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12 *Attorneys for Defendants*
13 The Regents of the University of California and
Michael V. Drake
14

15 SUPERIOR COURT OF THE STATE OF CALIFORNIA
16 COUNTY OF ALAMEDA

17 CINDY KIEL, J.D., an Executive Associate
Vice Chancellor at UC Davis, MCKENNA
18 HENDRICKS, a UC Santa Barbara student,
EDGAR DE GRACIA, a UCLA student, and
19 LELAND VANDERPOEL, an employee at the
Fresno satellite extension of the UCSF Medical
20 Education Program, and FRANCES OLSEN,
Professor of Law at UCLA,

21 Plaintiff,

22 v.

23 THE REGENTS OF THE UNIVERSITY OF
24 CALIFORNIA, a Corporation, and MICHAEL
V. DRAKE, in his official capacity as President
25 of the UNIVERSITY OF CALIFORNIA,

26 Defendants.
27
28

Case No. HG20072843
Unlimited Civil Jurisdiction
ASSIGNED FOR ALL PURPOSES TO:
Hon. Richard L. Seabolt
Department 521

**DECLARATION OF DR. LEE W.
RILEY IN SUPPORT OF
DEFENDANTS' OPPOSITION TO
PLAINTIFFS' MOTION FOR
PRELIMINARY INJUNCTION**

Date: October 14, 2020
Time: 01:30 p.m.
Dept.: 521
Reservation No.: 2206283

Complaint filed: August 27, 2020
Trial: None set

1 I, Dr. Lee W. Riley, declare:

2 1. I provide this declaration in support of Defendants The Regents of the University
3 of California and Michael V. Drake's ("Defendants") Opposition to Plaintiffs' Motion for
4 Preliminary Injunction. I base this declaration on my expertise as outlined below and facts within
5 my personal knowledge, to which I could and would testify competently if called upon to do so.

6 **Professional Background and Experience**

7 2. I am Professor and Chair of the Division of Infectious Disease and Vaccinology in
8 the School of Public Health at the University of California, Berkeley. I am a physician and I
9 conduct molecular epidemiology and bacterial pathogenesis research focused on infectious
10 diseases of global importance and diseases of urban slum settlements in developing countries. I
11 teach an annual course called Principles of Infectious Diseases, and have in the past taught a
12 course on Vaccinology.

13 3. I obtained my B.A. from Stanford University in Philosophy in 1972 and M.D.
14 from the University of California, San Francisco in 1978. I completed my residency in internal
15 medicine at Columbia Presbyterian Hospital and served in the Epidemic Intelligence Service at
16 the Centers for Disease Control and Prevention (CDC). I next served as Program Manager at the
17 World Health Organization (WHO), assigned to India. I have published more than 300 peer-
18 reviewed papers to date and two books, including *Molecular Epidemiology of Infectious*
19 *Diseases: Principles and Practices*. I am currently the Director of the Global Health Equity
20 Scholars Program, funded by Fogarty International Center of the National Institutes of Health
21 (NIH) and a fellow in the American Academy of Microbiology and of the Infectious Disease
22 Society of America. In 2014, I was appointed by the U.S. Secretary of Health and Human
23 Services to serve as a member of the Board of Scientific Counselors for the National Center for
24 Infectious Disease of the CDC.

25 4. Attached hereto as **Exhibit A** and incorporated by reference to this declaration is a
26 copy of my curriculum vitae.

27 5. Outside counsel for Defendants have asked me to provide my expert opinion on
28 influenza vaccinations and whether I support Defendants' mandate that University of California

1 (“University” or “UC”) students, faculty, and staff living, learning, or working on premises at UC
2 locations should receive an influenza vaccine this influenza season, subject to medical
3 exemptions and certain accommodations, particularly in light of the COVID-19 pandemic that
4 will overlap with the influenza season this year.

5 6. My opinions are based on my professional training, experience, and expertise, and
6 my review of the Executive Order, Plaintiffs’ Motion for Preliminary Injunction, and the
7 supporting declarations of Peter Gøtzsche, MD, Professor Laszlo Boros, MD, Associate Professor
8 Andrew Noymer, Associate Professor Peter Doshi, and Senior Clinical Tutor Tom Jefferson, MD.
9 I do not offer any legal opinion, nor do I intend to interpret the legal terms of the Executive
10 Order.

11 7. I find the arguments in these declarations proffered by Plaintiffs unconvincing and
12 unjustified. Many of their arguments are irrelevant to the issue of protecting UC students, faculty,
13 and staff from the severe consequences of the flu or COVID-19. Plaintiffs’ declarants make
14 arguments by selectively citing studies, and citing some studies that actually contradict what they
15 claim.

