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VIA E-MAIL AND FED EX

December 29, 2021

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COVID-19 Response Team

Centers for Disease Control and Prevention

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Re: Misconduct Relating to Paper Published October 29, 2021 in the MMWR

Dear Dr. Bozio, Dr. Reynolds, Dr. Ferdinands, Dr. Patel, Mr. Griggs, Ms. Porter, Ms. Blanton, Ms. Steffens, Ms. Olson, Mr. Williams, Ms. Dickerson, Dr. Azziz-Baumgartner, Dr. Schrag, Dr. Verani, Dr. Fry, Dr. Thompson, and Dr. McMorrow:

We write to you on behalf of the Informed Consent Action Network (“ICAN”) with regard to the non-peer reviewed paper titled Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19–Like Illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity — Nine States, January–September 2021, dated October 29, 2021 (the “paper”) published by the Centers for Disease Control and Prevention (“CDC”), of which you are listed authors, purportedly comparing risk of infection between those previously testing positive for SARS-CoV-2 (the “previously infected”) and those receiving a COVID-19 vaccine (the “vaccinated”).¹

¹ https://www.cdc.gov/mmwr/volumes/70/wr/mm7044e1.htm?s_cid=mm7044e1_w.

Our client has received numerous complaints, including from academics at prestigious universities, that this paper constitutes gross scientific misconduct. That its purpose was to concoct a study that would, despite an overwhelming number of prior studies to the contrary, support the CDC's policy to crush the civil and individual rights of the previously infected who do not submit to the CDC's policies regarding receipt of a COVID-19 vaccine (the "**vaccine**"). As this paper is being used to deprive Americans of their rights, your participation in this deceitful paper is a legal matter.

Absent notice by January 4, 2022 that you have withdrawn from this study as a listed author, you will be included in your individual capacity in the legal complaint that will be filed regarding this paper.

I. Fabricated Study Designed to Support the CDC's Rights-Crushing Policy

The CDC needed support for its policy and recommendation to vaccinate those previously infected – a policy which includes expelling children from school, firing federal government workers, discharging military personnel, and far more coercive and insidious conduct for those who decline to comply.

The CDC could not support this policy if it had compared the rate of those that later test positive after a previous infection ("**reinfections**")² with the rate of infections in the vaccinated ("**breakthrough cases**"), because peer reviewed studies reflect that breakthrough cases occur far more frequently than reinfections. The CDC also could not compare the rate of infections, hospitalizations, or death between the previously infected and the vaccinated because, again, the peer reviewed studies reflect that natural immunity is superior. In fact, even at its purported peak under optimal conditions of a clinical trial against the alpha variant, the "best" COVID-19 vaccine was purportedly 95% effective at preventing disease and waned rapidly whereas the peer reviewed studies to date show natural immunity provides durable protection with a greater than 99% chance of not becoming reinfected.

Since the truth was not going to work, the CDC chose to engineer a study to support its authoritarian policy and avoid a public relations disaster. After all, if the CDC admitted that its position regarding natural immunity was wrong, then individuals who declined vaccination were needlessly fired from their jobs, expelled from school, less than honorably discharged from the military, and worse. In fact, these life- and liberty-crushing results in large part happened when the evidence was already clear that natural immunity is more robust than vaccine-induced immunity. This is also made clear in the comprehensive petition exchange with the CDC regarding this precise topic available at <https://www.icandecide.org/wp-content/uploads/2021/12/Reply-to-CDC-Re-Natural-Immunity-v-Vaccine-Immunity.pdf>.

² It should be noted that as used herein, the term "reinfection" refers only to a SARS-CoV-2 positive test following a prior positive test in the same individual. An actual reinfection must meet a rigorous definition: 1) characteristic signs, symptoms, laboratory and radiographic findings of COVID-19; 2) two episodes more than six months apart; 3) on both occasions confirmatory positive testing with SARS-CoV-2 PCR testing at Ct <28, SARS-CoV-2 nucleocapsid antigen positive, and limited nucleocapsid genomic sequencing positive. Anything less than this is likely a simple persistence of positive testing or a false positive test since we now understand the virus and remnants are in the human body for a very long time. We are unaware, in approximately 279 million cases of SARS-CoV-2, of any case series meeting this definition.

