21-2179-cv

United States Court of Appeals

for the

Second Circuit

WE THE PATRIOTS USA, INC., DIANE BONO,
MICHELLE MELENDEZ, MICHELLE SYNAKOWSKI,

Plaintiffs-Appellants,

– v. –

KATHLEEN HOCHUL, HOWARD A. ZUCKER, M.D.,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NEW YORK

BRIEF FOR *AMICUS CURIAE* GREATER NEW YORK HOSPITAL ASSOCIATION IN SUPPORT OF DEFENDANTS-APPELLEES

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RULE 26.1 DISCLOSURE STATEMENT

Amicus is a nonprofit organization that has no parent corporation and that is not owned, in whole or part, by any publicly held corporation.

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INTEREST OF *AMICUS CURIAE*

Greater New York Hospital Association ("GNYHA") submits this brief as *Amicus Curiae* in opposition to Plaintiffs-Appellants' appeal of the denial of injunctive relief against enforcement of New York State Health Regulation § 2.61, which broadly mandates that healthcare workers obtain vaccination against COVID-19.[1]

Amicus represents approximately 150 hospitals and 60 long-term care facilities, most of which are located in New York State. *Amicus*'s members are all non-profit charitable organizations or public institutions that provide primary care and state-of-the-art tertiary services to their communities. *Amicus* assists its members by engaging in policy analysis, education, research, communication services, and advocacy at all levels of government. It also plays a pivotal role in helping its members prepare for and respond to emergencies affecting the healthcare sector, including the COVID-19 pandemic—an unprecedented health crisis for the country.

[1] This brief was authored by *Amicus* along with its counsel. No party's counsel authored this brief in whole or in part. Neither a party nor a party's counsel contributed money related to preparing or submitting this brief. No person other than *Amicus*, its members, and its counsel contributed money related to the preparation or submission of this brief.

Starting in February and early March 2020, *Amicus*'s members helped mount the largest mobilization of healthcare resources in United States history in response to the onset of the pandemic. Since then, its members have cared for and safely discharged over 143,000 COVID-19 inpatients, pioneering innovative techniques along the way that have been replicated across the country. For example, they converted non-patient-care spaces to intensive-care units, created field hospitals, redeployed staff, converted ventilators for use by two patients at a time, fixed oxygen tanks frozen from heavy usage, and acquired and distributed personal protective equipment (PPE) amid a worldwide shortage. At the same time, *Amicus* provided support through logistics, operations, advocacy, and study of the risks its members were facing in treating COVID-19. As a representative of a critical infrastructure sector, *Amicus* also worked closely with New York State in its emergency response to the pandemic by, among other things, providing administrative and logistical support as a vaccination hub for New York City during the initial phase of the State's vaccination roll-out.

Tragically, many of *Amicus*'s member hospitals and facilities endured staggering losses from COVID-19. Over 3,600 healthcare workers in the United

States died from the virus in just the first year, including 450 New Yorkers.[2] During the first wave, healthcare workers were much more likely to contract the virus than the general population[3] and to contract a severe infection than those working in "non-essential" sectors.[4] Rates of infection and death were highest among frontline staff, such as nurses and physicians.[5] As a result of this painful history, *Amicus* and its members have acquired not only extensive insight into the public-health threat caused by COVID-19, but also a profound stake in New York's regulatory efforts to address and ultimately end the pandemic.

In this brief, *Amicus* seeks to assist the Court by analyzing the dangers posed by COVID-19 within the hospital setting and the importance of the vaccine

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[2] *Our Key Findings about US healthcare Worker Deaths in the Pandemic's First Year*, The Guardian (Apr. 8, 2021), https://www.theguardian.com/us-news/ng-interactive/2020/dec/22/lost-on-the-frontline-our-findings-to-date.

[3] Long H. Nguyen *et al.*, *Risk of COVID-19 Among Front-Line Health-Care Workers and the General Community: A Prospective Cohort Study*, 5 Lancet Pub. Health e475, e480 (2020). In New York, for example, infection rates among healthcare workers were fairly "high compared to the community at the epicenter of the pandemic." Usha Venugopal *et al.*, *SARS-CoV-2 Seroprevalence Among Health Care Workers in a New York City Hospital: A Cross-Sectional Analysis During the COVID-19 pandemic*, 102 NCBI, Int'l J. of Infectious Diseases 63, 63 (2020).