16 8. Plaintiffs’ declarants particularly focus on the effectiveness or efficacy of the
17 influenza vaccine on reducing hospitalization rates or mortality. However, there are also other
18 outcome measures for which effectiveness of the vaccine is assessed. Influenza vaccines,
19 depending on the virus strain circulating during an influenza season, and the type of vaccine used
20 during that season, have been well documented to reduce symptomatic cases, severity of
21 symptoms, and secondary transmissions. For example, one systematic review examined 31
22 eligible studies from 1967 to 2011 and assessed outcomes based on test results for the influenza
23 virus. (Osterhom MT, Kelley NS, Sommer A, Belongia EA, *Efficacy and effectiveness of*
24 *influenza vaccines: a systematic review and meta-analysis*, The Lancet, 2012; 12(1):36-44).¹ The
25 authors compared positive tests for the virus in vaccinated and unvaccinated people, which
26 include people with a wide spectrum of respiratory symptoms who may or may have been
27 hospitalized. The conclusion of the study was that “Influenza vaccines can provide moderate

28 ¹ See [https://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(11\)70295-X/fulltext](https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(11)70295-X/fulltext).

1 protection against virologically confirmed influenza, but such protection is greatly reduced or
2 absent in some seasons. Evidence for protection in adults aged 65 years or older is lacking. Live
3 attenuated influenza vaccine (LAIVs) consistently show highest efficacy in young children (aged
4 6 months to 7 years).” Apart from hospitalization rates and mortality, none of the Plaintiffs’
5 declarants discussed “effectiveness” in terms of these other outcome measures, which are relevant
6 to UC’s Executive Order.

7 9. Vaccinating for influenza reduces the number of people with respiratory symptoms
8 from influenza. A reduction in the number of people with respiratory symptoms from influenza
9 would prevent overwhelming testing services for COVID-19 and influenza. Without widespread
10 influenza vaccinations, the number of people with respiratory symptoms will definitely increase,
11 well above those due to COVID-19. People with respiratory symptoms will need to be tested for
12 COVID-19. The testing services at UC campuses and elsewhere are already running at maximum
13 capacity. An inability to test people with respiratory systems for COVID-19 will jeopardize
14 timely initiation of contact investigation and quarantine, which could cause a resurgence of the
15 epidemic on all campuses.

16 10. While classes are now generally taught remotely, many UC students have elected
17 to stay on campus dormitories as well as in fraternity and sorority houses. Despite remote classes,
18 outbreaks of COVID-19 have already occurred among these students. There is also a large
19 number of laboratory research faculty, as well as students and staff, at all UC campuses who need
20 to be at work in person. The increased number of respiratory infections due to influenza would
21 mask those cases due to COVID-19, endangering those with underlying medical conditions
22 among students, staff, and faculty. Influenza vaccines are not devoid of potential adverse effects,
23 but none of those effects compare with the severity of COVID-19 in high-risk groups.

24 11. Another important reason for mandating influenza vaccination is that by reducing
25 the number of symptomatic cases of influenza (which the vaccine is well documented to do), and
26 reducing the severity of the symptoms for those who develop any symptoms (which the vaccine
27 can also do), the vaccine may avert severity of COVID-19 symptoms. It is well documented that
28 those with underlying, chronic respiratory illnesses (e.g., asthma, chronic obstructive pulmonary

1 disease) are at greater risk for severe COVID-19 clinical outcomes. Influenza illness can damage
2 the respiratory tract, including the lungs. If individuals who contract influenza subsequently get
3 infected with the COVID-19 virus, such persons could develop severe illness.

4 12. Perhaps the most important reason for mandating influenza vaccination at this time
5 of COVID-19 is the ability of widespread influenza vaccination to rapidly establish herd
6 immunity in a target community. (Kim TH, *Seasonal influenza and vaccine herd effect* Clin. Exp.
7 Vaccine Res., 2014;3(2):128-132.)² Effective influenza vaccines can interrupt transmission of
8 influenza and if a large proportion of a community is immunized rapidly, the number of
9 secondary transmissions can be greatly reduced. This could help to speed the identification of
10 individuals who have contracted COVID-19 (rather than influenza), clinical management, and
11 spread. This depends on how efficacious this influenza season's vaccine is in reducing
12 transmission, but even a modest reduction in the transmission of influenza would serve to help
13 protect the community.

