Covid-19 Vaccine Mandates Are Now Pointless:

Covid-19 vaccines do not keep people from catching the prevailing Delta variant and passing it to others

September 9, 2021

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Executive Summary:

1) Excellent scientific research papers published or posted in August 2021 clearly demonstrate that current vaccines do not prevent transmission of SARS-CoV-2.
2) Vaccines aim to achieve two ends:
    a. To protect the vaccinated person against the illness.
    b. To keep people from carrying the infection and transmitting it to others.
        i. If enough people are vaccinated or otherwise become immune, it is hoped that the disease will stop circulating. We call this herd immunity.
        ii. On the way to herd immunity, there is an assumption that people who are immunized can form safe clusters or groups within which no one is carrying or transmitting the virus.
3) Unfortunately, this last assumption (2.b.ii) is no longer true under the new variant of SARS-CoV-2, Delta (B.1.617.2), which now accounts for essentially all cases worldwide.
4) Delta is more infectious than the Alpha strain (B.1.1.7) that prevailed in the UK from January to May 2021 (and in the US from March to June 2021), meaning that Delta is passed more readily person-to-person than the previous dominant strain.
    a. Infectiousness is a correlate of high viral load (see section 5, below).
    b. From its origin in India, Delta has soared to nearly complete domination of COVID-19 viral strains everywhere in a matter of months, because it spreads so easily and infects both vaccinated and unvaccinated people.

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5) New research in multiple settings shows that Delta produces very high viral loads (meaning, the density of virus on a nasopharyngeal swab as interpreted from PCR cycle threshold numbers).
    a. Viral loads are much higher in people infected with Delta than they were in people infected with Alpha.
    b. Viral loads with Delta are equally high whether the person has been vaccinated or not.
    c. Viral load is an indicator of infectiousness. [13,14] The more virus one has in the nose and mouth, the more likely it is to be in this individual's respiratory droplets and secretions, and to spread to others.
6) Due to evolution of the virus itself, all the currently licensed vaccines (all based on the original Wuhan strain spike protein sequence) have lost their ability to accomplish vaccine purpose 2(b), above, "To keep people from carrying the infection and transmitting it to others."
7) Vaccine mandates are thus stripped of their justification, since to vaccinate an individual no longer stops or even slows his ability to acquire and transmit the virus to others.
8) Under Delta, natural immunity is much more protective than vaccination. All severities of COVID-19 illness produce healthy levels of natural immunity.

The Documentary Evidence:

Here are three studies whose findings and data support the above statements:

(A) The first is by the Massachusetts Department of Health and the CDC, published August 6, 2021 in the CDC's *Morbidity and Mortality Weekly Report*. An outbreak of COVID-19 occurred in Provincetown, Massachusetts in July 2021 during two weeks of heavily attended indoor and outdoor public gatherings. The study focuses on the 469 cases among Massachusetts residents who were in attendance. [1] All successfully gene-sequenced isolates (120) were the Delta variant.

346 of the cases in Massachusetts residents (74%) occurred in fully vaccinated people who had received a 2-dose course of the BioNTech/Pfizer or Moderna vaccine, or a single dose of the Johnson & Johnson. Vaccine coverage at this time among all Massachusetts residents was 69%. This suggests that vaccinated people became infected just as frequently as unvaccinated people in this outbreak.

We do not know the vaccination percentage among actual festival attendees who were Massachusetts residents, but we can assume given the demographics of the festival that it was the state average (69%) or higher. We also do not know the total number of Massachusetts residents who attended. Both of these numbers would be needed to determine actual values for vaccine efficacy in this outbreak.

However, we cannot brush the high percentage of vaccinated people in the infected sample under the carpet quite as easily as the authors do, when they say, "As population-level vaccination coverage increases, vaccinated persons are likely to represent a larger proportion of COVID-19 cases" (p. 1061). This is true, but we would still, if vaccine is protective, find vaccinated cases to be **underrepresented** in an illness sample compared to the number vaccinated in the whole population of attendees. As best we can tell at this festival, vaccination was not protective against infection, because the proportion of vaccinated in the sample (74%) is in the same numeric range as the proportion vaccinated, 69% or above.