[4] Miram Mutambudzi *et al.*, *Occupation and Risk of Severe COVID-19: Prospective Cohort Study of 120 075 UK Biobank Participants*, 78 Occupational & Envt'l Med. 307, 311 (2021).

[5] *Id.*

mandate for reducing those harms. The fate of the mandate will have critical implications for *Amicus*'s mission and the activities of its members, whose personnel remain at significant risk of contracting and spreading COVID-19 and whose ability to care safely for their patients is at issue.

PRELIMINARY STATEMENT

The COVID-19 pandemic has claimed over 700,000 American lives and millions more worldwide. As the early epicenter of the pandemic in the United States, New York State has recorded nearly 2.5 million cases and more than 55,000 deaths. The state's doctors, nurses, and other healthcare professionals have been on the front lines battling the pandemic since its first appearance, placing them at a heightened risk for contracting and transmitting COVID-19—both to the vulnerable patients they serve and to their colleagues. To counteract such transmission, New York enacted emergency regulations mandating COVID-19 vaccinations for a broad swath of healthcare workers in the state.

Pursuant to 10 N.Y.C.R.R. § 2.61, all healthcare workers who, if infected with COVID-19, could potentially expose other workers or patients to the disease, must be fully vaccinated against the virus, with the first dose for current staff received by September 27, 2021. Medical exemptions are permitted in limited cases—as defined by the CDC—where vaccination would be detrimental to an individual's health because of a preexisting condition, but no exemptions are

allowed on religious grounds. Any personnel who are not fully vaccinated and do not have a valid medical exemption or accommodation are subject to termination, irrespective of whether they engage in direct patient care.

The vaccine mandate is an essential measure to address the devastating and ongoing effects of COVID-19 in healthcare facilities and a key tool for bringing this pandemic to an end. Vaccination substantially mitigates the risk of transmission among infected healthcare workers and patients throughout the hospital ecosystem. Vaccination also dramatically reduces infection and death rates among healthcare workers and the community at large. In so doing, it also has the potential to mitigate the severe psychological distress and burnout plaguing personnel on the front lines of the pandemic. And vaccination helps to prevent significant staffing shortages caused by healthcare workers being sidelined by infection and exposure to the virus as well as burnout.

Plaintiffs-Appellants—an advocacy organization and three registered nurses who treat patients at several of *Amicus*'s member hospitals—nonetheless challenge the mandate as unconstitutional because it does not allow for religious exemptions. Among other things, they claim that the mandate does not serve a compelling interest because it allows exemptions on medical grounds. They are wrong. The state has an overwhelming interest in ensuring the greatest possible levels of vaccination among healthcare workers to stop the spread of COVID-19 and ensure

the safety of staff and patients alike. Exemptions on recognized medical grounds are consistent with the State's interest in promoting public health and safety. Allowing for additional, less clearly defined exemptions, on the other hand, risks weakening the effort to defeat COVID-19 in healthcare settings by preserving pathways for transmission.

ARGUMENT

I. NEW YORK HAS A COMPELLING INTEREST IN MANDATING VACCINATIONS FOR HEALTHCARE WORKERS.

Until the development of vaccines, the COVID-19 pandemic placed enormous strain on healthcare facilities, posing considerable challenges for infection prevention and control. Their arrival fundamentally changed the landscape, resulting in a "dramatic[]" reduction in infection and death rates among healthcare workers.[6] Studies show that vaccination reduces the likelihood of symptomatic or asymptomatic COVID-19 infection by up to 90%.[7] It also reduces

[6] Jane Spencer, *Twelve Months of Trauma: More than 3,600 US Health Workers Died in Covid's First Year*, The Guardian (Apr. 8, 2021), https://www.theguardian.com/us-news/2021/apr/08/us-health-workers-deaths-covid-lost-on-the-frontline.