14 **Rebuttal to Declaration of Dr. Laszlo Boros**

15 13. In his Declaration, Dr. Laszlo Boros refers to a study by Dr. Greg Wolff which
16 reported that an influenza vaccine increased the risk of coronavirus infection. (See Boros
17 Declaration, ¶ 5) (Wolff G, *Influenza vaccination and respiratory virus interference among Dept*
18 *of Defense personnel during the 2017-2018 influenza season*, Elsevier Public Health Emergency
19 Collection, 2020; 38(2):350-354.)³ The coronavirus reported in the study is the common cold
20 coronavirus, unrelated to the COVID-19 coronavirus. The study actually showed good efficacy of
21 the influenza vaccine against influenza viruses as well as other respiratory viruses, including RSV
22 and parainfluenza. Interestingly, and not mentioned by Dr. Laszlo, the influenza vaccination was
23 also associated with increased risk for "No Pathogen Detected." Such a result calls into question
24 the observation made with the common-cold coronavirus. The observation is likely to be a
25 statistical artifact, which resulted from not correcting for the large number of variables compared
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27
28 ² See <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4083064/>.

³ See <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7126676/>.

1 (e.g., by Bonferroni’s correction)⁴.

2 14. In his Declaration, Dr. Boros states that “A study conducted by the Centers for
3 Disease Control had suggested the possibility that women who received A/H1N1pdm2009
4 (pH1N1) antigen-containing influenza vaccine two years in a row had an increased risk of
5 miscarriage.” (See Boros Declaration, ¶ 11; Donahue JG, et al., *Association of spontaneous*
6 *abortion with receipt of inactivated influenza containing H1N1pdm09 in 2010-11 and 2011-12,*
7 *Vaccine* 2017; 35(40):5314-5322⁵.) The study he refers to was not a CDC study. Only one of the
8 authors was a CDC employee. Significantly, the same group of researchers reported two years
9 later – using a larger data set – that there was no association of two different types of influenza
10 vaccines given over three influenza seasons with spontaneous abortion (See Donahue JG, et al.,
11 *Inactivated influenza vaccine and spontaneous abortion in the Vaccine Safety Datalink in 2012-*
12 *13, 2013-14, and 2014-15,* *Vaccine* 2019; 37(44):6673-6681.)⁶ A meta-analysis of 5 to 13 papers
13 also found that pregnant women who received H1N1 influenza vaccine were less likely to give
14 birth preterm, and gave birth to heavier infants. (See Richards JL, et al., *Neonatal outcomes after*
15 *antenatal influenza immunization during the 2009 H1N1 influenza pandemic: impact on preterm*
16 *birth, birth weight, and small for gestational age birth,* *Clin. Infect. Dis.* 2013; 56(9):1216-22.)⁷
17 A Cochrane review, co-authored by Dr. Thomas Jefferson and cited by Dr. Peter Götzsche in his
18 Declaration, also concludes that “The administration of both seasonal and 2009 pandemic
19 vaccines during pregnancy had no significant effect on abortion or neonatal death.” (Demicheli V,
20 Jefferson T, et al., *Vaccines for preventing influenza in health adults,* *Cochrane Database Syst.*
21 *Rev.* 2018; 2(2):CD001269.)⁸ The declaration by Dr. Boros is misleading and contradicts the
22 studies provided by Plaintiffs’ own expert witness.

23 15. Dr. Boros’s explanation of the potential impact of the influenza vaccine on human
24 immune response is not in line with any established knowledge regarding human immune

25 ⁴ The Bonferroni correction is a multiple-comparison correction used when several dependent or
26 independent statistical tests are being performed simultaneously and is one of several methods
used to counteract the problem of multiple comparisons.

27 ⁵ See <https://pubmed.ncbi.nlm.nih.gov/28917295/#affiliation-12>.

28 ⁶ See <https://pubmed.ncbi.nlm.nih.gov/31540812/>.

⁷ See <https://pubmed.ncbi.nlm.nih.gov/23378281/>.

⁸ See <https://pubmed.ncbi.nlm.nih.gov/29388196/>.

1 response to vaccines. (See Boros Decl., ¶¶ 13-29.) He, nor anyone else, has published studies
2 supporting the claims he makes in his declaration. He states that he is “a medical scientist
3 working on immune system function” but I could not identify any paper for which he is an author,
4 or a grant for which he is a principal investigator, which indicates that he has conducted research
5 on “immune system function” related to infectious disease or vaccine-induced immune response.

