluded that the policy violated the First Amendment because it "punish[ed] physicians on the basis of the content of doctor-patient communications." See id. at 637.

In coming to this conclusion, the Ninth Circuit pointed out the distinction between a "recommendation" untethered from treatment of a patient, and a "recommendation [that] the physician intends for the patient to use . . . as the means for obtaining marijuana." See id. at 635. The former is speech, while the latter is regulable conduct -- akin to a doctor's "prescription" of a drug -- that could lead to criminal liability for aiding and abetting the patient's violation of federal law. See id. at 635-36. As the Pickup court explained, Conant indicates that "doctor-patient communications about medical treatment receive substantial First Amendment protection, [while] the government has more leeway to regulate the conduct necessary to administering treatment itself." See 740 F.3d at 1227.

It was not, as plaintiffs seem to suggest, the use of the word "recommendation" that was dispositive in Conant. If that were the case, doctors could frame their treatment as "recommendations" to shield themselves from regulation. Instead, it was the relationship of the doctors' marijuana recommendation to treatment that mattered. See Conant, 309 F.3d at 635-36; Pickup, 740 F.3d at 1227; see also Rumsfeld v. F. for Acad. and Inst. Rights, Inc., 547 U.S. 47, 66 (2006) ("If combining speech and conduct were enough to create expressive conduct, a regulated party could always transform conduct into 'speech' simply by talking about it.").

It is important to note the specific context presented by Conant where, by legal necessity, any physician's "recommendation" of marijuana was entirely disconnected from the physician's treatment of the patients. This is because to treat a patient with marijuana was illegal and would have subjected the physician to criminal liability (which the parties agreed was not constitutionally problematic). See 309 F.3d at 634-35; see also Pickup, 740 F.3d at 1229 (explaining that the policy at issue in Conant "prohibited speech wholly apart from the actual provision of treatment") (emphasis in original). Thus, in Conant, it was simple for the Ninth Circuit to create a clear "demarcation between conduct and speech." See Pickup, 740 F.3d at 1226 (citing Conant, 309 F.3d at 632, 635-36); see also Conant, 309 F.3d at 635 (indicating that the injunction upheld on review drew a "clear line between protected medical speech and illegal conduct").

Most situations in medical practice are not so clear-cut. Within the same patient conversation, a doctor could go from (1) speaking about his views on a particular treatment based on his experience and expertise, to (2) prescribing the use of that treatment for the patient's care. The former would be speech, while the latter would be conduct. This is because the "key component" of a doctor's prescription of a drug is the provision of the drug, not the speech itself. See NAAP, 228 F.3d at 1054. And "the First Amendment does not prevent a state from regulating treatment even when that treatment is performed through speech alone." Pickup, 740 F.3d at 1230. Thus, when a doctor speaks in his capacity as the patient's treating physician

1 and incident to his provision of medical care, the physician's
2 words constitute regulable conduct.

3 Returning to the situation posed by Dr. Kory, his
4 discussion with a patient of the "pros and cons" of ivermectin
5 and a statement that he generally recommends the use of that
6 treatment for COVID-19 could be considered speech. See Conant,
7 309 F.3d at 634; see also Pickup, 740 F.3d at 1229 (law banning
8 conversion therapy was constitutional in part because it
9 "allow[ed] discussions about treatment, recommendations to obtain
10 treatment, and expressions of opinions about" treatment). If Dr.
11 Kory were to prescribe the medication, instruct the patient to
12 take the medication, or otherwise use words to treat the patient
13 -- for example by saying, "I recommend that you take 10
14 milligrams of ivermectin once a day for seven days" -- Dr. Kory's
15 words could constitute conduct regulable by the state, as his
16 speech was incident to his treatment of the patient.[2] Cf.
17 Conant, 309 F.3d at 635-36 (indicating that when a "physician
18 intends for the patient to use [his recommendation] as the means
19 for obtaining" an illegal drug, the recommendation of the drug
20 can be considered criminal conduct).

21 The court recognizes that the distinction between
22 physician speech and conduct may be subtle at times.
23 Nonetheless, "[w]hile drawing the line between speech and conduct
24 can be difficult, [the Supreme Court's] precedents have long
25

26 [2] The court again emphasizes that it takes no position on
the propriety of using ivermectin to treat COVID-19. It only
27 concludes that, in the example raised by plaintiffs, treating a
patient with ivermectin falls within the bounds of "conduct" that
28 the state may permissibly regulate.

1 drawn it." NIFLA, 585 U.S. at 769.

2 B. Section 2234(c) Is a Facially Constitutional Regulation
3 of Physician Conduct

4 California Business & Professions Code § 2234 grants
5 the Boards authority to "take action against any licensee who is
6 charged with unprofessional conduct." Unprofessional conduct
7 includes, but is not limited to, incompetence, gross negligence,
8 and repeated negligent acts. Id. Plaintiffs seek to enjoin
9 enforcement of section 2234(c) pertaining to "repeated negligent
10 acts," which are defined as "[a]n initial negligent act or
11 omission followed by a separate and distinct departure from the
12 applicable standard of care." Id. § 2234(c).[3] Plaintiffs argue
13 that the Boards will impermissibly use section 2234(c) to
14 discipline physicians for constitutionally protected doctor-
15 patient communications concerning COVID-19.

16 The statute is neutral on its face and applies broadly
17 to the practice of medicine by all doctors. It does not
18 discriminate between different types of content or speakers and
19 is therefore not a content-based regulation requiring the
20 application of strict scrutiny. See NIFLA, 585 U.S. at 766
21 (content-based regulations are those that "target speech based on
22 its communicative content"); see also NAAP, 228 F.3d at 1055
23

24 [3] Plaintiffs state that they seek to enjoin the entirety
25 of section 2234. However, their arguments appear only to address
section 2234(c), and plaintiffs' counsel admits that he "has not
26 identified any other provision of the Business and Professions
Code which could be utilized by the board as an alternative"
27 basis for discipline. (See Docket No. 18 at 10.) The court
therefore construes plaintiffs' motion as a challenge to section
28 2234(c).

("California's [psychoanalyst] licensing scheme is content and viewpoint neutral; therefore, it does not trigger strict scrutiny.").

Further, the plain language of the statute -- which uses the terms "unprofessional conduct" and "act or omission" -- clearly contemplates disciplinary action for conduct, not speech. The statute's reference to the standard of care makes this plain as, by its very nature, the standard of care applies to care, not speech. See Alef v. Alta Bates Hosp., 5 Cal. App. 4th 208, 215 (1st Dist. 1992) (the standard of care determines "the minimum level of care to which the patient is entitled") (emphasis added). The statute is therefore a regulation of professional conduct with only an incidental effect on speech, if any. See NIFLA, 585 U.S. at 768; Casey, 505 U.S. at 884.

Because section 2234(c) regulates conduct, it need only satisfy rational basis review. See Tingley, 47 F.4th at 1078. Under this standard, a law need only be "rationally related to a legitimate state interest" to pass constitutional muster. See id. Section 2234(c) easily satisfies that standard.

A state has "a 'compelling interest in the practice of professions within [its] boundaries.'" Tingley, 47 F.4th at 1078 (quoting Goldfarb v. Va. State Bar, 421 U.S. 773, 792 (1975)). A state also has an interest in regulating health care providers to protect patient health and safety. See Gonzales v. Carhart, 550 U.S. 124, 166 (2007); NAAP, 228 F.3d at 1054. The requirement that doctors provide appropriate care is plainly related to advancing those interests.

Indeed, as the Supreme Court has explained:

1 2 3 4 5 6

> It is elemental that a state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state's police power. The state's discretion in that field extends naturally to the regulation of all professions concerned with health . . . . It is equally clear that a state's legitimate concern for maintaining high standards of professional conduct extends beyond initial licensing. Without continuing supervision, initial examinations afford little protection.

7 Barsky v. Bd. of Regents of Univ. of State of N.Y., 347 U.S. 442,
8 451 (1954). Accordingly, state "health and welfare laws" are
9 "entitled to a 'strong presumption of validity.'" See Dobbs, 597
10 U.S. at 301 (quoting Heller v. Doe, 509 U.S. 312, 319 (1993));
11 see also Conant, 309 F.3d at 639 (federal courts should respect
12 the "principles of federalism that have left states as the
13 primary regulators of [health professionals'] conduct"); NAAP,
14 228 F.3d at 1054 (citing Watson v. Maryland, 218 U.S. 173, 176
15 (1910)) ("It is properly within the state's police power to
16 regulate and license professions, especially when public health
17 concerns are affected.").

18 For the foregoing reasons, the court concludes that
19 section 2234(c) is a facially constitutional regulation of
20 physician conduct.

21 22 C. Plaintiffs' Have Not Established Standing to Bring an As-Applied Challenge to Board Enforcement

23 Because section 2234(c) is a regulation of physician
24 conduct, Board discipline of protected speech would be, by
25 definition, outside the scope of 2234(c). To obtain an
26 injunction, plaintiffs would therefore need to mount an as-
27 applied challenge to some policy or practice of disciplining
28 physician speech by the Boards. However, plaintiffs have failed

to establish standing to challenge any such policy or practice.[4]

Article III standing has three elements: "(1) injury-in-fact -- plaintiff must allege concrete and particularized and actual or imminent harm to a legally protected interest; (2) causal connection -- the injury must be fairly traceable to the conduct complained of; and (3) redressability -- a favorable decision must be likely to redress the injury-in-fact." Barnum Timber Co. v. U.S. EPA, 633 F.3d 894, 897 (9th Cir. 2011) (citing Lujan v. Defs. of Wildlife, 504 U.S. 555, 560 (1992)) (internal quotation marks omitted).

"[A] plaintiff satisfies the injury-in-fact requirement where he alleges 'an intention to engage in a course of conduct arguably affected with a constitutional interest, but proscribed by a statute, and there exists a credible threat of prosecution thereunder.'" Susan B. Anthony List v. Driehaus, 573 U.S. 149, 159 (2014) (quoting Babbitt v. United Farm Workers Nat'l Union, 442 U.S. 289, 298 (1979)). The Ninth Circuit applies a "three-factor inquiry to help determine whether a threat of enforcement is genuine enough to confer an Article III injury": "(1) whether the plaintiff has a 'concrete plan' to violate the law, (2) whether the enforcement authorities have 'communicated a specific warning or threat to initiate proceedings,' and (3) whether there is a 'history of past prosecution or enforcement.'" Tingley, 47 F.4th at 1067 (quoting Thomas v. Anchorage Equal Rts. Comm'n, 220 F.3d 1134, 1139 (9th Cir. 2000) (en banc)). "'Neither the mere

[4] Although defendants did not expressly argue that plaintiffs lack standing, the court nonetheless has a duty to evaluate Article III standing. See Bernhardt v. County of Los Angeles, 279 F.3d 862, 868 (9th Cir. 2002).

1 existence of a proscriptive statute nor a generalized threat of
2 prosecution' satisfies this test." Id. (quoting Thomas, 220 F.3d
3 at 1139).
4 Challenges that involve First Amendment rights "present
5 unique standing considerations" because of the "chilling effect
6 of sweeping restrictions" on speech. Ariz. Right to Life Pol.
7 Action Comm. v. Bayless, 320 F.3d 1002, 1006 (9th Cir. 2003).
8 "In order to avoid this chilling effect, the Supreme Court has
9 endorsed what might be called a 'hold your tongue and challenge
10 now' approach rather than requiring litigants to speak first and
11 take their chances with the consequences." Italian Colors Rest.
12 v. Becerra, 878 F.3d 1165, 1171 (9th Cir. 2018) (internal
13 quotation marks omitted). Accordingly, when the challenged law
14 "implicates First Amendment rights, the [standing] inquiry tilts
15 dramatically toward a finding of standing." LSO, Ltd. v. Stroh,
16 205 F.3d 1146, 1155 (9th Cir. 2000).
17 Nonetheless, a plaintiff challenging a law on First
18 Amendment grounds must still demonstrate that "there exists a
19 credible threat of prosecution thereunder." See Susan B. Anthony
20 List, 573 U.S. at 159; see also Italian Colors Rest., 878 F.3d at
21 1171 ("Even in the First Amendment context, a plaintiff must show
22 a credible threat of enforcement.").
23 Plaintiffs have failed to make the necessary showing,
24 as the record is utterly devoid of any evidence that the Boards
25 have or may use their authority under section 2234(c) to do
26 anything other than regulate physician conduct, let alone
27 discipline physicians for their protected speech in the manner
28 plaintiffs suggest.

1 1. Threat of Enforcement

2 To show that authorities have communicated a threat of
3 enforcement, plaintiffs point to a statement allegedly made by
4 Assemblyman Evan Low (a sponsor of AB 2098) following the repeal
5 of AB 2098. Low purportedly stated that, despite the law's
6 repeal, "the Medical Board of California will continue to
7 maintain the authority to hold medical licensees accountable for
8 deviating from the standard of care and misinforming their
9 patients about COVID-19 treatments." (See Verified Compl. ¶ 73.)
10 Assuming that Mr. Low, in fact, made that statement (which
11 plaintiffs have not established)[5], it provides no support for
12 plaintiffs' argument. Mr. Low is not a defendant in this action.
13 And the pronouncement of a politician, without more, does not
14 indicate that the Boards -- administrative agencies that operate
15 independently of the California Legislature -- will apply the law
16 in any particular way. See Dist. of Columbia v. Heller, 554 U.S.
17 570, 605 (2008) (explaining that so-called "postenactment
18 legislative history" is not legislative history at all and is not
19 a proper interpretive tool); Graham Cnty. Soil & Water
20 Conservation Dist. v. U.S. ex rel. Wilson, 559 U.S. 280, 297
21 (2010) ("a single sentence by a single legislator" is not
22

23 [5] The statement was provided by plaintiffs only in the form of an unsupported allegation. (See Verified Compl. ¶ 73.)
24 However, the court was able to locate a Los Angeles Times article containing the quote from Assemblyman Low. See Corinne Purtill,
25 Controversial law punishing doctors who spread COVID misinformation on track to be undone, Los Angeles Times (Sept.
26 11, 2023). The court takes judicial notice of the fact that said quote was attributed to Mr. Low "in the public realm at the time"
27 but expresses no opinion about "whether the contents of th[e] article[] were in fact true." See Von Saher v. Norton Simon
28 Museum of Art at Pasadena, 592 F.3d 954, 960 (9th Cir. 2010).

1 "entitled to any meaningful weight"); Chem. Producers & Distribs.
2 Ass'n v. Helliker, 463 F.3d 871, 879 (9th Cir. 2006), overruled
3 on other grounds by Bd. of Trs. of Glazing Health & Welfare Tr.
4 v. Chambers, 941 F.3d 1195 (9th Cir. 2019) ("Attributing the
5 actions of a legislature to third parties rather than to the
6 legislature itself is of dubious legitimacy, and the cases
7 uniformly decline to do so."); X-Men Sec., Inc. v. Pataki, 196
8 F.3d 56, 69 (2d Cir. 1999) (the actions of legislators who
9 "cajole" and "exhort" agencies concerning administration of a
10 statute are "political rather than legislative in nature");
11 Goolsby v. Blumenthal, 581 F.2d 455, 460 (5th Cir. 1978), on
12 reh'g, 590 F.2d 1369 (5th Cir. 1979) (quoting Reg'l Rail Reorg.
13 Act Cases, 419 U.S. 102, 132 (1974)) ("post-passage remarks of
14 legislators . . . 'represent only the personal views of these
15 legislators'").

16 To establish a history of prior enforcement, plaintiffs
17 point to the alleged Board discipline of a physician who is not a
18 plaintiff in this action, Dr. Ana Reyna, for her provision of
19 certain COVID-19-related information and opinions. However,
20 plaintiffs provide nothing more than bare, unverified allegations
21 concerning the basis for Dr. Reyna's Board discipline. (See
22 Verified Compl. ¶¶ 21, 74.) The only evidence before the court
23 concerning Dr. Reyna shows that she surrendered her license
24 following the commencement of disciplinary proceedings. (See
25 id.) Because plaintiffs have not provided (and the court was
26 unable to locate) evidence regarding the basis for the
27 disciplinary action, the court disregards these allegations.

28 Finally, plaintiffs rely on the administrative and

legislative history related to AB 2098 to demonstrate that their desired speech concerning COVID-19 is proscribed by Board policy. But this case pertains to section 2234, not the now-repealed AB 2098. Plaintiffs have provided no evidence that the Boards have or will treat the repeal of AB 2098 -- along with this court's preliminary injunction order and the Ninth Circuit panel's skepticism of the law during oral argument on the McDonald appeal[6] -- as anything other than a mandate to refrain from improper regulation of doctors' speech. See Rosebrock v. Mathis, 745 F.3d 963, 971 (9th Cir. 2014) ("We presume that a government entity is acting in good faith when it changes its policy."). Indeed, defendant Varghese stated in his capacity as Executive Director of the Medical Board that, following the passage of the repeal bill, AB 2098 would not be enforced even while it was still in effect. See McDonald, 94 F.4th at 869.

Accordingly, the court concludes that plaintiffs have failed to establish that there is any threat the Boards will enforce section 2234(c) or otherwise discipline physicians in a manner that implicates their protected speech.

2. COVID-19 and the Standard of Care

Plaintiffs additionally argue that they face a risk of discipline for any care provided to treat COVID-19 because "there is no legitimate [COVID-19] standard of care." (See Docket No. 14 at 13.) In support of that argument, they cite the declaration they relied upon in Hoang v. Bonta (see Hoang Docket

[6] See Oral Argument at 18:16 - 31:00, McDonald v. Lawson, 94 F.4th 864, No. 22-56220 (9th Cir. 2023), https://www.ca9.uscourts.gov/media/video/?20230717/22-56220/.

No. 4-2) and a declaration filed in this matter providing additional information and scientific updates (see Kory Docket No. 14-1). The declarations, authored by Dr. Sanjay Verma and not objected to by defendants, explain the various ways in which the scientific evidence on COVID-19 has changed over time and remains contested. They also explain several ways in which the pronouncements of public health authorities concerning COVID-19 have vacillated, at times to the point of either inconsistency with scientific evidence or direct contradiction of prior recommendations.

For example, Dr. Verma points out that at the beginning of the pandemic, the CDC represented that cloth masks prevented COVID-19 transmission and recommended their use among the general population. (See Hoang Decl. ¶¶ 13-18; Appendix 1 to Hoang Decl.) Later, scientific studies showed that cloth masks were not effective at preventing the spread of COVID-19, and the CDC eventually changed its recommendation concerning their use. (See id.) As another example, Dr. Verma avers that the CDC continues to recommend that the general population keep "up to date" on COVID-19 vaccines and boosters, despite studies showing dwindling vaccine efficacy and the potential for serious side effects. (See Kory Decl. ¶¶ 39-46.) From such changes, disagreement, and inconsistencies, plaintiffs make the logical leap that there is no standard of care for COVID-19 treatment, placing them at risk of discipline for all COVID-19-related care.

The court can understand plaintiffs' frustration over the various discrepancies and shifts in recommendations concerning COVID-19. And the inconsistencies apparent in many of

those recommendations unfortunately do not reflect well on the credibility of those who made them. However, it simply does not follow that there is no standard of care applicable to COVID-19. It cannot be the case that scientific disagreement and inconsistencies in public health recommendations exempt doctors from the requirement that they adhere to the standard of care.

The standard of care is a well-established legal concept, "requir[ing] that medical service providers exercise that degree of skill, knowledge and care ordinarily possessed and exercised by members of their profession under similar circumstances." See Barris v. County of Los Angeles, 20 Cal. 4th 101, 108 (1999). As defendants point out, this standard, in one formulation or another, has governed the practice of medicine for centuries. See Robert I. Field, The Malpractice Crisis Turns 175: What Lessons Does History Hold for Reform?, 4 Drexel L. Rev. 7, 10 (2011) ("[t]he earliest lawsuits for medical mistakes date back several centuries to the formative stages of the common law," with the "first reported case . . . decided in 1374"); see also Arnett v. Dal Cielo, 14 Cal. 4th 4, 7 (1996) ("[s]ince the earliest days of regulation," the California medical boards "have been charged with the duty to protect the public against incompetent, impaired, or negligent physicians"). The application of a professional standard of practice is hardly unique to the healthcare context. See, e.g., Gunn v. Minton, 568 U.S. 251, 264 (2013) (indicating that states have "a special responsibility for maintaining standards among members of the licensed professions," including through the imposition of standards of practice for lawyers) (internal quotation marks and

citations omitted).

"The standard of care against which the acts of a physician are to be measured is a matter peculiarly within the knowledge of experts; it . . . can only be proved by their testimony, unless the conduct required by the particular circumstances is within the common knowledge of the layman." Flowers v. Torrance Mem'l Hosp. Med. Ctr., 8 Cal. 4th 992, 1001 (1994). (See also Calderon Decl. (Docket No. 17-1) ¶¶ 6-7, Varghese Decl. (Docket No. 17-2) ¶¶ 5-6 (explaining that when the Boards investigate a physician, a "medical consultant . . . examines the medical record and any additional evidence to determine whether there is a potential violation of the standard of care," in which case the matter is subject to further review by a "retained outside medical expert"). Importantly, because determination of the appropriate standard of care "is inherently situational, the amount of care deemed reasonable in any particular case will vary." Flowers, 8 Cal. 4th at 997 (emphasis added). No court could make a broad pronouncement about the standard(s) of care applicable to an entire disease -- which can present a vast range of clinical presentations and possible treatment options -- let alone conclude that no such standard exists.

That the standard of care remains in force in the COVID-19 context is supported by common sense. Although there may be areas of uncertainty when it comes to COVID-19, there are nonetheless types of treatment that are clearly not permissible. As a purely hypothetical example, if a doctor were to order a patient under his care to drink a gallon of industrial rat poison

to treat COVID-19, no one could argue that would be consistent with the standard of care. To conclude otherwise would interfere with the State's appropriate exercise of its authority to ensure that patients are protected from "charlatan[s]" masquerading as professionals. See Pickup, 740 F.3d at 1228.

Seeking to brush aside the centuries-long regulation of the medical profession, plaintiffs seem to conflate the standard of care with the vague notion of "scientific consensus." Their argument is premised on this court's prior finding that COVID-19 was "a quickly evolving area of science that in many aspects eludes consensus," and therefore the term "scientific consensus" was unconstitutionally vague. See Høeg, 652 F. Supp. 3d at 1188. While the concept of a "consensus" among the medical community may be related to the standard of care, the terms are not interchangeable. And as indicated above, plaintiffs have not offered any evidence that, following the repeal of AB 2098, the Boards will discipline doctors in a manner that conflates the two.

Plaintiffs also appear to treat the standard of care as a rigid benchmark that cannot countenance reasonable medical disagreement. To the contrary, the standard of care can and does account for differing views among medical professionals. See McAlpine v. Norman, 51 Cal. App. 5th 933, 938-39 (3d Dist. 2020) (indicating that the standard of care in a medical malpractice action is routinely determined based on "competing expert testimony"); Blackwell v. Hurst, 46 Cal. App. 4th 939, 944 (2d Dist. 1996) ("a difference of medical opinion concerning the desirability of a particular medical procedure when several are

available does not establish that the one used was negligent"); Glover v. Bd. of Med. Quality Assurance, 231 Cal. App. 3d 203, 208 (1st Dist. 1991) ("As long as the differences of opinion [on the standard of care] are legitimate, we have no dispute with the notion that different methods of treatment can all be considered acceptable medical practice."); Fraijo v. Hartland Hosp., 99 Cal. App. 3d 331, 343 (2d Dist. 1979) (a physician's "error in medical judgment" in selecting among treatment options is not automatically considered negligent, but rather is "weighed in terms of the professional standard of care"); Gearhart v. United States, No. 15-cv-665 MDD, 2016 WL 3251972, at *9 (S.D. Cal. June 14, 2016) ("Under California law, a mere difference of medical opinion is insufficient evidence to support a finding of negligence.").

"Professionals might have a host of good-faith disagreements, both with each other and with the government, on many topics in their respective fields." NIFLA, 585 U.S. at 772. "Only rarely does the physician enjoy true certainty regarding any issue." 1 Am. Law Med. Malp. § 3:8. Disagreement between competent medical professionals on the best course of treatment for a given condition is common, and there is not necessarily any violation of the standard of care in those circumstances. See id. § 3:3 ("Within certain clinical settings, there may be reasonably applicable alternative methods of diagnosis or treatment. A physician choosing one or the other method would not violate a 'standard' of good medical practice."); see also Philip G. Peters, Jr., Doctors & Juries, 105 Mich. L. Rev. 1453, 1477 (2007) ("when researchers ask physicians to rate the quality

of care provided by other physicians, the participants disagree among themselves" at a "surprisingly high" rate, as "[r]easonable professionals often reach different conclusions about the same evidence"); Peter D. Jacobson & Stefanie A. Doebler, "We Were All Sold A Bill of Goods:" Litigating the Science of Breast Cancer Treatment, 52 Wayne L. Rev. 43, 79 (2006) (in evaluating whether a novel treatment option comports with the standard of care, part of a court's task is to determine "when the widespread disagreement among qualified medical experts over whether the treatment or procedure at issue has crossed the line from being an experimental procedure to become an acceptable medical practice"); James Ducharme, Clinical Guidelines and Policies: Can They Improve Emergency Department Pain Management?, 33 J.L. Med. & Ethics 783, 786 (2005) ("If there is more than one recognized course of treatment, most courts will allow some flexibility in what is regarded as customary."); Joan P. Dailey, The Two Schools of Thought and Informed Consent Doctrines in Pennsylvania: A Model for Integration, 98 Dick. L. Rev. 713, 714 (1994) ("Courts have long recognized that medicine is not an exact science and that therefore physicians are bound to disagree over the propriety of various treatments.").

Even medical approaches that are in the minority can be considered within the standard of care. See 1 Am. Law Med. Malp. § 3:3 ("What is custom and practice in the medical profession is usually a reliable measure of due care. However, that is not always the case.") (citing Texas & P. Ry. Co. v. Behymer, 189 U.S. 468, 470 (1903)). It could even be considered a violation of the standard of care to continue using a long-established

1 treatment if a doctor failed to remain informed of advances in
2 medical knowledge. See id. ("The standard of care clearly
3 requires a doctor to keep up to date and abreast of changes.").[7]
4 As the Supreme Court has stated, states have "wide
5 discretion to [regulate] areas where there is medical and
6 scientific uncertainty." See Gonzales, 550 U.S. at 163. COVID-
7 19 is far from the first medical topic to prompt controversy and
8 serious disagreement among doctors and scientists. See, e.g.,
9 Conant, 309 F.3d at 643 (Kozinski, J., concurring) (describing
10 the "genuine difference of expert opinion on the subject [of
11 medical marijuana], with significant scientific and anecdotal
12 evidence supporting both points of view"); Caroline Lowry,
13 Intersex in 2018: Evaluating the Limitations of Informed Consent
14 in Medical Malpractice Claims As A Vehicle for Gender Justice, 52
15 Colum. J.L. & Soc. Probs. 321, 339 (2019) ("[t]he standard of
16 care for treating intersex individuals is controversial and ever-
17 changing" due in part to "sparse and incomplete" research on the
18 topic); Katherine Goodman, Prosecution of Physicians As Drug
19 Traffickers: The United States' Failed Protection of Legitimate
20 Opioid Prescription Under the Controlled Substances Act and South
21
22 [7] Indeed, California law recognizes that medical science
is frequently changing and can offer worthwhile treatments that
23 are not broadly accepted. The California Right to Try Act, Cal.
Health & Safety Code § 111548, provides that a patient with a
24 life-threatening disease who has considered all available FDA-
approved treatment options and is unable to participate in an
25 applicable clinical trial has the right to undergo an
"investigational" treatment recommended by his physician, see id.
26 § 111548.1(b). A physician is immune from Board discipline for
27 prescribing investigational treatments under those circumstances,
when carried out in accordance with the procedural protocol
28 established by the relevant Board. See id. § 111548.3(a).