[7] Mark G. Thompson *et al.*, *Interim Estimates of Vaccine Effectiveness of BNT162b2 and mRNA-1273 COVID-19 Vaccines in Preventing SARS-CoV-2 Infection Among Health Care Personnel, First Responders, and Other Essential and Frontline Workers—Eight U.S. Locations, Dec. 2020–Mar. 2021*, 70 Morbidity & Mortality Wkly. Rep. 495, 495 (2021).

the risk of hospitalization from the virus by 90% and death by 91%.[8] And it reduces transmission by individuals who become infected post-vaccination by anywhere from 36% to 65%.[9] In short, vaccination is remarkably effective at mitigating the spread of COVID-19.

To realize these benefits, New York has mandated that healthcare workers in the State receive the vaccine, irrespective of religious objection. The parties disagree about whether the burden on religious exercise imposed by the mandate is subject to rational-basis review or strict scrutiny. Either way, the mandate should pass muster because it serves a compelling interest of the highest order: safeguarding vulnerable populations from a highly contagious and deadly disease.[10] The Supreme Court has long held that the "right to practice religion freely does not include liberty to expose the community . . . to communicable disease." *Prince v. Mass.*, 321 U.S. 158, 166–67 (1944). And it has recognized that the First Amendment's protection of religious liberty does not require

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[8] Heather M. Scobie *et al.*, *Monitoring Incidence of COVID-19 Cases, Hospitalizations, and Deaths, by Vaccination Status—13 U.S. Jurisdictions, Apr. 4–July 17, 2021*, 70 Morbidity & Mortality Wkly. Rep. 1284, 1286 (2021).

[9] David W. Eyre *et al.*, *The Impact of SARS-CoV-2 Vaccination on Alpha & Delta Variant Transmission*, medRxiv (Sept. 29, 2021), https://www.medrxiv.org/content/10.1101/2021.09.28.21264260v1.

[10] Although *Amicus* believes the mandate is narrowly tailored to accomplish that objective, that issue is beyond the scope of this brief.

exemptions from "compulsory vaccination laws." *See Employment Div., Dep't of Human Res. of Ore. v. Smith*, 494 U.S. 872, 889 (1990). Indeed, just last Term it noted that "[s]temming the spread of COVID-19 is unquestionably a compelling interest[.]" *Roman Catholic Diocese of Brooklyn v. Cuomo*, 141 S. Ct. 63, 67 (2020).

A vast array of scientific and epidemiological evidence shows that healthcare workers can play a critical role in alternately promoting or inhibiting nosocomial (*i.e.*, hospital-acquired) transmission of COVID-19. In situations where healthcare workers contract COVID-19, the impact on vulnerable patients, their colleagues, their families, and even themselves can be devastating. Unequivocally, vaccines help mitigate those harms. Accordingly, there is a compelling interest in imposing the widest possible vaccine mandate among healthcare workers.

A. Vaccination of Healthcare Workers is Key to Mitigating the Spread of COVID-19 within Hospitals and Other Healthcare Settings.

Various factors contribute to the rate of COVID-19 transmission in hospitals, including overall hospital population density, the numbers of vulnerable patients, and the concentration of infectious sources.[11] Asymptomatic spread and

[11] Qui Du *et al.*, *Nosocomial Infection of COVID-19: A New Challenge for Healthcare Professionals (Review)*, NCBI, Int'l J. of Molecular Med., Feb. 1, 2021, at 1, 7.

large-scale events (where one person or a small number of people infects a larger group) compound the risk of infection.[12] Because of their exposure both to infected patients and to community spread outside hospital settings, healthcare workers contracting COVID-19 have the potential to contribute to nosocomial spread of the virus.

1. Risk to Patients

One vector of infection within a hospital is transmission of the virus from healthcare workers to the patients they treat.[13] While the precise rate of staff-to-patient transmission is rather amorphous,[14] transmission is possible even when healthcare workers use appropriate PPE.[15]

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[12] *Id.*

[13] *See, e.g.*, Rachel M. Wake *et al.*, *Reducing Nosocomial Transmission of COVID-19: Implementation of a COVID-19 Triage System*, 5 Clinical Med. e141, e143–44 (2020); S. Paltansing, *et al.*, *Transmission of SARS-CoV-2 Among Healthcare Workers and Patients in a Teaching Hospital in the Netherlands Confirmed by Whole-Genome Sequencing*, 110 J. of Hosp. Infection 178, 181–82 (2021).