Among the 346 cases who were already vaccinated, 79% were symptomatic, reporting cough, headache, sore throat, muscle aches, and fever. Four of these vaccinated, infected individuals (1.2%) were hospitalized. No one died. The remainder of the vaccinated cases did not report symptoms.

Among the 123 cases who were unvaccinated or partially vaccinated, one was hospitalized (0.8%) and no one died. Percentage with symptoms was not reported.

Vaccinated and unvaccinated cases were found to have very similar viral loads (in a sample of 127 and 84 cases, respectively). This means the PCR tests showed that vaccinated and unvaccinated infected people were carrying similar amounts of virus in their upper respiratory tracts at diagnosis and were thus equally infectious.

(B) The next study, released August 10, 2021, examines the Delta viral load phenomenon in far more detail, and shows clearly that vaccinated people can become infected and pass the infection to other vaccinated people. The Hospital for Tropical Diseases in Ho Chi Minh City in southern Vietnam has about 900 staff members, including an Oxford University Clinical Research Unit. The entire hospital staff was vaccinated with the Oxford-AstraZeneca vaccine two-dose series in March and April 2021, and then enrolled in a post-vaccination study. Thus, a great deal of detailed information was available when the outbreak struck. [2]

The entire hospital staff was PCR negative for SARS-CoV-2 in mid-May 2021. The index case (first known case in a cluster) became mildly ill on June 11 and had a positive PCR with a high viral load. The whole staff was then re-tested. 52 additional cases were identified immediately. Ten more had high viral loads, a number being staff who shared an office with the index case. All the additional cases at first had no symptoms.

The hospital was then locked down. Over the next two weeks, 16 additional cases were identified in subsequent PCR surveys. 62 of the 69 PCR-positive cases participated in this study of the outbreak.

Forty-seven (76% of the 62 subjects) developed respiratory symptoms, three with pneumonia on chest x-ray and one requiring three days of nasal cannula oxygen (this is the least intensive form of oxygen therapy). Everyone recovered fully.

Peak viral loads in this fully vaccinated, infected group were, on average, 250 times higher than peak viral loads with older variants early in the pandemic (March-April 2020), when no one was vaccinated. This is a means of comparing the biology of the variants themselves: the Delta virus has gained the ability to replicate itself enormously in the upper respiratory tract, regardless of vaccination, thereby making itself more infectious.

In the current outbreak, viral loads (and thus infectiousness) peaked in the 2-3 days both before and after symptoms began.

All sequenced isolates were the Delta variant. The genetic sequences from hospital staff were more similar to each other than they were to contemporaneous isolates from the city at large or from more distant parts of the country. This means it is likely that the virus spread among the (fully vaccinated) hospital staff from a single infected (and vaccinated) staff member who brought it from the outside. Given the dynamics of symptoms and positivity among the staff, it is clear that asymptomatic or pre-symptomatic staff members, as well as symptomatic, were infecting others.

PCR tests continued to be positive up to 33 days after diagnosis (averaging 21 days). Case-control comparisons showed that staff members with lower titers of neutralizing antibodies after vaccination and at diagnosis were more likely to become infected. However, there was no correlation between vaccine-induced antibody levels at diagnosis and viral loads or the development of respiratory symptoms.

(C) The third study is an analysis of ongoing population-wide SARS-CoV-2 monitoring in the UK, whose primary purpose is following changes in vaccine efficacy. In the UK study, the PCR tests are done on members of randomly selected households across the UK, following a predetermined schedule that ignores symptoms, vaccination, and prior infection. The current analysis was released on August 24, 2021 and summarized in commentary in the *British Medical Journal* on August 19, 2021. [3, 4]

The study includes measures of viral load or “burden” under Alpha and Delta predominance. While Alpha was the dominant UK strain (January to mid-May 2021), vaccination or prior COVID-19 disease strongly reduced viral load compared to unvaccinated people who had never had COVID-19.

The sample size was large and random, obtained as described above. 12,287 new PCR-positives were found in the Alpha-dominant period, of which 88% were unvaccinated and had no evidence of prior infection. Only 0.5% of new positive tests were from fully vaccinated people,

and 0.6% from people with prior COVID-19 infection. Since it was a large, random sample and vaccination percentages increased dramatically in the UK across this time period, we can safely say that vaccination and prior infection were very protective against becoming infected with the Alpha variant. Virtually all the new infections occurred in unvaccinated people.