Australia's Alternative Regulatory Approach, 47 Colum. J. Transnat'l L. 210, 226–27 (2008) ("physicians widely disagree about the propriety of administering narcotics for short-term pain or to addicts, and there is little agreement about the addiction risks that narcotics present" and "the maximum thresholds for high-dose opioid therapy"). It would be absurd to conclude that the State forfeits its broad authority to regulate the practice of medicine whenever such disagreement is present.

For the court to conclude that no standard of care exists in the realm of COVID-19 would create an unprecedented exception to the long-established regulatory paradigm governing medical professionals. Such a conclusion would also functionally exempt doctors from both private malpractice actions and disciplinary proceedings under section 2234(c) whenever they provide care in connection with that disease, placing the public at risk of harm without recourse or adequate oversight.

Because plaintiffs have failed to establish a likelihood of success on the merits of their First Amendment challenge to California Business & Professions Code § 2234, IT IS HEREBY ORDERED that plaintiffs' motion for preliminary injunction (Docket No. 14) be, and the same hereby is, DENIED.

Dated: April 22, 2024

WILLIAM B. SHUBB
UNITED STATES DISTRICT JUDGE

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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

PIERRE KORY, M.D., BRYAN TYSON, M.D., LETRINH HOANG, D.O., PHYSICIANS FOR INFORMED CONSENT, a not-for-profit corporation, and CHILDREN'S HEALTH DEFENSE, a not-for-profit corporation,

Plaintiffs,

v.

ROB BONTA, in his official capacity as Attorney General of California, REJI VARGHESE, in his official capacity as Executive Director of the Medical Board of California, ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California,

Defendants.

2:24-cv-00001-WBS-AC

DECLARATION OF ERIKA CALDERON, EXECUTIVE DIRECTOR OF THE OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA, IN SUPPORT OF DEFENDANTS' OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION

Date:	April 1, 2024
Time:	1:30 p.m.
Dept:	5
Judge:	The Honorable William B. Shubb
Trial Date:	Not scheduled
Action Filed:	1/02/2024

///

1 I, Erika Calderon, declare:

2 1. I am the Executive Director of the Osteopathic Medical Board of California
3 ("Board"), Department of Consumer Affairs. I have been the Executive Director of the Board
4 since November 1, 2022. In my official capacity as the Executive Director for the Board, I have
5 personal knowledge of the facts stated herein and, if called as a witness I could and would testify
6 competently to those facts to the best of my knowledge.

7 2. The statutory authority and mandate for the powers and duties of Board is
8 provided in the Osteopathic Act (Bus. & Prof. Code, §§ 3600-1 – 3600-5), which provides that
9 the Board shall enforce the statutory provisions governing medical practitioners in Article 12
10 (commencing with Section 2220), of Chapter 5 of Division 2 of the Business and Professions
11 Code as to osteopathic practitioners. This statutory authority is further detailed in Business and
12 Professions Code §§ 2450-2459.7 ("Provisions Applicable to Osteopathic Physicians and
13 Surgeons"). Under the Osteopathic Act, the Board has established a comprehensive program for
14 licensing, regulating, investigating, and, where appropriate, disciplining physicians. The Board is
15 an entity within the California Department of Consumer Affairs.

16 3. The Board has the responsibility for enforcing the disciplinary provisions in
17 Article 12 applicable to its licensees and the Osteopathic Act. The Board is authorized to take
18 administrative action against all persons guilty of violating such laws and possesses all the
19 powers granted for that purpose, including investigating information that a physician may be
20 guilty of unprofessional conduct.

21 4. The mission of the Board is to protect health care consumers through the proper
22 licensing and regulation of the practice of osteopathic physicians and surgeons, and certain allied
23 health care professionals, as well as through the objective enforcement of the applicable law. The
24 Board also promotes access to quality medical care through its licensing and regulatory functions.
25 Protection of the public is the Board's highest priority in exercising its licensing, regulatory, and
26 disciplinary functions.

27 5. A primary way the Board protects the public is through the investigation of
28 consumer complaints involving the medical care patients have received from osteopathic

physicians and surgeons. The Board may also investigate osteopathic physicians and surgeons on its own initiative based upon information it receives from other sources (even anonymous ones).

6. Whether originating from a complaint or the Board's own initiative, each allegation is evaluated to determine whether there has been a potential violation of applicable law. Generally, if Board staff determine that the Board lacks jurisdiction over the alleged violation or that there is insufficient evidence of a violation, they will close the case and take no further action. Alternatively, if Board staff determine that there may be evidence of a violation, then an investigation is opened. This investigation includes a preliminary evaluation of the case by a medical consultant, who examines the medical record and any additional evidence to determine whether there is a potential violation of the standard of care.

7. If the medical consultant determines that the physician's conduct may fall below the standard of care, the case is referred for further investigation and will be reviewed by a retained outside medical expert under contract with the Board, who has the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint. That expert will independently evaluate the medical record (without seeing the medical consultant's earlier opinion) and any evidence in the case, and makes an objective evaluation of whether the subject physician violated the standard of care.

8. All investigations and their contents are confidential unless and until formal disciplinary action is taken and disciplinary proceedings are commenced.

9. At each step of review, including the initial intake review, the medical consultant review, and the independent expert review, the complaint against a physician may be closed and rejected if any of the reviewers conclude that there is not sufficient evidence to show a violation of applicable law, including if any reviewer concludes that there is not sufficient evidence to show the physician violated the standard of care. Investigations are often closed because no violation has been found.

10. If the reviewers conclude there is sufficient evidence of a violation to continue and disciplinary proceedings against the physician are filed, the Board has the burden of proof to show by clear and convincing evidence that the physician violated applicable law. For

disciplinary actions involving the quality of medical care a physician provided to patients, the Board has the burden of proof to show by clear and convincing evidence that the physician violated the standard of care.

11. If the Board initiates disciplinary proceedings against a physician, the physician is afforded full due process. The physician is entitled to dispute the charges at an administrative hearing presided over by an Administrative Law Judge. The physician's counsel has an opportunity to cross-examine the Board's expert on the issue of the standard of care and may present a defense expert challenging the Board expert on the standard of care.

12. After the hearing, the Administrative Law Judge writes a proposed decision. The proposed decision is then sent to the Board for consideration. The Board members make the final decision on disciplinary matters and can either adopt, modify, or reject the proposed decision, but they are required to give deference to the Administrative Law Judge's findings as to the respective credibility of conflicting expert testimony on the standard of care. If the decision finds grounds for discipline, the physician has the right to seek review of the decision in state court by way of administrative mandamus. Thus, investigations are multi-layered and comprehensive, can often take several months or years depending on the particular circumstances of each case, do not always result in the filing of any disciplinary action against a physician, and may not result in discipline even when an action is filed.

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13. Existing law currently provides a safe haven to protect physicians who wish to attempt innovative medical treatments from license discipline. The California "Right to Try Act," California Health and Safety Code section 111548 et seq., affords physicians the ability to attempt non-standard or scientifically accepted treatments in appropriate circumstances and with appropriate protections and regulatory oversight. The purpose of the Right to Try Act is to strike a balance between permitting physicians to attempt novel medical recommendations and treatments, while still protecting patients and the public from irresponsible or unregulated physician misconduct. The Act specifically states that, notwithstanding any other law, a physician who complies with the requirements of the act, including the notice and informed consent provisions, shall not be subject to license discipline.

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

Executed this 15th day of March, 2024, in Sacramento, California.

ERIKA CALDERON
Declarant

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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

PIERRE KORY, M.D., BRYAN TYSON, M.D., LETRINH HOANG, D.O., PHYSICIANS FOR INFORMED CONSENT, a not-for-profit corporation, and CHILDREN'S HEALTH DEFENSE, a not-for-profit corporation,

Plaintiffs,

v.

ROB BONTA, in his official capacity as Attorney General of California, REJI VARGHESE, in his official capacity as Executive Director of the Medical Board of California, ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California,

Defendants.

2:24-cv-00001-WBS-AC

DECLARATION OF REJI VARGHESE, EXECUTIVE DIRECTOR OF THE MEDICAL BOARD OF CALIFORNIA, IN SUPPORT OF DEFENDANTS' OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION

Date:	April 1, 2024
Time:	1:30 p.m.
Dept:	5
Judge:	The Honorable William B. Shubb
Trial Date:	Not scheduled
Action Filed:	1/02/2024

I, Reji Varghese, declare:

1. I am the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board"). I have held this position since June 23, 2023. Prior to becoming the Executive Director, I served as the Deputy Director from August 2020 until February 2023, and as the Interim Executive Director from February 2023 until I was sworn in as the Executive

Director. In my official capacity as the Executive Director for the Medical Board, I have personal knowledge of the facts set forth below and if called as a witness, I could and would competently testify to them.

2. The Medical Practice Act ("MPA") created the Board and established a comprehensive program for licensing, regulating, investigating, and, where appropriate, disciplining physicians. The Board is an entity within the California Department of Consumer Affairs. It has the responsibility for enforcing the disciplinary provisions of the MPA. The Board is authorized to take administrative action against all persons guilty of violating the MPA and possesses all the powers granted for that purpose, including investigating information that a physician may be guilty of unprofessional conduct.

3. The mission of the Board is to protect health care consumers through proper licensing and regulation of the practice of physicians and surgeons, and certain allied health care professionals, as well as through the objective enforcement of the MPA. The Board also promotes access to quality medical care through its licensing and regulatory functions. Protection of the public is the Board's highest priority in exercising its licensing, regulatory, and disciplinary functions.

4. A primary way the Board protects the public is through the investigation of consumer complaints involving the medical care patients have received from physicians and surgeons. The Board may also investigate physicians and surgeons on its own initiative based upon information it receives from other sources (even anonymous ones).

5. Whether originating from a complaint or the Board's own initiative, each allegation is evaluated to determine whether there has been a potential violation of the MPA. Generally, if Board staff determine that the Board lacks jurisdiction over the alleged violation or that there is insufficient evidence of a violation, they will close the case and take no further action. Alternatively, if Board staff determine that there may be evidence of a violation, then an investigation is opened. In cases where there is an allegation of substandard care by a physician or surgeon, this investigation includes a preliminary evaluation of the case by a medical

consultant who examines the medical record and any additional evidence to determine whether there is a potential violation of the standard of care.

6. If the medical consultant determines that the physician's conduct may have fallen below the standard of care, the case is referred for further investigation. During this further investigation, the case is reviewed by a retained outside medical expert, who practices in the same field of medicine as the physician under investigation. That expert will independently evaluate the medical record (without seeing the medical consultant's earlier opinion) and any evidence in the case, and provide an objective evaluation of whether the subject physician violated the standard of care.

7. All investigations and their contents are confidential unless and until formal disciplinary action is taken and disciplinary proceedings are commenced.

8. At each step of review, including the initial intake review, the medical consultant review, and the independent expert review, the complaint against a physician may be closed and rejected if any of the reviewers disagree that sufficient evidence exists to show a violation of the MPA, including if any reviewer concludes that there is not sufficient evidence to show the physician violated the standard of care. Investigations are often closed because no violation has been found.

9. If the reviewers conclude there is sufficient evidence of a violation to continue, disciplinary proceedings against the physician may be filed. During these proceedings, the Board has the burden of proof to show by clear and convincing evidence that the physician violated the MPA. For disciplinary actions involving the quality of medical care a physician provided to patients, the Board has the burden of proof to show by clear and convincing evidence that the physician violated the standard of care.

10. If the Board initiates disciplinary proceedings against a physician, the physician is afforded full due process. The physician is entitled to dispute the charges at an administrative hearing presided over by an Administrative Law Judge. The physician's counsel has an opportunity to cross-examine the Board's expert on the issue of the standard of care and may

present a defense expert challenging the Board expert's opinions on the standard of care and presenting alternative testimony as to the proper standard of care.

11. After the hearing, the Administrative Law Judge writes a proposed decision. The proposed decision is then sent to a panel of the Board for consideration. The Board members make the final decision on disciplinary matters and can either adopt, modify, or reject the proposed decision, but they are required to give deference to the Administrative Law Judge's findings on the respective credibility of conflicting expert testimony as to the standard of care. If the decision finds grounds for discipline, the physician has the right to seek review of the decision in Superior Court by way of administrative mandamus. Thus, investigations are multi-layered and comprehensive, can often take several months or years depending on the particular circumstances of each case, do not always result in the filing of any disciplinary action against a physician, and may not result in discipline even when an action is filed.

12. Existing law currently provides a safe haven to protect physicians who wish to attempt innovative medical treatments from license discipline. The California "Right to Try Act," California Health and Safety Code section 111548 et seq., affords physicians the ability to attempt non-standard or scientifically accepted treatments in appropriate circumstances and with appropriate protections and regulatory oversight. The purpose of the Right to Try Act is to strike a balance between permitting physicians to attempt novel medical recommendations and treatments, while still protecting patients and the public from irresponsible or unregulated physician misconduct. The Act specifically states that, notwithstanding any other law, a physician who complies with the requirements of the act, including the notice and informed consent provisions, shall not be subject to license discipline.

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

Executed this 13th day of March, 2024, in Sacramento, California.

REJI VARGHESE
Declarant

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

PIERRE KORY, M.D., LE TRINH HOANG, D.O., BRIAN TYSON, M.D., PHYSICIANS FOR INFORMED CONSENT, a not-for-profit corporation, and CHILDREN'S HEALTH DEFENSE, a not-for-profit corporation,

Plaintiffs,

v.

ROB BONTA, in his official capacity as Attorney General of California, REJI VARGHESE, in his official capacity as Executive Director of the Medical Board of California, ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California,

Defendants.

Case No: 2:24-cv-00001-WBS-AC

SANJAY VERMA, M.D. DECLARATION

Date: April 1, 2024
Time: 1:30 PM
Courtroom: 5, 14th Floor

Action Filed: January 2, 2024

1 I, SANJAY VERMA, MD declare as follows:
2 1. I have personal knowledge of the facts set forth herein. I submit this declaration
3 in support of Plaintiffs' Motion for a Preliminary Injunction to stop the medical and
4 osteopathic medical boards from disciplining physicians for the information and
5 recommendations they share with patients about COVID-19 infection, prognosis, treatments,
6 and vaccines.
7 2. I am a California licensed, board-certified internist with a subspecialty in
8 cardiovascular disease. My C.V. is attached as Exhibit A. I treat COVID-19 patients who
9 present with cardiac symptoms. I also treat patients who appear to present with severe adverse
10 cardiac side effects from the COVID-19 vaccines. I am frequently asked by patients about
11 various aspects of COVID-19 including the risks of cardiac complications, the efficacy of the
12 COVID-19 vaccines and boosters, the risks of COVID-19 vaccines, the extent to which the
13 new vaccines are tested, and post market surveillance for severe adverse effects (especially
14 cardiac issues) after COVID-19.
15 3. I also engage in research projects for Plaintiff Physicians for Informed Consent
16 ("PIC"). I interact with PIC's physician and lay members about my research and the reports I
17 write for the group. Consequently, I understand what concerns patients and front-line
18 physicians experience and what these physicians would want to tell patients. I have a good
19 working understanding on current scientific research on these topics. I understand what
20 information and scientific studies physicians might want to share with patients who want more
21 than a cursory overview or merely a perfunctory reiteration of public health recommendations
22 to take each successive booster.
23 4. I would bring to attention of the Court that in California as in most places
24 around the country, people who want to take the COVID-19 vaccine or booster can do so at a
25 pharmacy or clinic. At these facilities people do not have to pay for a medical visit to receive
26 the COVID-19 vaccines and boosters. My experience and common sense suggest that in
27 COVID-19 times, patients go to their doctors because they have questions or concerns about
28 the safety and efficacy of the COVID-19 vaccines despite the public health media campaign

1 extolling the benefits of the vaccines and their "exceedingly rare" side effects. In my
2 experience treating COVID-19 vaccine associated cardiac complications (especially
3 myocarditis), virtually all my patients had not previously heard of the risk of cardiac
4 complications before taking their primary series or boosters. Patients also have questions about
5 the off-label treatments for COVID-19. Patients go to physicians for information and advice
6 about COVID-19 vaccines and treatments and want to hear from an honest medical
7 professional who will be willing to transparently share information and perspectives that might
8 be at odds with what they hear from the public health authorities, the mainstream medical
9 associations and the large media outlets. The fact the most of my patients with cardiac
10 complications after COVID-19 vaccination had not previously been educated on these risks
11 underscores the material and sometimes fatal consequence of silencing physicians who engage
12 in an ethically transparent and comprehensive risk-benefit discussion.
13 5. However, sharing information contrary to the mainstream COVID-19 narrative
14 could subject California physicians to the same type of covid misinformation prosecutions
15 under Bus. & Prof. Code 2234, just as they could have been subjected to discipline under
16 Section 2270. I believe the boards' use of its statutory standard of care authority will certainly
17 dangerously censor speech of some California physicians the same way Section 2270 did.
18 Patients deserve to engage in comprehensive and transparent risk-benefit discussions with
19 physicians to fulfill the ethical edicts of informed consent.
20 6. Regarding the two different statutes being used to sanction and chill the
21 information and recommendations which have been used by the medical board, operatively,
22 from the physician's point of view there is little, if any, practical difference. First, the two
23 statutes have a common standard, being the "standard of care." However, for the same reasons
24 that it there is no actual contemporary scientific consensus regarding COVID-19, there is also
25 no actual standard of care. The standard of care is or is supposed to be based on the
26 contemporary scientific consensus, and the evidence of the problems with the latter is equally
27 applicable to evaluating the standard of care. Many physicians are simply regurgitating the
28 latest public health pronouncements to their patients concerned with key issues like the need

1 for continued boosters and the use off-label medications, despite the lack of evidence of
2 efficacy of the former and the emerging body of evidence for the later.
3 7. The "standard of care" has evolved so frequently during the past four years of the
4 COVID-19 era, that the public has lost all confidence in public health recommendations.
5 According to CDC, as of Dec 23, 2023 only 7.9% of children and 18.9% of adults nationally
6 have elected to be up to date with the current COVID-19 vaccine. Even in California, the rates
7 are 7.0% for children and 20.7% for adults. Even the highest risk group (65-74 year-old) only
8 have 37.5% rate of being up to date with current boosters. Clearly the public does not accept
9 public health experts' recommendations as "standard of care". The return of mask mandates
10 this winter is more aligned with political affiliation than with any agreed upon "standard of
11 care".
12 i. https://www.cdc.gov/vaccines/imz-
13 managers/coverage/covidvaxview/interactive/vaccination-dashboard.html
14 8. In addition to the information presented in my declaration in support of the
15 Preliminary Injunction Motion in the related case, *Hoang v Bonta* which challenged notions of
16 contemporary scientific consensus, herewith I present studies which have been published after
17 my previous declaration which further demonstrate that there is no such thing as a
18 contemporary scientific consensus, and/or studies which suggest that some of what is asserted
19 as scientific and part of the contemporary scientific consensus are actually invalid (i.e., have
20 proven to be incorrect or stultified). Rather, they are public health edicts which are not
21 consistent with the recent scientific literature. Or, they represent public health decisions made
22 by the U.S. government about vaccines, in contradistinction to other countries or public health
23 authorities who have made different decision and recommendations.
24 9. From the practicing physicians' point of view, in a time of rapidly evolving
25 public health situations, without the benefit of long-term studies and long-term epidemiological
26 data, public health expert recommendations are often erroneous and ephemeral (changing
27 before the recommendations can even be fully understood and adopted by practicing
28 physicians and general public). Public health authorities' edicts have repeatedly (and

1 tragically) lagged many months behind valid scientific concerns raised by scientists and
2 practicing physicians. This has led to a *de facto* rejection of any notion of *standard of* care on
3 almost all aspects of the COVID-19 both by the general public and by practicing physicians
4 who have undertaken a deep, comprehensive analysis of the epidemiological data. In all other
5 aspects of clinical medicine, *standard of care* is developed *and sustained* for years; it
6 withstands the scrutiny of repeated published scientific studies over time. For scientists,
7 practicing physicians and the general population, whimsical and ephemeral scientific
8 consensus of public health experts and standard of care regarding COVID-19 issues cannot be
9 materially distinguished.

10 10. I will focus on five specific issues:

11 (1) Differing public health approaches to vaccines in other countries which
12 supports the view that there is no contemporary scientific consensus, but
13 rather different countries make quite different risk/benefit decisions about
14 Covid vaccines.

15 (2) the increased risk of myocarditis from the vaccines,

16 (3) Changing views on the efficacy of the vaccines,

17 (4) The benefits of masking as a public health measure, and

18 (5) Use of off-label drugs

19 Any of the information covered in this (and my other) declaration could be included in
20 conversations between physicians and patients. This type of information is necessary for
21 patients to make educated decisions and give ethically mandated informed consent. However,
22 relating such information could lead to the California medical boards to charge a physician
23 with disseminating false or misleading information under Section 2270.

24 **A. DIFFERING PUBLIC HEALTH APPROACHES TO VACCINES IN**
25 **OTHER COUNTRIES**

26 11. The World Health Organization (WHO) no longer recommends COVID-19
27 vaccination in low-risk populations (e.g., pediatric population) depending upon the country's
28 specific disease burden. At this point in the (post) pandemic, "The update is based on the

1 scenario that assumes that the virus will continue to evolve but cause less severe disease" and
2 also considers the overall decline in disease severity, including post-COVID conditions."
3 Furthermore, the "update considers the steep increase in the seroprevalence of SARS CoV2
4 antibodies globally in all age groups, indicating high levels of immunity due to infection-
5 induced, vaccine-induced, or hybrid immunity." The recent FDA update acknowledges this
6 also, stating "Evidence is now available that most of the U.S. population 5 years of age and
7 older has antibodies to SARS-CoV-2, the virus that causes COVID-19, either from vaccination
8 or infection." In fact, 96% of the pediatric population in the United States has antibodies to
9 SARS-CoV2 (from vaccination or infection). Acknowledging the overall very low risk of
10 COVID-19 to children and accounting for the widespread seroprevalence (i.e., evidence of
11 immunity by infection or vaccination), the UK announced in January 2023 that it "will stop
12 widely providing the vaccine to those under 50 next month,"[i] (except to those at high risk for
13 severe illness).

14 i. https://www.who.int/news/item/28-03-2023-sage-updates-covid-19-
15 vaccination-guidance
16 ii. https://cdn.who.int/media/docs/default-source/immunization/sage/2023/march-
17 2023/sage_march_2023_meeting_highlights.pdf?sfvrsn=a8e5be9_4
18 https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-
19 update-fda-authorizes-changes-simplify-use-bivalent-mrna-covid-19-vaccines
20 iii. https://covid.cdc.gov/covid-data-tracker/#pediatric-seroprevalence
21 iv. https://apnews.com/article/fact-check-covid-pandemic-vaccine-uk-britain-
22 324766934158

23 12. In England, COVID-19 vaccines are no longer offered to young healthy people.
24 i. "Now, the vaccine will only be offered to those aged 65 and over along with
25 health and care workers and people living with certain health conditions."
26 ii. "Health officials are following advice on the UK booster programmes from the
27 Joint Committee on Vaccination and Immunisation (JCVI)."
28

iii. https://www.itv.com/news/2023-08-08/who-is-eligible-for-a-covid-booster-jab-under-new-guidelines

13. In Sweden COVID-19 vaccines are recommended to those 65 years and older, as well as those 18- 64 years old who have high risk chronic medical conditions. COVID-19 vaccines are not recommended for children or healthy adults under 65 years old.

i. https://www.folkhalsomyndigheten.se/the-public-health-agency-of-sweden/communicable-disease-control/vaccinations/vaccination-against-flu-and-covid-19/

14. Denmark only recommends that those "who are at risk of becoming severely ill should be vaccinated" against COVID-19.

i. https://www.sst.dk/en/english/Vaccination-against-influenza-and-covid-19

15. The common thread in all these examples is that many developed countries have made different vaccine recommendations, most notably concerning low risk demographic groups like children and healthy young adults, based on a risk-benefit analysis different from that made by the public health authorities and the U.S. infectious disease establishment. Some of the specific reason for these differing vaccine and other COVID-19 recommendations are set forth below.

B. COVID-19 VACCINES' RISK OF CARDIOVASCULAR COMPLICATIONS

16. As noted in my other Declaration, reports of vaccine associated myocarditis initially surfaced in April 2021 from Israel. CDC's initial response was quite dismissive. Although CDC later acknowledged myocarditis as a risk after COVID-19 vaccination, it continues to insist most cases are "generally mild" and "self-limiting". However, studies continue to be published that contradict CDC's dismissive and scientifically inaccurate assessment.

17. A study of 4928 high school students from Taipei City found that 1% had abnormal EKG and the incidence of myocarditis was 0.02% (1 in 5,000 or 200 per million). This corroborates previously published international studies on myocarditis after COVID-19

1 vaccination and is much higher than the rates calculated from Vaccine Adverse Event
2 Reporting System (VAERS), which CDC uses for part of its risk-benefit calculation.
3 i. https://link.springer.com/article/10.1007/s00431-022-04786-0
4 18. Heterologous dosing (mixing manufacturers for dose 1 and dose 2) has been
5 shown by two other studies to have an even higher risk of myocarditis after vaccination.
6 Despite this, CDC continues to state that heterologous dosing is acceptable. A case report from
7 Australia describes myocarditis in two individuals who had completely recovered from initial
8 myocarditis after dose 1, but subsequently developed myocarditis again after dose 2
9 (heterologous dosing whereby second dose was different manufacturer than first dose).
10 i. https://aacijournal.biomedcentral.com/articles/10.1186/s13223-022-00750-7
11 ii. https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-
12 considerations-us.html
13 19. CDC continues to describe myocarditis after vaccination to be "generally mild"
14 and report that "most recovered". Adding to previous cardiac MRI (CMR) studies, another
15 recent study found that 100% of adolescents with myocarditis had persistent late gadolinium
16 enhancement (LGE) on follow-up CMR 3-6 months later. Persistent LGE on follow-up CMR
17 indicates myocardial scar tissue and consequent increased risk of fatal cardiac arrhythmias. A
18 condition that increases the risk of fatal cardiac arrhythmias can hardly be characterized as
19 "generally mild". This is not merely a hypothetical concern. "Cardiac autopsy findings
20 consistent with (epi-)myocarditis were found in five cases of the remaining 25 bodies found
21 unexpectedly dead at home within 20 days following SARS-CoV-2 vaccination" as reported in
22 a recent study. A study that performed 6-month follow-up cardiac MRI in myocarditis patients
23 found that myocardial fibrosis is associated with a significantly worse survival (Appendix D).
24 i. https://www.tandfonline.com/doi/abs/10.1080/23744235.2022.2157478
25 ii. https://link.springer.com/article/10.1007/s00392-022-02129-5
26 iii. https://www.jacc.org/doi/abs/10.1016/j.jacc.2019.08.1061
27 20. A very large Nordic preprint study[ii] of 8.9 million residents found the risk of
28 myocarditis after BNT1262b2 (Pfizer) COVID-19 vaccine to be *359% higher* after dose 2 for

12-15-year-old males compared to unvaccinated controls. The rate was *1256% higher* after mRNA-1273 (Moderna) COVID-19 vaccine dose 2 in 12-39-year-old males.

i. https://www.medrxiv.org/content/10.1101/2022.12.16.22283603v1

21. One study in American Heart Association's flagship journal, *Circulation*, found a possible explanation for adolescents being at such higher risk of myocarditis after COVID-19 vaccination. The study "discovered distinct differences in how adolescents respond to mRNA vaccination compared with adults, which warrant further investigation." Unlike adults, the study found that adolescents have much higher rate of unbound (i.e., not bound by antibodies) circulating spike protein after vaccination. The differential immune response to COVID-19 vaccination between adults and adolescent children certainty warrants greater caution in categorical recommendations across all age groups.

i. https://www.ahajournals.org/doi/10.1161/CIRCULATIONAHA.122.061025

22. Persistence of spike protein and risk of myocarditis: One study found that *50% of patients had circulating spike protein has been detected 6 months (up to 187 days) after injection*. This is in stark contrast to CDC's claims that circulating spike protein from the COVID-19 vaccine is gone within a few days or weeks (as noted in my original Declaration). This would explain why a study found molecular damage in the heart (myocardial injury by altered gene expression) *up to 6 months after injection.* Circulating spike protein (up to 6 months after injection) and myocardial injury (up to 6 months after injection) may explain why two adolescent males were reported to have *(potentially unprovoked) relapsing* myocarditis 6 months after the initial episode of vaccine associate myocarditis.

i. https://onlinelibrary.wiley.com/doi/10.1002/prca.202300048

ii. https://www.sciencedirect.com/science/article/pii/S2452302X22003278?via%3Dihub

iii. https://pubmed.ncbi.nlm.nih.gov/37303596/

23. COVID-19 infection can also cause myocarditis. Contrary to CDC's assertion, the risk of myocarditis after infection is not greater than risk of myocarditis after vaccination. A large study from Israel found that *COVID-19 was not associated with an increased risk of*

1 *myocarditis* (compared to background rate in general population). Another recent large study
2 from Italy confirmed that *COVID-19 was not associated with an increased risk of myocarditis*.
3 Therefore, continued assertions that COVID-19 infection poses a greater risk of causing
4 myocarditis than COVID-19 vaccines (especially in children and young adults) are inaccurate
5 and not supported by the prevailing scientific research. A study from Canada compared the
6 incidence of myocarditis after mRNA COVID-19 vaccination with expected rates based on
7 historical background rates in British Columbia. The study found that young males receiving
8 mRNA-1273 (Moderna) COVID-19 vaccination were *148 times more likely* to suffer from
9 myocarditis (compared to historical background rate). Most studies on myocarditis limit their
10 analysis to within 21 or 28 days after COVID-19 vaccination. However, an autopsy report has
11 demonstrated death from myocarditis even *four months after vaccination*. As noted above,
12 circulating spike protein (and consequent molecular myocardial injury) persist for at least 6
13 months. Therefore, continued assertions that COVID-19 infection poses a greater risk of
14 causing myocarditis than COVID-19 vaccines (especially in children and young adults) are
15 inaccurate and not supported by the prevailing scientific research.