[14] While studies have estimated that nosocomial transmission accounts for 12 to 15% of patient infections, they generally fail to disaggregate the sources of such transmission. *See* Rosario Barranco *et al.*, *Hospital-Acquired SARS-Cov-2 Infections in Patients: Inevitable Conditions or Medical Malpractice?*, Int'l J. of Env't Rsch. & Pub. Health, Jan. 9, 2021, at 1, 5.

[15] *Rapid review: Risk of COVID-19 Transmission or Outbreaks Impacting Patients or Residents in Health Care Facilities*, Pub. Health Ontario (Dec. 18, 2020), https://www.publichealthontario.ca/-/media/documents/ncov/main/2020/12/covid-19-rapid-review-risk-of-transmission-or-outbreaks.pdf?la=en.

Patients in hospital settings are frequently elderly, frail, or beset with other health issues,[16] making them especially vulnerable to infection.[17] Many patients are also at heightened risk of infection because they are unvaccinated—whether by choice or because of a medical condition, or because they are immunocompromised such that vaccination might prove ineffective.[18]

2. Risk to Other Healthcare Workers

Another vector is transmission from healthcare workers to their colleagues. Modelling suggests most infections in healthcare workers may result from nosocomial transmission, with staff-to-staff transmission accounting for about one third of those infections.[19] Many cases originate with infected patients.[20] Staff

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[16] Barranco, *supra* note 13 at 5.

[17] Lucy Rivett *et al.*, *Screening of Healthcare Workers for SARS-CoV-2 Highlights the Role of Asymptomatic Carriage in COVID-19 Transmission*, eLife (May 11, 2020), https://elifesciences.org/articles/58728.

[18] *See* Michael Klompas *et al.*, *The Case for Mandating COVID-19 Vaccines for Health Care Workers*, Annals of Internal Med. (Jul. 13, 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8279142/.

[19] *See* Stephanie Evans *et al.*, *The impact of testing and infection prevention and control strategies on within-hospital transmission dynamics of COVID-19 in English hospitals*, Phil. Trans. of Royal Soc'y B, May 31, 2021, at 1, 1, 4.

[20] Mohamed Abbas *et al.*, *Nosocomial Transmission and Outbreaks of Coronavirus Disease 2019: The Need to Protect Both Patients and Healthcare Workers*, Antimicrobial Resistance & Infection Control, Jan. 6, 2021, at 1, 11.

who contract the virus in their community may also bring it into the facility.[21] Transmission among hospital staff may occur outside patient-care settings, such as in nursing stations and break rooms.[22] Despite compliance with safety measures, transmission may occur not only among frontline workers[23] but also between those workers and the administrative and other staff with whom they regularly interact.[24] Hospitals are not "compartmentalized" systems—quite the opposite—and thus there is no bright line between frontline workers and all other staff. Physicians and nurses regularly interact with registrars in an emergency department; surgeons interface with environmental staff who clean operating rooms; even purely administrative staff such as lawyers and finance professionals meet with caregivers

[21] *See id.* In one study, staff-to-staff transmission resulted in multiple outbreaks in a university's departments of nephrology and dialysis, anesthesiology, surgical pediatrics, and neurology. *See* Sandra Schneider *et al.*, *SARS-Coronavirus-2 Cases in Healthcare Workers May Not Regularly Originate From Patient Care: Lessons From a University Hospital on the Underestimated Risk of Healthcare Worker to Healthcare Worker Transmission*, Antimicrobial Resistance & Infection Control., Dec. 7, 2020, at 1, 3.

[22] Trina F. Zabarsky *et al.*, *What Are the Sources of Exposure in Healthcare Personnel With Coronavirus Disease 2019 Infection?*, 49 Am. J. of Infection and Control 3, 392–95 (2021).

