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November 12, 2021

Our File No. 99000

Via email [scott.mcleod@cpsa.ab.ca](mailto:scott.mcleod@cpsa.ab.ca)

Dr. Scott McLeod, Registrar  
College of Physicians and Surgeons  
2700, 10020 – 100 Street NW  
Edmonton, AB T5J 0N3

Dear Dr. McLeod:

**Re: COVID-19 Medical Exemption Inquiry**

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We have been contacted by a physician who wishes to remain anonymous given that this physician has become aware of the recent abusive practice of the College of Physicians and Surgeons (CPSA) sending agents to raid doctors' offices and root through patient files without the consent of patients looking for evidence that doctors may have granted a vaccine exemption.

The citizens of Alberta are rightfully concerned with the CPSA practice in accessing confidential patient records without consent of the patient so that doctors can be bullied and intimidated into not writing medical exemptions for citizens who have legitimate *bona fide* medical exemption requests.

It is a sad day for medicine in Alberta that Physicians must remain anonymous, in order to protect the confidential files of their patients and to be spared bullying and intimidation by the CPSA which has now adopted these deplorable tactics as part of its alleged regulatory mandate.

We attach for your reference the proposed form of medical exemption that the physician intends to write on behalf of one of their patients. The medical exemption letter clearly sets out that the patient suffers extreme anxiety with regard to the abusive COVID-19 vaccine program being presided over by AHS and the Alberta Government in violation of the CPSA Standards of Practice with regard to Informed Consent being required as part of the minimum standard of medical care provided in the Province of Alberta. Our client is also concerned that the current AHS policies supported by the CPSA are a gross violation of AHS' own policy on informed consent which clearly states that consent must be voluntary and not be the subject of "undue influence".

<https://rathcocovidlitigation.com/2021/11/05/ahss-policy-with-respect-to-consent-to-treatment-procedures/>

282050 Highway 22 West  
Foothills, Alberta T0L 1W2  
Phone: (403) 931-4047  
Fax: (403) 931-4048  
Toll-Free Number: 1-866-231-7284  
[www.rathandcompany.com](http://www.rathandcompany.com)

The proposed exemption letter sets out a *bona fide* medical exemption on the basis of lack of informed consent. We request, in writing, prior to close of business today, your approval for the attached form of letter, failing which we will be advising our client, and all other physicians in the Province of Alberta, that the proposed form of letter was forwarded to the CPSA for approval and the CPSA refused to respond in a timely fashion.

On a related note, we again attach for your reference, a highlighted copy of documentation from the Public Health Agency of Canada and the Genome Centre University of California – Davis. We also provide a hyperlink to the Early COVID Care Experts website.

<https://earlycovidcare.org/vaccinestudies/>

These documents and the referenced scientific journal articles all demonstrate that people double-vaccinated for COVID-19 are capable of transmitting COVID-19 at rates equal to or higher than unvaccinated people. As such, the entire vaccine mandate program supported by the CPSA is not *bona fide* from an occupational health and safety perspective. It is clear that the CPSA staff and CPSA Council are engaged in coercive, if not extortionate conduct, contrary to s. 346(1) of the *Criminal Code of Canada*. In the event the CPSA is not prepared to disengage from participation in a conspiracy to assault citizens of the Province of Alberta who do not wish to be vaccinated, every available legal recourse will be pursued.

**Please govern yourself accordingly.**

Yours very truly,

RATH & COMPANY



Jeffrey R. W. Rath, B.A. (Hons.), LL.B. (Hons.)  
Barrister and Solicitor

Attachments

On the \_\_\_\_\_ day of \_\_\_\_\_, 2021, I met with \_\_\_\_\_ in my office with regard to a requested medical exemption from either the Pfizer or Moderna vaccine.