16 i. https://pubmed.ncbi.nlm.nih.gov/35456309/
17 ii. https://journals.lww.com/jcardiovascularmedicine/Fulltext/2022/07000/Inciden
18 ce_of_acute_myocarditis_and_pericarditis.5.aspx
19 iii. https://www.cmaj.ca/content/194/45/E1529
20 iv. https://www.preprints.org/manuscript/202209.0051/v1

21 24. Despite CDC’s repeated assertions, myocarditis cases after COVID-19
22 vaccination are not “temporary and mild”. In a study of CDC's 90-day follow-up data
23 published in *Lancet*: *47% were lost to follow-up and about a third still had activity restrictions*
24 *at median follow-up of 98 days. 25% were treated in an intensive care unit.* (Appendix E) A
25 cardiac MRI study (in addition to prior cardiac MRI studies) indicated 100% of adolescents
26 had evidence of scar on follow-up MRI 3-6 months later. Evidence of scar 3-6 months later
27 indicates increased risk of fatal cardiac arrhythmias (as confirmed in autopsy study). While
28 CDC continues to insist most of the myocarditis cases after COVID-19 are “generally mild” a

1 study on autopsy findings of fatal fulminant myocarditis and persistent cardiac MRI
2 abnormalities are noted in 100% of patients with myocarditis in this follow-up study. Persistent
3 abnormalities on cardiac MRI at 6-month follow-up after myocarditis has been proven to be
4 associated with significantly increased mortality (Appendix F).

5-6 i. https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(22)00244-9/fulltext
7 ii. https://www.tandfonline.com/doi/abs/10.1080/23744235.2022.2157478
8 iii. https://www.jpeds.com/article/S0022-3476(22)00282-7/fulltext
9 iv. https://www.tandfonline.com/doi/abs/10.1080/23744235.2022.2157478
10-11 v. https://www.sciencedirect.com/science/article/pii/S0735109719377368?via%3Dihub

12 25. A one-year follow-up study of adolescents with myocarditis after COVID-19
13 vaccination found over 20% had persistent abnormalities on echocardiogram and over 50% had
14 persistent abnormalities on cardiac MRI.

15 i. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10373639/

16 26. A nationwide Korean study of vaccine related myocarditis (VRM) found severe
17 VRM in 19.8% of cases. Sudden Cardiac Death (SCD) attributable VRM was found in 1.7%
18 (8) of the 480 cases of VRM in the study. This comprehensive nationwide study starkly
19 contrasts with CDC's repeated assertions that these myocarditis cases are "generally mild" and
20 self-limiting.

21 i. https://pubmed.ncbi.nlm.nih.gov/37264895/

22 27. While CDC continues to insist that most cases of vaccine associated myocarditis
23 are self-limiting (most recover with supportive treatment) a recent study reported two cases of
24 relapsing myocarditis 8-9 months after the initial episode. Both cases were 16- year-old males
25 and had ostensibly fully recovered (with return to play at 6-month follow-up). This raises the
26 concern that even those who apparently fully recovered may continue to be at significantly
27 elevated risk of cardiovascular complications.

28 i. https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/myocarditis.html

1 ii. https://pubmed.ncbi.nlm.nih.gov/37303596/

2 28. Most of the follow-up data on myocarditis cases after vaccination is based upon
3 symptoms (as seen in CDC's follow-up data published in Lancet) and some even report data on
4 follow-up cardiac MRI. As noted above, evidence of fibrosis (scar) on follow-up cardiac MRI
5 portends an ominous prognosis (much lower survival in the long term). A study performing
6 serial heart biopsies on myocarditis patients found *persistent molecular changes (adversely*
7 *altered gene expression of key myocardial proteins) up to 182 days after mRNA COVID-19*
8 *vaccination!* This could explain the underlying mechanism of the relapsing myocarditis cases
9 reported above. It also underscores the importance of continued vigilance in surveillance even
10 after the initial acute myocarditis seems to have resolved.

11 i. https://pubmed.ncbi.nlm.nih.gov/36281440/

12 29. Myocarditis after COVID-19 vaccination occurs at a greater rate than CDC
13 estimates (which are exclusively based upon data from VAERS). Repeated studies have
14 affirmed that risk of myocarditis after vaccination (for children and young adults) is greater
15 than risk of myocarditis after COVID-19 infection. The cases are not "generally mild" as CDC
16 asserts. The long-term sequelae are just now being better elucidated. It is therefore of
17 paramount and critical importance that physicians be able to engage in a candid and
18 comprehensive informed consent dialogue with patients (especially younger ones) about the
19 safety of COVID-19 vaccines. In my own cardiology practice, virtually all my patients with
20 vaccine associated myocarditis or cardiomyopathy were unaware of the actual extent of the
21 risk prior to being vaccinated against COVID-19.

22 30. Risk-benefit analysis (and additional side effects of COVID-19 vaccination)

23 a. CDC has often misrepresented the risk of COVID-19 to children and young
24 adults. During the early months of the COVID-19 pandemic in 2020, it was
25 emphatically stated that "everyone is equally susceptible". Even when CDC
26 later conceded that children were at low risk compared to older adults, CDC
27 continues to promote COVID-19 vaccination for everyone starting at the age
28 of 6. The risk benefit analysis conducted by CDC has frequently neglected

seroprevalence data (i.e., underestimated the denominator for infections) and relied almost exclusively on data from VAERS (i.e., underestimated the numerator for severe adverse events after vaccination). CDC's risk-benefit analysis has been deeply and tragically flawed. AB 2098 would sanction physicians for challenging CDC's flawed data analysis on safety of COVID-19 vaccines (especially for children and young adults).

31. A concrete and comprehensive analysis of risks and benefits of COVID-19 booster vaccine amongst college aged students found that booster "may result in a net harm to healthy young adults". The authors emphasize that CDC's risk-benefit analysis is "not based on an updated (Omicron era) stratified risk-benefit assessment for this age group." With each subsequent variant, the virulence (i.e., risk of hospitalization and death) continues to decrease.

i. https://jme.bmj.com/content/early/2022/12/05/jme-2022-108449

32. CDC's risk-benefit analysis does not adjust for seroprevalence. Seroprevalence is the assessment of disease prevalence based upon antibodies in sera samples and accounts for those who may never have tested for COVID-19 but nevertheless have evidence of prior infection. CDC's own seroprevalence estimates now indicate that 96% of all children have already been infected with COVID-19. A robust analysis of 31 national seroprevalence studies found the infection fatality rate (IFR) in 0-19-year-olds to be 0.0003%. CDC continues to use only PCR confirmed cases for their denominator to calculate COVID-19 morbidity and mortality (grossly overestimating the risk of hospitalization and death). When adjusting for seroprevalence, the actual IFR calculated is far lower, thereby supporting conclusions that the COVID-19 vaccines may result in net harm for children and young adults.

i. https://covid.cdc.gov/covid-data-tracker/#pediatric-seroprevalence

ii. https://www.sciencedirect.com/science/article/pii/S001393512201982X?via%3Dihub

33. COVID-19 infection can also cause myocarditis. Contrary to CDC's assertion, the risk of myocarditis after infection *is not greate*r than risk of myocarditis after vaccination. A large study from Israel found that COVID-19 as not associated with an increased risk of

myocarditis (compared to background rate in general population). Another recent large study from Italy confirmed that COVID-19 was not associated with an increased risk of myocarditis. Therefore, continued assertions that COVID-19 infection poses a greater risk of causing myocarditis than COVID-19 vaccines (especially in children and young adults) are inaccurate and not supported by the prevailing scientific research. A study from Canada compared the incidence of myocarditis after mRNA COVID-19 vaccination with expected rates based on historical background rates in British Columbia. The study found that young males receiving mRNA-1273 (Moderna) COVID-19 vaccination were *148 times more likely* to suffer from myocarditis (compared to historical background rate). Most studies on myocarditis limit their analysis to within 21 or 28 days after COVID-19 vaccination. However, autopsy report has demonstrated death from myocarditis even *four months after vaccination*. Therefore, continued assertions that COVID-19 infection poses a greater risk of causing myocarditis than COVID-19 vaccines (especially in children and young adults) are inaccurate and not supported by the prevailing scientific research.

i. https://pubmed.ncbi.nlm.nih.gov/35456309/
ii. https://journals.lww.com/jcardiovascularmedicine/Fulltext/2022/07000/Incidence_of_acute_myocarditis_and_pericarditis.5.aspx

34. One reason for this common misconception is the assessment of myocarditis after vaccination based upon aggregate population analysis (i.e., not performing stratified analysis by age, sex, etc.). A systematic review of myocarditis studies found that only 28% of studies were comprehensively stratified. When appropriately stratified, the risk of myocarditis (in younger population) is far greater than pooled analysis suggests (when combining all ages). This study demonstrates the risk is much higher in in adolescent males for both Pfizer (390 / million) and Moderna.

i. https://onlinelibrary.wiley.com/doi/10.1111/eci.13947

35. Numerous studies have demonstrated an increased risk of myocarditis after mRNA COVID-19 vaccination (especially for adolescent males after mRNA-1273 Dose 2). As noted, a common (mistaken) refrain by CDC and other public health experts is that the risk of

myocarditis after COVID-19 infection is greater than after mRNA vaccination. Yet another recently published study contradicts CDC's claims that the risk of myocarditis is greater after COVID-19 infection. This study of almost 300,000 persons[iii] found that the risk of myocarditis after mRNA COVID-19 vaccination was about 150% greater than after COVID-19 infection. Furthermore, previous reports suggested the increased risk of myocarditis in adolescent males occurred mostly with mRNA-1273. However, the FDA recently published a very large study analyzing about three million children ages 5-17 years old who received the BNT162b2 mRNA COVID-19 vaccination. This study by the FDA found the BNT1262b2 mRNA COVID-19 vaccination to have almost *twenty-two times* increased risk of myocarditis within 7 days of vaccination for 12-15-year-olds and almost *thirty times* for 16-17-year-olds. (Table 2) The study analysis combined males and females. Since previous studies have all demonstrated that adolescent males have higher risk than female for myocarditis after COVID-19 vaccination, it is scientifically reasonable to conclude with certainty that if the FDA authors had ethically performed subgroup analysis (by males and females), the reported risk would be even higher for adolescent males (i.e., combining males and females dilutes the true risk to males alone).

i. https://www.nature.com/articles/s44161-022-00177-8
ii. https://pubmed.ncbi.nlm.nih.gov/34432976/
iii. https://www.sciencedirect.com/science/article/pii/S1878540922001128

C. CHANGING VIEWS ON THE EFFICACY OF THE COVID-19 VACCINES

(1) STUDIES CORRECTING THE MISREPRESENTATION THAT THE VACCINE PREVENT INFECTION

36. In the early stages of implementing mass COVID-19 vaccine administration, the claim that COVID-19 vaccines prevent transmission was repeated by numerous public health officials (including CDC Director Dr. Rochelle Walensky). In fact, this was the entire basis of the OSHA employer COVID-19 vaccine mandate (as well as for schools and colleges). Supreme Court Justice Kagan (during oral arguments on the OSHA mandate) stated, “the best way” to prevent the spread of COVID-19 is “for people to get vaccinated”. However, the

COVID-19 vaccines were never tested for preventing secondary transmission (as Pfizer CEO Peter Bourla subsequently admitted).

i. https://www.washingtonexaminer.com/opinion/liberal-supreme-court-justices-spread-covid-19-misinformation

ii. https://www.news.com.au/technology/science/human-body/pfizer-did-not-know-whether-covid-vaccine-stopped-transmission-before-rollout-executive-admits/news-story/f307f28f794e173ac017a62784fec414

iii. https://www.michigancapitolconfidential.com/news/pfizer-admits-covid-vaccine-was-never-meant-to-stop-transmission

37. Emails recently obtained through a Freedom of Information Act request show that CDC Director Rochelle Walensky and former NIH Director Francis Collins were aware of, and discussed, "breakthrough cases" of COVID in January 2021 — right when the vaccines became widely available. In her email, Walensky says that "clearly," it is an "important area of study," links to a study raising the issue, and assures the person she is sending it to that Dr. Anthony Fauci is looped into these conversations. However, in public, Walensky's rhetoric was quite different. Two months after discussing this data, she said vaccinated people "don't carry the virus" and "don't get sick." In congressional testimony, after it became evident vaccinated people were able to get infected with COVID-19, she defended her original statements by claiming it was true at the time she said it — namely, for the strands we were dealing with in early 2021.

i. https://www.washingtonexaminer.com/opinion/new-emails-show-covid-vaccine-mandates-were-based-on-a-lie

ii. https://twitter.com/michaelpsenger/status/1668669558054600708

iii. https://www.businessinsider.com/cdc-director-data-vaccinated-people-do-not-carry-covid-19-2021-3?r=US&IR=T

38. The unproven and false claim that COVID-19 vaccines prevent secondary transmission (i.e., prevent infecting others) was the entire bases of the Occupational Safety and Health Administration (OSHA) mandate as well as school and university COVID-19 vaccine

mandates. Early on many physicians had been challenging this claim. Food and Drug Administration (FDA) briefing documents for (Emergency Use Authorization (EUA) application for both Pfizer and Moderna *did not contain any data analysis on secondary prevention* to warrant such claims. In my own practice, I have several young adults who chose to be vaccinated against COVID-19 "to protect the elderly" (older more vulnerable family members) who subsequently developed vaccine associated myocarditis and cardiomyopathy. If the general populace were permitted to have a more genuine and comprehensive risk-benefit analysis (i.e., engage in informed consent) many of these cases of myocarditis might have been prevented. Children, who are otherwise at very low risk for hospitalization and death from COVID-19 should never have been subjected to COVID-19 vaccine mandates "to protect the vulnerable" elderly and teachers (since they do not prevent transmission to others). As noted below, CDPH elected not to add COVID-19 vaccine to the children's school schedule of mandated vaccines. CDC's misrepresentation of the COVID-19 vaccine's ability prevent transmission was not only scientifically unjustified, their recommendations may have actually caused harm to low-risk individuals who mistakenly took the COVID-19 vaccine "to protect the elderly".

(II) COVID-19 VACCINES' WANING EFFICACY AND RISK OF REPEATED VACCINATION

39. CDC continues to recommend everyone (regardless of prior infection or individual risk stratification) be "up to date" on COVID-19 vaccines by receiving at least one Pfizer-BioNTech or Moderna updated (bivalent) COVID-19 vaccine (November 8, 2023): However, this recommendation is not based on a contemporary scientific consensus because the published scientific research does not support the recommendations.

i. https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html

40. Repeated studies have demonstrated rapidly waning vaccine efficacy (VE) with both the original (monovalent) and updated (bivalent) COVID-19 vaccines. Furthermore, some studies also suggest that repeated vaccination may *increase* the risk of infection and hospitalization and cause harm to the immune system.

41. For example, a meta-analysis of 40 studies found VE of primary (monovalent) COVID-19 vaccination series against Omicron to be *less than 20%* at six months. Nine months after booster administration, VE against Omicron was *lower than 30%*. Previous recommendations by public health experts indicated repeated boosters were needed because of this well-established waning VE. However, research now suggests that repeated vaccination may have numerous deleterious effects. Authors of one study caution that repeated vaccination "could promote unopposed SARS-CoV2 infection and replication by suppressing natural antiviral responses." Additionally, the authors caution that repeated vaccination "may also cause autoimmune diseases, and promote cancer growth and autoimmune myocarditis in susceptible individuals." This risk of worsening infection risk with repeated vaccination is not merely speculative. In a study from Cleveland Clinic, the authors found "The higher the number of vaccines previously received, the higher the risk of contracting COVID-19" (Appendix E). However, up until very recently, CDC continued to recommend repeated boosters and repeated its refrain that they were "safe and effective".

i. https://pubmed.ncbi.nlm.nih.gov/37133863/
ii. https://pubmed.ncbi.nlm.nih.gov/37243095/
iii. https://pubmed.ncbi.nlm.nih.gov/37243095/
iv. https://www.nature.com/articles/s41598-023-40103-x
v. ttps://academic.oup.com/ofid/article/10/6/ofad209/7131292
vi. https://www.cdc.gov/media/releases/2022/s0901-covid-19-booster.html

42. The original (monovalent) vaccines have not been found to be effective against the predominant variants in circulation end of 2022 thru mid-2023. A study evaluating effectiveness of antibodies against current variants found that "BQ and XBB subvariants … render inactive all authorized antibodies, and may have gained dominance in the population because of their advantage in evading antibodies."[iv] The bivalent booster did not perform better as the authors note that "[s]erum neutralization was markedly reduced, including with the bivalent booster."

i. https://www.cell.com/cell/pdf/S0092-8674(22)01531-8.pdf

1 43. CDC's own presentation June 15, 2023 of COVID-19 vaccine efficacy reported
2 abysmally low VE for the monovalent and bivalent COVID-19 vaccines. VE against
3 hospitalizations and critical illness for monovalent vaccines was 21% and 31%, respectively.
4 The bivalent vaccines did not perform much better, with VE of 24% and 52% against
5 hospitalizations and critical illness, respectively. In fact, analysis of their IVY network found
6 that the monovalent and bivalent vaccines *may increase* the risk of hospitalization with XBB
7 variant. (See Appendix C)

8 i. https://s3.documentcloud.org/documents/23852341/cdc-presentation-on-
9 vaccine-effectiveness.pdf?fbclid=IwAR3HLG-eUHA4JSW-qr25-
10 242Aph4tXg8B9GOlmRDaZ3nJemRI2RPFK9e39I

11 44. A study from Cleveland Clinic found rapid precipitous drop on VE for the
12 bivalent COVID-19 boosters and an *increased risk of COVID-19 with each additional booster*.

13 i. "The estimated vaccine effectiveness was 29% (95% confidence interval,
14 21%–37%), 20% (6%–31%), and 4% (−12% to 18%), during the BA.4/5-, BQ-,
15 and XBB-dominant phases, respectively. The risk of COVID-19 also increased
16 with time since the most recent prior COVID-19 episode and with the number
17 of vaccine doses previously received. "
18 ii. https://academic.oup.com/ofid/article/10/6/ofad209/7131292

19 45. Vaccinated people have increased risk of immune escape compared to unvaccinated.

20 i. "Overall, the relatively higher intra-host diversity among vaccinated
21 individuals and the detection of immune-escape mutations, despite being rare,
22 suggest a potential vaccine-induced immune pressure in vaccinated
23 individuals."
24 ii. https://www.cell.com/iscience/fulltext/S2589-0042(22)01710-2

25 46. In addition to the well-established risk of myocarditis after COVID-19
26 vaccination, new research has now demonstrated other severe adverse reactions not previously
27 recognized by CDC. A meta-analysis found increased risk of autoimmune skin disorders.
28 Another study found increased risk of retinal vascular occlusion (and consequent blindness)

1 that persisted for *two years* after COVD-19 vaccination. This corroborates my own
2 professional experience in which I have seen an increasing number of patients with retinal
3 vascular occlusion. Other visual complications include macular neuroretinopathy and
4 paracentral acute middle maculopathy. A link between COVID-19 vaccines and Long Covid-
5 like illness is also now being recognized, as are new onset multiple sclerosis and inflammatory
6 rheumatic disease. COVID-19 vaccination has also been associated with postural orthostatic
7 tachycardia syndrome (POTS).

8 i. https://onlinelibrary.wiley.com/doi/full/10.1111/ddg.15114
9 ii. https://www.nature.com/articles/s41541_023_00661_7
10 iii. https://www.mdpi.com/2076-393X/11/2/474
11 iv. https://www.science.org/content/article/rare-link-between-coronavirus-
12 vaccines-and-long-covid-illness-starts-gain-acceptance
13 v. https://pubmed.ncbi.nlm.nih.gov/37077605/
14 vi. https://rmdopen.bmj.com/content/rmdopen/9/2/e003022.full.pdf
15 vii. https://pubmed.ncbi.nlm.nih.gov/37303827/

16 47. COVID-19 infection may be *no worse* than influenza and sepsis for long term
17 medical and mental complications

18 i. https://pubmed.ncbi.nlm.nih.gov/37338892/

19 48. To have a meaningful discussion with patients with genuine and comprehensive
20 informed consent, physicians need to be able to share accurate risks of COVID-19
21 (individualized risk stratification). It is undeniably untrue that "everyone is equally
22 susceptible". For children and young-adults the risk of hospitalization and death from COVID-
23 19 is very, very low. This should be factored into all the risk-benefit analyses before making
24 blanket recommendations. The risks after COVID-19 vaccination need to be discussed with
25 accurate representation of the incidence and severity of each of the side effects. All the known
26 side effects ought to be discussed freely and without restrictions. The putative standard of care
27 (which is indistinguishable from contemporary scientific consensus) would sanction physicians
28 for contradicting CDC's risk-benefit analysis. Many of the disabling and fatal side effects of

1 COVID-19 vaccination in children and young adults may have been prevented had there been
2 more objective and transparent discussion of stratified risks and benefits earlier.

3 **E. EFFICACY OF MASKING**

4 49. This is an issue which is becoming more important again as many institutions,
5 corporations, and local governments are considering mask mandates for the new variants. The
6 Court will recall that masks were heavily promoted with slogans "masks save lives" and
7 mandated by numerous government agencies, often relying upon CDC's recommendations and
8 published 'studies' for their justification. Any suggestion that masks are ineffective for an
9 airborne virus (and *may* even be harmful) was deemed 'misinformation' for which physicians
10 were censured and censored. However, the mounting scientific evidence indicates that
11 community mask mandates may have had no meaningful contribution to curtailing the spread
12 of this airborne virus. Some evidence even suggests mask mandates may have caused harm to
13 specific subsets of the population.

14 50. *New York Times* now openly discusses the futility of mask mandates, where it
15 previously strongly promoted masks to prevent COVID-19 spread:

16 i. https://www.nytimes.com/2023/02/21/opinion/do-mask-mandates-work.html
17 ii. https://www.nytimes.com/article/coronavirus-masks.html
18 iii. https://www.nytimes.com/2023/03/10/opinion/masks-work-cochrane-
19 study.html

20 51. A study entitled "Correlation between mask compliance and COVID-19
21 outcomes in Europe" found that "countries with high levels of mask compliance did not
22 perform better than those with low mask usage."

23 i. https://www.cureus.com/articles/93826-correlation-between-mask-compliance-
24 and-covid-19-outcomes-in-
25 europe?fbclid=IwAR1Gi9MaLy36UtUZX8VDqNj3EQl6IqopliaOVlrNLvcd4Z
26 pTIHjdjjo6xBA#!/

27 52. Another study found "no additional effect was gained from mandating face
28 masks" for children in schools:

1 i. https://pubmed.ncbi.nlm.nih.gov/37085807/
2 ii. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-023-
3 15624-9
4 53. Masks may even cause harm, as noted by this study:
5 i. "The findings contribute to existing literature by demonstrating that wearing
6 the N95 mask for 14 hours significantly affected the physiological,
7 biochemical, and perception parameters. The effect was primarily initiated by
8 increased respiratory resistance and subsequent decreased blood oxygen and
9 pH, which contributed to sympathoadrenal system activation and epinephrine
10 as well as norepinephrine secretion elevation"
11 ii. https://pubmed.ncbi.nlm.nih.gov/37294572/
12 54. Masks may increase quantity of harmful volatile organic compounds
13 i. https://pubmed.ncbi.nlm.nih.gov/37079939/
14 55. Masks may increase toxic chronic carbon dioxide exposure, particularly in
15 pregnant women, children, and adolescents
16 i. https://www.cell.com/heliyon/pdf/S2405-8440(23)01324-
17 5.pdf?fbclid=IwAR34-
18 NOACEQBNvdPwUDd0uehjfQz2w5QlrYKJ7Y1Vx6Z3MC8E9LdDBCDGpA
19 _aem_AWWCmc1X2PqFlxT9QrBv1QatliNX47F14gOYP2B7sH9DAnC5zNN
20 Qt4wT9j1FlPdPTpY&mibextid=Zxz2cZ
21 56. A preprint study reviewing quality of evidence in CDC's Morbidity and
22 Mortality Weekly Report (MMWR) mask studies found: "MMWR publications pertaining to
23 masks drew positive conclusions about mask effectiveness over 75% of the time despite only
24 30% testing masks and <15% having statistically significant results. No studies were
25 randomized, yet over half drew causal conclusions. The level of evidence generated was low
26 and the conclusions drawn were most often unsupported by the data."
27 i. https://www.medrxiv.org/content/10.1101/2023.07.07.23292338v1
28 57. The study "Bacterial and fungal isolation from face masks under the COVID-19

1 pandemic" found pathogenic microbes on face masks and authors "propose that
2 immunocompromised people should avoid repeated use of masks to prevent microbial
3 infection." Perhaps this explains why CDC's own data show that more children died of
4 bacterial pneumonia than COVID-19 infection throughout the COVID-19 pandemic.

5 i. https://www.nature.com/articles/s41598-022-15409-x
6 ii. https://data.cdc.gov/d/9bhg-hcku/visualization?fbclid=IwAR3YQqnTb3-
7 2lyeCzw-LPp9U3IClHGOrF8mr5lG_Oii6-_wBKFRP9YTacv4

8 58. Despite virtually universal school mask mandates for primary schools, 92% of all
9 children have evidence of COVID-19 antibodies from prior infection by CDC's own data
10 (higher than any other age group). This strongly suggests that universal school mask mandates
11 in schools were in fact futile.

12 i. https://covid.cdc.gov/covid-data-
13 tracker/?fbclid=IwAR00sfsJCL8PLQj6DsWXM6ewC-
14 x2ussgogfcwjcNw87r5TkJnGZJQH0dBfM#pediatric-seroprevalence

15 59. In a letter sent in November 2021 to the CDC, epidemiologist Michael
16 Osterholm, informed the agency it was promoting flawed data and excluding data that did not
17 reinforce their narrative on masks. "We believe the information and recommendations as
18 provided *may actually put an individual at increased risk of becoming infected with SARS-*
19 *CoV-2* and for them to experience a serious or even life-threatening infection," [emphasis
20 mine] Mr. Osterholm wrote. He admonished the IDSA to remove the suggestion that masking
21 prevents severe disease from its website and urged the CDC to reconsider its statements about
22 the "efficacy of masks and face coverings for preventing transmission of SARS-CoV-2."