[23] *See id.*

[24] Li-Sha Luo *et al.*, *COVID-19: Presumed Infection Routes and Psychological Impact on Staff in Administrative and Logistics Departments in a Designated Hospital in Wuhan, China*, Frontiers in Psych., Jun. 12, 2020, at 1.

for numerous reasons critical to the functioning of a hospital, health system, or other healthcare facility.

The potential harm to infected staff resulting from nosocomial transmission extends beyond their own health. Because they are not hospital-bound, infected healthcare workers may bring the infection home to their families and further the spread in their communities.[25]

3. Factors Complicating Containment Efforts

Transmission within hospital settings cannot be solved merely by quarantining patients or healthcare workers with COVID-19 symptoms because of the possibility of pre-symptomatic and asymptomatic spread.[26] The propensity of COVID-19 to spread rapidly among unvaccinated or vulnerable populations also heightens the risk[27] by creating a situation where a small percentage of infected individuals have the potential to infect large numbers of people. While vaccinated individuals may still pass along the virus, the risk is substantially reduced—

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[25] Katie Marquedant, *Study Reveals the Risk of COVID-19 Infection Among Health Care Workers*, Mass. Gen. Hosp. (May 5, 2020), https://www.massgeneral.org/news/coronavirus/study-reveals-risk-of-covid-19-infection-among-health-care-workers.

[26] *See* Michael A. Johansson *et al.*, *SARS-CoV-2 Transmission From People Without COVID-19 Symptoms*, JAMA Network Open (Jan. 7, 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774707.

[27] Du, *supra* note 10 at 2.

approximately one-third to two-thirds less.[28] This is so even for the Delta variant, which is more contagious and sometimes causes breakthrough infections.

Contrary to Plaintiffs-Appellants, so-called "herd immunity" does not obviate the need for a broad vaccine mandate for healthcare workers. To begin with, the concept of herd immunity is meaningful only within a large community, not within smaller units such individual workplaces or hospitals that are not closed off to the broader community.[29] Hospitals and other facilities are public accommodations, open to patients and visitors from the community, with care delivered by teams of professionals and other staff who interact constantly with each other and with their own communities—their families, friends, and other outside parties. Even in the context of the broader community, herd immunity is a controversial topic still under study. Moreover, far too many unknowns continue to exist—chiefly, the impact of future variants that may behave differently among the population—to rest on the laurels of the current vaccination rate. A broad vaccine mandate applied continuously through the ups and downs of the pandemic is necessary to protect and preserve the healthcare sector, which in turn is critical to protect and preserve public health.

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[28] Eyre, *supra* note 9.

[29] Carrie Macmillan, *Herd Immunity: Will We Ever Get There?*, Yale Med. (May 21, 2021), https://www.yalemedicine.org/news/herd-immunity.

Plaintiffs-Appellants are also misguided in arguing that measures short of vaccination would be sufficient to protect this critical sector and the vulnerable people it serves. They argue that those with religious objections could be redeployed to working only with low-risk populations or be required to undergo frequent testing. But both of those measures are challenging to implement. "Low risk" is not easily defined or detected, nor is a patient's condition static—especially in an inpatient environment. It is also operationally challenging to move staff into different roles, especially where doing so requires moving incumbent workers who serve the same populations. While New York's healthcare workforce was in fact redeployed in unprecedented ways during the height of the first surge in spring 2020, there are limits to such maneuvers. Healthcare workers are not easily interchangeable, and patients are not easily categorized by risk profile. And as we have learned with testing mandates, frequent (for example, weekly) testing is costly, cumbersome to implement and enforce, and, worst of all, not foolproof. These measures may be useful as adjuncts to vaccination, but they are not ideal substitutes.