I discussed with my patient in a confidential manner, my patient's anxiety with regard to both the Pfizer and the Moderna vaccinations. My patient has advised me that the patient is aware of media reports of the College of Physicians and Surgeons sending investigators to inappropriately access private patient information. As such, the patient specifically requested that I do not chart the full nature of our discussion with regard to vaccinations nor am I to allow the College of Physicians and Surgeons to access this patient's medical records out of a concern raised by the patient that the College of Physicians and Surgeons' access to patient records violates the *Freedom of Information and Privacy Act*, the *Alberta Human Rights Act*, and will cause my patient even greater levels of anxiety as it pertains to the patient's own personal health. The patient does not consent to providing their contact information.

The patient has consented to my disclosing that the patient has extreme anxiety over both the Pfizer and the Moderna vaccinations, that I have fully advised the patient as to the benefits of the Pfizer and Moderna vaccinations, as well as discussing with the patient, the patient's concerns with regard to all of the potential side effects of the Pfizer and Moderna vaccinations, including myocarditis, pericarditis, Bell's Palsy, and death.

The patient advised me that the patient is aware that the minimum standard of care set by the CPSA for the provision of a medical treatment or procedure in Alberta is "informed consent". The patient is further aware is that the Alberta Health Services Policy for any medical treatment or procedure is that of "informed consent" and that by AHS policy, such "consent" must be "voluntary" and "without undue influence". The patient has advised me that the patient does not consent to the disclosure of their personal medical records to the College of Physicians and Surgeons, AHS, the Government of Alberta, or their employer for the purposes of placing them on a leave of absence without pay or forcing them to take part in a discriminatory testing regime based on "vaccination status". The patient takes the position that threatening someone with a leave of absence without pay or a discriminatory testing regime amounts to undue influence in violation of AHS' own policies on informed consent.

The patient has stated unequivocally that the patient views any injection with the Pfizer or Moderna COVID-19 vaccine as constituting an assault contrary to s. 265(1) and 265(3) of the *Criminal Code of Canada* under extortionate circumstances contrary to s. 346(1) of the *Criminal Code of Canada*.

Given the above, I hereby grant a medical exemption from the Pfizer and Moderna vaccinations to \_\_\_\_\_ on the basis of the medical reason of the patient's anxiety in and around the vaccinations' potential side effects, as well as the patient's unwillingness to accept medical treatment below the minimum accepted standard of care for the practice of medicine in the Province of Alberta which requires their consent which they do not provide.

This exemption is valid for 12 months from the date of this document to the \_\_\_\_\_ day of \_\_\_\_\_, 2022.

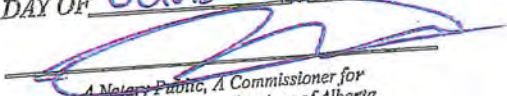
Signed: Dr. Caring Physician, MD  
Physician ID# \_\_\_\_\_  
Physician Contact Information \_\_\_\_\_

# Coronavirus disease (COVID-19)



## Testing for COVID-19 in vaccinated populations

THIS IS EXHIBIT "E" REFERRED  
TO IN THE AFFIDAVIT OF  
Dr Eric Payne  
SWORN BEFORE ME THIS 25  
DAY OF October 2021

  
A Notary Public, A Commissioner for  
Oaths in and for the Province of Alberta

JEFFREY R.W. RATH  
Barrister & Solicitor  
My Commission Expires at the  
pleasure of the Attorney General

## Current state of COVID-19 testing

### Role of government

The government plays an important role in the health and well-being of Canadians. Health care in Canada is an area of shared responsibility between federal and provincial/territorial governments. The provinces and territories are mainly responsible for health care delivery. The federal government plays a role in a number of areas, including:

- safeguarding the Canada Health Act
- coordinating responses to national emergencies
- managing health care delivery for certain populations
- providing financial support and expertise to provinces and territories
- publishing ethical and technical guidance on COVID-19 for various audiences
- regulating market access in Canada for drugs, medical devices and controlled substances
- communicating health information to people in Canada in a timely, accurate and accessible fashion

### COVID-19 trends and vaccination

Rates of COVID-19 in Canada have been declining [since the middle of April 2021](#) and rates of vaccination are increasing. As of July 30, 2021, [over 80%](#) of eligible Canadians have received at least 1 vaccine dose and 56% have been fully vaccinated.