23 i. https://img.theepochtimes.com/assets/uploads/2023/08/21/id5477758-Letter-
24 on-deadly-risks-on-CDC-IDSA-website-
25 1.pdf?_gl=1*zgulv9*_gcl_au*MjA2NDcyNjY5Ny4xNjkzMDgwMTA3

26 60. Cochrane Database of Systemic Reviews is deemed to be one of the most robust
27 and respectable sources of evidence-based medicine. In its very recent review ("Physical
28 interventions to interrupt or reduce the spread of respiratory viruses") the authors conclude:

1 “There is uncertainty about the effects of face masks. The low to moderate
2 certainty of evidence means our confidence in the effect estimate is limited,
3 and that the true effect may be different from the observed estimate of the
4 effect. The pooled results of RCTs did not show a clear reduction in
5 respiratory viral infection with the use of medical/surgical masks. There
6 were no clear differences between the use of medical/surgical masks
7 compared with N95/P2 respirators in healthcare workers when used in
8 routine care to reduce respiratory viral infection. Hand hygiene is likely to
9 modestly reduce the burden of respiratory illness, and although this effect
was also present when ILI and laboratory-confirmed influenza were
analysed separately, it was not found to be a significant difference for the
latter two outcomes. Harms associated with physical interventions were
under-investigated.”

10 i. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006207.pub6/
11 epdf/full?fbclid=IwAR0FAHQLl_UtEmdYKB8bI3E0J9wy3zrLDNhNShxyKd
12 KXxl4ygbRfMm91BxY

13 61. The exorbitant resources that were spent in mandating masks “to prevent the
14 spread of COVID-19” and censoring any contrarian views did not have any proven incremental
15 benefit in containing the spread of this airborne virus. Furthermore, these futile efforts *may*
16 have actually caused harm for some subsets of the population in susceptible individuals.
17 Scientific integrity, informed consent, and medical ethics demand that physicians have the
18 freedom to discuss the scientific risks and benefits of these interventions with their patients
19 (especially for those whom prolonged wearing of masks throughout the day may have been
20 unduly burdensome, impaired their cardiorespiratory status, or increased their risk of bacterial
21 pneumonia). Patients deserve to have a candid informed scientifically balanced discussion of
22 the risks and benefits (or lack thereof) of any intervention that putatively prevents disease.

23 **F. THE USE OF OFF-LABEL DRUGS**

24 62. Prior to 2020, SARS-CoV2 virus was not publicly known to the general medical
25 community. Therefore, treatment options were not readily available as SARS-CoV2 began
26 rapidly spreading in 2020, with many hospitals overwhelmed by critically ill patients. Despite
27 the tremendous research efforts invested here in the US and internationally, physicians
28 motivated to provide the best treatment options for their patients could not wait the customary

months or years required for development, research, and testing of new therapeutics. The impetus to try off-label medications was therefore scientifically and ethically justified. Off-label use of medications is more common in medical practice than many may realize. One of the most relevant here is the use of colchicine for pericarditis after COVID-19 infection or COVID-19 vaccination. Despite being off-label, colchicine is the standard of care for pericarditis.

63. Examples of off label medications routinely used:

a. Actiq (oral transmucosal fentanyl citrate) is approved solely for breakthrough cancer pain. However, it is used off-label to treat moderate to severe chronic, non-malignant pain.
   i. https://www.drugs.com/actiq.html
   ii. https://pubmed.ncbi.nlm.nih.gov/17305684/
b. Bevacizumab has been used off label against wet age-related macular degeneration, as well as macular edema.
   i. https://www.theguardian.com/society/2006/jun/17/health.medicineandhealth
c. Buprenorphine has been shown experimentally to be effective against severe, refractory depression.
   i. http://www.naabt.org/documents/The_Buprenorphine_effect_on_Depression.pdf
   ii. https://journals.lww.com/psychopharmacology/abstract/1995/02000/buprenorphine_treatment_of_refractory_depression.8.aspx
d. Bupropion when sold under the brand name Wellbutrin is indicated for depression. It is also sold as a smoking cessation drug, under the name Zyban. A physician can write a prescription for Wellbutrin to assist with giving up the habit of smoking. Sometimes it is also prescribed as second-line treatment of ADHD, often in combination with the stimulant being used, but it was also shown to work on its own.

   i. https://onlinelibrary.wiley.com/doi/10.1111/j.1440-1819.2011.02264.x

e. Carbamazepine, (Tegretol), has been used as a mood stabilizer and is accepted treatment for bipolar disorder.

   i. http://www.leeheymd.com/charts/dep4_1.html

f. Clonidine (Catapres) for ADHD: clonidine is approved and commonly used for the treatment of hypertension. Other off-label uses include cancer pain, hot sweats, certain psychiatric disorders, nicotine dependence, opioid withdrawal, migraine headaches, and restless leg syndrome.

   i. https://www.drugs.com/monograph/clonidine.html#uses

g. Colchicine for pericarditis: colchicine is indicated for the treatment and prevention of gout, though it is also generally considered first-line treatment (standard of care) for acute pericarditis (Appendix A, scientific recommendations from American College of Cardiology), as well as preventing recurrent episodes.

   i. https://pubmed.ncbi.nlm.nih.gov/31918837/

h. Dexamethasone and Betamethasone are used off label in premature labor, to enhance pulmonary maturation of the fetus.

   i. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/antenatal-corticosteroid-therapy-for-fetal-maturation

i. Doxepin is a tricyclic antidepressant that has also been used to treat severe allergic reactions due to its strong antihistamine properties.

   i. https://pubmed.ncbi.nlm.nih.gov/3782654/

j. Gabapentin, approved for treatment of seizures and postherpetic neuralgia in adults, is used off-label for a variety of conditions including bipolar disorder, essential tremor, migraine prophylaxis, neuropathic pain syndromes, phantom limb syndrome, and restless leg syndrome.

i. https://universityhealthnews.com/daily/pain/gabapentins-off-label-uses-include-pain-relief/

k. Lithium is approved by the FDA for the treatment of bipolar disorder and is widely prescribed off-label as a treatment for major depressive disorder. often as an augmentation. Lithium is recommended for the treatment of schizophrenic disorders only after other antipsychotics have failed.

i. https://pubmed.ncbi.nlm.nih.gov/15982996/

ii. https://rxce.com/materials/Lithium-Antimanic-and-Off-label-Uses-Tech-Ceu.pdf

l. Magnesium sulfate is used in obstetrics for premature labor and preeclampsia.

i. https://pubmed.ncbi.nlm.nih.gov/19211496/

m. Memantine (Namenda) is approved for the treatment of Alzheimer's disease, but has also been used off-label for Obsessive Compulsive Disorder (OCD).

i. https://pubmed.ncbi.nlm.nih.gov/31846244/

n. Methotrexate (MTX), approved for the treatment of choriocarcinoma, is frequently used for the medical treatment of an unruptured ectopic pregnancy. There is no FDA-approved drug for this purpose and there is little incentive to sponsor an unpatented drug such as MTX for FDA-approval.

i. https://www.aafp.org/pubs/afp/issues/2020/0515/p599.html

o. Prazosin for nightmares: prazosin is approved for the use of hypertension. A meta-analysis and systematic review showed a small benefit for the treatment of PTSD-associated night terrors[v]. Other non-FDA-approved uses for prazosin include the treatment of Raynaud's disease and poisoning due to scorpion venom.

i. https://pubmed.ncbi.nlm.nih.gov/32362287/

p. Propranolol for performance anxiety: propranolol is a non-selective beta-blocker used for the treatment of hypertension and the prophylaxis of angina pectoris. Propranolol has been used off label for the treatment of anxiety

disorders. Other off-label uses for propranolol include the treatment of thyroid storm, portal hypertension, and neuroleptic-induced akathisia.

i. https://pubmed.ncbi.nlm.nih.gov/26487439/
ii. https://pubmed.ncbi.nlm.nih.gov/26487439/
iii. https://www.ebmconsult.com/articles/propranolol-preferred-thyroid-storm-thyrotoxicosis
iv. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5718179/
v. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1192441/

CONCLUSION

I wish to stress that the purpose of this declaration is to support the Plaintiffs' contention that it is not correct to say that there is a true standard of care about almost all the important scientific issues related to SARS-Covi 2 virus. Many of the edicts put out by the public health authorities have had to be changed or abandoned because of new data. As the new edicts change, so do the recommendations of many physicians, but I believe that it is a misuse of the term to call what most physicians are telling patients to be an actual standard of care. Of course, the standard of care can differ in different parts of the country and in different countries, but the divergence of views (as some of the key elements such as the need for continued boosters) shows that the so-called standard of care, at least in this country, is just opinion of public health authorities. Inconsistently, the opinions get promoted in various literature and media, which many physicians simply relate to their patients.

I submit this declaration under penalty of perjury under the laws of the State of California. Executed on February 9, 2024, at Palm Desert, California.

Sanjay Verma, MD

1 **APPENDIX A**

2 • Figure 3: Treatment for Acute and Recurrent Pericarditis and Their Complications
3 from "Management of Acute and Recurrent Pericarditis: *JACC* State-of-the-Art Review"
4 (PMID: 31918837 DOI: 10.1016/j.jacc.2019.11.021)
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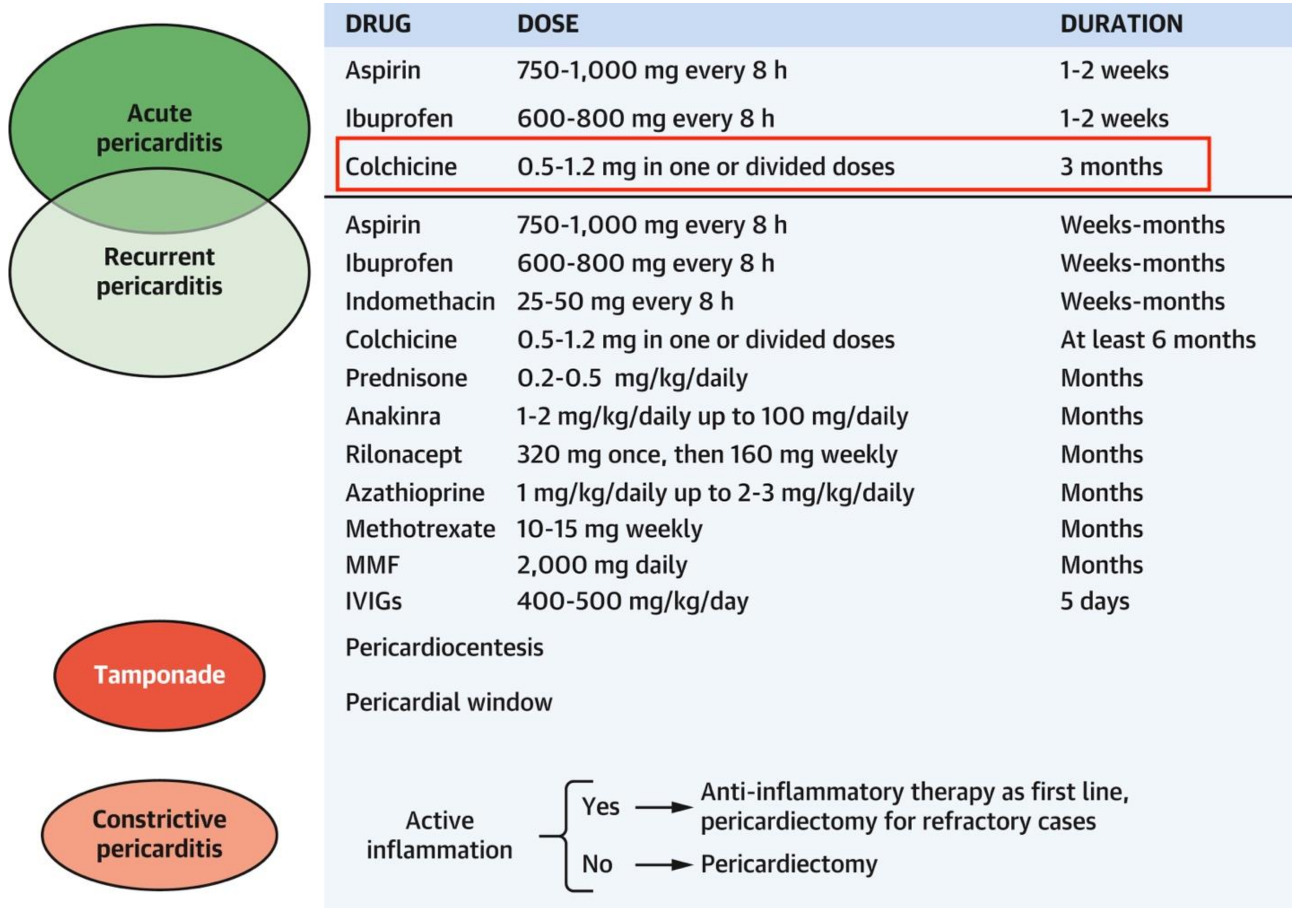


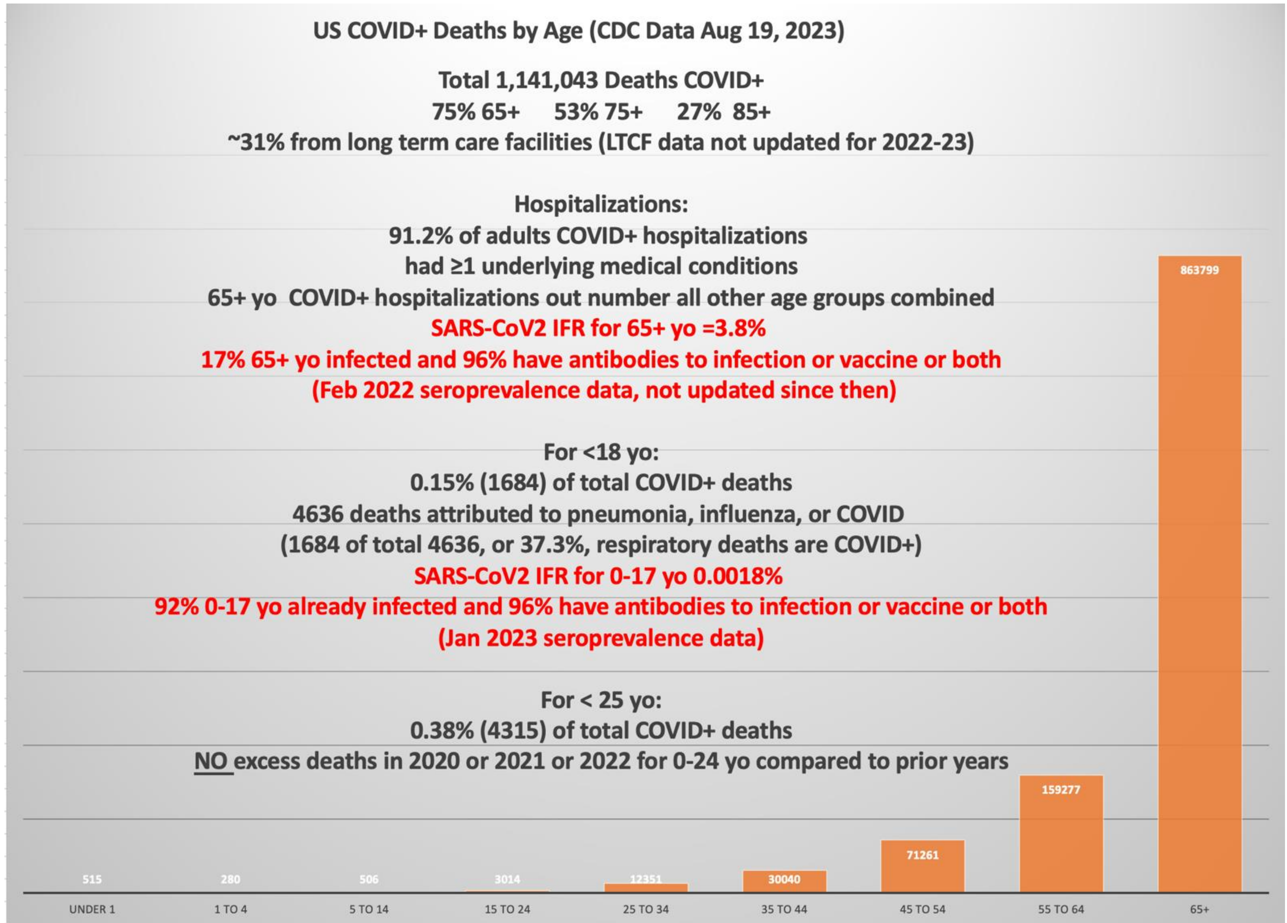
DRUG	DOSE	DURATION
Aspirin	750-1,000 mg every 8 h	1-2 weeks
Ibuprofen	600-800 mg every 8 h	1-2 weeks
Colchicine	0.5-1.2 mg in one or divided doses	3 months
Aspirin	750-1,000 mg every 8 h	Weeks-months
Ibuprofen	600-800 mg every 8 h	Weeks-months
Indomethacin	25-50 mg every 8 h	Weeks-months
Colchicine	0.5-1.2 mg in one or divided doses	At least 6 months
Prednisone	0.2-0.5 mg/kg/daily	Months
Anakinra	1-2 mg/kg/daily up to 100 mg/daily	Months
Rilonacept	320 mg once, then 160 mg weekly	Months
Azathioprine	1 mg/kg/daily up to 2-3 mg/kg/daily	Months
Methotrexate	10-15 mg weekly	Months
MMF	2,000 mg daily	Months
IVIGs	400-500 mg/kg/day	5 days
Pericardiocentesis		
Pericardial window		

APPENDIX B

CDC data on COVID+ deaths by age and seroprevalence

https://data.cdc.gov/d/9bhg-hcku/visualization?fbclid=IwAR3YQqnTb3-2lyeCzw-LPp9U3IClHGOrF8mr5lG_Oii6-_wBKFRP9YTacv4

https://covid.cdc.gov/covid-data-tracker/#pediatric-seroprevalence



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APPENDIX C

Centers for Disease Control and Prevention
National Center for Immunization and Respiratory Diseases

COVID-19 vaccine effectiveness updates

15 June 2023

Ruth Link-Gelles, PhD, MPH
LCDR, US Public Health Service
COVID-19 Vaccine Effectiveness Program Lead
Centers for Disease Control and Prevention

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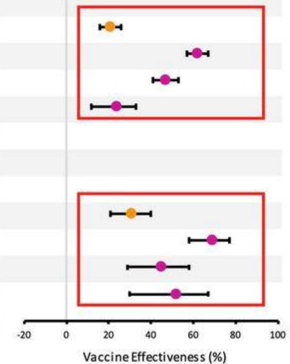
VISION: *Absolute* VE of *monovalent* and *bivalent* booster doses against *hospitalization* and *critical illness* among immuno*competent* adults aged ≥18 years – September 2022 – May 2023

mRNA Dosage Pattern	Total tests	SARS-CoV-2-test-positive, N (%)	Median interval since last dose, days (IQR)	Adjusted VE (95% CI)
Hospitalization				
Unvaccinated (ref)	16,219	1,835 (11)	--	Ref
Monovalent doses only	38,843	4,086 (11)	381 (275-513)	21 (16-26)
Bivalent booster, 7-59 days earlier	4,894	329 (7)	35 (21-47)	62 (57-67)
Bivalent booster, 60-119 days earlier	5,283	491 (9)	87 (73-103)	47 (41-53)
Bivalent booster, 120-179 days earlier	3,756	346 (9)	146 (132-161)	24 (12-33)
Critical illness				
Unvaccinated (ref)	14,762	378 (3)	--	Ref
Monovalent doses only	35,415	658 (2)	380 (275-514)	31 (21-40)
Bivalent booster, 7-59 days earlier	4,614	49 (1)	34 (21-47)	69 (58-77)
Bivalent booster, 60-119 days earlier	4,880	88 (2)	87 (73-103)	45 (29-58)
Bivalent booster, 120-179 days earlier	3,445	35 (1)	146 (132-161)	52 (30-67)



Critical illness defined as admission to intensive care unit or death; case-patients were persons admitted to ICU or who experienced death associated with COVID-19, and control patients were persons hospitalized without COVID-19. VE estimates adjusted for age, sex, race and ethnicity, geographic region, and calendar time. Updated from: Link-Gelles et al., MMWR, https://www.cdc.gov/mmwr/volumes/72/wr/mm7221a3.htm

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IVY Network: *Absolute* VE against COVID-19 *hospitalization* among immuno*competent* adults aged *≥18 years* by lineage period — September 8, 2022 – May 24, 2023

	Total Cases and Controls	Cases (%)	Median time since last dose, days (IQR)	Adjusted VE*, % (95% CI)
BA.4/5 (September 8 – November 13, 2022)				
Unvaccinated (Ref)	313	138 (44)	--	**Ref**
Monovalent doses only	1003	398 (40)	304 (188–386)	**30 (8– 47)**
Bivalent booster dose, 7–59 days earlier	83	26 (31)	25 (13–40)	**59 (21–78)**
BQ.1 (November 14, 2022 – January 22, 2023)				
Unvaccinated (Ref)	458	190 (41)	--	**Ref**
Monovalent doses only	1262	504 (40)	386 (297–518)	**17 (-5 to 34)**
Bivalent booster dose, 7–59 days earlier	226	52 (23)	40 (25–52)	**63 (44–75)**
Bivalent booster dose, 60–119 days earlier	225	68 (30)	83 (69–95)	**49 (24–66)**
XBB (January 23 – May 24, 2023)				
Unvaccinated (Ref)	514	209 (41)	--	**Ref**
Monovalent doses only	1246	558 (45)	464 (378–590)	**-8 (-34 to 13)**
Bivalent booster dose, 7–89 days earlier	155	56 (36)	64 (46–78)	**29 (-8 to 53)**
Bivalent booster dose, 90–179 days earlier	478	208 (44)	137 (118–154)	**-8 (-44 to 19)**

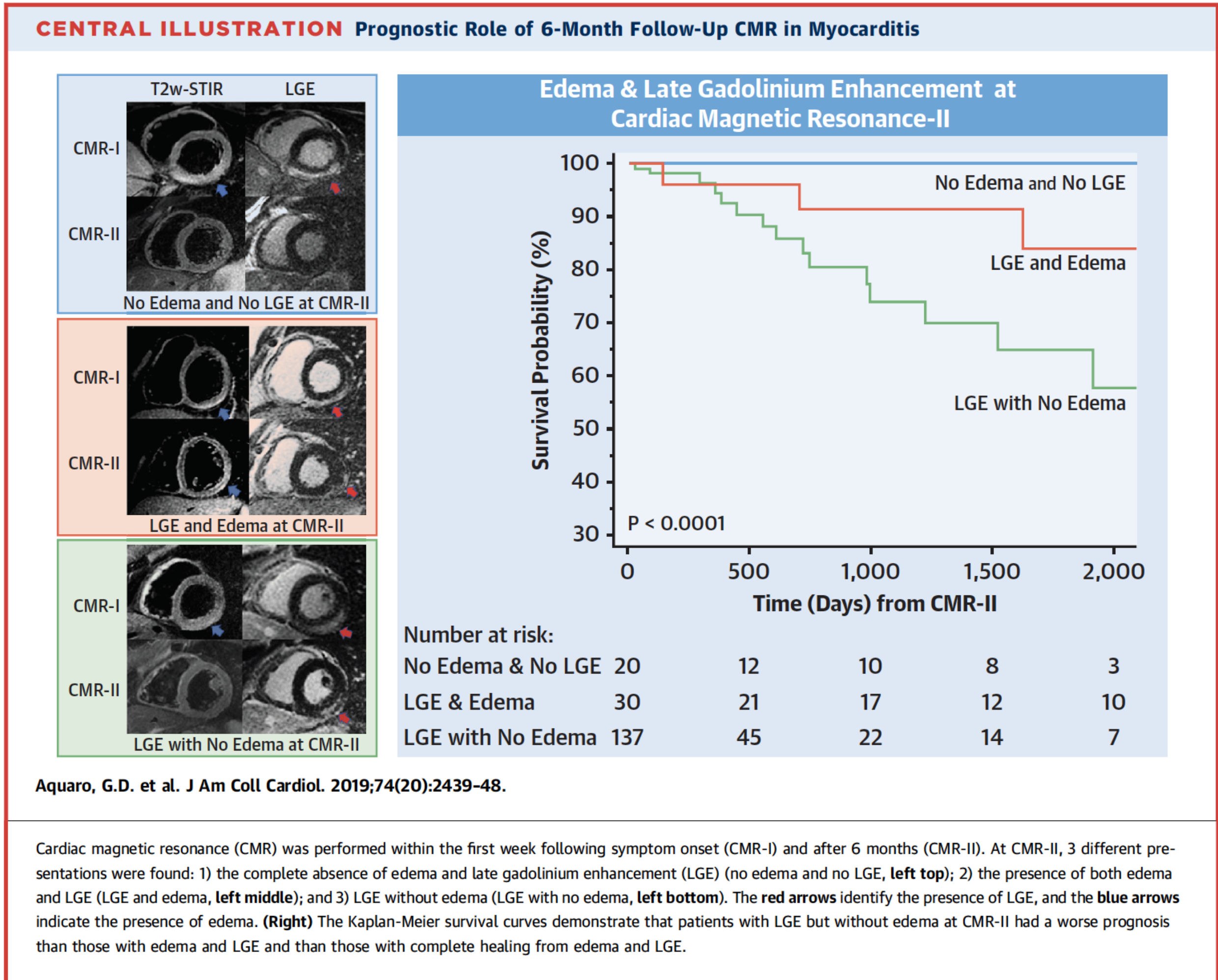
*VE adjustments: Age, sex, race, ethnicity, admission date (biweekly), and HHS region

-5 -35 -15 5 25 45 65 85
Vaccine Effectiveness (%)

1 **APPENDIX D**

2 Prognostic Role of 6-Month Follow-Up CMR in Myocarditis

3 https://www.jacc.org/doi/abs/10.1016/j.jacc.2019.08.1061



Cardiac magnetic resonance (CMR) was performed within the first week following symptom onset (CMR-I) and after 6 months (CMR-II). At CMR-II, 3 different presentations were found: 1) the complete absence of edema and late gadolinium enhancement (LGE) (no edema and no LGE, **left top**); 2) the presence of both edema and LGE (LGE and edema, **left middle**); and 3) LGE without edema (LGE with no edema, **left bottom**). The **red arrows** identify the presence of LGE, and the **blue arrows** indicate the presence of edema. **(Right)** The Kaplan-Meier survival curves demonstrate that patients with LGE but without edema at CMR-II had a worse prognosis than those with edema and LGE and than those with complete healing from edema and LGE.