II. Study Design that Permitted Cooking the Results

You chose to conduct a weaker case control study even though data were available to the CDC to conduct a cohort study that could have compared the infection, hospitalization, and death rates between the previously infected and the vaccinated. A cohort study would have been simpler to understand and far less easy to manipulate. Large cohort studies comparing vaccinated and previously infected individuals have consistently found that the vaccinated are far more likely to be infected, hospitalized or die. Here are but a few examples:

- a. United Kingdom's official government COVID-19 data from the past 7 months reflects a probable reinfection rate of 0.025% (and a confirmed reinfection rate of 0.0026%)³ but a breakthrough rate of 23% of all Delta cases.⁴
- b. Maccabi Healthcare and Tel Aviv University study of 42,000 previously infected and 62,000 fully vaccinated individuals found that the fully vaccinated individuals were 8 times more likely to be hospitalized, 13 times more likely to get infected, and 27 times more likely to have symptoms, concluding that “natural immunity 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 [Pfizer] two-dose vaccine-induced immunity.”⁵
- c. Israeli Health Ministry review of 835,792 individuals found that the vaccinated had 6.72 times the rate of infection as compared to the previously infected.⁶
- d. Technion and Hebrew University study of over 6 million individuals found that natural immunity was more effective than vaccine-induced immunity at preventing infection, hospitalizations and severe illness.⁷
- e. Cleveland Clinic study of 52,238 health care workers over a five-month period found that none of the previously infected who remained *unvaccinated* contracted SARS-CoV-2 despite a high background rate of COVID-19 in the hospital.⁸
- f. Ireland's Health Information & Quality Authority review of 11 cohort studies involving over 600,000 total recovered COVID-19 patients, monitored over 10

³ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1012240/Weekly_Flu_and_COVID-19_report_w33.pdf at 17-18.

⁴ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1014926/Technical_Briefing_2_21_09_02.pdf at 21. Meanwhile, the CDC – relying upon “passive and voluntary reporting” – reported 14,115 breakthrough cases, <https://www.cdc.gov/vaccines/covid-19/health-departments/breakthrough-cases.html>, while Louisiana alone had 14,650 breakthrough infections as of August 25, 2021, <https://www.politico.com/news/2021/08/25/cdc-pandemic-limited-data-breakthroughs-506823>.

⁵ Sivan Gazit, *et al.*, *Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections*, medRxiv (August 25, 2021) <https://www.medrxiv.org/content/10.1101/2021.08.24.21262415v1>.

⁶ <https://www.israelnationalnews.com/News/News.aspx/309762>.

⁷ Yair Goldberg, *et al.*, *Protection of previous SARS-CoV-2 infection is similar to that of BNT162b2 vaccine protection: A three-month nationwide experience from Israel*, medRxiv (April 24, 2021) <https://www.medrxiv.org/content/10.1101/2021.04.20.21255670v1>.

⁸ Nabin K. Shrestha, *et al.*, *Necessity of COVID-19 vaccination in previously infected individuals*, medRxiv (June 19, 2021) <https://www.medrxiv.org/content/10.1101/2021.06.01.21258176v3>.

months, found that reinfection was “an uncommon event” and there was “no study reporting an increase in the risk of reinfection over time.”⁹

- g. WHO and Weill Cornell Medicine-Qatar study analyzed the population-level risk of reinfection based on whole genome sequencing, tracking 43,044 individuals for up to 35 weeks, and found that just 0.02% experienced reinfection (an estimated risk of <1 reinfection (0.66) per 10,000 person-weeks) with no evidence of waning immunity during the over seven month follow-up period.¹⁰

III. Rigged Study

If the CDC wanted to compare natural immunity to vaccine-induced immunity, it would have conducted a simple cohort study, such as the ones cited above. But that was not the purpose of your study. The purpose was to concoct a result that would support the CDC’s chosen policy regarding vaccinating the previously infected. That is the very definition of scientific misconduct.

Even more pernicious, the rigged results will be and have been used to justify crushing the civil and individual rights of millions of Americans. You should be distraught about participating in this authoritarianism by our government.

It is not surprising that the CDC would engage in this type of result-driven study because, as the CDC explains: “By the time a report appears in *MMWR*, it reflects, or is consistent with, CDC policy.”¹¹ That is not science. Not truth. It is the perversion of science and truth.

A. Engineers an Irrelevant Comparison

This study does not answer whether vaccination or previous infection is better at decreasing the risk of subsequent COVID-19 disease. Had it studied this question, it would likely show what over 50 other studies have shown: previous infection is more durable, robust, and effective. Instead, it compares, on the one hand, the percentage of previously positive patients admitted with COVID-like illnesses (“CLI”) that test positive, with, on the other hand, the percentage of previously vaccinated patients admitted with CLI that test positive.

That comparison is meaningless. For example, under this approach, if there are 100,000 vaccinated individuals admitted with CLI and 10% of them test positive *but* there are only 10 previously infected individuals admitted with CLI and 100% of them test positive, your study would find that the previously infected individuals are 10 times (100%/10%) more likely to test

⁹ Eamon Murchu, *et al.*, *Quantifying the risk of SARS-CoV-2 reinfection over time*, *Reviews of Medical Virology* (May 27, 2201) <https://pubmed.ncbi.nlm.nih.gov/34043841/>.