As vaccination rates increase, the rate of transmission and incidence of COVID-19, as well as severe outcomes among infected vaccinated people, may decrease. (See [eLife](#) and [Baillly and others](#).)

Nevertheless, COVID-19 infections and severe disease continue to occur [mainly among unvaccinated](#) people, including those who may face health, social and economic barriers. In June 2021, Yukon saw widespread community transmission for the first time, when about 75% of Yukon adults were fully vaccinated. However, 85% of the cases were in people who were not vaccinated.

Israel and the United Kingdom may also provide insight on expected COVID-19 trends in a vaccinated population. The number of cases [rose](#) in June in both countries despite high rates of vaccination and the presence of new variants. However, the number of hospitalizations [remained relatively low](#) compared to active cases, especially compared with trends earlier in the pandemic. This demonstrates the ability of vaccination to improve outcomes in vaccinated people (for example, reduce hospitalizations and deaths) even if they do become infected.

In response to the changing landscape, the Public Health Agency of Canada [released guidance](#) on June 25. This guidance outlines measures that need to be taken by vaccinated adults.

Some research indicates that vaccinated people who test positive for COVID-19 and do not carry the Delta variant are likely to have low viral loads ([Teran and others](#), [Baillly and others](#)), particularly when symptoms are mild or the person is [asymptomatic](#). There is also evidence that vaccination can greatly reduce rates of SARS-CoV-2 infections with [high viral shedding and symptoms](#).

**Emerging evidence for the Delta variant points to the possibility of high viral loads in some breakthrough cases in fully vaccinated people, which can be as high as in unvaccinated people. Preliminary data from the [United States Centres for Disease Control and Prevention](#) (U.S. CDC) and from [Public Health England](#) indicate that levels of virus in fully vaccinated people who become infected with Delta may be similar to levels found in unvaccinated people, and therefore they may be as likely to transmit the virus.** Based on this evidence, U.S. CDC revised its [masking guidance](#) for vaccinated individuals on July 27 to recommend indoor masking in areas of high or substantial transmission. However, further studies are needed to confirm these levels of infectiousness and also the extent of vaccine effectiveness against Delta, which at present appears to be only slightly less than for other variants, such as Alpha. These new studies highlight the importance of monitoring and responding to the ever-evolving science.

No Significant Difference in Viral Load Between Vaccinated and Unvaccinated, Asymptomatic  
and Symptomatic Groups Infected with SARS-CoV-2 Delta Variant

Charlotte B. Acharya<sup>1</sup>, John Schrom<sup>2</sup>, Anthea M. Mitchell<sup>3</sup>, David A. Coil<sup>1</sup>, Carina Marquez<sup>2, 4</sup>,  
Susana Rojas<sup>2</sup>, Chung Yu Wang<sup>3</sup>, Jamin Liu<sup>5</sup>, Genay Pilarowski<sup>2, 6</sup>, Leslie Solis<sup>1</sup>, Elizabeth  
Georgian<sup>1</sup>, Maya Petersen<sup>2, 7</sup>, Joseph DeRisi<sup>3</sup>, Richard Michelmore<sup>1</sup>, Diane Havlir<sup>2, 4</sup>

<sup>1</sup>Genome Center, University of California, Davis, USA

<sup>2</sup>Unidos en Salud, San Francisco, CA, USA

<sup>3</sup>Chan Zuckerberg Biohub, and Dept of Biochemistry & Biophysics, University of California,  
San Francisco, USA

<sup>4</sup>Department of Medicine, Division of HIV, Infectious Disease and Global Medicine, University  
of California, San Francisco, USA