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APPENDIX E

CDC's intermediate term follow-up study on myocarditis (Lancet study)

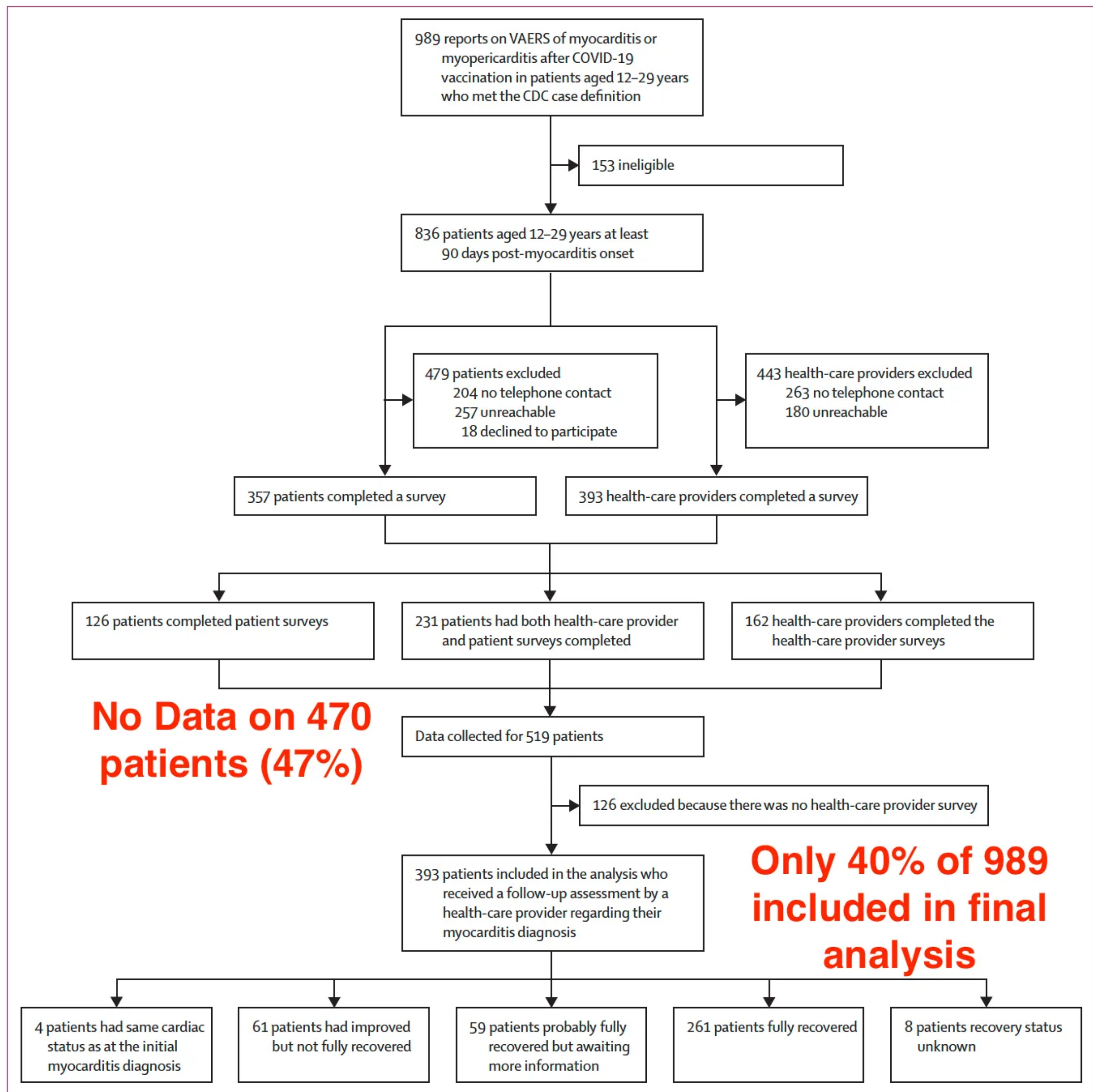

Figure 1: **Survey participation of patients with myocarditis after mRNA COVID-19 vaccination reported to VAERS at least 90 days since symptom onset**
CDC=US Centers for Disease Control and Prevention. VAERS=Vaccine Adverse Event Reporting System.

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	Patients fully or probably fully recovered (n=320)	Patients not recovered (n=65)	All patients (n=519)	p value
(Continued from previous page)				
Patient-reported symptoms in the patient survey	n=195§	n=28§	n=357	..
At least one symptom	94 (48%)	18 (64%)	178 (50%)	0·16
Chest pain or discomfort	55 (28%)	13 (46%)	113 (32%)	0·082
Chest pain or discomfort while resting	45 (23%)	11 (39%)	92 (26%)	0·011
Fatigue	40 (21%)	12 (43%)	89 (25%)	0·018
Fatigue while resting	28 (14%)	10 (36%)	63 (18%)	0·012
Shortness of breath	38 (19%)	9 (32%)	80 (22%)	0·28
Shortness of breath while resting	15 (8%)	4 (14%)	38 (11%)	0·42
Heart palpitations	36 (18%)	6 (21%)	77 (22%)	0·71
Heart palpitations while resting	28 (14%)	5 (18%)	59 (17%)	0·84

~50% still had symptoms of myocarditis!

Data are n (%) unless specified otherwise. Data are based on the completion of 357 patient surveys, 393 provider surveys, and 231 linked surveys, resulting in 519 patients for which data were collected. Health-care provider determination of patient myocarditis recovery was provided for 393 patients, of whom 320 were considered fully or probably fully recovered and 65 were not considered recovered (and eight patients had an undetermined recovery status; figure 1). Based on the last patient encounter, health-care providers reported that 62 (16%) of 393 patients had at least one symptom that might occur with myocarditis. *Previous SARS-CoV-2 infection before the diagnosis of myocarditis, as determined by a positive laboratory-confirmed test; the interval from a positive SARS-CoV-2 test result to mRNA COVID-19 vaccination was a median of 139 days (IQR 92–198; n=15 with a date provided). †Asthma, for which prescription medicine within the past 2 years was needed; if asthma was only with exercise, it was not recorded. ‡BMI was calculated using measurements obtained at the earliest follow-up visit: the formula weight (pounds) / [height (inches)]^2 × 703. The denominators reflect the number of individuals with data available to calculate BMI. §All patients who self-reported symptoms in the patient survey and had a provider-reported recovery status.

***Table 1:* Demographic characteristics and symptoms of patients by provider-reported recovery status from myocarditis after mRNA COVID-19 vaccination**

APPENDIX F

From "Effectiveness of Coronavirus Disease 2019 Bivalent Vaccine"

- Risk of COVID-19 infection *increases* with each additional COVID-19 vaccine dose
- https://academic.oup.com/ofid/article/10/6/ofad209/7131292
- https://pubmed.ncbi.nlm.nih.gov/37274183/

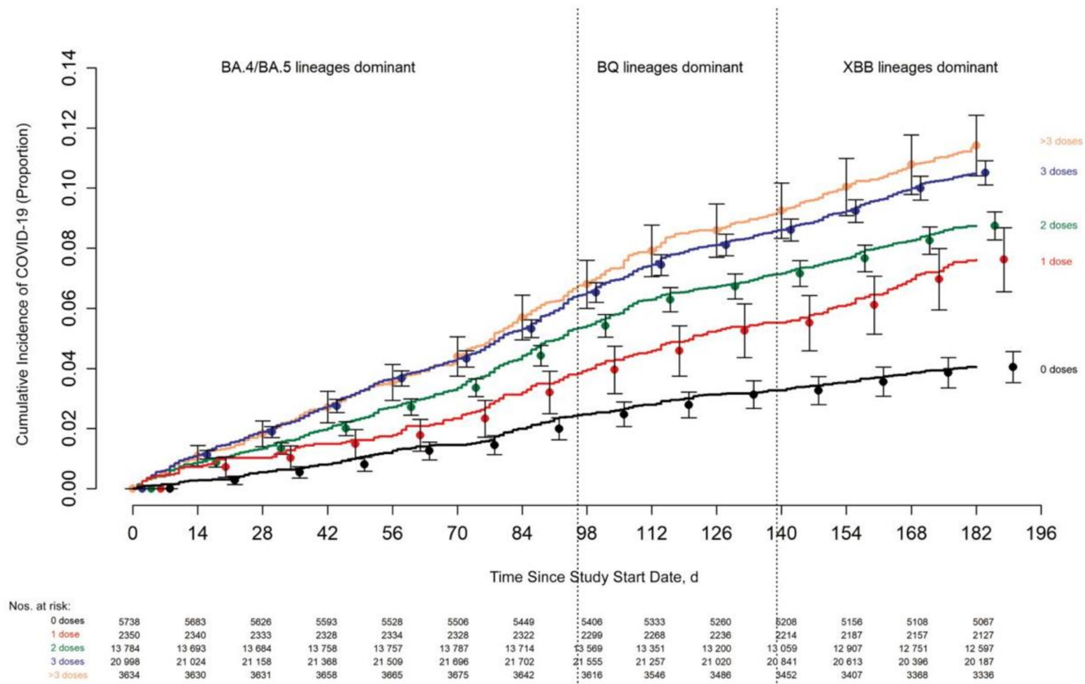

Figure 2. Cumulative incidence of coronavirus disease 2019 (COVID-19) for study participants stratified by the number of COVID-19 vaccine doses previously received. Day 0 was 12 September 2022, the date the bivalent vaccine was first offered to employees. Point estimates and 95% confidence intervals are jittered along the x-axis to improve visibility.

1 **APPENDIX G**

2 Decreased survival in those with persistent abnormalities on cardiac MRI at 6-month follow-up
3 after myocarditis

4 - https://www.sciencedirect.com/science/article/pii/S0735109719377368?via%3Dihub

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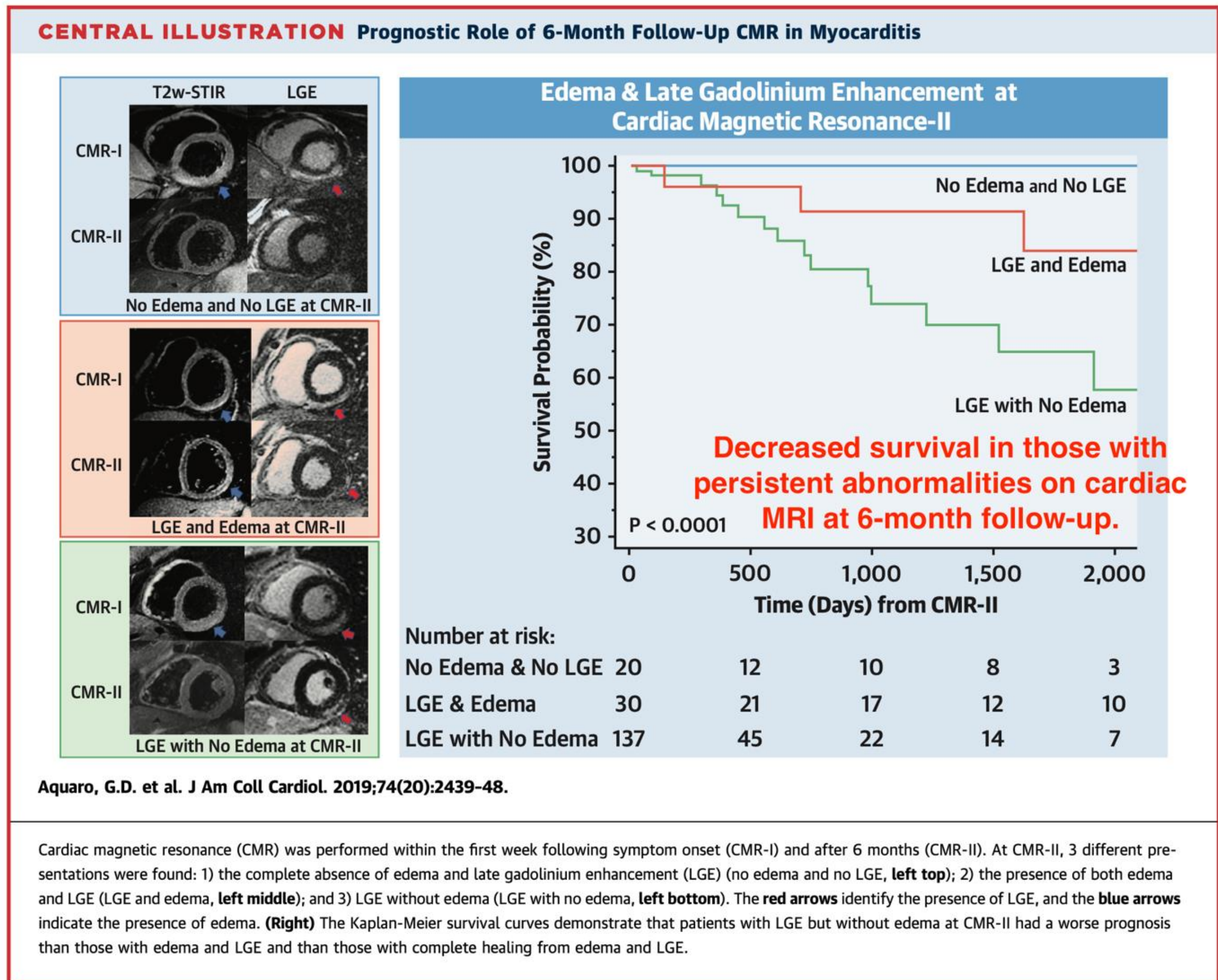

Cardiac magnetic resonance (CMR) was performed within the first week following symptom onset (CMR-I) and after 6 months (CMR-II). At CMR-II, 3 different presentations were found: 1) the complete absence of edema and late gadolinium enhancement (LGE) (no edema and no LGE, **left top**); 2) the presence of both edema and LGE (LGE and edema, **left middle**); and 3) LGE without edema (LGE with no edema, **left bottom**). The **red arrows** identify the presence of LGE, and the **blue arrows** indicate the presence of edema. **(Right)** The Kaplan-Meier survival curves demonstrate that patients with LGE but without edema at CMR-II had a worse prognosis than those with edema and LGE and than those with complete healing from edema and LGE.

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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

PIERRE KORY, M.D., LE TRINH HOANG, D.O., BRIAN TYSON, M.D., PHYSICIANS FOR INFORMED CONSENT, a not-for-profit corporation and, CHILDREN'S HEALTH DEFENSE, a not-for-profit corporation,

Plaintiffs,

v.

ROB BONTA In his official capacity as Attorney General of California, REJI VARGHESE, in his official capacity as Executive Director of the Medical Board of California, ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California; and

Defendants.

Case No: 2:24-cv-00001 WBS-AC

DECLARATION OF PIERRE KORY, M.D. IN SUPPORT OF PRELIMINARY INJUNCTION MOTION

Date: April 1, 2024
Time: 1:30 PM
Courtroom: 5, 14th Floor

Action Filed: January 2, 2024

1 I, Pierre Kory, M. D., declare as follows:
2 1. I am one of the individual plaintiffs in this case. I have personal knowledge of
3 the facts set forth herein, and I have already verified parts of the complaint in a verification
4 attached to the Verified Complaint.
5 2. I would like to give my perspective as a fifteen plus year critical care physician,
6 which is the specialty that supervises ICUs and all staff including physicians. This medical
7 specialty routinely deals with patients on ventilators, which is why I became so distressed
8 during the first months of the pandemic because the use of ventilators was so obviously not
9 helping preventing deaths and was increasing the likelihood of death. Plus, the so-called
10 standard of care practice to send Covid patients home completely untreated until they needed
11 to be hospitalized, at which point it was often too late.
12 3. This led me and other critical care physicians to look for treatments, especially
13 repurposed drugs like HCQ and Ivermectin. Since that time, me and my like-minded
14 colleagues have treated over 20,000 patients with protocols involved repurposed drugs and
15 other things like antibiotics and certain vitamins and minerals.
16 4. In the case of Ivermectin, there are currently 100 controlled clinical trials from
17 around the world, the summary analysis of which demonstrates the efficacy of Ivermectin
18 within these protocols. There are a small number of studies which instead find little evidence
19 of efficacy. I have addressed the methodological problems with those studies in my book, but
20 that is beyond the scope of this declaration, except to summarily state that these protocols
21 require specific dosages, the treatments must be started before hospitalization, and treatments
22 must be continued until the patient is fully recovered. The lack of adherence to these protocol
23 requirements are just some of the reasons for the negative results in the studies not confirming
24 the benefit.
25 5. It is my belief and the belief of many of my colleagues that the reason these
26 repurposed drugs and treatment protocols were dismissed was because of the requirement that
27 emergency use authorization ("EUA") of investigational drugs and biologics are only available
28 if there is no effective treatment for the condition, in which cases, even though not fully tested,

these investigational products can be marketed despite the lack of long-term safety data. Thus, effective repurposed drugs threatened a massive global market for Covid vaccines of over 100 billion dollars.

6. Early on, there were concerns raised by the safety of these vaccine products, and as time has passed these concerns have not been resolved, despite the eventual full approval of these products.

7. Now, three years after the public health authorities' constant drumbeat for the use of these products, even the media is starting to report a significant increase in deaths which is not explained by Covid, especially since the Omicron variant became much less lethal than prior variants. *See* https://www.usatoday.com/story/opinion/2023/08/11/more-americans-dying-than-before-pandemic-covid-deaths/70542423007/ and https://www.newsweek.com/why-are-death-disability-rising-among-young-americans-opinion-1837006

8. These reports are consistent with the insurance industries' findings of increased deaths since vaccines were administered. *See* https://thehill.com/opinion/healthcare/4354004-this-is-bigger-than-covid-why-are-so-many-americans-dying-early/.

9. In fact, a shocking and unexplained fact by the public health authorities is that the death rate attributed to Covid went up after the vaccines were widely distributed in 2021, compared to 2020, which of course is inconsistent with the Covid shots saving lives.

10. All this information is, to varying degrees out there in the public. Patients come to physicians like me for our honest opinions, uncertain about whether to continue to take each successive booster and whether to use off label drugs or protocols such as the ones used by Dr. Tyson and many others, including myself. This is especially true because as Dr. Tyson has noted in his declaration, the Omicron variant is much less lethal than prior variants. I also agree with the idea that the public's mistrust of the public health authorities' edict is largely a self-created phenomenon due to the unjustified certainty of their pronouncements coupled with how often their edicts have had to be changed or abandoned.

11. I also agree with Dr. Tyson, that Covid has allowed the public health authorities and the government overseers of medicine to debase and repudiate the collective wisdom and experience of practitioners who were trying repurposed drugs and other logical treatment, rather than follow the public health authorities' promotion of new drugs with numerous known serious side effects. *See* https://www.paxlovid.com/side-effects. In addition, Paxlovid has drug interactions with 125 different medicines across 25 classes. *See* https://www.med.umich.edu/asp/pdf/outpatient_guidelines/Paxlovid-DDI.pdf

12. I am also not surprised by the findings Dr. Hoang has related to the Court, given the new mRNA technology and its effect on human biology and immunology.

13. To end on a broader point, I think it is a dangerous thing to allow the government to determine what is truth in medicine, and to force physicians to toe the party in discussions with patients. I found it both unprecedented and unconscionable that during a period of rapidly emerging knowledge and insights into a novel disease, "scientific consensus" was so rapidly achieved and soon after disbanded only to be replaced with a new one. Yet, each time one was supposedly established, any physician who questioned or reached a contrary scientific conclusion due to the identification of severely conflicting data, were persecuted and threatened for violating such hasty "standards of care." Further, many of us are deeply aware of the decades long influence of the pharmaceutical industry along with the civil and criminal fines accrued in the tens of billions of dollars. Thus, we rightly adopted a skeptical stance in a situation where the only drugs or treatments for Covid that were approved by our regulatory and professional societies uniformly consisted of only patented, barely-tested, immensely profitable pharmaceuticals and vaccines. All inexpensive, re-purposed drugs were ignored and vilified. We believe our publicly voiced skepticism and alternative conclusions were entirely appropriate given the agencies' prior failures and the almost constant apologies and promises to do better as outlined in the complaint. Until Covid, compelling physicians to limit discussions with patients was not something we have seen in this country, but I understand that it was all too familiar in some of the world's most repressive regimes.

14. It is for these reasons, to help correct the record and ask the Court to once again allow physicians to speak their truth to patients, and give patients the right to hear information other than the government's messaging on Covid.

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

Signed: February 9, 2024.

Pierre Kory

Pierre Kory, M.D.

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

PIERRE KORY, M.D., LE TRINH HOANG, D.O., BRIAN TYSON, M.D., PHYSICIANS FOR INFORMED CONSENT, a not-for-profit corporation and, CHILDREN'S HEALTH DEFENSE, a not-for-profit corporation,

Plaintiffs,

v.

ROB BONTA In his official capacity as Attorney General of California, REJI VARGHESE, in his official capacity as Executive Director of the Medical Board of California, ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California; and

Defendants.

Case No: 2:24-cv-00001 WBS-AC

DECLARATION OF LE TRINH HOANG, D.O. IN SUPPORT OF PRELIMINARY INJUNCTION MOTION

Date: April 1, 2024
Time: 1:30 PM
Courtroom: 5, 14th Floor

Action Filed: January 2, 2024

I, Le Trinh Hoang, D.O., declare as follows:

1. I am one of the individual plaintiffs in this case. I am also a plaintiff in the related case Hoang v. Bonta. I have personal knowledge of the facts set forth herein, and I have already verified parts of the complaint in a verification attached to the Verified Complaint.

2. First, I would like to thank the Court for issuing the preliminary injunction in the related cases. It allowed me and other members of Physicians for Informed Consent the freedom and security to speak our minds to patients about Covid without fear of prosecution by the California medical boards. Some of my patients who know about the case have told me that they feel better about seeing me and other physicians knowing that we have been protected by this court. Of course, that protection has now been eliminated because of the repeal of the law and indications that the boards still think they have the power to sanction doctors who challenge the mainstream Covid narrative under their standard of care authority. That is the reason why I and PIC, CHD and two medical doctors have filed this new action, to ask you to stop this latest effort by the boards to do the same thing and basically intimidate doctors against providing their honest opinions.

3. I of course agree with what Dr. Verma said in his declaration. Beyond that however, I would like to relate some of the disturbing thing I am seeing in my practice treatment patients who have taken multiple mRNA shots.

4. I have seen multiple things which I would medically unusual. Patients' bodies become inflamed and they are not the same, altered; labs come back abnormal -clotting, heart injury, inflammation, autoimmune conversion (going haywire); when I touch & do muscular treatments (looks like acupressure & PT at the same time), if I forget to put on gloves, the jabbed patients turn my finger pads visibly purplish. In my 20 plus years of practicing osteopathic medicine, I have never encountered these phenomena.

5. Everyone who has been jabbed, anyone with 2020 COVID not treated, anyone with persistent cough, anyone unjabbed but with persistent symptoms with a jabbed spouse, I now order blood work for them.

1 6. I have recently met other like-minded physicians at a conference and I learned
2 that other practitioners have experienced some of the same things. We believe that the
3 conditions we are seeing in the unvaccinated spouses and co-habitants is a result of vaccine
4 shedding, and it is causing alarming and surprising phenomena, the details of which are
5 beyond the scope and need of this motion.[1]
6 7. Let me provide you with a few examples of families who appear to be struggling
7 and suffering because of these mRNA shots. For I have treated one 19 years girl since she was
8 a baby. She was healthy, as an athlete-her periods were off (considered normal); she hardly
9 ever comes in for health issues. College demanded the injections. Because I hardly ever see
10 them, I did not reach out to them to tell them not to take the shots. A year and a half later,
11 suddenly, the periods stop & she has a near passing out episode in class. It seems likely, but
12 unprovable that the mRNA shots are to blame. I put her on some off label treatments and at
13 least her period is normal but Labs show-autoimmune conversion, organ injury (likely the
14 ovaries).
15 8. Her dad, for 15 years, only came in for musculoskeletal/back issues related to his
16 desk work-cyclist & marathon runner; no prior history 2-weeks ago chest pain- Aortic Valve
17 Stenosis-in 6-8 weeks they want to do valve replacement heart surgery.
18 9. A 39-year-old mother of 3: I see her & her 4 kids for musculoskeletal work for
19 over 5 years. She had mRNA shots so I check her- 2 specific markers of clotting are positive,
20 and she has been having a bad cough for 3 months; COVID tests are negative I am using off
21 label medications on her and she seems to be responding.
22 10. In general, I am seeing far too much clotting and new autoimmune conditions in
23 my patients which conditions have only occurred after Covid and after the patients had take
24 the shots. As indicated, many of my colleagues are seeing the same thing and we are all
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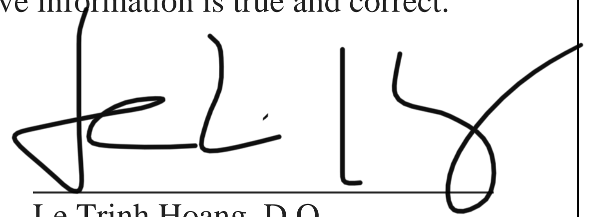
26
27 [1] Even the CDC recognizes vaccine shedding from live virus vaccines such as MMR. But
28 shedding from the Covid shots is something debated in the emerging literature. *See* e.g.,
https://covid19criticalcare.com/wp-content/uploads/2024/02/Shedding-of-COVID-mRNA-Vaccines-A-review-of-evidence-2024-02-03.pdf.

becoming quite alarmed. These phenomena do not seem to be reported in the mainstream media.

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

Signed this February 9, 2024.



Le Trinh Hoang, D.O.

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

PIERRE KORY, M.D., LE TRINH HOANG, D.O., BRIAN TYSON, M.D., PHYSICIANS FOR INFORMED CONSENT, a not-for-profit corporation and, CHILDREN'S HEALTH DEFENSE, a not-for-profit corporation,

Plaintiffs,

v.

ROB BONTA In his official capacity as Attorney General of California, REJI VARGHESE, in his official capacity as Executive Director of the Medical Board of California, ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California; and

Defendants.

Case No: 2:24-cv-00001 WBS-AC

DECLARATION OF BRIAN TYSON, M.D. IN SUPPORT OF PRELIMINARY INJUNCTION MOTION

Date: April 1, 2024
Time: 1:30 PM
Courtroom: 5, 14th Floor

Action Filed: January 2, 2024

I, Brian Tyson, M.D., declare as follows:

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1. I am one of the individual plaintiffs in this case. I have personal knowledge of the facts set forth herein, and I have already verified parts of the complaint in a verification attached to the Verified Complaint.

2. I of course agree with what Dr. Verma said in his declaration. Beyond that however, I would like to relate some observations and conclusions I have now that my clinic has treated 20,000 plus Covid patients, and perhaps because of our large patient population, the California public health authorities have routinely visited our clinic to collect certain limited data about our Covid patient population, and what data they do not collect.

3. Early on the first thing we noticed is that the public health authorities did not collect the vaccine breakthrough rate, which our data showed to be approximately 20%, compared to basically zero reinfection rate based on natural immunity (i.e., prior infection) (This was through the Alpha to Delta variant, and from the Omicron, we have seen little to no benefit from either the vaccine or prior infection in terms of a protective effect from either). The point is that the public health authorities were not collecting the data to see if the vaccines were preventing reinfections, what as stated we thought was odd.

4. The other observation I would like to share is that at our clinic we have not seen Covid in lungs in a patient in almost two years. The patient testing positive for Covid during Omicron have essentially head cold symptoms. We do not even treat these patients with the off-label drugs like Ivermectin and HCQ because of the mildness of the infection (and we do not use the on-label medications for Covid because of their known serious side effects. Our treatment consists of Z Pac, Tylenol, and some other over-the-counter

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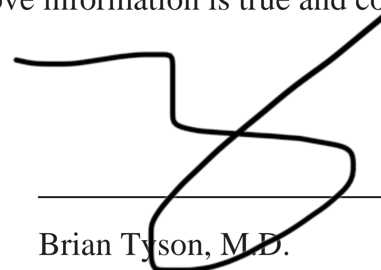
medications. We have had a zero-death rate from Covid when treated at our clinic with our protocol

5. If I had to point to one overarching problem which the country has faced since the beginning of the pandemic it is the debasement of the clinical experience of physicians like myself, Dr. Kory and members of his group and hundreds of other front-line physicians who have employed treatments which we know have saved lives, and have been give by us and our staff at great personal risk during the dark days of Covid.

6. Then and especially now because as stated, Covid mostly present with mild symptoms for all but those with very significant co-morbidities, we physicians must be able to talk to our patients honestly about the relative risks of vaccines and the on-label Covid treatments, even if it is at odds with the public health authorities whose pronouncements seem to be mindlessly repeated by many physicians. I can tell you that our patients expect nothing less from us. And that is a big reason why I have decided to be a plaintiff in this case; to protect the physicians' rights to speak their truth and relate their experience, and the right of patients to receive this information.

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

Signed: February 2, 2024.



Brian Tyson, M.D.