After mid-June 2021, when greater than 92% of PCR positives in the UK were Delta, the differences in viral load between vaccinated, unvaccinated, and people with past COVID-19 disease nearly vanished. Viral loads in all three groups were much higher than with Alpha, indicating increased infectiousness. More vaccinated people were now showing symptoms when they became positive, also correlated with viral load.

During the Delta-dominant period, the sample was 1939 new positive PCR tests. Of these, 17% (326) were from unvaccinated people without prior COVID-19 disease, 1% (20) were unvaccinated with evidence of prior disease, and 82% (1593) were fully vaccinated. This is approximately the percentage of the UK population who were vaccinated by August 18, 2021—when 75-83% of UK residents were fully vaccinated and 84-89% had received at least one dose. [5]

Like the Massachusetts study reviewed above, this suggests that the new Delta variant infects vaccinated and unvaccinated people with equal probability. To go from 0.5% of randomly sampled new infections in vaccinated people (under Alpha) to 82% (under Delta) in several months, as the population is becoming more and more vaccinated—these are extraordinary numbers.

If vaccination is still effective in preventing infection, we would expect the proportion of infections in a random population sample to be less than the proportion of the population vaccinated. If 82% of randomly obtained positive tests occur in vaccinated people, and about 82% of people are vaccinated, then vaccination is not reducing the likelihood of infection at all. Efficacy at preventing infection has become zero.

The UK study addresses vaccine efficacy in much more complex ways than the straightforward numbers I present here. The authors conclude that both of the earlier UK-approved vaccines (BioNTech/Pfizer and Oxford-AstraZeneca) have lost some efficacy against Delta compared to Alpha. But both vaccines, they maintain, remain substantially effective at keeping people from becoming infected with the Delta strain, in the range of 67 to 80%. If this is the case, why was 82% of their random sample of new positive PCR tests from vaccinated people?

If a vaccine reduces the risk of becoming infected by two-thirds (67%), we would expect the proportion of vaccinated in the positive sample to be less than the proportion of vaccinated in the population. Say we start with 1000 people in the country, of whom we will randomly sample 100. The country is 80% vaccinated. This means that in our sample of 100 we have 80 vaccinated and 20 unvaccinated people. Let's say that the virus has infected 10% of the people

across the sampling period, or 10 total cases. If 8 of the infected are among the vaccinated, and 2 in the unvaccinated (80% and 20% of the positives, matching the ratio of vaccinated and unvaccinated in the population), the vaccine has made no difference in whether one can get infected (0% efficacy). If the vaccine is 67% effective, the cases in the vaccinated group would be reduced by 2/3 to 2.67 cases, and the total cases would be only 4.67 cases (2.67 vaccinated and 2 unvaccinated). This means that only 2.67/4.67 or 57% of the cases would be in the vaccinated group, and 43% in the unvaccinated. (We can go back to 10% overall being positive just using ratios, yielding 5.7 cases among the vaccinated and 4.3 among the unvaccinated.)

This is why the proportion vaccinated in the infected sample, very close to the proportions vaccinated in the total population, are incompatible with the efficacy numbers generated by the authors. It appears to me—as in the Massachusetts study—that **the vaccine is not decreasing susceptibility to infection at all**, and is in reality somewhere between **slightly (insignificantly) decreasing susceptibility** and **slightly increasing susceptibility** to the Delta variant.

The UK study is clear that viral load (and thus infectiousness to others) is much greater with Delta than with Alpha, and that, with Delta, **viral load and infectiousness are equal in vaccinated and unvaccinated infected people.**

Discussion #1:

These three different studies in three countries with three different population sampling methods produced the **same result: with the current, dominant Delta strain, vaccinated people become infected and carry just as much infectious virus in their upper respiratory tracts when infected as unvaccinated people. The reproducibility of this finding makes it a very strong finding.**

The study in Vietnam shows clearly that **infected, vaccinated people transmit the infection to others.**

Under the current dominance of the Delta variant, being vaccinated or not has **no influence on a chief determinant of infectiousness: the size of the viral load carried in the nose and mouth of an infected person**. **In addition, both vaccinated and unvaccinated become infected in significant numbers, approximating the ratios of vaccinated and unvaccinated in the population.**

The **rationale for mandates**—that each individual has a responsibility to be vaccinated to limit spread of the virus to others—is hereby **seriously or even fatally undermined.** The decision to be vaccinated, under Delta predominance, has become **entirely personal, affecting only the future health and well-being of the individual** receiving the vaccine.