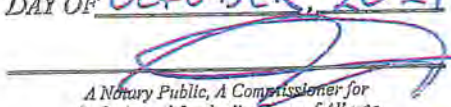
<sup>5</sup>Joint UCB/UCSF Bioengineering Program, University of California, Berkeley and University of  
California, San Francisco, USA

<sup>6</sup>The Public Health Company, Oakland, California, USA

<sup>7</sup>School of Public Health, University of California, Berkeley, USA

**Joint Authors for Correspondence:** Diane Havlir, Richard Michelmore

JEFFREY R. W. RATH  
*Barrister & Solicitor*  
My Commission Expires at the  
pleasure of the Attorney General

THIS IS EXHIBIT "F" REFERRED  
TO IN THE AFFIDAVIT OF  
DR. ERIC PAYNE  
SWORN BEFORE ME THIS 25  
DAY OF October, 2021  
  
A Notary Public, A Commissioner for  
Oaths in and for the Province of Alberta

**Abstract:** We found no significant difference in cycle threshold values between vaccinated and unvaccinated, asymptomatic and symptomatic groups infected with SARS-CoV-2 Delta. Given the substantial proportion of asymptomatic vaccine breakthrough cases with high viral levels, interventions, including masking and testing, should be considered for all in settings with elevated COVID-19 transmission.

## Background

Vaccines reduce infection, severe disease, and death from SARS-CoV-2 (COVID-19) [1], yet breakthrough cases occur [2]. Several reports show no difference in cycle threshold values (Ct-values) between vaccinated and unvaccinated individuals [2, 3, 4]; however, others have suggested that breakthrough infections, particularly among asymptomatic individuals, have a lower viral load and therefore may be less likely to result in transmission [5, 6].

Effective epidemic control requires contemporary data to guide public health mitigation measures. Here, we report on Ct-values among fully vaccinated and unvaccinated individuals, asymptomatic and symptomatic at time of testing, during a period of high transmission of the Delta variant in two distinct populations: a Unidos en Salud (UeS) community-based site in the Mission District of San Francisco and Healthy Yolo Together (HYT) asymptomatic testing through the University of California (UC), Davis.

## Materials and Methods

### Study Populations

Data was collected on individuals who voluntarily sought testing for SARS-CoV-2 from two demographically distinct populations in California during a two-month period from June 17 to August 31, 2021, during which Delta was the predominant variant.

HYT: As part of the response to the COVID-19 pandemic, UC Davis deployed an extensive free asymptomatic testing program that included the City of Davis and Yolo County ([Healthy Yolo Together](#)). Asymptomatic individuals over the age of 2 were eligible for testing. Asymptomatic cases were classified as individuals not reporting symptoms at the time of testing. Samples were collected through a supervised method in which individuals transferred their saliva into a barcoded tube ([COVID-19 Testing | Campus Ready](#)). Smaller numbers of symptomatic



individuals were processed using a different workflow and an antigen test; therefore, they were not included in this study.

UeS: The study population included individuals who sought SARS-CoV-2 testing at the UeS walk-up site, an ongoing academic (UC San Francisco, CZ Biohub, and UC Berkeley), community organization (Latino Task Force), and government (SFDPH) partnership. The outdoor, free BinaxNOW™ testing site was located at a public transport and commercial hub in the Mission District, a setting of ongoing transmission in San Francisco [7]. Individuals one year of age and older, with or without symptoms, were eligible for testing.

### Measurements

Infections were classified as breakthrough infections if the individual was fully vaccinated (two weeks following receipt of all vaccine doses). Individuals that had had only one dose or were tested within two weeks of the second dose, in the case of Pfizer and Moderna vaccines, were not included in the analysis.