B. Vaccination of Healthcare Workers Can Mitigate Other Significant Impacts of the COVID-19 Crisis.

1. Deferred Care

The potential for transmission of COVID-19 in healthcare settings has ancillary effects on patient health, deterring individuals with serious ailments from

even seeking urgent medical care for fear of contracting COVID-19 from healthcare workers.[30] That was particularly true at the height of the pandemic when as many as 41% of American adults may have delayed or avoided routine and urgent care,[31] though the deterrent phenomenon has persisted with the emergence of newer, deadlier strains of the virus. The consequences of that deterrence are sobering. Studies have found increases in deaths from myocardial infarctions, cerebrovascular accidents, and other acute conditions as a result of patients delaying and deferring care.[32] Patients have also avoided ambulatory follow-up for chronic conditions and cancer screenings, potentially leading to more than 10,000 excess deaths in the United States from breast and colorectal cancer alone.[33]

While improved safety practices in healthcare settings have reduced the actual risk of contracting COVID-19 in healthcare settings, residual concerns and

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[30] Meghan A. Baker *et al.*, *Low Risk of Coronavirus Disease 2019 (COVID-19) Among Patients Exposed to Infected Healthcare Workers*, 73 Clinical Infectious Diseases e1878, e1878 (2021).

[31] *Study: 4 in 10 U.S. Adults Deferred Medical Care Due to COVID-19 Worries*, American Hospital Association (Sept. 11, 2020), https://www.aha.org/news/headline/2020-09-11-study-4-10-us-adults-deferred-medical-care-due-covid-19-worries.

[32] *See* Baker, *supra* note 29 at e1878.

[33] *See id.*

perceptions about that risk continue to deter patients from seeking out necessary care. Widely vaccinating healthcare workers would help to instill confidence in patients that they are safe seeking the medical care that they need.

2. Mental Health of Healthcare Workers

In addition to claiming the lives of many healthcare workers, the pandemic has exacted a significant toll on healthcare workers' mental health. More than half of all healthcare workers report fear of exposure to or transmission of the virus, while 38% suffer anxiety and depression.[34] Another 43% report work overload and 49% experience burnout.[35] Various factors contribute to this "parallel pandemic," such as psychological trauma in overworked physicians forced to ration care, a crushing sense of guilt in personnel who unwittingly infect patients or family members, and lingering fatigue in staff who survive COVID-19 infections.[36] Among New York healthcare workers, the most common sources of acute distress include a perceived lack of control, treatment of other healthcare workers for

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[34] Kriti Prasad *et al.*, *Prevalence and Correlates of Stress and Burnout among U.S. Healthcare Workers During the COVID-19 Pandemic: A National Cross-Sectional Survey Study*, EclinicalMedicine, May 16, 2021, at 1, 1.

[35] *Id.*

[36] Andrew Jacobs, *A Parallel Pandemic Hits Health Care Workers: Trauma and Exhaustion*, N.Y. Times (Feb. 8, 2021), https://www.nytimes.com/2021/02/04/health/health-care-workers-burned-out-quitting.html.

COVID-19, and uncertainty about colleagues' infection status.[37] The cumulative toll of these stressors has been unbearable for many New York healthcare workers, some of whom have taken their own lives.[38]

These phenomena underscore the urgent need for the largest possible number of healthcare workers to be vaccinated against COVID-19. Indeed, not only are unvaccinated healthcare workers at heightened risk of becoming infected and transmitting infection to others, but they may further the collective distress of the healthcare workforce. Contrary to Plaintiffs-Appellees' assertions, vaccination affects not only the individual who is vaccinated, especially in the healthcare context. Indeed, the mere anticipation of vaccination has provided some reprieve from psychological distress,[39] which signals the importance of vaccination in combating the pandemic's many fronts.

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[37] Ari Schechter *et al.*, *Psychological Distress, Coping Behaviors, and Preferences for Support among New York Healthcare Workers During the COVID-19 Pandemic*, 66 Gen. Hosp. Psychiatry 1, 3 (2020).

[38] *See, e.g.*, Wendy Dean, *Suicides of Two Health Care Workers Hint at the Covid-19 Mental Health Crisis to Come*, STAT News (Apr. 30, 2020), https://www.statnews.com/2020/04/30/suicides-two-health-care-workers-hint-at-covid-19-mental-health-crisis-to-come/.

[39] Karin Brulliard, *After Months of Trauma, Vaccinated Health-Care Workers Welcome a Surprising Emotion: Hope*, Wash. Post (Jan. 18, 2021), https://wapo.st/308yglE.