Blaming the unvaccinated for the rapid spread of the Delta variant has **no merit whatsoever, since both vaccinated and unvaccinated infected people are equally infectious to others,** and vaccinated and unvaccinated people are represented in illness samples in proportion to their representation in the general population, showing they are **equally likely to become infected**.

These findings also equalize vaccinated and unvaccinated in terms of quarantine, vaccine-based exclusion, or the wearing of masks.

The Delta variant has entirely changed our expectations of the effects of vaccination on containing the SARS-CoV-2 virus.

What about natural immunity from previous COVID-19 infection?

What about natural immunity from previous COVID-19 infection, with regard to the change in virus strain? An Israeli study posted on August 25, 2021 powerfully shows that "natural immunity [from previous COVID-19 infection] confers longer-lasting and stronger protection against infection, symptomatic disease and hospitalization caused by the Delta variant of SARS-CoV-2 compared to the BNT162b2 [BioNTech/Pfizer] two-dose vaccine-induced immunity." If a person is both naturally immune and received one vaccine dose, immunity to Delta infection is even stronger. [6]

To demonstrate this, the authors studied the records of a large Israeli Health Maintenance Organization covering 2.5 million people (26% of the population). They compared the numbers of positive PCR tests from June 1 to August 14, 2021, when the Delta variant was dominant, in people who were either immunized in January-February 2021 or had COVID-19 infection in January-February 2021.

Those who were vaccinated but never had COVID-19 disease were 13 times more likely to develop a new SARS-CoV-2 infection than those made naturally immune by COVID-19 disease. The increased risk was also significant for having symptoms or not.

When the prior COVID-19 disease was allowed to happen earlier in the course of the pandemic, from March 2020 through February 2021, vaccinees who had never had COVID-19 disease were still (a) 6 times more likely to have a positive PCR in June-August 2021 than a naturally immune person, (b) 7 times more likely to have symptomatic disease, and (c) at greater risk for COVID-19-related hospitalization.

By comparison, under Alpha strain dominance during the first half of 2021, over 50,000 staff members of the Cleveland Clinic in Ohio demonstrated that vaccine-induced immunity (from

any of the three US-authorized vaccines) and natural immunity were equally protective against COVID-19 disease. [7]

The Israeli study shows at a later time period how the Delta variant has escaped the control of at least one of these vaccines, while natural immunity to earlier forms of SARS-CoV-2 still confers protection.

A Danish study of 203 recovered COVID patients shows that COVID-19 infection/disease provokes robust immune responses in the vast majority of people regardless of disease severity, including mild cases and even true asymptomatic cases (excluding those with false positive tests). [8]

Discussion #2:

It is difficult to tell anything about the virulence or pathogenicity of the Delta variant itself—how sick it makes people—since the available studies are all done in highly vaccinated populations. Vaccination has protected against severe disease and death with all the other variants, and may well do the same with the Delta variant. **This remains the most compelling reason individuals may decide to be vaccinated.**

What drives people—especially PhD's, together with certain minorities [9]—to choose not to be vaccinated? There is substantial recorded and written evidence from first-hand observers and vaccine recipients themselves, and in the immunization "adverse effects" registries of both the US and Europe, that we are tolerating with COVID-19 vaccines a level of severe adverse effects, including death, that would have been unthinkable for any earlier vaccine.

So far, convincing evidence that these effects are "not related to vaccine" has not emerged. Convincing evidence would be research-lab-level autopsy studies of people deceased soon after vaccination (or ill soon after vaccination and eventually deceased), including immunofluorescence or other specific staining for the unique proteins, nucleic acids, and lipids of vaccine or SARS-CoV-2 itself in different tissues. (Some excellent examples of this approach are autopsy studies illuminating the pathophysiology of COVID-19 disease by C Magro and others at Weill Cornell Medical Center [e.g. 10].) Biopsy studies of key tissues in living affected people, such as those with persistent neurologic deficits after vaccination for COVID-19, would also provide powerful evidence. It is highly irregular and indeed unacceptable that such autopsy and biopsy studies have not been done.

