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UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF WASHINGTON

ZACHARY PILZ, an individual, BRENDA )	
CONTINE, an individual, JUAN LOPEZ, an )	CASE NO. 3:21-cv-05735-BHS
individual, )	
<i>et al.</i> )	DECLARATION OF DR. WEI-
)	HSUNG LIN
)	
Plaintiffs, )	
)	JURY DEMANDED
v. )	
)	
JAY INSLEE, the Governor of the State of )	
Washington, )	
)	
<i>et al.</i> )	
)	
)	
Defendants. )	

Dr. Wei-hsung Lin declares under penalty of perjury.

1. I am an adult citizen of the State of Washington, competent to testify, and hereby make this declaration of my personal knowledge.
2. I graduated from Sun Yat-sen University of Medical Science in China in 1983.

- 1 3. I received four years of surgical residence training in China before studying pharmacology  
2 at SUNY at Buffalo, where I received my Ph.D in 1992.
- 3 4. I received my internal medicine residency training at Duke University Medical Center,  
4 Durham, NC from 1993-1996; I have been practicing internal medicine continuously since  
5 then.
- 6 5. I recognize that submitting this declaration will likely result in significant professional  
7 consequences for me.
- 8 6. I have reviewed the arguments for vaccine mandates made by Dr. Lindquist.
- 9 7. While Dr. Lindquist listed voluminous historical facts and scientific findings, he also  
10 omitted some very important ones which I would like to introduce, because these findings,  
11 and the logical conclusions thereafter, would argue against Dr. Lindquist's position that  
12 vaccination should be mandated.
- 13 8. The vaccine, while in the initial studies submitted by manufacturers based on three months  
14 observation, appeared to be very effective against infection, in real world data it has proven  
15 very ineffective against infection, particularly the Delta variant.
- 16 9. The most up-to-date and extensive data from England, a country with much higher  
17 vaccination rate, showed that infection by the delta variant, the prominent strain currently  
18 causing outbreak in the US, occur just as much among fully vaccinated as the unvaccinated.<sup>1</sup>  
19
- 20 10. The England reports gives a breakdown of confirmed cases vs vaccination status. Age  
21 stratified at page thirteen.  
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25 <sup>1</sup>[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1023849/Vaccine\\_surveillance\\_report\\_-\\_week\\_40.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1023849/Vaccine_surveillance_report_-_week_40.pdf)

**Table 2. COVID-19 cases by vaccination status between week 36 and week 39 2021**

Cases reported by specimen date between week 36 and week 39 2021	Total	Unlinked*	Not vaccinated	Received one dose (1-20 days before specimen date)	Received one dose, ≥21 days before specimen date	Second dose ≥14 days before specimen date	Rates among persons vaccinated with 2 doses (per 100,000)	Rates among persons not vaccinated (per 100,000)
Under 18	305,428	20,967	272,981	4,973	5,898	609	278.8	2,325.7
18-29	67,820	8,556	23,440	1,119	12,593	22,112	409.6	688.1
30-39	81,532	7,534	21,449	690	7,468	44,391	763.6	738.4
40-49	101,094	6,839	11,662	297	3,653	78,643	1,281.8	690.2
50-59	70,731	4,668	5,144	89	1,464	59,366	839.5	502.5
60-69	36,953	2,585	1,798	26	546	31,998	563.1	332.9
70-79	22,142	1,367	693	6	207	19,869	428.9	281.4
80+	10,581	869	403	4	199	9,106	354.4	319.5

\*individuals whose NHS numbers were unavailable to link to the NIMS

\*\* Interpretation of the case rates in vaccinated and unvaccinated population is particularly susceptible to changes in denominators and should be interpreted with extra caution.

11. From the table above, one can see the vaccinated people in the age groups which would have been affected by Governor Inslee’s mandate did not have lower infection rate.
12. Other nations that are highly vaccinated, including Israel<sup>2</sup> and Singapore,<sup>3</sup> also saw spikes of cases after achieving vaccination rate as high as 80%.
13. Dr. Fauci and CDC Director Dr. Walensky both have stated publicly, after seeing outbreaks in the US with high number of cases of fully vaccinated patients, that the vaccinated and the unvaccinated harbor as high a viral load in the pharynx as the unvaccinated

<sup>2</sup> <https://www.science.org/content/article/grim-warning-israel-vaccination-blunts-does-not-defeat-delt>

<sup>3</sup> <https://www.msn.com/en-us/money/other/highly-vaccinated-singapore-sees-rising-covid-cases/ar-AAP9u4X>