3. Workforce Continuity

Even before the pandemic, the healthcare labor market faced serious challenges, with the demand for personnel outpacing supply in some areas.[40] Almost a third of nurses who left their jobs in 2018 did so because of burnout, while another 43.4% identified burnout as a factor that might drive them to quit.[41] As a result of this trend, the World Health Organization predicted a global shortfall of more than 10 million nurses by 2030.[42]

COVID-19 has exacerbated these problems. At different times during the pandemic, surging cases outstripped hospital capacity, causing staffing shortages in

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[40] *Major US Healthcare Labor Shortages Projected in Every State by 2026, Mental Health Professionals Grow in High Demand, Mercer Report Shows*, Mercer (Sept. 28, 2021), https://www.mercer.com/newsroom/us-projected-to-have-major-healthcare-labor-shortages-in-every-state-mental-health-professionals-grow-in-high-demand.html.

[41] Megha K. Shah *et al.*, *Prevalence of and Factors Associated With Nurse Burnout in the US*, JAMA Network Open (Feb. 4, 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775923.

[42] Lauren Beechly, *Building Resilience and Well-Being: Keys to Avoiding the Worst of a Looming Shortage of Health Care Workers*, STAT News (Sept. 27, 2021), https://www.statnews.com/2021/09/27/building-resilience-and-well-being-keys-to-avoiding-the-worst-of-a-looming-shortage-of-health-care-workers/.

New York[43] and across the country.[44] Increasing rates of infection among healthcare workers compounded the problem, as nurses and doctors became sick or had to quarantine after being exposed to COVID-19 cases.[45] Some healthcare workers resigned from their jobs as a result of burnout or trauma from watching so many patients die—also amid a resurgence of cases driven by the Delta variant of the virus.[46] The combination of these forces put extraordinary strain on the industry, causing personnel to burn out and retire at a rate faster than expected and increasing demand for healthcare workers around the country.[47]

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[43] Bernadette Hogan & Kate Sheehy, *Gov. Cuomo: NY Hospitals Close to Staffing Shortages as COVID-19 Cases Surge*, N.Y. Post (Nov. 30, 2020), https://nypost.com/2020/11/30/gov-cuomo-ny-hospitals-close-to-capacity-as-covid-19-cases-surge/.

[44] Sean McMinn & Selena Simmons-Duffin, *1,000 U.S. Hospitals Are "Critically" Short on Staff—And More Expect To Be Soon*, NPR (Nov. 20, 2020), https://www.npr.org/sections/health-shots/2020/11/20/937152062/1-000-u-s-hospitals-are-short-on-staff-and-more-expect-to-be-soon.

[45] Olivia Goldhill, *"People are Going to Die": Hospitals in Half the States are Facing a Massive Staffing Shortage as Covid-19 Surges*, STAT News (Nov. 19, 2020), https://www.statnews.com/2020/11/19/covid19-hospitals-in-half-the-states-facing-massive-staffing-shortage/.

[46] Bridget Balch, *"Worst Surge We've Seen": Some Hospitals in Delta Hot Spots Close to Breaking Point*, AAMC (Aug. 24, 2021), https://www.aamc.org/news-insights/worst-surge-we-ve-seen-some-hospitals-delta-hot-spots-close-breaking-point.

[47] *See id.*

New York took a variety of actions to address the pandemic's impact on staffing. For example, during its declared emergency, the State allowed retired and out-of-state healthcare workers to assist in battling surging cases in the state.[48] And it permitted hospitals to obtain waivers allowing staff exposed to COVID-19 to return from mandatory quarantines when necessary to address shortages threatening the provision of essential medical services.[49] While these solutions provided some relief, they should be last resorts. They did not remove the risk of healthcare workers contracting the virus—triggering further rounds of isolations.

The only way out of this vicious cycle is a broad vaccination mandate. Mandatory vaccination lessens the need for medical leave to be taken by exposed or infected healthcare workers; diminishes the trauma and resulting burnout associated with caring for seriously ill patients and colleagues; and reduces the numbers of COVID-19 patients to be cared for in the first place. Thus, even if imposition of the mandate causes a portion of the workforce to be separated from

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[48] Alyssa Paolicelli, *Retired Healthcare Workers Join The Front Line To Help Battle Coronavirus*, NY1, Spectrum News (Apr. 5, 2020), https://www.ny1.com/nyc/all-boroughs/news/2020/04/05/retired-healthcare-workers-join-the-front-line-to-help-battle-coronavirus.