HYT: Demographic information was collected from individuals at the time of registration. Vaccination status information was obtained at the time of contact tracing and confirmed in the California Vaccine Registry. Only confirmed, fully vaccinated individuals were used in the analysis; discordant samples, self-reported as vaccinated but unconfirmed, were treated as status unknown. Saliva samples from asymptomatic individuals were tested for the presence of the N1 and N2 regions of the viral nucleocapsid (N) gene using primers and probes described in the CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel, using IntelliQube high-throughput quantitative PCR instruments (LGC Biosearch Technologies). Ct-values were calculated with FastFinder software ([UgenTec | FastFinder](#)).

Genotypes of all N1/N2 positive samples were determined using RT-PCR SNP analysis at 11 loci diagnostic for variants of concern ([SARS-CoV-2 Variant ValuPanel assays | LGC Biosearch Technologies](#)). A subset of samples (39%) were also sequenced using the Illumina MiSeq sequencing platform. Consensus genomes were generated with Viralrecon2 and variants called in Pangolin version 3.1.11 and PLEARN-v1.2.66. Sequencing confirmed the variants called by genotyping.

UeS: Individuals provided demographic data and information on symptoms immediately prior to testing using BinaxNOW™ kits. COVID-19 vaccine status, including date of final shot, was obtained through the California Vaccine Registry. Anterior-nasal swab samples (iClean, Chenyang Global) collected by certified lab assistants from BinaxNOW positive individuals were placed in DNA/RNA Shield (Zymo, Inc.) and processed for qRT-PCR, genome recovery, and variant/lineage determination as previously described [8, 9]. Ct-values for the detection of N and E genes [8] were determined via the single threshold Cq-determination mode using Bio-Rad CFX Maestro v4.1 (Bio-Rad Inc). SARS-CoV-2 genomes were sequenced using the Illumina NovaSeq platform. Consensus genomes were generated via the COVID module of the IDseq pipeline (<https://idseq.net>) as described [9].

### Analysis

Ct-values were plotted, stratified by site; fully vs. not vaccinated; and symptom status. Partially vaccinated samples and stratification by age and vaccine type are reported in supplementary materials. Ct-values between strata were compared using a two sided t-test.

### Ethics Statement

HYT: The Genome Center laboratory that conducted COVID-19 testing was CLIA approved as an extension to the Student Health Center's laboratory. The UC Davis IRB

Administration determined that the study met criteria for public health reporting and was exempt from IRB review and approval.

UeS: The UC San Francisco Committee on Human Research determined the study met criteria for public health surveillance. All participants provided informed consent for testing.

## Results

A total of 869 samples, 500 from HYT and 369 from UeS, were included in the analysis. All analyzed samples from HYT were asymptomatic at the time of collection and 75% of the positive samples were from unvaccinated individuals (N=375). Positive samples from UeS were from both symptomatic (N=237) and asymptomatic individuals (N=132). The frequency of vaccine breakthroughs among the UeS samples (171 fully vaccinated, 198 unvaccinated) was greater than among the HYT samples reflecting the different types of populations sampled. The Delta variant was the predominant variant detected in both populations (Supplementary Table 1).

There were no statistically significant differences in mean Ct-values of vaccinated (UeS: 23.1; HYT: 25.5) vs. unvaccinated (UeS: 23.4; HYT: 25.4) samples. In both vaccinated and unvaccinated, there was great variation among individuals, with Ct-values of <15 to >30 in both UeS and HYT data (Fig. 1A, 1B). Similarly, no statistically significant differences were found in the mean Ct-values of asymptomatic (UeS: 24.3; HYT: 25.4) vs. symptomatic (UeS: 22.7) samples, overall or stratified by vaccine status (Fig. 1B). Similar Ct-values were also found among different age groups, between genders, and vaccine types (Supplemental Figure 1).

In all groups, there were individuals with low Ct-values indicative of high viral loads. A total of 69 fully vaccinated individuals had Ct-values <20. Of these, 24 were asymptomatic at the time of testing.