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- 14. The breakthrough infection case number quoted by Dr. Lindquist most likely underestimates the current infection risk of the vaccinated. I offer the following explanations.
- 15. The current policies and rules used by many employers, that when an exposure to known case is reported, an unvaccinated person is required to be tested, while the vaccinated is not.
- 16. This policy leads to less testing of the vaccinated, and therefore, underestimation of the true rate of “breakthrough infection.”
- 17. I personally observed this with my patients.
- 18. In my panel of about 1,000 patients, of whom I would assume at least 50% are vaccinated (using the Benton County average), I can count more than 10 cases of Covid infections among the fully vaccinated, including at least two cases requiring hospitalization, and one death of a 72-year-old who had been in reasonably good health prior to the Covid infection.
- 19. In addition, the data from Israel and England both showed that the portion vaccinated patients who developed severe disease appear to be increasing as time goes on, suggesting waning of immunity over time after the vaccination.
- 20. We see the same thing from hospitalization data even in our state, for the 65+ age group who were the first to receive the vaccination.
- 21. I am also seeing the same trend among my patients.
- 22. All the above findings clearly, irrefutably, demonstrate that vaccination does not prevent infection.

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23. Therefore, being unvaccinated does not pose a greater threat to others in terms of Covid transmission than being vaccinated.

24. This would remove the argument to vaccinate as a means to protect others from getting infected.

25. I do appreciate that protection against severe disease leading to hospitalization as the data provided showed. However, there are some counterpoints to consider here.

26. Using “hypothetical” situation of what it would be like if none had been vaccinated to address the current reality when more than 50% had been vaccinated is a fallacy.

27. When we make decision on using medical resources for an individual, it should be based on situation facing the individual as is at that time, not the hypothetical situation if all the population had behaved that way.

28. There is a long list of conditions where we can make the argument that our medical system would have bankrupted if the whole population were to have behaved the same way, but our respect for individual’s right keeps us from doing that. We shouldn’t start using that logically false argument here.

29. While there is a significant reduction in the relative risk of hospitalization in the 12-34 age group, the actual, or absolute risk of hospitalization without vaccination was 20 per 100,000.

30. If the premise is to reduce the crunch on hospital resource, would the change have substantially altered the crunch in hospital? The most important group to reduce the risk of, is the 65 and over. But for majority of the people affected by the mandate, those who are employed, fall outside of this risk group.

31. Dr. Lindquist opined that people who would rather contract COVID-19 to get “natural immunity” are gambling their lives. I would suggest that the much greater sin is to gamble

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other people’s lives by coercing them to receive a vaccine which is far from being risk-free. In fact, there has been staggering number of deaths and severe adverse event related to the Covid vaccine reported. The WHO VigiAccess system registered over two million reports of adverse reaction worldwide for Covid-19 vaccine. Consistent with such report, I have personally treated more than ten patients with severe adverse reactions from the vaccination and detailed information available upon request.

32. Even more alarming, The VAERS database, intended to function as an “early warning” system for potential health risks caused by vaccines, is broadcasting a red alert. In ten years prior to COVID (2009-2019) there were 1,529 vaccine deaths, whereas as of October 4, there have been 17,358 deaths reported for 2021. Of these, 99% are caused by the COVID-19 Vaccines and only 1% being by the numerous other vaccines combined. Furthermore, this report is very likely an underestimate of the actual occurrence of adverse reaction and death related to the vaccine. A2011 report by Harvard Pilgrim Healthcare for DHHS estimated that VAERS only captures 1% to at best 10% of all vaccine adverse events, and such low report rate is understandable as the laborious and time-consuming process to finish a report tends to deter reporting by busy clinician who alone would have know the detail information to file it.( 3Harvard Pilgrim Health Care, Inc., Electronic System for Public Health Vaccine Adverse Event Reporting System AHRQ 2011).

33. If VAERS only reports 1% of adverse events then potentially 1,631,000 deaths have occurred. If VAERS reports 10% of cases then there may have been 1,467,900 deaths due to the vaccine. In comparison, the number of deaths attributed to COVID-19 infection as of October 4, 2021 is 733,057. It is possible the vaccine may actually kill more people than those whom have succumbed to COVID-19 infection. In this case, the cure may be worse

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than the disease. As of October 4, 2021 there have been 778,685 adverse events reported in VAERS that translates to as many as 77,868,685 potentially dangerous reactions to the COVID -19 vaccines.

34. To illustrate a deficiency in VAERS, the occurrence of anaphylaxis, for example, is grossly underreported. Anaphylaxis is a life-threatening allergic reaction to a triggering antigen. Anaphylaxis can be caused by a medication, insect sting, chemical, vaccine or other trigger. The CDC has stated that “Anaphylaxis after COVID-19 vaccination is rare and occurred in approximately 2 to 5 people per million vaccinated in the United States based on events reported to VAERS (<https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html>). However, a recent study by Mass General Brigham found severe reactions consistent with anaphylaxis occurred at a rate of 2.47 per 10,000 vaccinations. (<https://jamanetwork.com/journals/jama/fullarticle/2777417>) . This is 50 to 120 times more cases than reported by VAERS and the CDC, meaning that only between 0.8% and 2% of all anaphylaxis cases are being reported to VAERS.