Some prominent scientists and a significant number of physicians take these allegations of vaccine-caused injury very seriously. *Doctors for Covid Ethics*, a British/European/worldwide group of physicians, link the known pathophysiology of clots in COVID-19 disease [10] with a

possible pathophysiologic mechanism explaining the numerous cases of thrombosis after vaccination, such as those in published literature due to the Oxford-AstraZeneca vaccine. [11,12] This mechanism would not be unique to one vaccine type or brand, nor are the reports of postvaccination thrombosis unique to one type or brand of vaccine.

Why are PhD's the group most stable in their resistance to this vaccine? [9] It is because we have been trained to look at data analytically and to think about how the authors reached their conclusions. We all know through our own research experience the ways data analysis may be slanted to make the data say one thing or another. We come out of training, jaded.

In the four major papers reviewed above (Massachusetts, Vietnam, UK, and Israel), the biologic facts of the new Delta variant and its relationship to vaccination are clearly and reproducibly established. This is the value of good science.

Conclusion:

Given all the above evidence, mandating others to take a vaccine is a potentially harmful, damaging act.

Since the principal reason for COVID-19 vaccine mandates—protecting others from infection—has evaporated with the ascendance of the Delta variant, those who mandate COVID-19 vaccines may wish to seek legal counsel regarding their culpability and liability (including personal) for potential long-lasting harm to those whom they pressure into vaccination with threat of exclusion from employment or education or other public activity. Remind your attorney that if an unborn or nursing baby is damaged, liability persists until the child is age 23—plenty of time for discovery of the ways whereby vaccine producers and government regulators may have suppressed important information about harmful effects.

References:

1. Brown CM, Vostok J, Johnson H, Burns M, Gharpure R, Sami S, Sabo RT, Hall N, Foreman A, Schubert PL, Gallagher GR, Fink T, Madoff LC, MD, Gabriel SB, MacInnis B, Park DJ, Siddle KJ, Harik V, Arvidson, D, Brock-Fisher T, Dunn M, Kearns, Laney AS. 2021. Outbreak of SARS-CoV-2 infections, including COVID-19 vaccine breakthrough infections, associated with large public gatherings — Barnstable County, Massachusetts, July 2021. *MMWR Morb Mortal Wkly Rep* 70:1059-1062: https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7031e2-H.pdf; published August 6, 2021.

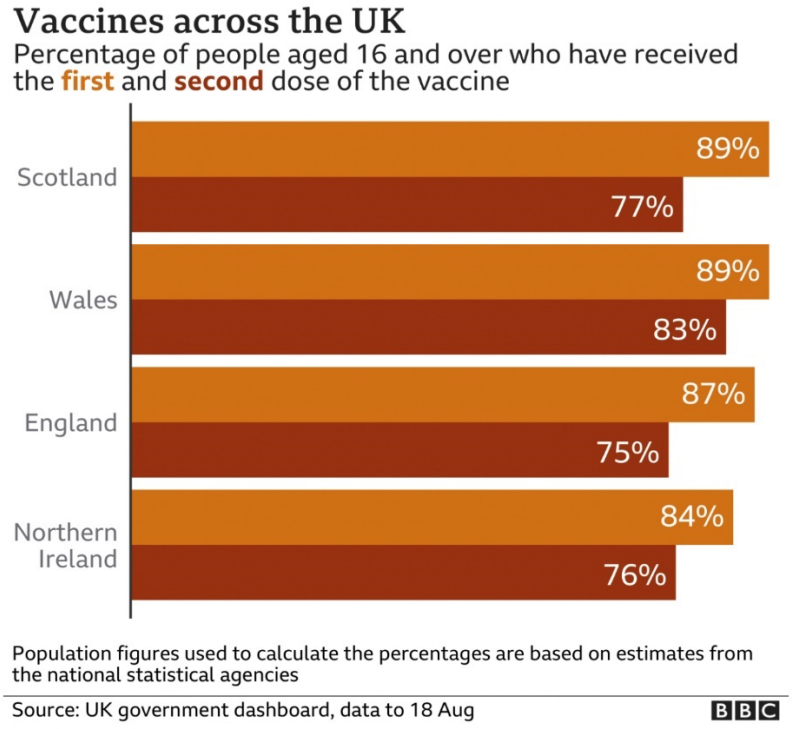
2. Chau NVV, Ngoc NM, Nguyet LA, Quang VM, Ny NTH, Khoa DB, Phong NT, Toan LM, Hong NTT, Tuyen NTK, Phat VV, Nhu LNT, Truc NHT, That BTT, Thao HP, Thao TNP, Vuong VT, Tam