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

PIERRE KORY, M.D., LE TRINH HOANG, D.O., BRIAN TYSON, M.D., PHYSICIANS FOR INFORMED CONSENT, a not-for-profit corporation and, CHILDREN'S HEALTH DEFENSE, a not-for-profit corporation, Plaintiffs, v. ROB BONTA In his official capacity as Attorney General of California, REJI VARGHESE, in his official capacity as Executive Director of the Medical Board of California, ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California; and Defendants.	**Case No: 2:24-cv-00001 WBS-AC** **DECLARATION OF DEBBIE HOBEL IN SUPPORT OF PRELIMINARY INJUNCTION MOTION** **Date:** March 18, 2024 **Time:** 1:30 PM **Courtroom:** 5, 14th Floor Action Filed: January 2, 2024

1 I, Debbie Hobel, declare as follows:
2 **1.** My family currently lives in Ventura County. My son M.H. is a 17-year-old who
3 attends school in Oxnard Union High School District. He is in his senior year.
4 **2.** I have previously submitted a declaration in Hoang v. Bonta. Concerning my son
5 and the question of Covid boosters, the prior injunction order issued by the Court last January
6 was very helpful for my family because it gave us the confidence for Dr. Hoang to provide us
7 with her honest opinion with respect to the boosters. However, now that the AB2098's
8 author's office has announced that the medical boards can *continue* to prosecute physicians
9 despite AB 2098's repeal, I feel we are back to square one, and have concerns that Dr. Hoang
10 and other physicians with whom we may consult in the future will not provide their actual
11 opinions for fear of prosecution.
12 **3.** To recap from my prior declaration, we are patients of Dr. Hoang and would
13 gladly make an appointment to see her again to discuss Covid. We currently see an Osteopath
14 in our County who is very conventional in his advice and recommendations – he is still
15 recommending the Covid-19 shots and boosters, but we want a second opinion from Dr.
16 Hoang as the science evolves. We like our local osteopath a lot (he has a good rapport with my
17 son), but we do want a second opinion.
18 **4.** In our family we are not against Covid-19 vaccination. Each member of our
19 family received Covid-19 vaccinations originally. We are pro informed consent, and I am a
20 health freedom member of the group Physicians for Informed Consent. M.H. received two
21 doses of the Pfizer vaccine. However, after my husband received a Covid-19 vaccine in
22 October 2021, he immediately suffered a sore arm, which then became inflammation
23 throughout his arm and hand. He is a musician so he had to stop playing piano professionally
24 for a while because the adverse reaction has been so bad. He needs to wear splints on his
25 fingers every day. It has been over one year and his fingers still do not function properly. He
26 can now play some piano again but with diminished capacity. It's been really difficult for us.
27 Shortly after the booster he also got tinnitus in both ears, which is constant (not intermittent)
28 and has never gone away.

1 **5.** M.H. has had intermittent breathing problems that have been difficult to
2 diagnose and treat. Our osteopath sent us to a specialist (pediatric pulmonologist), who
3 suggested it could be stress-related but he didn't know.
4 **6.** I am filing this declaration because I want Dr. Hoang and other physicians with
5 whom we may consult to be free to speak candidly with me about their recommendations and
6 how they may see things differently than our local osteopath or medical doctor, should we
7 consult with one. In the past, we found Dr. Hoang to be knowledgeable and we trust her. At
8 this point the only thing that stands in the way for us is the fact that the California authorities
9 believe they can still prosecute physicians for the same opinions that they could under the now
10 repealed law.
11 **7.** My plan at this point is just to wait to make future medical appointments on
12 Covid-19 vaccines with our osteopath and Dr. Hoang until I know whether so-called "covid
13 misinformation" prosecutions are considered constitutional in court. If doctors can be
14 prosecuted for giving a second opinion based on their review of published covid science, I
15 figure there is really no point in me continuing to go to Dr. Hoang for a second opinion
16 because I would just get her in trouble asking her for candid advice. I realize one option would
17 be to travel out of State for a second opinion, but that just seems outrageous. Like the Court
18 originally solved the first problem (AB 2098) in Hoang v. Bonta, I am hoping the Court can
19 fix this new situation for families like mine.
20 I declare under penalty of perjury that the above information is true and correct.
21 Signed this 20th day of January 2024, in Oxnard, California.
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23 Debbie Hobel
24 Debbie Hobel
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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

PIERRE KORY, M.D., LE TRINH HOANG, D.O., BRIAN TYSON, M.D., PHYSICIANS FOR INFORMED CONSENT, a not-for-profit corporation and, CHILDREN'S HEALTH DEFENSE, a not-for-profit corporation,

Plaintiffs,

v.

ROB BONTA In his official capacity as Attorney General of California, REJI VARGHESE, in his official capacity as Executive Director of the Medical Board of California, ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California; and

Defendants.

Case No: 2:24-cv-00001 WBS-AC

DECLARATION OF NEIL SELFLINGER IN SUPPORT OF PRELIMINARY INJUNCTION MOTION

I, Neil Seflinger , declare as follows:

1. I am currently 73 years old. I am a resident of Los Angeles, California. I had been in excellent health with no major health issues or what would be considered to be co-

1 morbidities to Covid (other than my age). Because my wife has some chronic medical
2 problems, I took the first shot of the Moderna vaccine in January-2021. Approximately 28
3 hours later I began shaking uncontrollably and was literally unable to walk. That lasted for
4 nearly an hour and was quite disconcerting to me. Over the next few weeks, I experienced
5 significant side effects including sporadic shaking in my upper body. I also was experiencing
6 electric shocks throughout my body. I had never had these problems prior to the vaccine. I
7 received the Moderna vaccine at Dodger Stadium.

8 **2.** I contacted my physician soon after the onset of my symptoms and asked him
9 whether I should still take the second shot. He expressed some concern about my side effects,
10 but initially said he was "wrestling with the idea" I continued to have sporadically the same
11 side effects I had been experiencing including problems with my gait, and tremors.

12 **3.** After further explaining my symptoms a few weeks later, my doctor had a
13 completely different reaction from the last time we spoke. He now told me that the CDC
14 recommends the second dose and that side effects are rare and that the benefits to me and
15 others outweighed the risks. I told him I would think about it. My primary concern was my
16 wife, but I was also concerned because the vaccine had obviously had a dramatic negative
17 impact of my prior excellent health.

18 **4.** Within the next few weeks other symptoms started to occur: Tinnitus, a kind of
19 hissing sound would come and go and made it more difficult to concentrate or go to sleep.
20 Tingling in my upper left leg, which has been fairly constant. Numbness in different areas,
21 particularly my upper left leg. Excessive sweating during very light activity. Itching on the
22 backs of my hands and upper back—no amount of scratching or lotion could relieve it. Brain
23 fog—a departure from my normally clear thinking that was very frustrating. Besides these
24 newer symptoms, the electric shocks, particularly in my hands, forearms, feet and ankles,
25 increased. There was no warning, or any way to anticipate when these shocks were coming. I
26 also had difficulty walking, an exercise I love to do. At times, walking barely 50 yards would
27 be excruciating.
28

5. I elected not to take the second shot and searched for someone to treat the side effects from the first shot.

6. I eventually found Dr. Kory. His advice and recommendations have greatly diminished the side effects from the vaccine, both in terms of intensity and frequency. I am not completely better yet. But I am encouraged by the results so far. He also explained to me some of the side effects of these mRNA vaccines which are underreported and underemphasized by the public health authorities.

7. I have seen first-hand how physicians like my PCP literally just recited what the CDC says in public, despite other considerations like my on-going side effects. This experience has made me much less trustful of him.

8. I appreciate all that Dr. Kory has done for me in providing me information which although not mainstream seems to be consistent with my symptoms and advice and recommendations which are reversing the side effects from the Moderna shot.

I declare under penalty of perjury that the above information is true and correct. Signed this 28th day of January 2024, in Los Angeles, California.

Neil Seflinger

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

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Plaintiffs,

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ROB BONTA, in his official capacity as Attorney General of California, REJI VARGHESE, in his official capacity as Executive Director of the Medical Board of California, ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California,

Defendants.

Case No: 2:24-cv-00001-WBS-AC

VERIFIED COMPLAINT

Plaintiffs by their undersigned counsel, hereby allege against the Defendants as follows:

1. This is a 42 U.S.C. section 1983 civil rights action for which this Court has jurisdiction under 28 U.S.C. section 1331. This Court has authority to grant the requested injunctive relief under 28 U.S.C. section 1343; the requested declaratory relief under 28 U.S.C. sections 2201 and 2202; and costs and attorneys' fees under 42 U.S.C. section 1988 (b).

2. Venue is proper in the federal Eastern District of California pursuant to 28 U.S.C. section 1391 (b). Defendant ROB BONTA, the California Attorney General, has his principal office in this District, as does REJI VARGHESE, the Executive Director of the Medical Board of California, and ERICA CALDERON, the Executive Director of the Osteopathic Medical Board of California (both boards are referred to herein as "Boards"). Enforcement of the challenged actions by the individual Defendants in their official capacity takes place in this district.

INTRODUCTION

3. This is a follow-up action involving most of the parties in *Hoang v. Bonta* and *Hoeg v. Newsom,* currently pending before the Hon. William B. Shubb. *Hoang* and *Hoeg* challenged AB 2098 enacted as Business and Professions Code section 2270, effective January 1, 2023, enjoined January 23, 2023, and repealed January 1, 2024. The law had granted the California medical boards the specific statutory authority to sanction physicians for providing information, recommendations, and advice to their patients which the boards considered to be "Covid misinformation" as defined in the repealed statute.

4. Despite its repeal, the Medical Board of California (hereinafter the "Medical Board") is still targeting "Covid misinformation," and physicians are still being intimidated and threatened with disciplinary action. The only difference is that now the investigations and public threats are based on the general standard of care statute. The Medical Board continues to ally itself with, and adopt the recommendations of, the Federation of State Medical Boards (the "Federation"), which calls for its member medical boards to prosecute physicians for "Covid

misinformation."[1]

5. Plaintiffs expect the Defendants to make the same argument they made in *Hoang* and *Hoeg* (and the two other AB 2098 lawsuits), namely that all communications between a doctor and patient are part of patient/medical care, and hence unprotected by the First Amendment under the so-called professional speech exception.

6. However, the professional speech exception was specifically rejected by the Supreme Court in *Nat'l Inst. Advocates & Life Advocates v. Becerra* ("*NIFLA*") 138 S. Ct. 2361, 2371-2373 (2018) which involved the previous unsuccessful effort by the California Legislature to impose government control over health care professionals' protected speech. And in so doing, the *NIFLA* court also rejected by name (*Pickup v Brown*) an earlier Ninth Circuit decision upholding yet another California Legislature's restriction on the protected speech by health care professionals.

7. In rejecting these two prior restrictions to physician speech, the Supreme Court forcefully decried California (and other states) attempts to circumvent free speech protections of licensed professionals by the illegitimate transformation/recharacterization of all speech by a professional to a patient/client into unprotected professional conduct. *NIFLA*, 138 S. Ct. at 2371-73.

8. Despite *NIFLA*'s clear statement to the state governments that they could not unprotect protected speech by its wholesale transmutation into conduct (*i.e.*, patient/medical care), California passed AB 2098. And how did that work out?

9. We are now faced with the fourth time California is attempting to regulate protected speech by calling it conduct supposedly regulatable under standard of care authority.

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[1] *See*, *e.g.*, Stacy Weiner, *Is spreading medical misinformation a physician's free speech right? It's complicated*, AAMC.ORG (Dec. 26, 2023), https://www.aamc.org/news/spreading-medical-misinformation-physician-s-free-speech-right-it-s-complicated; *Enforcement Monitor Final Report Findings and Recommendations*, For Department of Consumer Affairs, MEDICAL BOARD OF CALIFORNIA (Aug. 18, 2023), https://www.mbc.ca.gov/Download/Reports/enforcement-report-final-2023.pdf; *Manual of Model Disciplinary Orders and Disciplinary Guidelines*, State of California, MEDICAL BOARD OF CALIFORNIA (12th Ed. 2016), https://www.mbc.ca.gov/Download/Documents/disciplinary-guidelines.pdf.

1 10. When does it end? Plaintiffs ask the Court to send a clear message to the
2 Defendants that the government does not get to "manipulate the content of doctor-patient
3 discourse..." (*NIFLA,* 138 S. Ct. at 2374) by censoring and sanctioning physicians for
4 providing information and expressing opinions that the government does not want patients to
5 hear. Such government overreach is common in the world's most repressive regimes, but
6 should not be countenanced here.[2]
7 11. From the pandemic's beginning, the public health authorities have continuously
8 apologized to the public for their erratic and oftentimes contradictory edicts about masking, the
9 use of ventilators, the wishful thinking, if not fraudulent edicts about the ability of the vaccines
10 to prevent infection and transmission.[3] Slowly, the public and the courts are starting to
11 recognize that the primary purveyors of Covid misinformation are the public health authorities
12 and their enforcers like the Defendants, not the physicians who challenge these irrational,
13 magical thinking, and often short-lived edicts.
14 12. It has been four years since the start of the pandemic, and nine months after
15 President Biden said the pandemic is over. If not now, when does California's pandemic
16 generated attack on physicians' First Amendment rights end?
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18 **THE PLAINTIFFS AND THEIR STANDING**
19 13. Plaintiff Pierre Kory, MD is a critical care doctor and a co-founder and president
20 of the Front Line COVID-19 Critical Care Alliance ("FLCCC"), an organization which, *inter*
21 *alia* advocates for the use of Ivermectin as a treatment for the virus.
22 14. He is a co-author of several peer reviewed articles on Ivermectin[4] and he has
23 written a book aptly titled *The War on Ivermectin* which is a detailed description about how
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25 [2] *See NIFLA,* 138 S. Ct. at 2374, *quoting Wollschlaeger v. Governor*, 848 F.3d 1293,
26 1325 (11th Cir. 2017) (*en banc*), (W. Pryor, J. concurring).
27 [3] *See* footnote 12 on page 19 for references to some of these apologies.
28 [4] *See, e.g.*, *Review Of The Emerging Evidence Demonstrating The Efficacy Of Ivermectin In The Prophylaxis And Treatment Of Covid-19*, AM. J. THER, 2021 May-June 28(3): E299-E318, https://www.ncbi.nlm.nih.gov/pmc/articles/pmc8088823/.

those in power and authority have engaged in a campaign of disparagement against Ivermectin and personally attack pioneers like him who advocate for its use.[5,6]

15. Dr. Kory and his fellow FLCCC members have successfully treated over 5,000 Covid patients with the drug. The medical authorities consider all these successfully treated patients to be merely anecdotal evidence. However, the patients and their family members would either disagree, or else do not care and are grateful that there are physicians brave enough to stand up and do what they in their experience think is the best treatment. Dr. Kory laments that somehow the clinical experience of scores of doctors who have treated many thousands of patients has been disvalued.

16. Dr. Kory has testified twice before congressional committees, as well as state Legislatures in Pennsylvania, Maryland, and Wisconsin. He is one of the country's leading advocates for the off-label use of Ivermectin.

17. Dr. Kory provided important evidence in *Stock v. Gray*, No. 2:22-CV-04104-DGK, 2023 U.S. Dist. LEXIS 48300, at *8-9, *23-24 (W.D. Mo. Mar. 22, 2023), where the district court granted a preliminary injunction against a Covid misinformation statute in Missouri, and pointed out that:

> Numerous lawmakers also endorsed Dr. Kory's testimony and promoted ivermectin as a COVID-19 drug.... The Court concludes Stock is likely to demonstrate that the statute is unconstitutional. Because Stock has demonstrated a likelihood of success on her First Amendment claim, the other requirements for

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[5] Like all wars where medical mavericks take on the so called "contemporary scientific consensus," there are attacks against the maverick doctors and this is no exception. Recently, the private internal medicine board ("ABIM") removed Dr. Kory's and two other physicians' board certification for spreading Covid "misinformation," but of course a private organization has no obligation to comply with the First Amendment. In addition, he and other authors of a published article were forced to retract a publication (not the one cited above). That all comes with the turf of fighting the medical establishment, sometimes known as the church of medical orthodoxy. *See Galileo's Lawyer*, Richard Jaffe, 2008, Chapters 1-9.

[6] There are now 99 published studies from around the world, many of which are fully controlled, which demonstrate the benefit of the drug for Covid. A list of these publications can be found at https://c19ivm.org/. A systematic review of the flaws of the studies which have not demonstrated efficacy can be found at such reputable source, and see the article referenced in footnote 4 above.

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> obtaining a preliminary injunction are deemed satisfied. *Rodgers*, 942 F.3d at 456. Conclusion. For the reasons discussed above, Plaintiff's motion for a preliminary injunction is GRANTED. Defendants are prohibited from reviewing, investigating, prosecuting, adjudicating, or enforcing violations of the second sentence of Missouri Revised Statute § 338.055.7 until after a final order is entered.

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18. Dr. Kory has a telehealth medical practice providing information and advising patients and maintains a California license, and consults with California based patients.

19. As a leading expert on Ivermectin, Dr. Kory's consulting medical practice includes dealing with patients with questions and concerns about Ivermectin, and whether he recommends its use.

20. He of course explains that the drug is FDA approved, but not specifically for Covid, and hence would only be available off label. He informs patients that there are some published studies and meta studies showing that the drug is not effective for Covid, but also explains that currently there are 99 controlled studies, both observational and randomized, from around the world, the summary analysis of which demonstrates a statistically significant efficacy reducing mortality, hospitalization, rates of viral clearance, and rates of clinical recovery. Of note is that the WHO, in their last guideline recommendation, found that ivermectin use led to an 81% reduction in mortality, yet a recommendation for use was never issued. He disagrees with this decision, for obvious reasons. His patients understand that the FDA, the manufacturer, and all mainstream medical associations recommend against the use of the drug for Covid, but patients consult with him specifically to obtain his perspective.

21. Dr. Kory has significant and reasonable concerns regarding the statement by AB 2098 sponsor Evan Low that despite the repeal, the medical boards will continue to investigate, prosecute, and sanction physicians who depart from the mainstream Covid narrative. Furthermore, there is at least one such medical board prosecution already forcing a physician to surrender her license to the Board. See *In the Matter of the Accusation Against: Ana Rebecca Reyna, M.D.*, Medical Board of California (Accusation June 23, 2023; Decision December 21, 2023; Case No. 800-2021-076688), available at

https://www2.mbc.ca.gov/BreezePDL/document.aspx?path=%5cDIDOCS%5c20231222%5cDMRAAAJD2%5c&did=AAAJD231222191633890.DID.

22. Accordingly, Dr. Kory has a direct interest in the subject matter of this lawsuit. His protected speech to his patients is being threatened and chilled, which, upon information and belief, is exactly what Assemblyman Low and others who support the repression of physician speech intend.

23. Plaintiff Le Trinh Hoang, is a pediatric osteopathic physician. Dr. Hoang has an office in Los Angeles County. She had been licensed by the Board for more than twenty-five years and treats children and sees adults for osteopathic muscular treatments.

24. Her practice includes advising her patients (and their families) about the risk versus benefits of Covid vaccines and boosters, based on the patient's age, health status, and co-morbidities. The level of detail or granularity of the information she conveys to patients depends on the patient (or the family member in the case of young children) and can range from just the broad strokes to discussion of the latest literature on vaccines and the reported deficits in the science behind FDA approved or Emergency Use Authorization ("EUA") drugs.

25. Of course, her patients are informed of the exact FDA status of the vaccine or drug (in the case of Covid treatment drugs) and the government's recommendation. Dr. Hoang would like to provide information to her male patients between ages 17-39 of the increased risks of cardiomyopathy and other cardiac serious adverse events of the mRNA shots to this patient subset. This information is evidence based and widely reported in the medical literature.[7] It may not be consistent with the U.S. infectious disease consensus, but the increased risk is plainly evidence based. Here again, the level of detail would depend on physician judgment and experience with the patient. Assuming Plaintiff Hoang provides this

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[7] *See, e.g.*, Oster et al., *Myocarditis Cases Reported After mRNA-Based COVID-19 Vaccination in the US From December 2020 to August 2021* that found the risk of myocarditis after receiving mRNA-based COVID-19 vaccines was increased across multiple age and sex strata and was highest after the second vaccination dose in adolescent males and young men. 2021. *JAMA*. 2022;327(4):331–340. doi:10.1001/jama.2021.24110, https://pubmed.ncbi.nlm.nih.gov/35076665/.

important information (in whatever the level of detail) to a patient and recommends against the vaccine for such a patient, Dr. Hoang believes she may be prosecuted for a standard of care violation for her fully protected speech based on AB 2098's bill sponsor statements and the fact that the medical board has prosecuted and disciplined one physician for information and opinions shared with a patient.

26. Sometimes, her patients ask her to comment on the general reliability of the CDC's edicts and the fact that the edicts seem to change so frequently and sometimes in a contradictory fashion.

27. Here again, Dr. Hoang would like to continue to provide such truthful information and evidence-based advice to her patients, but since this information and advice could be targeted as a violation of the standard of care, she is reluctant to do so unless this Court enjoins the Boards from using prosecutorial power to chill free speech.

28. As of the date of the filing of this Verified Complaint, Plaintiff Hoang intends to provide her patients with the best available information concerning the safety and efficacy of vaccines and Covid treatments, even where such information and recommendations might fall within her board's view that it violates the standard of care.

29. Plaintiff Brian Tyson, M.D. is a board-certified family practitioner who owns an urgent care facility in Southern California. Since the beginning of the pandemic, he has successively treated thousands of Covid patients with a variety of medications, on and off label.

30. As part of his practice, he has occasion to inquire about the vaccine status of patients. One specific context is providing physicals for high school and college athletes. Some athletes have reported chest pains, which requires inquiring about vaccine status since known side effects of the Covid vaccines are heart-related issues like myocarditis.

31. This inquiry almost always leads to a discussion of the safety and efficacy of the vaccines and whether the reported side effects were caused by the vaccine. Dr. Tyson provides information and his opinions based on his research, which is not the same as the CDC's position that these side effects are exceedingly rare. Dr. Tyson's opinion is in part based on the

thousands of vaccinated patients he has seen since the start of the pandemic and the dozens of patients who have first experienced chest pains after receiving one or more Covid shots. More disturbingly, most of the patients reporting chest pains have had the original shots plus at least one booster.

32. Once a patient reports chest pains (whether or not temporally associated with the Covid vaccine), Dr. Tyson refers the student athlete to a cardiologist and will not clear the student to play sports unless or until the cardiologist signs off.

33. Dr. Tyson's discussion with these patients may implicate or trigger a medical board's investigation and prosecution since he is not providing the CDC and FDA's mantra that vaccines are completely safe and cardiac side effects are exceedingly rare.

34. Another type of patient interaction which may trigger an investigation is when treating Covid patients who are fully vaccinated and boosted (and most of his Covid patients are in this category), he is frequently asked whether they should keep getting boosted. Since he is now an urgent care doctor and not a PCP (primary care physician), he has the status not to answer the question and can refer the patient to his/her PCP. He does this out of an abundance of caution to avoid problems with the medical board.

35. Dr. Tyson was previously investigated for over a year by the medical board for allegedly spreading Covid "misinformation" to the public, but that investigation was terminated earlier in 2023 without any disciplinary action taken.

36. Based on the above, Dr. Tyson has a reasonable and grounded fear that his protected speech to patients might subject him to further board investigation and possible prosecution. As indicated, his protected speech is being chilled by the medical board's conduct.

37. Plaintiff Physicians for Informed Consent (PIC) is a 501(c)(3) not-for-profit corporation based in California whose mission is, *inter alia*, to advocate for the right of physicians to provide true and evidence-based information to patients concerning the risks and benefits of vaccines. Many of its members are physicians, other health care professionals, and scientists who publish and speak about vaccine safety and efficacy issues.

38. PIC is deeply involved in identifying, collecting, and analyzing the evolving

worldwide scientific literature on vaccine safety and efficacy. It writes up summaries of these studies and disseminates this information to physicians, so that they can provide their patients with the best available information selected from the United States and throughout the world.

39. The scientific evidence collected and distributed by PIC is sometimes at odds with what is at any given time the view of the U.S. health authorities and what may be the U.S. scientific consensus. However, such information is based on the best available worldwide evidence. And frequently, PIC's written summaries have foreshadowed changes subsequently made to the mainstream scientific consensus.

40. PIC also supports the rights of its members to advise about and prescribe the off-label use of drugs such as Ivermectin and HCQ in the treatment of Covid-19. PIC provides its physician members with information about the hundreds of studies (as of the date of this Complaint) which support the use of these drugs, and encourages its physician members to discuss these studies (and the studies which do not show a benefit) with their patients. However, PIC's physician members are uncertain whether providing patients with studies which have found a benefit would violate the Board's stated position that it can still discipline physicians for Covid "misinformation" despite the repeal of Business and Professions Code section 2270.

41. Some patients ask PIC physician members specifically whether there are any studies which support the use of Ivermectin. Arguably, responding to this question truthfully could be considered spreading Covid misinformation to the patient, but responding in the negative would be false. Some physicians respond by advising patients that in fact there are many such studies, but those studies receive limited or no recognition within certain medical communities for many different reasons, and the only studies the FDA currently recognizes for purposes of standard of care are those studies which have not found a benefit. Would conveying this information be sanctionable under the Boards' interpretations of the law? Any answer would be arbitrary and untethered to principle.

42. Because the Board still maintains that it has the right to discipline physicians in violation of their (and their patients') constitutional rights, many of PIC's physician members

are faced with choosing between providing accurate and complete information about the risks of the vaccine and the different Covid treatments, putting them at risk of Board investigation and discipline, or reciting the latest FDA and CDC-promulgated edict. Or they can choose to keep silent and refuse to answer questions about the latest Covid booster and Covid treatments. This choice is a necessary but completely intolerable result of the Board's pronouncements and actions. Indeed, primary care physicians like Plaintiff Hoang (a PIC member) are especially pincered under Business and Professions Code section 2234 (the very statute the Boards claim as authority over misinformation), because primary care physicians are routinely expected to *answer* patient inquiries and not deflect. Not only deflection but also hesitation to candidly answer can and does injure the doctor-patient relationship.

43. Moreover, due to the Boards' broad power to investigate physicians, many of PIC's physician members are afraid of speaking out in public or even to publicly support this case for fear of triggering a Covid misinformation investigation. Accordingly, the Boards' position on providing information contrary to the government's edicts has a chilling effect of PIC physicians' free speech rights.

44. PIC's physician members in California who wish to disseminate information to their patients, like the information which the two individual Plaintiffs seek to disseminate, would have standing to participate in this action.

45. PIC's physician rights it seeks to assert in this case are germane to and go to the very heart of the organization's educational purpose "to deliver data on infectious diseases and vaccines."

46. Neither the claims asserted herein nor the relief requested require the participation of PIC's individual member physicians in this lawsuit. Accordingly, PIC has associational standing to protect the constitutional rights of its physician members in California.

47. In addition, the foregoing paragraphs regarding PIC can also be said for PIC's lay members in California who wish to receive the information which is or could be deemed disciplinable conduct. There is an obvious stigma and intimidation upon patients if their

1 medical records are subpoenaed by the medical board, and the patients are then called as
2 witnesses to remember what their doctor told them about Ivermectin studies a year or two
3 years earlier. History has shown a healthy doctor-patient relationship needs the First
4 Amendment. Many of PIC's lay members would like to be able to candidly receive
5 information about off-label drugs for Covid-19 if they contract the virus. Therefore, PIC has
6 associational standing to sue on behalf of its lay members in California on the claims for relief
7 in this case.

8 48. Plaintiff Children's Health Defense is a 501(c)(3) non-profit corporation whose
9 mission is to end childhood health epidemics by working aggressively to eliminate harmful
10 exposures, hold those responsible accountable, and to establish safeguards to prevent future
11 harm. Its mission also includes advocating for medical freedom, bodily autonomy, and an
12 individual's right to receive the best information available based on a physician's best
13 judgment.

14 49. CHD educates and advocates concerning the negative risk-benefit profile of the
15 Covid shots for healthy children, and concerns such as these have caused some of the countries
16 (which have had the best pandemic response outcomes) to stop recommending Covid
17 vaccination or boosters, or both, for healthy children (*see* recent recommendations of
18 Denmark, Sweden, the UK, and the European Medicines Agency).