35. The real misinformation is the effort by many who try to brush away questions brought on by the above statistics, obscure the true risk of the vaccination in order to coerce people to accept the vaccination. If people decide to take a risk on a higher likelihood of having more severe infection in rejection of vaccine riddled with many potential side effects including death, they are doing so in a way consistent with any other medical procedures patients opt to accept or decline, open heart surgery for coronary disease, liver transplant for liver cancer, gastric bypass for obesity, etc, etc. But if the government decides for a citizen, who is of sound mind, that he/she should accept the government prescribed medical intervention

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or lose livelihood, that is tyrannical and will be the precedent to destroy all long-standing medical ethics.

36. In regard to the people with naturally acquired immunity after recovering from previous infection, there are overwhelming data showing naturally acquired immunity is superior to the vaccine immunity.

37. The Israeli study, using real world data from a registry of 2.5 million people (1/4 of the Israeli population) showed that naturally acquired immunity from previous infection afford at least 6 folds greater protection than the vaccine.<sup>4</sup>

38. Serial monitoring of specific immunity against COVID after infection showed broad and durable immunity involving B cell and T cell.<sup>5</sup>

39. Professor Marty Makary summed it up very well in his op-ed published last month in the Washington Post – unfortunately, many elected leaders and public health officials have held on far too long to the hypothesis that natural immunity offers unreliable protection against covid-19 — a contention that is being rapidly debunked by science.<sup>6</sup>

40. Dr. Lindquist stated on his argument at ¶ 98 that recent CDC study of individuals with previous COVID-19 infections were 2.34 times more likely to get reinfected compared with those who were fully vaccinated.

41. This argument suffers two flaws – 1) the study was a case control study, which is considered less robust when being used as evidence, especially compared to multiple other better designed studies with larger cohorts; 2) it was comparing previously infected patients without additional vaccination to previously infected patients plus subsequent vaccination,

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<sup>4</sup> [medrxiv.org/content/10.1101/2021.08.24.21262415v1.full-text](https://medrxiv.org/content/10.1101/2021.08.24.21262415v1.full-text)

<sup>5</sup> [https://www.cell.com/cell-reports-medicine/fulltext/S2666-3791\(21\)00203-2](https://www.cell.com/cell-reports-medicine/fulltext/S2666-3791(21)00203-2)

<sup>6</sup> <https://www.washingtonpost.com/outlook/2021/09/15/natural-immunity-vaccine-mandate/>

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so the only weak conclusion it could have made would be that additional vaccination could potentially augment the protection from naturally acquired immunity.

42. That study was not a comparison between just being fully vaccinated and just having naturally acquired immunity.

43. If the naturally acquired immunity is already proven better than vaccine produced immunity, as had been shown in above studies, and even the inferior vaccine produced immunity would have already been acceptable to the state, one would logically ask, why should those who have the already superior immunity be required to receive the vaccine in order to be treated equally?

44. Insisting even those who have previously been infected must receive the vaccine has serious consequence, part of it being the erosion of the public’s trust in the “science” which people making public health decisions are based on, and it substantially increases vaccine hesitance.

45. The unreasonably restrictive criteria for medical exception or contraindication – only if patient has highly rare acute allergy to their ingredients.

46. The first code of medical ethic is, “first, do no harm.”

47. When we administer vaccine, we are injecting something into a unique human body different in genetic make-up and past history from anyone else.

48. So, when a person has history of pericarditis or myocarditis, or had blood clot related disorder, we should exercise greater degree of caution prescribing a vaccine which has been associated with these problems.

49. We do that for patients with history of Guillian-Barre Syndrome when it comes to flu shots, even if the previous GBS may be unrelated to flu shot.

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50. The recommendation by the CDC to go ahead with the 2nd dose even after having had pericarditis from 1st dose seems to be substantially deviating from the “first, do no harm” principle that has long guided clinicians.

51. The percentage of patients to develop severe disease would be substantially reduced, saving more lives while further decreasing the crunch on health care system, if the effective treatments are implemented early.

52. Outpatient protocols developed by physicians both US and abroad can be used to treat more of the outpatients to prevent progression.<sup>7</sup>

53. Now, with the availability of the monoclonal antibody therapy, the hospital rate has already trended down in some counties and flattened in others.

54. This makes the argument to coerce vaccination of healthy individuals with low risk of severe COVID-19 disease against their objection even more of an overreach.

EXECUTED this 13th day of October 2021 at Richland, WA

\_\_\_\_\_  
Dr. Wei-hsung Lin

<sup>7</sup> <https://covid19criticalcare.com/covid-19-protocols/>