6 **Rebuttal to Declaration of Prof. Peter Doshi**

7 16. In his Declaration, Prof. Doshi is correct that “Assessing the efficacy of influenza
8 vaccines is not as straightforward as it might be for drugs.” (See Doshi Decl., ¶ 11.) However,
9 this is not only because vaccines are “biologics,” as he states. The effectiveness of influenza
10 vaccines is difficult to assess because during every influenza season, the epidemic is caused by a
11 different strain of the virus, sometimes differing by a few mutations (called antigenic drift) and
12 less frequently by abrupt large genetic changes (called antigenic shift). The CDC, WHO, and
13 other health agencies predict which viral strain will cause the annual epidemic and rapidly
14 produce the best vaccine that matches the epidemic strain. Thus, the effectiveness of the vaccine
15 fluctuates year to year.

16 17. That is not to say that the influenza vaccine is not effective. Effectiveness is
17 assessed not only on the vaccine’s effect on reducing death or hospitalization rates, but also for its
18 effect on reducing other outcomes, such as severity of symptoms, number of outpatient visits, and
19 secondary transmissions. In the United States, influenza vaccines have been administered to the
20 civilian population since 1946 (not 1960 as stated by Prof. Doshi), and clinical trials of the
21 vaccines began even earlier in the 1930s. Thus, we have much accumulated evidence supporting
22 efficacy and effectiveness of various influenza vaccines from well-controlled randomized trials
23 for these outcomes.

24 18. Prof. Doshi gives two examples of adverse events associated with the influenza
25 vaccines, including febrile convulsions in children less than five years of age in Australia, and
26 cases of narcolepsy in teenagers in Finland and Sweden in 2009. (See Doshi Decl., ¶ 15.) Whether
27 these adverse events were truly caused by influenza vaccines can be debated, but adverse events
28 of one type or another have been reported for just about all vaccines that are licensed. It is curious

1 that Prof. Doshi did not refer to the Cochrane review, highlighted by Dr. Gøtzsche, that covered
2 many studies conducted from 1969 to 2009 that concluded that there was no evidence of serious
3 adverse events associated with the influenza vaccines used in the studies. (Demicheli V, Jefferson
4 T, et al., *Vaccines for preventing influenza in health adults*, Cochrane Database Syst. Rev. 2018;
5 2(2):CD001269.)

6 19. Prof. Doshi states that “There should be at least two randomized trials that both
7 demonstrated influenza vaccines reduce hospitalizations, ICU admissions, or mortality.” (See
8 Doshi Decl., ¶ 17.) I agree, but this point is not relevant to the question of whether the University
9 should require influenza vaccination for its students, faculty, and staff. The influenza vaccine can
10 reduce the number of respiratory illnesses to help prevent overwhelming COVID-19 testing
11 services. An inability to diagnose COVID-19 in a timely manner will disrupt contact investigation
12 and quarantine, which could cause resurgence of the epidemic (as has already begun to happen on
13 college campuses throughout the United States).

14 **Rebuttal to Declaration of Dr. Peter Gøtzsche**

15 20. In his Declaration, Dr. Peter Gøtzsche cites a Cochrane review of 52 randomized
16 clinical trials of influenza vaccines and states that vaccination “could be considered a worthwhile
17 effect at the population level but hardly at the individual level, as ‘71 healthy adults need to be
18 vaccinated to prevent one of them experiencing [laboratory-confirmed] influenza.’” (See
19 Gøtzsche Decl., ¶ 9.) (Demicheli V, Jefferson T, et al., *Vaccines for preventing influenza in*
20 *health adults*, Cochrane Database Syst. Rev. 2018; 2(2):CD001269.) The same review showed
21 that 29 healthy adults need to be vaccinated to prevent one influenza-like illness (ILI). Based on
22 this review, at the UC Berkeley campus alone where I understand about 1,500 students are
23 presently on campus, this would prevent 21 laboratory-confirmed cases of influenza and 71 ILIs.
24 Across all 10 campuses, assuming a similar number of students are presently on campus,
25 influenza vaccination could prevent more than 200 cases and 710 ILIs, just among students and
26 not including faculty and staff.

27 21. More importantly, the purpose of a vaccine is not only to protect an individual
28 receiving the vaccine, but to protect members of the public at large who are at risk for

1 transmission of an infectious disease. Preventing just 200 cases of influenza could have a large
2 impact on secondary spread of the disease on campuses. Mandated influenza vaccination assures
3 rapid establishment of herd immunity, which can greatly blunt transmissions of influenza in a
4 college campus community. (Kim TH, *Seasonal influenza and vaccine herd effect*, Clin. Exp.
5 Vaccine Res., 2014; 3(2):128-132.)