19 50. CHD members include numerous California physicians who wish to provide
20 information about the latest studies about the Covid booster shots, as well as information about
21 the off-label treatments for Covid. California parents who are CHD members want to receive
22 objective, non-coerced information from California physicians about the risk profile of the
23 Covid vaccines for the current boosters.

24 51. However, the Board's statements that it will take action against physicians for
25 providing information and opinions challenging the mainstream Covid narrative will have a
26 chilling effect and will dissuade many physicians from providing their candid opinions, which
27 creates a risk of self-censorship significantly impairing the ability of CHD physicians to
28 provide such information, which will militate against CHD lay members in California from

receiving such nonconforming opinions from their physicians. An actual and justiciable controversy exists therefore between Plaintiff CHD and Defendants.

52. Plaintiff CHD sues in its own capacity and on behalf of its constituent members in California who have been and will continue to be adversely affected by Defendants' actions.

53. CHD members would have been able to sue. The interests which CHD seeks to protect are germane to and go to the heart of CHD's purpose. Neither the claims asserted nor the relief requested requires the participation of CHD's individual members in this lawsuit.

54. None of the individual plaintiffs are currently the subject of investigation or prosecution by the Defendants. To the best of the organizational plaintiffs' knowledge and belief, none of their California physician members are subject to investigation or prosecution by the Defendants.

THE DEFENDANTS

55. Defendant ROB BONTA is the California Attorney General and is thus the ultimate decisionmaker in the Attorney General's office who enforces the laws of the State of California, including Business and Professions Code section 2234, the general statutory standard of care statute. He is a defendant in his official capacity only.

56. Upon information and belief, the Attorney General's office represents the two medical boards in administrative actions against its licensees, including participating in initial interviews with the licensees in the investigation phase of board proceedings, preparing accusations against the licensees and acting as the prosecutor in disciplinary actions. Accordingly, Defendant Bonta has the authority to stop the Attorney General's office from preparing and filing accusations against the Boards' licensees, if this Court grants the relief requested.

57. Defendant REJI VARGHESE is the executive director of the Medical Board of California. He is a defendant in this case in his official capacity only for the requested declaratory and injunctive relief.

58. Upon information and belief, Defendant VARGHESE is the final decision-maker on the Board's decision to investigate physicians for violations for providing Covid

1 misinformation, or at least he supervises the subordinate Board employee(s) who make such
2 decisions.
3 59. Upon information and belief, Defendant VARGHESE has the authority to
4 implement a preliminary and permanent injunction stopping the Board from investigating and
5 filing charges against a medical doctor for an alleged standard of care violation based on the
6 licensee's exercising his/her protected speech rights to patients on the subject (content) about
7 Covid and which does not conform with the CDC's narrative, to wit, the viewpoint of the
8 speech.
9 60. Defendant ERIKA CALDERON is the executive director of the Osteopathic
10 Medical Board of California. She is a defendant in this case in her official capacity for the
11 requested declaratory and injunctive relief.
12 61. Upon information and belief, Defendant CALDERON is the final decisionmaker
13 on the Osteopathic Board's decision to investigate physicians for providing so-called Covid
14 misinformation to patients, or at least she supervises the subordinate employee(s) who make
15 such decisions.
16 62. Upon information and belief, Defendant CALDERON has the authority to
17 implement a preliminary and permanent injunction stopping the Board from investigating and
18 filing charges against an osteopathic medical doctor for an alleged standard of care violation
19 based on the licensee's exercising his/her protected speech rights to patients on the subject
20 (content) about Covid and which does not conform with the CDC's narrative, to wit, the
21 viewpoint of the speech.
22 **FACTUAL BACKGROUND**
23 **The Origins of Nationwide Covid Misinformation Disciplinary Campaign**
24 63. By press release dated July 21, 2021, the Federation of State Medical Boards (the
25 "Federation"[8]) issued the following press release:
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27
28 [8] According to its website, "The Federation of State Medical Boards represents the state medical and osteopathic regulatory boards – commonly referred to as state medical boards –

> Physicians who generate and spread COVID-19 vaccine misinformation or disinformation are risking disciplinary action by state medical boards, including the suspension or revocation of their medical license. Due to the specialized knowledge and training, licensed physicians possess a high degree of public trust and therefore have a powerful platform in society, whether they recognize it or not. They also have an ethical and professional responsibility to practice medicine in the best interests of their patients and must share information that is factually, scientifically grounded and consensus driven for the betterment of public health. Spreading inaccurate COVID-19 vaccine information contradicts that responsibility, threatens to further erode public trust in the medical profession and thus puts all patients at risk.

FSMB: Spreading Covid-19 Vaccine Misinformation May Put Medical License At Risk, FEDERATION OF STATE MEDICAL BOARDS, News Releases (Jul. 29, 2021), https://www.fsmb.org/advocacy/news-releases/fsmb-spreading-covid-19-vaccine-misinformation-may-put-medical-license-at-risk/.

64. Upon information and belief, Kristina Lawson is or was the Chairman of the Federation's Ethics Committee, the California medical board's representative to the Federation, and the President of the Medical Board.

65. The following statement by Board President Kristina D. Lawson, appears in the Board's February 10-11, 2022 meeting minutes:

> Ms. Lawson stated it is the duty of the board to protect the public from misinformation and disinformation by physicians, noting the increase in the dissemination of healthcare related misinformation and disinformation on social media platforms, in the media, and online, putting patient lives at risk in causing unnecessary strain on the healthcare system.
>
> Ms. Lawson elaborated in July 2021, the Federation of State Medical Boards released a statement saying physicians spreading misinformation or disinformation risk disciplinary action by their state medical board.

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within the United States, its territories and the District of Columbia. It supports its member boards as they fulfill their mandate of protecting the public's health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals." *About FSMB*, FEDERATION OF STATE MEDICAL BOARDS, https://www.fsmb.org/about-fsmb/.

1 66. The Federation's press release is listed as a rationale for AB 2098, which was
2 introduced on February 14, 2022. In its original form, the bill tracked the Federation's press
3 release (and Board President Lawson's statement in the minutes) and targeted the public
4 speech of physicians in addition to communications between physicians and patients.[9]
5 67. AB 2098 as amended was passed by the Legislature and signed into law by
6 Governor Newsom September 30, 2022.
7 **AB 2098/Section 2270, Its Injunction and Repeal**
8 68. On January 1, 2023, AB 2098 became effective as Business and Professions
9 Code section 2270, which law implemented the Federation's Covid misinformation press
10 release, limited to communications between doctors and patients "in the form of treatment or
11 advice." Bus. & Prof. Code, § 2270(a)(3).
12 69. The law defined Covid misinformation as "false information that is contradicted
13 by contemporary scientific consensus contrary to the standard of care." *Id.* subparagraph (4).
14 70. On January 23, 2023, the law was preliminarily enjoined on Fifth Amendment
15 grounds by Eastern District Judge William B. Shubb in two related cases, *Hoang v. Bonta*, and
16 *Høeg v. Newsom*, No. 2:22-cv-01980 WBS AC, 652 F.Supp.3d 1172, 2023 WL 414258 (E.D.
17 Cal. Jan. 23, 2023), with respect to three of the five Plaintiffs and two of the three defendants
18 in this case.[10]
19 71. In September 2023, the Legislature added a provision to SB 815 which would
20 repeal Section 2270 as of January 1, 2024. On September 30, 2023, the Governor signed SB
21 815.
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25 [9] AB 2098 references the Federation's July 2021 press release as justification for the bill.
California Legislative Information, https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?
26 bill_id=202120220AB2098#99INT, Section 1 (f).
27 [10] Two other cases were filed against the law. In *McDonald v. Lawson,* a Central District
28 judge denied a similar preliminary injunction motion which decision is currently *sub judicia*
before the Ninth Circuit, together with the fourth case. *McDonald v. Lawson*, Nos. 22-56220,
23-55069, 2023 U.S. App. LEXIS 27561 (9th Cir. Oct. 17, 2023).

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Statements and Actions by the Medical Board and AB 2098's Sponsor Demonstrating that the Medical Boards Intend to Continue Violating the Free Speech Rights of Physicians

72. News that the California Legislature was repealing Section 2270 was first reported in a Los Angeles Times article on September 11, 2023.

73. The article quoted a spokesman for sponsor Evan Low as saying, "Fortunately, with this update, the Medical Board of California will continue to maintain the authority to hold medical licensees accountable for deviating from the standard of care and misinforming their patients about COVID-19 treatments." Mr. Low's statement is consistent with the Federation's position, which is also the Medical Board's position, that it can discipline physicians for so-called Covid misinformation regardless of the repeal of AB 2098.[11]

74. By December 2023, the Medical Board disciplined at least one physician for information, opinions, and recommendations she made to a patient about the vaccine, including her opinion the vaccine was associated with increases in miscarriages and that the patient's girlfriend should avoid the Covid shot if she wanted to get pregnant; and the physician shared other information about the vaccines and miscarriages. *See* ¶ 30, *ante* (Accusation, p. 4, ¶ 10, ln. 8 & ¶ 12, lns. 16-19).

75. Plaintiffs maintain this kind of information is protected speech. And it is especially noteworthy there was no doctor-patient relationship between the physician and the patient's girlfriend. To be clear, this information would not have been sanctionable under Section 2270 since it was not said to a patient "in the form of treatment or advice." So, the Medical Board is exercising powers it did not even have under the repealed statute.

76. Other examples of the conduct which the board unconstitutionally contended as disciplinable include opinions that:

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[11] Accusation referenced in paragraph 30, *ante*; and *see* CALIFORNIA REGULATORY LAW REPORTER, Vol. 28, No. 2 (Spring 2023), https://digital.sandiego.edu/cgi/viewcontent.cgi?article=3149&context=crlr.

a. masks do not stop the virus (even though recent published studies, including one reported by CNN, indicate the truth of this statement).

b. Covid vaccines do not stop infection and transmission (this too was proven true, as the CDC ultimately admitted after many studies proved it. So, now the shots are in the special category of vaccines that neither prevent infection nor stop transmission).

77. The Medical Board also asserts that "all interactions that occur between a doctor and a patient, particularly during a clinic visit must be conducted professionally. There may be no limitation to what topics can be discussed between doctor and patient, but the discussion must remain professional." *See* ¶ 30, *ante* (Accusation at p. 5, ¶ 19, lns. 25-28). And thus, the medical board attempts to revive the professional speech exception to free speech which has been expressly rejected by the Supreme Court in *NIFLA*.

78. However, all this information and opinion expressed by the doctor and charged in the Accusation involves First Amendment protected speech, according to all judicial authority (other than Judge Slaughter's opinion).

79. Upon information and belief, members and or employees of the Medical Board continue to be in contact with the Federation, and they continue to push the Federation's agenda set out in its July 2021 press release, despite the clear unconstitutionality of that agenda, a constitutional fact which is known or should be known by the Medical Board's personnel as well as the Federation.

80. The above referenced accusation and decision, together with the AB 2098 sponsor's statement, and the Medical Board's continued adherence to the Federation's policy/call-to-arms which created this Covid misinformation board sanctioning idea, clearly establish that the Defendants intend to continue to violate the free speech rights of California physicians.

81. These actions send a chill throughout the part of the California medical community which questions the information put out by the CDC and other parts of the medical establishment.

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82. However, the more the public health authorities speak, the more the public loses faith and trust in the information and recommendations in the public health institutions' Covid edicts, despite the almost continuous failed results and the repeated empty promises that the public health authorities will do better.[12]

83. Upon information and belief, the public's lack of trust is not the result of what critics of the mainstream Covid narrative say in public or to patients. Rather, it is the overpromising of the benefits of the vaccines and every booster, even though they neither

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[12] *See, e.g.*, Nicholas Florko, *Public trust in CDC, Fauci, and other top health officials is evaporating, poll finds*, STATNEWS.COM (Sept. 10, 2020), https://www.statnews.com/2020/09/10/trust-cdc-fauci-evaporating/ [Redfield];

Selena Simmons-Duffin, *Poll Finds Public Health Has A Trust Problem*, NPR.ORG, health (May 13, 2021), https://www.npr.org/2021/05/13/996331692/poll-finds-public-health-has-a-trust-problem [Walensky];

The CDC is beholden to corporations and lost our trust. We need to start our own The People's CDC, THEGUARDIAN.COM, opinion (Apr. 3, 2022), https://www.theguardian.com/commentisfree/2022/apr/03/peoples-cdc-covid-guidelines [Walensky];

How to Make the CDC Matter Again, BLOOMBERG.COM, Opinion (May 2, 2022) https://www.bloomberg.com/opinion/articles/2022-05-02/the-cdc-needs-reform-to-restore-public-trust-after-covid-19#xj4y7vzkg [Walensky];

Randy Aldridge, *CDC Announces Sweeping Changes to Restore Public Trust*, NORTH CAROLINA MEDICAL SOCIETY (Aug. 18, 2022), https://ncmedsoc.org/cdc-announces-sweeping-changes-to-restore-public-trust [Walensky];

Tina Reed, *Survey finds concern of political influence leads lack of trust in health agencies*, AXIOS.COM (May 7, 2023), https://www.axios.com/2023/03/07/trust-in-cdc-public-health-agencies ("too many conflicting recommendations"; "Private-sector influence on recommendations and policies" are the second and third most common reasons for lack of trust in the CDC) [Cohen];

NPR one year late, same tune: Sacha Pfeiffer, Megan Lim, Christopher Intagliata, *The new CDC director outlines 3 steps to rebuild trust with the public*, NPR.ORG (Aug. 2, 2023), https://www.npr.org/2023/08/02/1191302954/the-new-cdc-director-outlines-3-steps-to-rebuild-trust-with-the-public [Cohen];

Chelsea Cirruzzo, *The CDC wants your trust back: It'll 'take time to rebuild,'* POLITICO.COM (Sept. 16, 2023), https://www.politico.com/news/2023/09/16/cdc-director-public-trust-00116348 [Cohen].

prevent infection or transmission, and whatever effectiveness they have is extremely short-lived, a fact which the public health authorities irrationally both downplay and use to justify each successive booster.

84. Upon information and belief, between the studies which hint at a direct relationship between repeated boosters and increased risk of infection, excess death statistics which show increased deaths after the Covid vaccines were introduced (based on insurance company data from the United States and England), and the recent concern manifest from preliminary studies that increased Covid vaccinations are or may be associated with super cancers, plus the fact that emails and public testimony from public health officials which show that they have admitted or knowingly misled the public, it is no wonder that a significant percentage of the public does not believe what comes out of the mouths of the public health authorities and their proxies.[13]

85. Upon information and belief, there is a disinformation campaign which has affected the public discourse. However, it is being orchestrated by the public health authorities with the help of corporate interests to foist on the public, *inter alia*, a never-ending number of boosters. Part of this disinformation campaign is to silence critics both through the Federation-inspired Covid misinformation laws or standard of care prosecutions. Another part of the overall campaign (though beyond the scope of this lawsuit) are the federal government's direct attempts to force, intimidate or cajole the social media companies to remove content which is not consistent with the government's public health narrative. All the time vilifying physicians and others who dare to speak up. This is straight from the Orwellian 1984 government's playbook. Newspeak is now the coin of the realm promoted by the public health authorities and

[13] The individual Plaintiff physicians, the physician members of the two organizational Plaintiffs, and many other physicians have the possibly quaint notion that a physician has a professional obligation/duty of informed consent which would include apprising patients of potential risks (and the risks listed on the vaccines' labels), rather than simply robotically repeating the public health/standard of care mantra that the Covid shots and every booster have been proven to be completely safe and effective for everyone including young children and pregnant women, and everyone (over the age of six months) should take every booster.

their newspeak co-interlocutors.

86. The false and misleading overselling of the safety and efficacy of the Covid vaccines and boosters is most poignantly demonstrated by a recent Elon Musk tweet of a video which is a montage of headlines and public health officials' statements initially making ludicrously false and exaggerated claims, and then having to backtrack, retract and explain away the evidence, all the time insisting that every booster (tested on 8 mice or in one case, 50 people over a two-week period of time) is safe and highly effective (because it increased antibodies for as long as two weeks, and that is called a surrogate endpoint), and that everyone over six months of age needs to take every shot and every booster to protect themselves and to protect the public. But the public is not buying it anymore, and the Musk tweeted montage shows why. *See* and view https://twitter.com/elonmusk/status/1706676593261785178.

87. In times such as these, many people go to their physicians for information, advice, and recommendations about what they should do about Covid, prophylactically and for treatment. And the same will be true for the next pandemic. It is imperative that physicians be permitted to speak their minds without fear of government reprisal. This kind of physician/patient communication is within the heartland of the speech the First Amendment protects. And, that is exactly the subject of this lawsuit, whether the government's assault on this protected speech comes from a specific (and repealed) statute, or the general standard of care provision.

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FIRST CLAIM FOR RELIEF

42 U.S.C. SECTION 1983 VIOLATION OF THE FREE SPEECH CLAUSE OF THE FIRST AMENDMENT OF THE UNITED STATES CONSTITUTION ASSERTED AGAINST THE DEFENDANTS

88. Plaintiffs repeat and reallege the foregoing allegations.

89. The First Amendment provides in relevant part: "Congress shall make no law... abridging the freedom of speech." The First Amendment applies to actions by state agencies such as the Boards via the Fourteenth Amendment.

90. The individual Plaintiffs and the members of organizational Plaintiffs CHD and PIC's physicians have the right to free speech, including the right to freely communicate information to their patients even if the government does not agree with the information conveyed.

91. Furthermore, the patients of the individual Plaintiffs, and CHD's and PIC's non-physician members have the right to receive such information and engage in a genuine free speech dialogue, even if the government does not agree with the information or message conveyed by these physicians.

92. The statements by the individual Plaintiffs and the organizational Plaintiffs constitute a concrete plan to engage in activity, which based on statements and actions by the Defendants and AB 2098's sponsor, strongly suggest that Plaintiffs' speech is within the zone of prosecution under the current policy of prosecuting so-called "Covid misinformation."

93. These same Board actions and statements by the Boards' legislative supporters communicated to the California public constitute an intended specific warning or threat to initiate proceedings for the purpose of dissuading physicians from saying anything to patients which is inconsistent with the government messaging concerning, *inter alia,* taking every available Covid booster, and limiting Covid therapeutics to on-label FDA approved drugs.

94. The fact that there is now at least one consummated disciplinary action against a physician for alleged Covid misinformation under the pretext of a standard of care violation, in conjunction with absence of any Medical Board statement that this prosecution is unique, is

1 sufficient for a finding of a prior history of enforcement, in the absence of any evidence to the
2 contrary. Accordingly, Plaintiffs have satisfied the three requisite elements for First
3 Amendment standing. *See Høeg v. Newsom*, No. 2:22-cv-01980 WBS AC, 652 F.Supp.3d
4 1172, 2023 WL 414258, page 6-14 (E.D. Cal. Jan. 25, 2023) (Dkt Entry 30 in *Hoang v.*
5 *Bonta*). Absent injunctive and declaratory relief against Defendants, Plaintiffs will have been
6 and will continue to be harmed in the manner specified herein. Plaintiffs have no plain, speedy,
7 and adequate remedy at law to prevent Defendants from continuing to chill speech and
8 continuing additional prosecutions for so-called Covid misinformation.
9 95. The Medical Board's practice and policy of investigating and sanctioning
10 physicians for their protected speech is a violation of the First Amendment rights of physicians
11 to convey information to patients, and the patients' First Amendment rights to receive such
12 information.
13 96. Further, the anticipated defense that the Defendants have the statutory authority
14 to enforce the standard of care as justification would render the statutes unconstitutionally
15 overbroad.
16 97. Upon information and belief, there can be no clearly defined standard of care
17 during this rapidly evolving pandemic in terms of Covid treatments and recommendations.
18 There are only public health edicts based on the last and usually incomplete and often cherry-
19 picked data, while downplaying or avoiding non-supporting data. The data and edicts change
20 with such rapidity that the standard of care concept becomes distorted and completely
21 inconsistent with the collective experience of front-line physicians treating the disease. As a
22 result, the standard of care does not provide sufficient guidance to justify interference with
23 physicians' protected speech under any form of heightened scrutiny.
24 98. For the foregoing reasons, pursuant to 42 U.S.C section 1983, Plaintiffs request a
25 declaratory judgment that it is a First Amendment violation for the California medical boards
26 to investigate, prosecute or sanction physicians based on information and opinions they
27 provide to patients concerning the safety and efficacy of Covid vaccines, FDA approved drug
28 treatments for Covid whether on or off label, or dietary supplements, or public health measures

1 such as the benefits of masks, at least as long as there is some published scientific evidence
2 supporting the information, opinions, recommendations or advice. Plaintiffs seek preliminary
3 and permanent injunctive relief preventing the commencement of any such investigation or
4 prosecution.
5 99. With respect to recommendations or advice, Plaintiffs seek a declaration that the
6 Boards do not have the First Amendment constitutional authority to investigate, prosecute or
7 sanction physicians for providing such recommendations about Covid vaccines/boosters, or on
8 or off-label FDA approved treatments for Covid, or for any other Covid-related subject, at least
9 so long as there is some published scientific evidence supporting the recommendation or
10 advice. Pursuant to 42 U.S.C. section 1983 and Federal Rules of Civil Procedure, Rule 65,
11 Plaintiffs seek preliminary and permanent injunctive relief preventing the commencement of
12 any such investigation or prosecution.
13
14 WHEREFORE the Plaintiffs request that judgment be entered in their favor and against
15 the Defendants as set forth in this Verified Complaint, and specifically that the Court:
16 1. Issue a declaratory judgment that it is a First Amendment violation for the
17 Defendants to investigate, prosecute or sanction physicians based on information,
18 opinions, recommendations or advice they provide to patients concerning the safety
19 and efficacy of Covid vaccines, FDA approved drug treatments for Covid whether
20 on or off label, or dietary supplements, or public health measures such as the
21 benefits of masks, based on their statutory authority to enforce the standard of care,
22 so long as there is some published scientific evidence supporting the information,
23 opinions, recommendation or advice.
24 2. Issue a preliminary and then permanent injunction enjoining the Defendants from
25 commencing any such investigation or prosecution in violation of the First
26 Amendment rights of physicians and their patients.
27 3. Costs and attorneys' fees as permitted by law.
28 4. Such other and further relief as the Court deems just and proper.

1 Dated: January 15, 2024

2 Respectfully submitted,

RICHARD JAFFE, ESQ.
State Bar No. 289362
428 J Street, 4th Floor
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Fax: 713-626-9420
Email: rickjaffeesquire@gmail.com

ROBERT F. KENNEDY JR., ESQ.
Pro hac vice admitted)
48 Dewitt Mills. Rd.
Hurley, NY 12433
Tel: 845-481-2622

Attorneys for Plaintiffs

3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

VERIFICATION/DECLARATION OF PIERRE KORY, MD

Pierre Kory, MD declares as follows:

1. I am one of the Plaintiffs in this case. I have personal knowledge of the facts set out about me in paragraphs 13-22 of the Verified Complaint, and the same are true and correct based on my knowledge and belief.
2. I submit this declaration/verification under penalties of perjury under the laws of the United States and California.

January 9, 2024

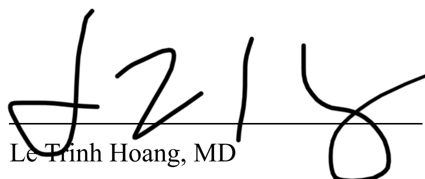
Pierre Kory, MD

VERIFICATION/DECLARATION OF LE TRINH HOANG, DO

Le Trinh Hoag, DO declares as follows:

1. I am one of the Plaintiffs in this case. I am also a plaintiff in the related case Hoang v. Bonta. I have personal knowledge of the facts set out about me in paragraphs 23-28 of the Verified Complaint and the same are true and correct based on my knowledge and belief.
2. In addition, based on my participation in these two cases, and my strong interest in these issues, I am also very familiar with the history of AB 2098, as alleged in the Statement of Facts, as well as the medical and public health factual information contained in the Statement of Facts, and the same are true and correct to the best of my knowledge and belief.
3. I submit this declaration/verification under penalties of perjury under the laws of the United States and California.

January 9, 2024



Le Trinh Hoang, MD

VERIFICATION/DECLARATION OF BRIAN TYSON, MD.

Brian Tyson, MD declares as follows:

1. I am one of the Plaintiffs in this case. I have personal knowledge of the facts set out about me in paragraphs 29-36 in the Verified Complaint, and the same are true and correct based on my knowledge and belief.
2. In addition, I am also familiar with the history of AB 2098, as alleged in the Statement of Facts, and the information contained therein is true and correct to the best of my knowledge and belief.
3. I submit this declaration/verification under penalties of perjury under the laws of the United States and California.

January 9, 2024

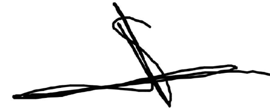
Brian Tyson, MD

VERIFICATION OF SHIRA MILLER, MD.

Shira Miller MD, declares as follows:

1. I am the President of Physicians for Informed Consent ("PIC"), one of the plaintiffs in this lawsuit. I have personal knowledge about the facts set forth about PIC in paragraphs 37-47 of the Verified Complaint, and the same is true and correct based on my knowledge and belief.
2. I submit this verification under penalty of perjury under the laws of the United States.

January 10, 2024



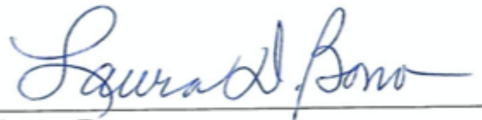
Shira Miller, MD
President, Physicians for Informed Consent

Laura Bono, declares as follows:

1. I am the Executive Vice President of Children's Health Defense, ("CHD"), one of the plaintiffs in this lawsuit. I have personal knowledge about the facts set forth about CHD in paragraphs 48-54 of the Verified Complaint, and the same is true and correct based on my personal knowledge and belief.

2. I submit this declaration/verification under penalties of perjury under the laws of the United States and California.

January 8, 2024



Laura Bono
Executive Vice President,
Children's Health Defense

RICHARD JAFFE, ESQ.
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Tel: 845-481-2622

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

PIERRE KORY, M.D., LE TRINH HOANG, D.O., BRIAN TYSON, M.D., PHYSICIANS FOR INFORMED CONSENT, a not-for-profit corporation, and CHILDREN'S HEALTH DEFENSE, a not-for-profit corporation,

Plaintiffs,

v.

ROB BONTA, in his official capacity as Attorney General of California, REJI VARGHESE, in his official capacity as Executive Director of the Medical Board of California, ERIKA CALDERON, in her official capacity as Executive Officer of the Osteopathic Medical Board of California,

Defendants.

Case No: 2:24-cv-00001 WBS-AC

NOTICE OF APPEAL:

PRELIMINARY INJUNCTION APPEAL

1
2 Notice is hereby given that all Plaintiffs hereby appeal to the United States Court of Appeals
3 for the Ninth Circuit the Order denying their motion for a preliminary injunction entered by
4 this Court on April 22, 2024 (Dkt. 23).
5
6 Dated: April 29, 2024 Respectfully submitted,
7
8
9

10
RICHARD JAFFE, ESQ.
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CIVIL,APPEAL

U.S. District Court
Eastern District of California – Live System (Sacramento)
CIVIL DOCKET FOR CASE #: 2:24–cv–00001–WBS–AC

Kory et al v. Bonta et al
Assigned to: Senior Judge William B. Shubb
Referred to: Magistrate Judge Allison Claire
Related Cases: 2:22–cv–01980–WBS–AC
2:22–cv–02147–WBS–AC
Case in other court: US Court of Appeals, 24–02946
Cause: 42:1983 Civil Rights Act

Date Filed: 01/02/2024
Jury Demand: None
Nature of Suit: 440 Civil Rights: Other
Jurisdiction: Federal Question

Plaintiff

Pierre Kory
MD

represented by **Robert F. Kennedy, Jr. , PHV**
Email: rfk1954@gmail.com
PRO HAC VICE
ATTORNEY TO BE NOTICED

Richard Aaron Jaffe
Richard Jaffe ESQ.
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Email: rickjaffeesquire@gmail.com
ATTORNEY TO BE NOTICED

Plaintiff

Le Trinh Hoang
DO

represented by **Richard Aaron Jaffe**
(See above for address)
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Robert F. Kennedy, Jr. , PHV
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

Plaintiff

Brian Tyson
MD

represented by **Robert F. Kennedy, Jr. , PHV**
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

Richard Aaron Jaffe
(See above for address)
ATTORNEY TO BE NOTICED

Plaintiff

Physicians for Informed Consent

represented by **Robert F. Kennedy, Jr. , PHV**
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PRO HAC VICE
ATTORNEY TO BE NOTICED

Richard Aaron Jaffe
(See above for address)
ATTORNEY TO BE NOTICED

Plaintiff

Children's Health Defense represented by **Richard Aaron Jaffe**
(See above for address)
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Robert F. Kennedy, Jr. , PHV
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

V.