## Discussion

In our study, mean viral loads as measured by Ct-value were similar for large numbers of asymptomatic and symptomatic individuals infected with SARS-Cov-2 during the Delta surge, regardless of vaccine status, age, or gender. This contrasts with a large ongoing UK community cohort in which the median Ct-value was higher for vaccinated individuals (27.6) than for unvaccinated individuals (23.1) [5]. Also, a study from San Francisco reported that 10 fully vaccinated asymptomatic individuals had significantly lower viral loads than 28 symptomatic, vaccinated individuals [6]. Our study is consistent with other recent reports showing similar viral loads among vaccinated and unvaccinated individuals in settings with transmission of the Delta variant. In a Wisconsin study, Ct-values were similar and culture positivity was not different in a subset of analyses between 11 vaccinated and 24 unvaccinated cases [4]. In both Massachusetts and Singapore, individuals with vaccination breakthroughs caused by the Delta variant had similar Ct-values as unvaccinated individuals [3, 10]. Our findings are supported by consistency across large sample sets using different assays from two distinct locations.

A substantial proportion of asymptomatic, fully vaccinated individuals in our study had low Ct-values, indicative of high viral loads. Given that low Ct-values are indicative of high levels of virus, culture positivity, and increased transmission [11], our detection of low Ct-values in asymptomatic, fully vaccinated individuals is consistent with the potential for transmission from breakthrough infections prior to any emergence of symptoms. Interestingly, the viral loads decreased more rapidly in vaccinated than unvaccinated individuals in Singapore [3], suggesting that vaccinated individuals may remain infectious for shorter periods of time.

Over 20% of positive, vaccinated individuals had low Ct-values (<20), a third of which were asymptomatic when tested. This highlights the need for additional studies of the immunological status of such vaccine escapes and how infectious they are. If such individuals

carry high loads of active virus, asymptomatic vaccinated individuals may increasingly contribute to the ongoing pandemic as the proportion of vaccinated individuals grows.

Ct-values in some children under 12 who are not yet eligible for vaccination were also low. Twenty out of 109 (18.3%) children under 12 years of age had Ct-values <20, of which 14 were asymptomatic at the time of testing. Low Ct indicates that the children had high viral loads and were likely infectious. This emphasizes the value of regular, rapid testing for school children to detect infection early and block chains of transmission in settings where the Delta variant is circulating.

The data gathered in this study during the surge of the Delta variant strongly support the notion that neither vaccine status nor the presence or absence of symptoms should influence the recommendation and implementation of good public health practices, including mask wearing, testing, social distancing, and other measures designed to mitigate the spread of SARS-CoV-2.

**Author Contribution Statement:**

JD, RWM, DH, and MP conceived the project. DC, CM, SR, DH, and GP helped collect the data. CA, AM, CYW, and JL helped perform the tests, genotyping, and sequencing. CA, JH, LS, JD, AM, CYW, JS, and JL prepared the data for publication. RM, EG, DH, MP, DC, JS, and JD contributed to the writing of the manuscript. All authors read and approved the final manuscript.

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**Acknowledgements:** Many people were responsible for collecting the samples, running the tests, performing the genotyping and sequencing, and processing the data as listed in Supplementary Table 2.

**Conflict of Interest:** Dr. DeRisi reports being a scientific advisor to the Public Health Co. and a scientific advisor to Allen & Co. Dr. Havlir reports non-financial support from Abbott outside of the submitted work. The other authors declare no competing interests.