6 22. Regarding adverse effects of influenza vaccines, Dr. Gøtzsche cites a 2014
7 Cochrane review report which concluded, “Inactivated vaccines caused local harms and an
8 estimated 1.6 additional cases of Guillain-Barré Syndrome per million vaccinations. (*See*
9 *Gøtzsche Decl.*, ¶ 7.) The harms evidence base is limited.” However, he does not mention that
10 the most updated Cochrane review concludes that “Inactivated vaccines cause an increase in fever
11 from 1.5% to 2.3%,” but does not even mention Guillain-Barré syndrome. (Demicheli V,
12 Jefferson T, et al., *Vaccines for preventing influenza in health adults*, Cochrane Database Syst.
13 Rev. 2018;2(2):CD001269). Furthermore, the review concludes that “The administration of both
14 seasonal and 2009 pandemic vaccines during pregnancy had no significant effect on abortion or
15 neonatal death.” Therefore, the very review to which Dr. Gøtzsche refers shows that there is no
16 scientific basis for his statement that “administering the flu vaccine to the 510,000 members of
17 the University of California community might cause serious harm and will likely cause more
18 harm than good.” (*Gøtzsche Decl.*, ¶16).

19 23. Dr. Gøtzsche states that “The Executive Order from Janet A. Napolitano is a three-
20 page document where she quotes the literature selectively to such an extent that I consider it
21 scientific misconduct. According to the US Office of Research Integrity, research misconduct
22 includes ‘changing or omitting data or results such that the research is not accurately represented
23 in the research record.’” (*See Gøtzsche Decl.*, ¶ 11.) This is disingenuous on the part of Dr.
24 Gøtzsche. The same can be said of his selectively citing parts of Cochrane reviews to support his
25 argument. The Cochrane reviews he cites include only studies reported from 1966 to 2016, even
26 though influenza vaccine trials go back to the 1930s. The Cochrane reviews he selected include
27 studies covering influenza seasons from 1969 to 2009 in multiple geographic regions involving
28 different influenza virus types, which is like comparing “apples to oranges.” He does not describe

1 the inherent limitations of reviews that report summary effectiveness data based on highly
2 disparate studies. Dr. Gøtzsche is a co-founder of the Cochrane Collaboration, so it is in his
3 interest to give greater scientific credence to Cochrane reviews. He did not fully disclose all the
4 conclusions of those reviews by overstating the danger of the vaccines. But I would not say that
5 Dr. Gøtzsche committed “scientific misconduct” by selectively citing results that support his
6 arguments.

7 **Rebuttal to Declaration of Dr. Thomas Jefferson**

8 24. In his Declaration, Dr. Jefferson states that “I would like to make the further
9 broader points based on 25 years’ of trial research synthesis: the current influenza vaccines have
10 such low effectiveness that the US CDC has assigned a negative value to their effectiveness,
11 coercion to use them is ideological.” (*See* Jefferson Decl., ¶ 7.) This statement appears to be an
12 opinion based on his vague use of the term “effectiveness.” What does he mean by
13 “effectiveness”? Effectiveness for reducing hospitalization? Effectiveness against reducing severe
14 symptoms? Effectiveness against interrupting transmission? His sweeping statement about the
15 “negative value of their effectiveness” and describing CDC’s recommendation for the vaccine as
16 “coercion” appears to be an “ideological” statement itself.

17 25. The arguments made by Prof. Doshi, Dr. Gøtzsche, and Dr. Jefferson are based
18 mostly on Cochrane reviews, which is one of many ways to assess vaccine efficacy and
19 effectiveness. This way of assessing vaccines may work for some types of vaccines, but not for
20 influenza vaccines. There are now three vaccine formulations licensed in the United States, and
21 the influenza virus strain types change every influenza season. Vaccine efficacy/effectiveness
22 studies included in the Cochrane reviews are reported from a wide spectrum of geographic
23 regions with very different histories of previous epidemics. It is not surprising that the summary
24 data do not show convincing results when outcomes such as hospitalization rates and deaths are
25 assessed. Hospitalization rates and deaths are dependent on many other factors that vary across
26 regions, and not all of these factors are measured in the studies included in the reviews.

27 **Rebuttal to Declaration of Professor Andrew Noymer**

28 26. Prof. Noymer’s statement in his Declaration that influenza vaccines are not tested

1 before they are administered is correct. (See Noymer Decl., ¶¶ 3-5.) Unfortunately, there is no
2 choice, given the nature of the seasonal influenza viruses as described previously. When there is a
3 mismatch between a new season’s vaccine and the epidemic virus strain, effectiveness can be
4 negative, as pointed out by Prof. Noymer. But when there is a match, a vaccine can be quite
5 effective in reducing severe disease and interrupting transmission. Prof. Noymer’s argument does
6 not address why requiring influenza vaccination is necessary in the time of the COVID-19
7 pandemic.