TTT, Tai NT, Bao HT, Nhung HTK, Minh NTN, Tien NTM, Huy NC, Choisy M, Man DNH, Ty DTB, Anh NT, Uyen LTT, Tu TNH, Yen LM, Dung NT, Hung LM, Truong NT, Thanh TT, Thwaites G, Tan LV, OUCRU COVID-19 Research Group. 2021. Transmission of SARS-CoV-2 Delta variant among vaccinated healthcare workers, Vietnam. *Preprints with The Lancet*, available at http://dx.doi.org/10.2139/ssrn.3897733; posted August 10, 2021.

3. Pouwels KB, Pritchard E, Matthews PC, Stoesser N, Eyre DW, Vihta KD, House T, Hay J, Bell JI, Newton JN, Farrar J, Crook D, Cook D, Rourke E, Studley R, Peto T, Diamond I, Walker AS, and the COVID-19 Infection Survey Team. 2021. Impact of Delta on viral burden and vaccine effectiveness against new SARS-CoV-2 infections in the UK. *medRxiv* preprint: https://doi.org/10.1101/2021.08.18.21262237; posted August 24, 2021.

4. Griffin S. 2021. Covid-19: Fully vaccinated people can carry as much delta virus as unvaccinated people, data indicate. *BMJ* 374:2074: http://dx.doi.org/10.1136/bmj.n2074; published 19 August 2021.

5. BBC News: "Covid vaccine: How many people in the UK have been vaccinated so far?" Downloaded on August 23, 2021. Updated article and graph available at https://www.bbc.com/news/health-55274833



6. Gazit S, Shlezinger R, Perez G, Roni Lotan R, Peretz A, Ben-Tov A, Cohen D, Muhsen K, Chodick G, Patalon T. 2021. Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections. *medRxiv* preprint: https://doi.org/10.1101/2021.08.24.21262415; posted August 25, 2021.

7. Shrestha NK, Burke PC, Nowacki AS, Terpeluk P, Gordon SM. 2021. Necessity of COVID-19 vaccination in previously infected individuals. 2021. *medRxiv* preprint: https://doi.org/10.1101/2021.06.01.21258176; posted June 5, 2021.

8. Nielsen SSF, Vibholm LK, Monrad I, Olesen R, Frattari GS, Pahus MH, Højen JF, Gunst JD, Erikstrup C, Holleufer A, Hartmann R, Østergaard L, Søgaard OS, Schleimann MH, Tolstrup M. 2021. SARS-CoV-2 elicits robust adaptive immune responses regardless of disease severity. *EBioMedicine* 68:103410, https://doi.org/10.1016/j.ebiom.2021.103410; published June 4, 2021.

9. King WC, Rubinstein M, Reinhart A, Mejia RJ. 2021. Time trends and factors related to COVID-19 vaccine hesitancy from January-May 2021 among US adults: Findings from a large-scale national survey. *medRxiv* preprint: https://doi.org/10.1101/2021.07.20.21260795; posted July 23, 2021.

10. Magro C, Mulvey JJ, Berlin D, Nuovo G, Salvatore S, Harp J, Baxter-Stoltzfus A, Laurence J. 2020. Complement-associated microvascular injury and thrombosis in the pathogenesis of severe COVID-19 infection: A report of five cases. *Translational Research* 220:1–13: https://doi.org/10.1016/j.trsl.2020.04.007; published online April 15, 2020.

11. Bhakdi, S. et al. 2021. Letter to Physicians: Four new scientific discoveries regarding COVID-19 immunity and vaccines—implications for safety and efficacy.. Doctors for Covid Ethics website, https://doctors4covidethics.org/letter-to-physicians-four-new-scientific-discoveries-crucial-to-the-safety-and-efficacy-of-covid-19-vaccines/; posted July 9, 2021.