Defendant

Rob Bonta represented by **Kristin A. Liska**
Office of the Attorney General
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Email: kristin.liska@doj.ca.gov
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Defendant

Reji Varghese represented by **Kristin A. Liska**
(See above for address)
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Defendant

Erika Calderon represented by **Kristin A. Liska**
(See above for address)
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Date Entered	#	Docket Text
01/02/2024	1	COMPLAINT against All Defendants by All Plaintiffs. Attorney Jaffe, Richard Aaron added. (Filing fee $ 405, receipt number BCAEDC–11265915) (Attachments: # 1 Civil Cover Sheet)(Jaffe, Richard) (Entered: 01/02/2024)
01/02/2024	2	SUMMONS ISSUED as to *Rob Bonta, Erika Calderon, Reji Varghese* with answer to complaint due within *21* days. Attorney *Richard Aaron Jaffe* *Richard Jaffe ESQ.* *428 J St., 4th Floor* *Sacramento, CA 95814*. (Benson, A.) (Entered: 01/02/2024)
01/02/2024	3	CIVIL NEW CASE DOCUMENTS ISSUED; (Attachments: # 1 Standing Order, # 2 Consent Form, # 3 VDRP) (Benson, A.) (Entered: 01/02/2024)
01/02/2024	4	NOTICE of RELATED CASE(S) 2:22–cv–02147, 2:22–cv–01980 by Pierre Kory. (Jaffe, Richard) (Entered: 01/02/2024)
01/03/2024	5	RELATED CASE ORDER signed by Senior Judge William B. Shubb on 01/03/24 RELATING cases 2:22–cv–1980 WBS AC, 2:22–cv–2147 WBS AC and 2:24–cv–0001 DJC AC. This related case is REASSIGNED to District Judge William B. Shubb for all further proceedings; Magistrate Judge Allison Clair will remain on the case; any dates currently set in this case are VACATED. District Judge Daniel J. Calabretta is no longer assigned to case. The case number on all future filings shall be: 2:24–cv–0001 WBS AC (cc: DJC). (Benson, A.) (Entered: 01/03/2024)
01/03/2024	6	CIVIL NEW CASE DOCUMENTS ISSUED; Initial Scheduling Conference set for 4/22/2024 at 01:30 PM in Courtroom 5 (WBS) before Senior Judge William B. Shubb.

		(Attachments: # 1 Consent Form, # 2 VDRP) (Benson, A.) (Entered: 01/03/2024)
01/05/2024		PAYMENT for 7 Pro Hac Vice Application in the amount of $ 300, receipt number ACAEDC−11275295. (Jaffe, Richard) Modified on 1/8/2024 (Clemente Licea, O). (Entered: 01/05/2024)
01/05/2024	7	PRO HAC VICE APPLICATION and PROPOSED ORDER by Pierre Kory for attorney Robert F. Kennedy Jr. to appear Pro Hac Vice. (Jaffe, Richard) Modified on 1/8/2024 (Clemente Licea, O). (Entered: 01/05/2024)
01/10/2024	8	PRO HAC VICE ORDER signed by Senior Judge William B. Shubb on 01/09/2024 GRANTING 7 Application for Pro Hac Vice. Added Attorney Robert F. Kennedy, Jr., PHV for Children's Health Defense, Le Trinh Hoang, Pierre Kory, Physicians for Informed Consent, and Brian Tyson. The Pro Hac Vice Attorney is directed to request electronic filing access through PACER. (Lopez, K) (Entered: 01/10/2024)
01/15/2024	9	VERIFIED COMPLAINT against All Plaintiffs by Pierre Kory. (Jaffe, Richard) (Entered: 01/15/2024)
01/16/2024	10	SUMMONS RETURNED EXECUTED: All Defendants. (Jaffe, Richard) (Entered: 01/16/2024)
01/31/2024	11	NOTICE of APPEARANCE by Kristin A. Liska on behalf of Rob Bonta, Erika Calderon, Reji Varghese. Attorney Liska, Kristin A. added. (Liska, Kristin) (Entered: 01/31/2024)
01/31/2024	12	STIPULATION and PROPOSED ORDER for Extension of Time to Respond to Complaint by Rob Bonta, Erika Calderon, Reji Varghese. (Attachments: # 1 Proposed Order)(Liska, Kristin) (Entered: 01/31/2024)
02/01/2024	13	ORDER signed by Senior Judge William B. Shubb on 02/01/24, per 12 Stipulation, EXTENDING time for Defendants to respond to complaint to 03/04/24. (Benson, A.) (Entered: 02/01/2024)
02/10/2024	14	MOTION for PRELIMINARY INJUNCTION by Pierre Kory. Motion Hearing set for 4/1/2024 at 01:30 PM in Courtroom 5 (WBS) before Senior Judge William B. Shubb. (Attachments: # 1 Declaration Sanjay Verma MD, # 2 Declaration Pierre Kory MD, # 3 Declaration Le Trinh Hoang DO, # 4 Declaration Brian Tyson MD, # 5 Declaration Debbie Hobel, # 6 Declaration Neil Selflinger, # 7 Proposed Order)(Jaffe, Richard) (Entered: 02/10/2024)
02/16/2024	15	STIPULATION and PROPOSED ORDER for Deadlines for Briefing Plaintiffs Motion for a Preliminary Injunction and to Extend the Time to Respond by Rob Bonta, Erika Calderon, Reji Varghese. (Attachments: # 1 Proposed Order)(Liska, Kristin) (Entered: 02/16/2024)
02/21/2024	16	ORDER signed by Senior Judge William B. Shubb on 02/20/24 SETTING the date for Defendants' opposition to Plaintiffs' motion for a preliminary injunction to 03/15/24 and Plaintiffs' reply in support of their motion for a preliminary injunction to 03/22/24. (Licea Chavez, V) (Entered: 02/21/2024)
03/15/2024	17	OPPOSITION to 14 Motion for Preliminary Injunction by Rob Bonta, Erika Calderon, Reji Varghese. (Attachments: # 1 Declaration of Erika Calderon, # 2 Declaration of Reji Varghese) (Liska, Kristin) Modified on 3/18/2024 (Clemente Licea, O). (Entered: 03/15/2024)
03/21/2024	18	REPLY in Support of 14 Motion for Preliminary Injunction by Pierre Kory. (Attachments: # 1 Proposed Amended Order) (Jaffe, Richard) Modified on 3/22/2024 (Clemente Licea, O). (Entered: 03/21/2024)
03/28/2024	19	PROPOSED ORDER re 14 Motion for Preliminary Injunction,. (Jaffe, Richard) Modified on 3/29/2024 (Mena−Sanchez, L). (Entered: 03/28/2024)
04/01/2024	20	MINUTES (Text Only) for proceedings held before Senior District Judge William B. Shubb: MOTION HEARING held on 4/1/2024 re Plaintiffs' Motion for Preliminary Injunction 14 . Counsel argue. MOTION SUBMITTED. The Court to issue a separate order. Plaintiffs' Counsel Richard Jaffe present. Defendants' Counsel Kristin Liska, Megan O'Carroll present. Court Reporter: Kimberly Bennett. (Kirksey Smith, K) (Entered: 04/01/2024)

04/10/2024	21	STIPULATION and PROPOSED ORDER for a Continuance of the April 22, 2024 Status Conference by Rob Bonta, Erika Calderon, Reji Varghese. (Attachments: # 1 Proposed Order)(Liska, Kristin) (Entered: 04/10/2024)
04/12/2024	22	ORDER signed by Senior District Judge William B. Shubb on 4/11/24 CONTINUING the Status Conference to 6/17/2024 at 01:30 PM in Courtroom 5 (WBS) before Senior District Judge William B. Shubb, pending ruling on the pending motion for preliminary injunction. The parties' joint status report shall be filed no later than 6/3/24. (Kastilahn, A) (Entered: 04/12/2024)
04/23/2024	23	ORDER signed by Senior District Judge William B. Shubb on 4/22/2024 DENYING 14 Motion for Preliminary Injunction. (Woodson, A) (Entered: 04/23/2024)
04/29/2024	24	NOTICE of INTERLOCUTORY APPEAL by Pierre Kory. (Filing fee $ 605, receipt number ACAEDC−11495388) (Jaffe, Richard) Modified on 5/3/2024 (Clemente Licea, O). (Entered: 04/29/2024)
05/03/2024	25	APPEAL PROCESSED to Ninth Circuit re 24 Notice of Appeal filed by Pierre Kory. Notice of Appeal filed *4/29/2024*, Complaint filed *1/2/2024* and Appealed Order / Judgment filed *4/23/2024*. Court Reporter: *Kimberly Bennett*. *Fee Status: Paid on 4/29/2024 in the amount of $605.00* (Attachments: # 1 Appeal Information) (Clemente Licea, O) (Entered: 05/03/2024)
05/10/2024	26	TRANSCRIPT REQUEST by Pierre Kory for proceedings held on 4/1/2024 before Judge Shubb. Court Reporter Kimberly Bennett. (Jaffe, Richard) (Entered: 05/10/2024)
05/10/2024	27	STIPULATION and PROPOSED ORDER for Extension of Time to Respond by Rob Bonta, Erika Calderon, Reji Varghese. (Attachments: # 1 Proposed Order)(Liska, Kristin) (Entered: 05/10/2024)
05/14/2024	28	TRANSCRIPT REQUEST by Pierre Kory for proceedings held on 4/1/2024 before Judge Shubb re 24 Notice of Appeal. Court Reporter Kimberly Bennett. (Jaffe, Richard) (Entered: 05/14/2024)
05/15/2024	29	TRANSCRIPT REQUEST by Pierre Kory for proceedings held on 04/01/2024 before Judge Shubb. Court Reporter Kimberly Bennett. (Jaffe, Richard) (Entered: 05/15/2024)
05/15/2024	30	USCA CASE NUMBER 24−2946 for 24 Notice of Appeal filed by Pierre Kory. (Licea Chavez, V) (Entered: 05/15/2024)
05/17/2024	31	ORDER signed by Senior District Judge William B. Shubb on 05/17/24 DIREICTING Defendants' response to Plaintiffs; complaint be filed no later than 30 days after a mandate issues from the Ninth Circuit and CONTINUING the Scheduling Conference to 9/9/2024 at 01:30 PM in Courtroom 5 (WBS) before Senior District Judge William B. Shubb and CONTINUING the joint status report deadline no later than 08/26/24. (Licea Chavez, V) (Entered: 05/17/2024)
05/29/2024	32	TRANSCRIPT REQUEST by Pierre Kory for proceedings held on 03/01/2024 before Judge Shubb. Court Reporter Kimberly Bennett. (Jaffe, Richard) (Entered: 05/29/2024)

Special Reports > Features

California Misinfo Law Is Destined for the Dustbin

— Amendment repeals language, but licensing boards apparently had authority all along

by Cheryl Clark, Contributing Writer, MedPage Today September 13, 2023

California's attempt to pave a path for its physician licensing boards to discipline doctors who give false COVID information to patients appears to be headed for the dustbin of failed ideas.

Inserted two-thirds of the way down in a bill on September 5, a Senate committee amendment would repeal state law authorized by the controversial AB 2098. That law had specifically defined the dissemination of COVID-19 misinformation or disinformation by a licensee as unprofessional conduct, subject to board disciplinary action.

A vote on the bill is expected this week.

During the heaviest days of the pandemic, some board members as well as physicians fed up with misinformation -- especially about the value and safety of COVID vaccines -- said they wanted such guidance in the belief they needed a clear mandate to rein in contrarians to prevent hospitalizations and save lives.

Signed into law by Gov. Gavin Newsom on September 30, 2022 with a statement of caution, AB 2098 said that a doctor who spread false or misleading information about COVID prevention and treatment or questioned the effectiveness of COVID-19 vaccines could have his or her license suspended, placed on probation, or revoked.

Newsom wrote at the time that he believed the new law "is narrowly tailored to apply only to those egregious instances in which a licensee is acting with malicious intent or clearly deviating from the required standard of care while interacting directly with a patient under their care."

But there was confusion about the bill from the start. Initially, the idea behind it was to discipline doctors who spread false information about COVID anywhere, including on social media or at public events. Authors of the bill had in mind curtailing activities such as that of California licensee Simone Gold, MD, JD, who breached the U.S. Capitol during the January 6, 2021 insurrection and gave a speech opposing COVID-19 vaccine mandates and government-imposed lockdowns, and who publicly advocated unproven COVID treatments such as hydroxychloroquine.

But concerns about the First Amendment prompted lawmakers to narrow the scope, applying the language only to those physicians who convey such misinformation to a patient under the licensee's care, which is much harder to prove.

Medical News from Around the Web

STAT

A breakthrough cystic fibrosis drug gave them the gift of time. But miracles come with complications.

HARVARD HEALTH

When — and how — should you be screened for colon cancer? - Harvard Health

ABC NEWS

Mississippi sees 10-fold increase in babies born with syphilis since 2016: Report

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Further, the law specified that the misinformation conveyed had to be "contradicted by contemporary scientific consensus contrary to the standard of care," which many argued was up for broad interpretation, especially given that knowledge about some aspects of the virus, its mutations, prevention, and treatment regimens were scientifically unclear and evolving.

The law immediately provoked outcries from some physicians who claimed it violated their First Amendment rights, and prompted several lawsuits challenging its constitutionality. The American Civil Liberties Union filed briefs in support of several of the legal challenges.

Opposing physicians argued that the science behind effective treatment, especially during COVID, could rapidly change, as could "contemporary scientific consensus" at any point in time.

On January 25, Sacramento U.S. District Judge William Shubb granted a temporary injunction prohibiting anyone from enforcing the law against plaintiffs, saying that the law's language was "unconstitutionally vague."

Jenin Younes, an attorney with the New Civil Liberties Alliance and lead counsel in that case, said she's pleased that requirements set forth by 2098 are likely being repealed. The state legislature, she said, is "apparently recognizing that the law is unlikely to survive court challenges," including the one

she filed on behalf of California licensees Tracey Hoeg, MD, Ram Duriseti, MD, Aaron Kheriaty, MD, Pete Mazolewski, MD, and Azadeh Khatibi, MD.

"It's a shame that these doctors had to take the state to court to see their First Amendment and Due Process rights vindicated. The clearly unconstitutional law never should have been passed in the first place," she said.

Chessie Thacher, senior attorney with the Northern California ACLU, also was glad the repeal seemed to be moving forward. "As we argued in court, that bill was dangerously overbroad and confusing. It chilled doctor speech and risked compromising the medical advice patients receive," she said. "AB 2098 was also unnecessary because the state had -- and continues to have -- numerous ways to handle doctors that practice below the standard of care."

Indeed, several members of the Medical Board of California, as well as speakers at last year's legislative hearings, said they believed the board already had the power to discipline doctors for disseminating false COVID-19 information.

As an example, the MBC filed an accusation on June 23 against Ana Rebecca Reyna, MD, a Tehachapi-based internal medicine doctor who, the board document alleges, made a number of false statements to a patient in her care in April 2021 -- nearly 18 months before the bill was signed into law.

State documents said that Reyna told her patient that available COVID vaccines "contained fetal tissue, would alter his DNA irreparably, and were linked to a significant increase in miscarriages." She also allegedly "indicated that masks do not stop COVID."

Reyna, the accusation continued, also told the same patient that "when dealing with patients who exhibited COVID symptoms she directed them to purchase veterinary ivermectin, intended for horses."

She also told her patient that his girlfriend should "avoid the COVID vaccines if she wants to get pregnant" because the vaccines "were responsible for a 366% increase in miscarriages."

"By making one or more of the statements set forth, Respondent [Reyna] committed an extreme departure from the standard of care by providing advice about COVID-19 that was not accurate, and did not clearly relay to Patient A that the advice did not comport with the standard of care in the community," the board accusation said. The law resulting from 2098 was not mentioned.

The allegations against Reyna await a final determination by the board, and Reyna will have a chance to defend herself.

Nick Sawyer, MD, a Sacramento-area emergency physician who has been outspoken against COVID misinformation, also agreed that the legislature didn't need to pass AB 2098 to stop doctors from potentially harming patients with false medical advice.

"The Medical Board of California already had the mandate and means to address these doctors even before the pandemic," he said.

However, he said he's perplexed to see so much celebration of its repeal. "I trust that the MBC will prioritize public safety by ensuring doctors base prescriptions and their medical opinions on science, not ideology," he said.

Asked what he thought of the amendment that appears destined to repeal the law he fought hard to pass, Assemblyman Evan Low (D-Campbell), seemed to be on board.

Through a spokesman, he said, "fortunately, with this update, the Medical Board of California will continue to maintain the authority to hold medical licensees accountable for deviating

from the standard of care and misinforming their patients about COVID-19 treatments."

Cheryl Clark has been a medical & science journalist for more than three decades.

4 Comments

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Ana Rebecca Reyna, M.D. Physician's and Surgeon's Certificate No. G 51558 Respondent.	Case No. 800-2021-076688

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on January 19, 2024.

IT IS SO ORDERED December 21, 2023.

MEDICAL BOARD OF CALIFORNIA

Jenna Jones for

Reji Varghese
Executive Director

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
TRINA L. SAUNDERS
Deputy Attorney General
State Bar No. 207764
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 269-6516
Facsimile: (916) 731-2117
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: ANA REBECCA REYNA , M.D. P.O. Box 2538 Tehachapi, CA 93581-2538 Physician's and Surgeon's Certificate No. G 51558 Respondent.	Case No. 800-2021-076688 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Trina L. Saunders, Deputy Attorney General.

2. Ana Rebecca Reyna, M.D. (Respondent) is represented in this proceeding by attorney Dennis Thelen, whose address is 5001 E. Commercenter Drive, Suite 300 Bakersfield, California 93309.

1 3. On October 31, 1983, the Board issued Physician's and Surgeon's Certificate No. G
2 51558 to Ana Rebecca Reyna, M.D. (Respondent). That license was in full force and effect at all
3 times relevant to the charges brought in Accusation No. 800-2021-076688 and will expire on
4 October 31, 2023, unless renewed.

5 **JURISDICTION**

6 4. Accusation No. 800-2021-076688 was filed before the Board and is currently pending
7 against Respondent. The Accusation and all other statutorily required documents were properly
8 served on Respondent on June 23, 2023. Respondent timely filed her Notice of Defense
9 contesting the Accusation. A copy of Accusation No. 800-2021-076688 is attached as Exhibit A
10 and is incorporated by reference.

11 **ADVISEMENT AND WAIVERS**

12 5. Respondent has carefully read, fully discussed with counsel, and understands the
13 charges and allegations in Accusation No. 800-2021-076688. Respondent also has carefully read,
14 fully discussed with counsel, and understands the effects of this Stipulated Surrender of License
15 and Order.

16 6. Respondent is fully aware of her legal rights in this matter, including the right to a
17 hearing on the charges and allegations in the Accusation; the right to confront and cross-examine
18 the witnesses against her; the right to present evidence and to testify on her own behalf; the right
19 to the issuance of subpoenas to compel the attendance of witnesses and the production of
20 documents; the right to reconsideration and court review of an adverse decision; and all other
21 rights accorded by the California Administrative Procedure Act and other applicable laws.

22 7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and
23 every right set forth above.

24 **CULPABILITY**

25 8. Respondent understands that the charges and allegations in Accusation No. 800-2021-
26 076688, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and
27 Surgeon's Certificate.

28 //

1 9. For the purpose of resolving the Accusation without the expense and uncertainty of
2 further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual
3 basis for the charges in the Accusation and that those charges constitute cause for discipline.
4 Respondent hereby gives up her right to contest that cause for discipline exists based on those
5 charges.
6 10. Respondent understands that by signing this stipulation she enables the Board to issue
7 an order accepting the surrender of her Physician's and Surgeon's Certificate without further
8 process.

9 **CONTINGENCY**

10 11. This stipulation shall be subject to approval by the Board. Respondent understands
11 and agrees that counsel for Complainant and the staff of the Board may communicate directly
12 with the Board regarding this stipulation and surrender, without notice to or participation by
13 Respondent. By signing the stipulation, Respondent understands and agrees that she may not
14 withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers
15 and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the
16 Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this
17 paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not
18 be disqualified from further action by having considered this matter.
19 12. The parties understand and agree that Portable Document Format (PDF) and facsimile
20 copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures
21 thereto, shall have the same force and effect as the originals.
22 13. In consideration of the foregoing admissions and stipulations, the parties agree that
23 the Board may, without further notice or formal proceeding, issue and enter the following Order:

24 **ORDER**

25 **IT IS HEREBY ORDERED THAT** Physician's and Surgeon's Certificate No. G 51558,
26 issued to Respondent Ana Rebecca Reyna, M.D., is surrendered and accepted by the Board.
27 1. The surrender of Respondent's Physician's and Surgeon's Certificate and the
28 acceptance of the surrendered license by the Board shall constitute the imposition of discipline

against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board her pocket license and, if one was issued, her wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2021-076688 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $12,111.25, prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2021-076688 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: ______________________ ______________________________
ANA REBECCA REYNA, M.D.
Respondent

against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board her pocket license and, if one was issued, her wall certificate on or before the effective date of the Decision and Order.

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5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $12,111.25, prior to issuance of a new or reinstated license.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: August 15, 2023

ANA REBECCA REYNA, M.D.
Respondent

1 I have read and fully discussed with Respondent Ana Rebecca Reyna, M.D. the terms and
2 conditions and other matters contained in this Stipulated Surrender of License and Order. I
3 approve its form and content.
4
5 DATED: ______________________ ______________________________
6 DENNIS THELEN
Attorney for Respondent
7
8
9 **ENDORSEMENT**
10 The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted
11 for consideration by the Medical Board of California of the Department of Consumer Affairs.
12
13 DATED: ____________________ Respectfully submitted,
14 ROB BONTA
Attorney General of California
15 ROBERT MCKIM BELL
Supervising Deputy Attorney General
16
17
18 TRINA L. SAUNDERS
Deputy Attorney General
Attorneys for Complainant
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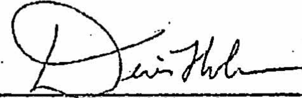
28

I have read and fully discussed with Respondent Ana Rebecca Reyna, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: August 15, 2023



DENNIS THELEN
Attorney for Respondent

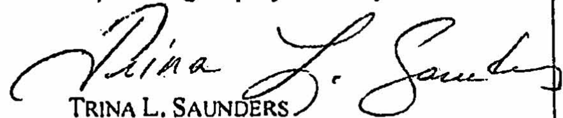
ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: October 23, 2023

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General



TRINA L. SAUNDERS
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2021-076688

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 800-2021-076688
ANA REBECCA REYNA, M.D.	**ACCUSATION**
Post Office Box 2538 **Tehachapi, California 93581-2538**	
Physician's and Surgeon's Certificate No. G 51558,	
Respondent.	

PARTIES

1. Reji Verghese (Complainant) brings this Accusation solely in his official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On October 31, 1983, the Board issued Physician's and Surgeon's Certificate Number G 51558 to Ana Rebecca Reyna, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2023, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2234 of the Code, states:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically

appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

COST RECOVERY

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence - Failure to Wear a Mask & Misleading Statements)

8. Respondent is subject to disciplinary action under section 2234 (b) of the Code, in that she failed to wear a mask during a patient visit and she provided medical advice to Patient A that advanced below standard of care treatment. The circumstances are as follows:

9. On April 2, 2021, Patient A presented for a clinic visit with Respondent with complaints of inflammation of several of his toes. Patient A wore a KN-95 mask during his visit

///

with Respondent. However, Respondent did not wear a mask. Patient A and Respondent discussed the patient's work environment and potential causes of the inflammation.

10. Patient A shared that he had been working from home because his girlfriend had the flu, and his job required a two-week quarantine before returning to the office if exposed to someone with COVID-19 like symptoms. This was met with a lengthy rant by Respondent regarding COVID-19. Respondent advised Patient A against being vaccinated. According to Patient A, Respondent, represented that the three available vaccines contained fetal tissue, would alter his DNA irreparably, and were linked to a significant increase in miscarriages. Respondent advised that they were not true vaccines, but gene therapy. Respondent further indicated that the Respondent referred to a medical podcast for the source of some of her advice. In addition, she expressed a belief that any information representing that COVID was worse than a common flu was politically motivated, with an intent to negatively impact the then current administration. Respondent also indicated that masks do not stop COVID.

11. Respondent told Patient A that when dealing with patients who exhibited COVID symptoms she directed them to purchase veterinary Ivermectin[1], intended for horses.

12. At the end of the visit, Respondent told Patient A that his girlfriend should avoid the COVID vaccines, if she wants to get pregnant. Respondent told Patient A that the vaccines were responsible for 366% increase in miscarriages. Respondent read this information in a European paper. Respondent is not a treating physician of Patient A's girlfriend, and had not been provided with her medical history, or information related to whether the couple had an interest in having children.

13. On September 30, 2022, during her Medical Board investigatory interview, Respondent indicated that during the visit with Patient A, she was speaking to him "off the record." Respondent referred to it as a friendly conversation.

[1] Ivermectin is an anti-parasitic medication used in people and animals. Ivermectin is approved for use in people, but only for specific parasitic diseases, not COVID. In addition, Ivermectin intended to veterinary use – as recommended by this doctor -- contains much larger concentrations of the active ingredient, and also ingredients that have not been approved for use in humans.

14. At the time of Patient A's visit, wearing a mask at all time in the presence of patients was standard medical practice, as well as required by a public health mandate.

15. Respondent's failure to wear a face mask during Patient A's visit constitutes an extreme departure from the standard of care.

16. Respondent made the following misleading statements and/or provided the following advice to Patient A, without telling Patient A that she was advising actions/inactions that fell below the standard of care in the community:

a. Masks do not stop viruses;

b. COVID-19 vaccines are not true vaccines. They are gene therapy and they work on genes;

c. The vaccines are produced with aborted fetal cells; and

d. Encouraging the use of veterinary Ivermectin;

Whether singly or in combination with one another, by making one or more of the statements set forth, Respondent committed an extreme departure from the standard of care by providing advice about COVID-19 that was not accurate, and did not clearly relay to Patient A that the advice did not comport with the standard of care in the community.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

17. Respondent is subject to disciplinary action under Code section 2234, subdivision (c) of the Code, in that Respondent committed repeated negligent acts in connection with his provision of medical services to Patient A. The circumstances are as follows:

18. The allegations of the First Cause for Discipline are incorporated herein by reference. as if fully set forth, and represent repeated negligent acts.

19. Respondent further departed from the standard of care by purporting to have an "off the record" or "friendly" conversation with Patient A during the clinic visit. All interactions that occur between a doctor and a patient, particularly during a clinic visit, must be conducted professionally. There may be no limitation to what topics can be discussed between doctor and patient, but the discussion must remain professional.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 51558, issued to Ana Rebecca Reyna, M.D.;

2. Revoking, suspending or denying approval of her authority to supervise physician assistants and advanced practice nurses;

3. Ordering her to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

5. Taking such other and further action as deemed necessary and proper.

DATED: JUN 23 2023

Jenna Jones for
REJI VERGHESE
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

Reyna Accusation - SDAG Reviewed.docx