8 27. Prof. Noymer states that “the most effective strategy for an individual may be to
9 experience some influenza infection as a healthy adult, thus generating a better immunity
10 portfolio against influenza for old age.” (See Noymer Decl., ¶ 8.) This type of argument has been
11 made for COVID-19, mostly by politicians, and it has been roundly debunked by scientists. As
12 mentioned above, the influenza vaccine is not designed solely to protect an individual. It is
13 designed to interrupt transmissions. The idea that one can avoid getting severely sick in old age
14 by intentionally exposing oneself to influenza at a young age shows a lack of understanding of
15 public health.

16 **Summary**

17 28. The arguments of Plaintiffs’ declarants are unconvincing because they do not
18 focus on the assessment of the impact of influenza vaccine effectiveness on reducing the number
19 of laboratory-confirmed asymptomatic infections, symptomatic infections, influenza-like illness
20 (ILI), outpatient clinic visits, severity of disease, and herd immunity (effectiveness in non-
21 vaccinated contacts of vaccinated people). These are the relevant issues that need to be assessed
22 to argue for or against mandated influenza vaccination in the UC community. There are many
23 studies (not necessarily Cochrane reviews) that show effectiveness of influenza vaccines on these
24 other types of outcomes, supporting why requiring influenza vaccination throughout the UC
25 community is especially important during this COVID-19 pandemic period.


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I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct to the best of my knowledge.

Executed in Berkeley, California, on this 29 day of September 2020.



Dr. Lee W. Riley

EXHIBIT A

Curriculum Vitae

Lee W. Riley, MD

Professor and Chair, Division of Infectious Diseases and Vaccinology

CURRENT ADDRESS

School of Public Health, UC Berkeley
Division of Infectious Diseases
530E Li Ka Shing Bldg, Berkeley, CA 94720
tel: [REDACTED] email: [REDACTED]

EDUCATION

High School--International School of Bangkok, 1968
B.A. with Distinction, Stanford University, 1972
M.D., University of California, San Francisco 1978

LICENSURE

New York, 1979-present (inactive)
California, 1984-present

MEMBERSHIP, ADVISORY GROUPS

American Society for Microbiology
Fellow, American Association for the Advancement of Sciences, 1998
Fellow, Infectious Disease Society of America, 2002
International Society for Infectious Diseases
Medical Advisory Board: Public Health Research Institute, NJ
Member, Bacteriology-Mycolology Study Section I, NIAID, NIH, 1994-1998
Panel member, NIH Persian Gulf Experience and Health, 4/26-29, 1994
National Advisory Committee: RWJ Harold Amos Medical Faculty Development Program 2000-present
Diplomate, American Board of Internal Med, 1981
Advisory Committee, Fogarty International Center, NIH: 2003-2007
National Tuberculosis Curriculum Consortium: 2003-2009
National judge: Young Epidemiology Scholars (YES) competition: 2004-2011
Member, Clinical Res/Field Studies Infectious Diseases NIH Study Section, 2008-2012
Board of Scientific Counselors, CDC, appointed by Secretary of HHS (K. Sebelius): 2014-now

EDITORIAL BOARD

Associate Editor, *International J of Infectious Diseases*, 1996-2001
Section Editor, *Tubercle and Lung Disease*, 1997-2002
Editorial staff: *Wellness Letter*, 1997-2000
Editorial board: *Pathogens and Disease*, 2012-now

HONORS, GRANTS

Cornell Scholar in Biomedical Science, 1991-94
Pew Scholar in Biomedical Sciences, 1992-96
Jack Friedman Young Investigator Prize (First prize)
Michael Wolk Foundation Clinical Scholar Award, 1993
Heiser Program for Research in Leprosy and Tuberculosis, 1992-93
AmFAR research grant, 1992-1993
German-American Academic Council Distinguished Lectureship Award, 1998;
Fellow, American Association for the Advancement of Sciences (AAAS), 1998;
Fellow, Infectious Disease Society of America, elected in 2002
Fellow, American Academy of Microbiology, elected in 2004
Ellison Foundation Senior Investigator Award in Global Infectious Diseases, 2002-06
ASM International Professorship, Salvador, Brazil, 2001
Selection for re-publication (Riley et al, *New Engl J Med*, 1983) in *Microbiology: A*

Centenary Perspective, 1899-1999 (ASM Press)

UBS Optimus Foundation award: 2011-2014

Honorary Member, Hungarian Society for Microbiology, 2012

Honoris Causa, Carol Davila University of Medicine and Pharmacy, Bucharest, Romania, May, 2015

Special Visiting Researcher Award, Science-without-Borders Program, Brazil: 11/2014-2017

NIH Grants:

9/1993-8/2003: RO1AI35266: Molecular biology of infection with *Mycobacterium tuberculosis*
12/1993-11/2003: RO1HL51967: Antioxidant genes of *Mycobacterium tuberculosis*
9/1997-7/2003: TWD43 TW00905: Lab-based field epid training in emerging infectious diseases
9/1998-8/2000: RO3 AI43032: Peptide-based Salmonella vaccine delivery system
9/1998-9/2000: R21 AI44287: Peptide-based delivery of HIV immunogens
9/2002-9/2004: RO3 AI053754: Epidemiology of an uropathogenic *E. coli* clonal group
9/2003-3/2013: TW006563: Emerging infectious diseases
12/2004-11/2008: RO1AI059523: Origin of multidrug-resistant uropathogenic *E. coli*
7/2005-6/2007: R21AI63350: Therapeutic vaccine against tuberculosis
7/2009-6/2012: R01AI073204: *In vivo* regulation of *M. tuberculosis* cell wall lipids
9/2010-12/2012: R24TW008822: Framework to address drug-resistant infections and global health
4/2012-7/2017: R25TW009338: Global health fellows and scholars training program
4/2015-3/2020: R01AI117064: Consortium for drug-resistant Gram-negative pathogen detection
7/2015-6/2020: R21/33AI119115: Maltose-targeted antibiotics
7/1/2017-6/30/2022: D43TW010540: Global Health Equity Scholars Program
6/1/2018-2/28/2023: D43 TW010332: Research Training at the Confluence of Infectious and Non-Communicable Diseases in India

USAID Grant:

12/2001-12/2004: USAID CALR-2001-02972: Resistance of *Salmonella enteritidis* to egg albumen

CDC Grant:

8/1/2017-7/31/2019: CDC BAA 2016-N-17812: Risk factors, resistance and genetics of community acquired foodborne urinary tract infections

PROFESSIONAL POSITIONS

1978-1979 Intern, Internal Medicine, Columbia-Presbyterian Hospital, New York
1979-1981 Resident, Internal Medicine, Columbia-Presbyterian Hospital, New York
1981-1984 Epidemic Intelligence Service, Enteric Diseases Branch, Division of Bacterial Diseases, Centers for Disease Control, Atlanta, GA
1984-1988 Infectious Disease Fellowship/Medical Microbiology Post-Doctorate, Stanford University
1988-1990 Centers for Disease Control, assigned to WHO in New Delhi (SEARO), Laboratory Project Manager, India Biomedical Support Project
1990-1994 Assistant Professor of Medicine, Division of International Medicine, Department of Medicine, Cornell University Medical College (CUMC)
1994-1996 Associate Professor of Medicine, CUMC
1996-present Professor of Infectious Diseases and Epidemiology, University of California, Berkeley
2008-present Chair, Division of Infectious Diseases and Vaccinology, School of Public Health University of California, Berkeley

INTERNATIONAL WORK EXPERIENCES:

1964-1968	High School, International School of Bangkok, Thailand (because of father's work)
1970, 71, 72	Bangkok, Thailand each summer to work as an English instructor
1972-1973	Tokyo, Japan, as an exchange student and English instructor
1977	Chiengmai, Thailand for 3 months for medical clerkship during medical school
1981	Santo Domingo and Haiti for investigation of gastroenteritis outbreak on a cruise ship as CDC EIS Officer
1982 (Nov-Dec)	Sao Paulo, Brazil for epidemiologic investigation of multiresistant Salmonella as EIS Officer (by invitation of Escola Paulista de Medicina)
1983 (Sep-Nov)	Dhaka, Bangladesh, to assess surveillance of cholera as EIS Officer (by invitation of International Center for Diarrheal Disease Research, Bangladesh)
1986, 1987	Chiapas, Mexico, to help establish a field site for the study of diarrheal diseases for the division of Geographic Medicine at Stanford University
1988 (Aug)	Manila, Philippines, to assess public health laboratories and their relationship to their Field Epidemiology Training Program (FETP): CDC Consultant
1988-1990	New Delhi, India, as a Laboratory Project Manager, WHO/Southeast Asia Regional Office, on assignment from CDC, Atlanta
1989 (May)	Beijing, China, to discuss the role of the laboratory in epidemiology
1989 (Aug)	Myanmar (Burma) and Thailand to conduct a WHO workshop on Transfer of Appropriate Technology in Diagnosis and Surveillance of Shigellosis in Southeast Asia
1990-1996	Established a project on invasive diarrhea, Cornell Research Unit, Salvador, Brazil
1992-now	Tuberculosis research projects in Brazil (Sao Paulo, Rio de Janeiro-Salvador)
1994 (Dec)	Temporary Advisor, WHO, Geneva, Evaluate use of RFLP and other molecular subtyping techniques for epidemiological studies
1992, 94, 97, 07, 11	Infectious Disease Update courses, given in Taipei, Taiwan and Shanghai, China
2014, 2016	Sino-American Infectious Disease Update course, Shanghai, China
1998-2001	Course: Molecular Epidemiology; University of Zurich, Switzerland (given for 1-2 days every Dec or July as part of an MPH program of the University of Zurich)
1996-2011	Cornell Salzburg Seminar in Infectious Diseases and Epidemiology; (course given over a 1-week period every year to East European physicians and public health professionals)
1997-2002	Director, UC Berkeley Fogarty International Training and Research in Emerging Infectious Diseases
1998-2003	Director, Fogarty International Training and Research in Tuberculosis
1998-2000	Consultant, International Clinical Epidemiology Network (INCLIN) for India
Summer, 2002	ASM International Professorship to give a course on Molecular Epidemiology of Infectious Diseases, Salvador Brazil
Summers, 2001-now	Ibero-American Course on Molecular Epidemiology of Infectious Diseases I-IV, Salvador, Brazil
2003-2013	Director, UC Berkeley Fogarty International Center program in Global Infectious Diseases
January, 2006	American Society of Microbiology (ASM) Indo-US Visiting Professorship, Mahatma Gandhi Institute of Medical Sciences, Sevagram, India
Since 2009	Short-term consultant to teach Molecular Epidemiology of Infectious Disease, FETP-Japan, National Institute of Infectious Diseases, Tokyo (every 2 years).
2012-now	Director, Global Health Scholars and Fellows Training and Research Program (Global Health Equity Scholars Program)
2014-now	Special visiting researcher, Science-without-Borders, Ministry of Health, Brazil
2016 (Jan):	Course: Molecular epidemiology of infectious diseases, Institute of Hygiene and Tropical Medicine, Universidade Nova de Lisboa, Lisbon, Portugal
2015, 16, 19	Course: Molecular epidemiology of infectious diseases, Zhejiang Provincial CDC, Hanzhou,

China

PATENTS BASED ON RESEARCH WORK:

US Patent #	Date of Issue	Inventor	Description of patent
6,008,201	12/28/1999	Riley	DNA molecule encoding cellular uptake of Mtb
6,072,048	6/6/2000	Riley	DNA molecule encoding cellular uptake of Mtb
6,214,543	4/10/2001	Riley	DNA molecule encoding cellular uptake of Mtb
6,177,086	1/23/2001	Riley, Nathan, Ehrt	DNA molecule conferring upon Mtb resistance against RNI
6,224,881	5/1/2001	Riley	DNA molecule encoding cellular uptake of Mtb
6,399,764	6/4/2002	Riley	DNA molecule encoding cellular uptake of Mtb
6,509,151	1/21/2003	Riley	DNA molecule encoding cellular uptake of Mtb
6,995,255	2/07/2006	Riley, Lu	Cellular delivery agent
8,445,658	05/21/2013	Ko, Mitermayer, Croda, Riley	Proteins with repetitive bacterial IgG-like proteins
9,835,624	12/07/2017	Riley, Mathies, Goodridge	Composition and methods for detecting Mycobacteria

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Journal Articles

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- Riley LW, Cohen ML, Seals JE, Blaser MJ, Birkness KA, Hargrett NT, Martin SM, Feldman RA. Importance of host factors in human salmonellosis caused by multiresistant strains. **J Infect Dis.** 1984; 149:878-883.
- Riley LW, Ceballos BSO, Trabulsi LR, Toledo MRF, Blake PA. Significance of hospitals as reservoirs for endemic multiresistant *S. typhimurium* causing infections in urban Brazilian children. **J Infect Dis.** 1984; 150:236-241.
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- Riley LW. Hemorrhagic colitis--a "new" disease. **Clin Micro Newslet.** 1985; 7:47-49.
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- Riley LW, Waterman SH, Faruque ASG, Huq MI. Breastfeeding children in the household as a risk factor for cholera in rural Bangladesh: an hypothesis. **J Trop Geogr Med.** 1987; 39:9-14.
- Riley LW. The epidemiologic, clinical, and microbiologic features of hemorrhagic colitis. **Annual Rev of Microbiol.** 1987; 41:383-407.
- Riley LW, Junio L, Libaek LB, Schoolnik GK. Plasmid-encoded expression of lipopolysaccharide O-antigenic polysaccharide in enteropathogenic *Escherichia coli*. **Infect Immun** 1987; 55:2052-56.

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