[49] *UPDATE to Interim Health Advisory: Revised Protocols for Personnel in Healthcare and Other Direct Care Settings to Return to Work Following COVID-19 Exposure—Including Quarantine and Furlough Requirements for Different Healthcare Settings*, N.Y. Dep't of Health (Apr. 1, 2021), https://www.gnyha.org/wp-content/uploads/2021/05/4-1-2021-return-to-work-HOSP-AND-NH.pdf.

employment under certain circumstances, it will yield benefits in the form of mitigating the COVID-19-related effects on staffing and, most importantly, maximizing the opportunity for a healthy and stable workforce.

II. THE MANDATE IS WORKING.

Since COVID-19 vaccines became available in December 2020, New York has made it a priority to vaccinate healthcare workers. Indeed, the first person in the country to receive a COVID-19 vaccination was a registered nurse. Within a month of the vaccine's rollout, however, approximately 30% of eligible healthcare workers had already declined to take it—including a substantial number of frontline personnel.[50] A similar number continued to hold out through June 2021.[51]

The recent announcement of the vaccine mandate abruptly overcame such resistance, especially among the roughly 450,000 hospital workers in New York. Former New York Governor Andrew Cuomo announced the mandate on August 16, 2021, when just 75% of hospital workers were fully vaccinated.[52] Vaccination

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[50] Nolan Hicks, *Around 30% of Eligible NY Medical Workers Refusing COVID-19 Vaccine: Official*, N.Y. Post (Jan. 5, 2021), https://nypost.com/2021/01/05/around-30-of-ny-medical-workers-refusing-covid-19-vaccine-official/.

[51] Carl Campanile & Bernadette Hogan, *State Data Shows One-Third of NY Hospital Workers are Unvaccinated*, N.Y. Post (Jul. 18, 2021) https://nypost.com/2021/07/18/one-third-of-ny-hospital-workers-are-unvaccinated-data-shows/.

[52] Jonathan Allen, *New York Orders All Healthcare Workers to Get COVID-19 Vaccine*, Reuters, Aug. 16, 2021, https://reut.rs/2YzOQdq.

among hospital workers ticked up to 76% the next day, then increased to 87% by September 28—the day after the first-dose requirement took effect.[53] That 11% increase is more than twice the rate at which adults in the state became vaccinated over the same period.[54] Vaccination rates have since continued to increase at hospitals around the state.[55]

While these data are encouraging, further vaccinations are necessary to stop the spread of COVID-19 and the development of new, more virulent strains.[56] As with other highly contagious diseases, vaccination acts as a barrier against COVID-19, breaking the potential chain of transmission to vulnerable populations. A substantial and continuous rate of immunity among healthcare workers is necessary to bring the virus to a halt within healthcare settings and beyond.

Respect for individual religious convictions is indeed a cornerstone of our democracy. But the need for a vaccine mandate to protect patients and healthcare

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[53] Max Rust *et al.*, *Covid-19 Vaccinations in New York Accelerated Ahead of Healthcare Worker Mandates*, Wall St. J. (Oct. 2, 2021), https://on.wsj.com/3FvORA0.

[54] *See id.*

[55] Hospital Worker Vaccinations, https://on.ny.gov/3Duaijb (last visited Oct. 13, 2021).

[56] The alpha and delta variants, for example, demonstrate that the virus is already evolving to spread more efficiently through the air. Apoorva Mandavilli, *Is the Coronavirus Getting Better at Airborne Transmission?*, N.Y. Times (Oct. 1, 2021), https://www.nytimes.com/2021/10/01/health/coronavirus-aerosols-airborne.html.

workers in hospitals is compelling. New York's vaccine mandate for healthcare workers should be as broad as legally permissible to finally bring this pandemic to a close.

CONCLUSION

For the foregoing reasons, this Court should reject Plaintiffs-Appellants' request to enjoin the enforcement of 10 N.Y.C.R.R. § 2.61.

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Respectfully submitted,

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