12. Kantarcioglu B, Iqbal O, Walenga JM, Lewis B, Lewis J, Carter CA, Singh M, Lievano F, Tafur A, Ramacciotti E, Gerotziafas GT, Jeske W, Fareed J. 2021. An update on the pathogenesis of COVID-19 and the reportedly rare thrombotic events following vaccination. *Clin Appl Thrombosis/Hemostasis* 27:1-14. https://journals.sagepub.com/doi/10.1177/10760296211021498; published June 1, 2021.

13. Jones TC, Biele G, Mühlemann B, Veith T, Schneider J, Beheim-Schwarzbach J, Bleicker T, Tesch J, Schmidt ML, Sander LE, Kurth F, Menzel P, Schwarzer R, Zuchowski M, Hofmann J, Krumbholz A, Stein A, Edelmann A, Corman VM, Drosten C. 2021. Estimating infectiousness throughout SARS-CoV-2 infection course. *Science* 373, 180. https://doi.org/10.1126/science.abi5273; published July 9, 2021.

14. van Kampen JJA, van de Vijver DAMC, Fraaij PLA, Haagmans BL, Lamers MM, Okba N, van den Akker JPC, Endeman H, Gommers DAMPJ, Cornelissen JJ, Hoek RAS, van der Eerden MM, Hesselink DA, Metselaar HJ, Verbon A, de Steenwinkel JEM, Aron GI, van Gorp ECM, van Boheemen S, Voermans JC, Boucher CAB, Molenkamp R, Koopmans MPG, Geurtsvankessel C, van der Eijk AA. 2021. Duration and key determinants of infectious virus shedding in hospitalized patients with coronavirus disease-2019 (COVID-19). *Nature Communications* 12, 267. https://doi.org/10.1038/s41467-020-20568-4; published January 11, 2021.

Calvin Luther Martin, PhD

September 9, 2021

Professor Julie Ponesse
Department of Philosophy
Huron College
University of Western Ontario
Ontario, Canada

Dear Prof. Ponesse,

I was one of tens of thousands who watched your video explaining that you were being fired for refusing the Covid vaccine mandated by the University of Western Ontario. As you are painfully aware, you are one of hundreds of thousands of people in North America, and likely one of many millions around the world, being denied employment or other public activity for declining the vaccine.

I am attaching a document you can use to fight against and, hopefully, reverse this outrageous, unscientific, non-clinical discrimination and harassment:

> Nina Pierpont, MD, PhD, "Covid-19 Vaccine Mandates Are Now Pointless: Covid-19 vaccines do not keep people from catching the prevailing Delta variant and passing it to others" (September 9, 2021).

I recommend you print off copies, including hard copies of all of Pierpont's references, and send these by registered, certified mail to the university administration. You should fill out a notarized affidavit of service certifying that your employer received the documents. In your cover letter, insist that you be reinstated.

Next, hire an attorney and provide him (her) with all these documents. Ask your attorney to seek a court injunction against your termination. If the court grants the injunction, proceed with a lawsuit based on Pierpont's report. If the court declines the injunction, go directly a lawsuit.

19 Clay Malone NY 12953 518-348-4731 19clay@gmail.com

If you get nowhere with a court, all is not lost. Hang onto the affidavit of service and the other proof of delivery, so that whenever you do finally get your day in court you can demonstrate to the judge that you furnished your employer with credible and clear scientific and clinical evidence showing that you were terminated for unjustifiable reasons.

It's important to alert the media to what you're doing, to raise public awareness of this travesty while underscoring that people are not going to accept this without pushing back.

Note that you can do all of this *pro se*: you can represent yourself, rather than hire legal counsel.

I recommend the same process to anyone else who has been denied employment or other public performance and participation. I recommend it, as well, to individuals who were forced by their employer to get the Covid vaccine and who subsequently suffered harm from the vaccine. Ditto to pregnant and nursing women. This outrage must be stopped.

I am attaching a generic affidavit of service for your convenience.

Sincerely,

Calvin Luther Martin, PhD
Associate Prof. of History (retired)
Rutgers University
New Brunswick, New Jersey
USA

STATE OF NEW YORK
COUNTY OF_____ss:
(County where notarized)

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