¹⁰ Laith J. Abu-Raddad, *et al.*, *SARS-CoV-2 antibody-positivity protects against reinfection for at least seven months with 95% efficacy*, *EClinical Medicine* (April 28, 2021) <https://pubmed.ncbi.nlm.nih.gov/33937733/>.

¹¹ <https://www.cdc.gov/mmwr/preview/mmwrhtml/su6004a2.htm>.

positive for the virus (see table in footnote below).¹² That finding is meaningless. Yet it is precisely the comparison you conduct in this study to support the CDC’s policy of expelling employees, students, and military members with natural immunity that will not give up their rights to dignity, informed consent, bodily integrity, liberty, or submit to the CDC’s vaccine regiment.

B. Adjusts in the Wrong Direction

Incredibly, even if this nonsensical comparison was meaningful, its primary finding is incorrect because the study incorrectly adjusts its primary outcome up instead of down. As you know, the vaccinated group was much older than the previously infected group.

Characteristic	No. (column %)	
	Unvaccinated with previous SARS-CoV-2 infection	Fully vaccinated ⁶ without previous documented infection
All hospitalizations with COVID-19-like illness	1,020 (100)	6,328 (100)
SARS-CoV-2 test result associated with COVID-19-like illness hospitalization		
Positive	89 (9)	324 (5)
Negative	931 (91)	6,004 (95)
Age group, yrs		
18-49	313 (31)	560 (9)
50-64	243 (24)	865 (14)
65-74	207 (20)	1,757 (28)
75-84	177 (17)	2,018 (32)
≥85	80 (8)	1,128 (18)

Older individuals are far more likely to be hospitalized for CLI that are unrelated to COVID-19 than are younger individuals. This should have resulted in adjusting the risk ratio downward from its current unadjusted rate of 1.77.

Instead, your study adjusts the odds ratio from 1.77 to 5.49 on the basis that, *inter alia*, older cohorts are more likely be hospitalized with COVID-19 than younger cohorts. Adjusting upward for this fact would make sense if this was a cohort study, and you were comparing a cohort of older vaccinated individuals with a cohort of younger previously infected individuals. But here you did not conduct a cohort study. You are instead comparing the percentage of vaccinated individuals that are hospitalized with CLI and test positive (and who are overall older) with the percentage of previously positive individuals that are hospitalized with CLI that test positive (and who are overall younger). **In this comparison, the confounding is reversed because older individuals are more likely to be hospitalized for CLI unrelated to COVID-19.** This means we expect the percentage of younger people hospitalized with CLI, and who test positive for COVID-19, to be generally *higher* than among those 65 and older.

¹²

Flawed Study Design Example		
	Vaccinated, No. (%)	Unvaccinated + Prior Positive Test, No. (%)
Hospitalized with CLI, No.	100,000	10
SARS-CoV-2 Positive , No. (%)	10,000 (10%)	10 (100%)
SARS-CoV-2 Negative , No. (%)	90,000 (90%)	0 (0%)

For example, community acquired pneumonia (CAP), which includes cough, fever, chills, fatigue, shortness of breath,¹³ meets the CDC’s definition of CLI,¹⁴ and individuals 65 and older are nine times more likely to be hospitalized for CAP than those younger than 65 years of age.¹⁵ CAP is only one of several diseases, such as chronic obstructive pulmonary disorder, acute respiratory distress syndrome, and congestive heart failure, that mimic CLI in older individuals more frequently than the young. Collectively, this increases the number of individuals hospitalized with CLI that test negative for SARS-CoV-2 (the denominator) among the older vaccinated group in your study. But you fail to account for this fact.

C. What Your Study Really Shows

Had you simply compared the infection rate between those vaccinated and those previously infected, the result would most certainly be consistent with the large robust cohort studies showing previous infection is superior.

Your study does, however, provide just enough information to see that this would have been the likely result. As noted, your study includes two groups: (i) previously positive individuals who were unvaccinated and (ii) vaccinated individuals who did not previously test positive. From June to September 2021, approximately 43% of adults in the United States were fully vaccinated while roughly 37% had a positive test.¹⁶ Given same, the cohort of vaccinated individuals in the United States was likely similarly sized to that of the previously infected.