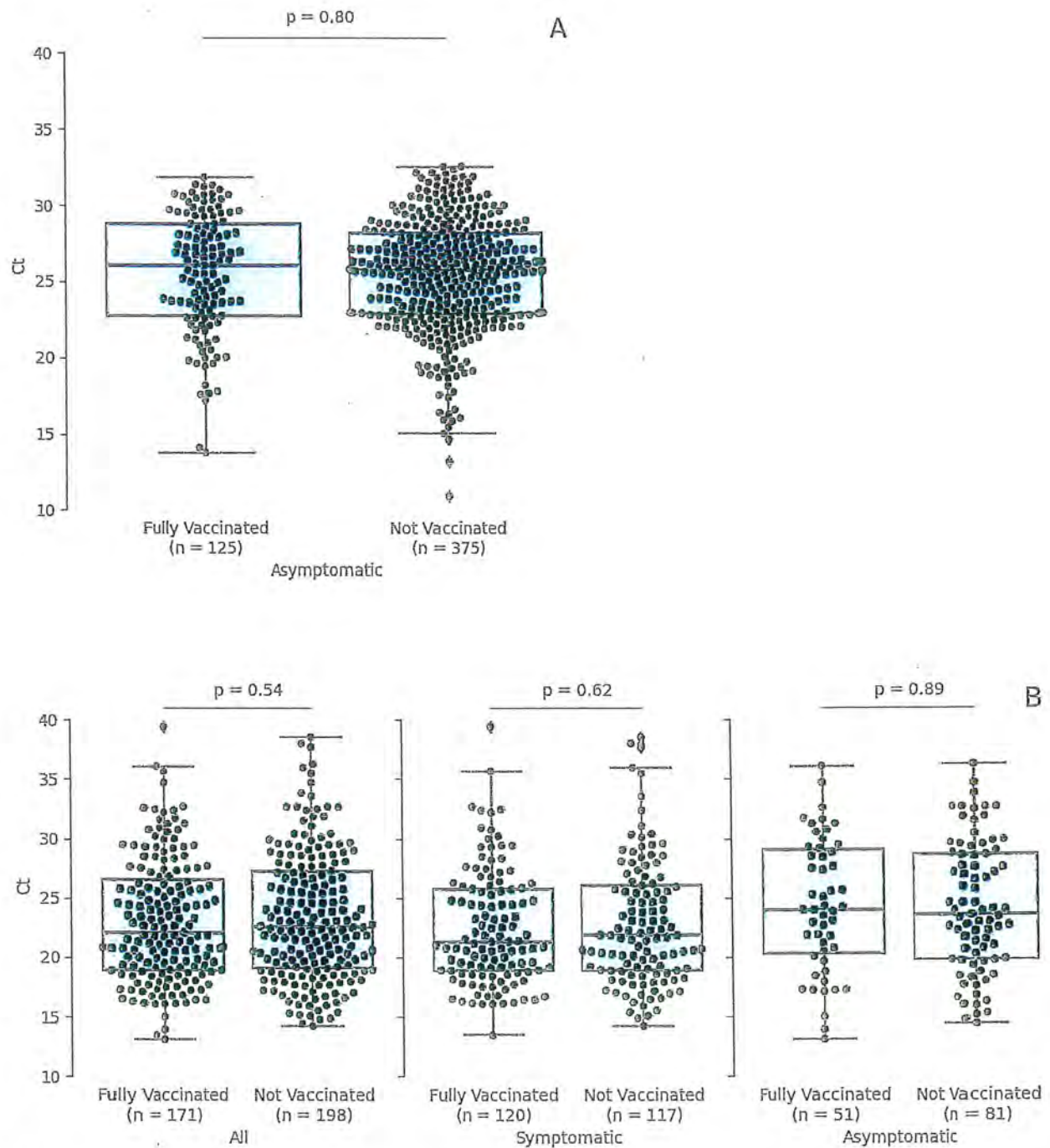
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## Figures



**Figure 1. SARS-CoV-2 cycle threshold values in asymptomatic, symptomatic, vaccinated, and unvaccinated individuals in California.** SARS-CoV-2 reverse transcription-polymerase chain reaction cycle threshold values for specimens from patients by vaccine status from Healthy

Yolo Together (City of Davis and Yolo County, California) (Panel A) and from specimens by vaccine and symptom status from Unidos en Salud (Mission District, San Francisco, California) (Panel B). Box plots show first quartile, median, and third quartiles in shaded region; diamonds indicate outliers beyond 1.5 times the interquartile range; p-values were calculated with two-sided t-tests.