Hence, there should be approximately the same number of individuals in each group hospitalized for CLI from June to September 2021. Instead, your study found that, during this same period, **the vaccinated had a 27-fold risk of being hospitalized with a CLI compared to the previously infected:**

During Delta Predominance (June - September 2021)	Total no.	No. (row %) of SARS-CoV-2 Positive Test Results
Fully vaccinated without previous documented infection	5,213	306 (5.9)
Unvaccinated with a previous SARS-CoV-2 infection	189	89 (8.7)

So, again, between June and September 2021, when approximately 37% of Americans had been infected and approximately 43% were fully vaccinated, your study (which excluded those that received the vaccine before and after recovering from infection) found that the vaccinated had

¹³ Lutfiyya, N. *et al.*, *Diagnosis and Treatment of Community-Acquired Pneumonia*. Am Fam Physician (Feb 1st, 2006). <https://www.aafp.org/afp/2006/0201/p442.html>.

¹⁴ https://cdn.ymaws.com/www.cste.org/resource/resmgr/nssp/Presentation-NSSP_CoP_Update.pdf.

¹⁵ In fact, the historical rate of CAP-related hospitalizations, among those 65+, is higher than the rate of COVID-19 hospitalizations, among the same age group, during the time period your study was performed (January through September 2021). McLaughlin, *et al.*, *Rates of hospitalization for community-acquired pneumonia among US adults: A systemic review*. Vaccine, (October 31st, 2019). Median number of annual CAP hospitalizations is 1830 and 199 for those 65 years of age and older and those <65, respectively. <https://documentcloud.adobe.com/link/review?uri=urn:aaid:scds:US:1c3eaa14-d14f-4fd4-9b9e-0fe1af8bbb2a>. https://gis.cdc.gov/grasp/COVIDNet/COVID19_3.html.

¹⁶ Our World in Data <https://ourworldindata.org/covid-vaccinations?country=USA>.

5,213 cases of CLI and 306 positive cases while the previously infected had only 189 cases of CLI and 89 positive cases. That should be the jaw dropping finding. But the study wasn't about the truth.

Meaning, had you actually conducted a study intended to reflect reality, it would almost certainly have been consistent with the Israeli study and other cohort studies cited *supra*. But the point was not to show the truth. It was to reach a predetermined answer. So instead, the study used COVID-19 negative patients with CLI as the controls. And with that concocted nonsensical comparison, you find something you can misrepresent as being proof of vaccine-induced immunity being superior to natural immunity to crush the rights of those previously infected.¹⁷

The foregoing makes plain why every paper from the CDC needs to be peer reviewed and not just undergo a “clearance process” to “ensure that the content of *MMWR* comports with CDC policy.”¹⁸

Conclusion

Those with natural immunity have a negligible rate of reinfection, and no documented cases of subsequent transmission. The vaccinated, in contrast, are frequent asymptomatic carriers, have a high breakthrough rate of infection, and have many documented cases of subsequent transmission after breakthrough. **Your study is designed to support the irrational, illogical, authoritarian, and punitive policies of the CDC to apply limitations to those previously infected that do not apply to those vaccinated.**

The CDC has even used this study to publish a deceptive advertisement that it, no doubt, knows the public and media will interpret to mean that the previously infected are five times more likely to spread the virus than the vaccinated:

A study of hospitalized patients with symptoms similar to COVID-19* found...

Unvaccinated people with a previous infection were **5x** more likely to have a positive COVID-19 test compared to vaccinated people†

*COVID-19-like illness hospitalizations 90-179 days after prior infection or full vaccination
†Received two doses of an mRNA vaccine and no previous infection

Get vaccinated as soon as possible

CDC.gov bit.ly/MMWR7044e1 MMWR

¹⁷ Moreover, your study fails to note that PCR tests have a high probability of producing a false positive. There was mass testing of healthy individuals in 2021. Hence, a major weakness of your study is that many of the unvaccinated individuals that previously tested positive likely did not have COVID-19, but rather had a false positive. You fail to note this major weakness in your study.

¹⁸ <https://www.cdc.gov/mmwr/preview/mmwrhtml/su6004a2.htm>.

Scientists should always strive to **disprove** their hypothesis. However, the CDC continuously designs studies aimed at **proving** their hypothesis. This is not science.

We have been authorized to file a formal complaint and hold the authors of this study individually accountable for the deprivation of millions of Americans of their rights, including a number of previously infected individuals whose employers directly relied on this deceptive study to terminate their employment.

If you provide notice to us on or before January 4, 2022 that you have withdrawn your name from this paper, you will not be included in our formal complaint. If you fail to do so, you will be included in your individual capacity in the complaint.

If you believe anything said herein is incorrect, please provide a detailed explanation regarding same on or before January 4, 2022.

Govern yourselves accordingly.

Best regards,



Aaron Siri, Esq.
Elizabeth A. Brehm, Esq.
Matthew Menendez, Ph.D.