UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
GALVESTON DIVISION

ASSOCIATION FOR MOLECULAR PATHOLOGY, and MICHAEL LAPOSATA, M.D., PH.D., Plaintiffs, v. UNITED STATES FOOD AND DRUG ADMINISTRATION, ROBERT M. CALIFF, M.D., in his official capacity as Commissioner of Food and Drugs, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, and XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services, Defendants.	Case No. _____

DECLARATION OF ERIC KONNICK, M.D., M.S.

I, Eric Konnick, M.D., M.S., hereby declare under penalty of perjury as follows:

1. I am a board-certified anatomic, clinical, and molecular pathologist at the University of Washington Medical Center and the Fred Hutchinson Cancer Center in Seattle, Washington. I have been practicing medicine at the University of Washington since 2010 and have dedicated my career to advancing the diagnosis and treatment of adults and children with

cancer through the use of personalized medicine. I hold several positions at the University of Washington, including Associate Professor of Laboratory Medicine and Pathology, Director of Genetics and Preanalytical Services, and Associate Director of the Genetics and Solid Tumor Lab. Additionally, until it was decomissioned in 2024, I was a Clinical Laboratory Director for the Seattle Flu Study COVID-19 Testing Laboratory. I make this declaration in support of the Complaint in the above-captioned case, have personal knowledge of the matters set forth herein, and can and will testify thereto if called upon to do so.

2. I received a B.S. in Biology, with a minor in Chemistry, in 1998; a M.S. in Laboratory Medicine and Biomedical Science in 2006; and a M.D. in 2010, all from the University of Utah in Salt Lake City, Utah. I performed my post-doctoral training at the University of Washington as an Anatomic and Clinical Pathology Resident from 2010 to 2014 and a Molecular Genetic Pathology Fellow from 2014 to 2015. I am licensed to practice medicine in the state of Washington (MD60296017) and am board certified in Anatomic and Clinical Pathology by the American Board of Pathology (ABP) and in Molecular Genetic Pathology jointly by ABP and the American Board of Medical Genetics and Genomics.

3. I am an active member of several professional organizations, including the Association for Molecular Pathology, where I serve on the Board of Directors; College of American Pathologists, where I am a Fellow and serve as the Chair of the Genomic Medicine Committee; the Association of Clinical Laboratory Physicians and Scientists; and the Washington State Society of Pathologists, where I serve as the President of the Board of Directors.

4. As a practicing pathologist, I diagnose disease and identify biomarkers used to develop treatment plans for my patients in conjunction with the patient's treating physician. To do so, I review patient medical records; communicate with treating physicians and consult

regarding laboratory testing; determine what samples are appropriate and useful for testing; request that specific samples (*e.g.*, tissue, body fluids, and/or blood) be collected; conduct analyses of the samples collected; and review any findings in the context of a patient's medical record. I then generate a comprehensive written report detailing the analyses conducted, the methodologies used, the results obtained, and the limitations of those methodologies and results, and I discuss my findings with the patient's clinical team. In addition, I regularly participate in molecular tumor boards—several of which I founded—to engage in collaborative group discussions about laboratory findings, disease diagnosis, and appropriate treatment for a particular patient in light of their specific clinical context.

5. I specialize in the detection, diagnosis, and management of solid tumors and blood cancers in my adult and pediatric patients. In doing so, I rely on analytical procedures that my colleagues and I develop within our laboratory, for use exclusively within our laboratory. These kinds of laboratory developed testing procedures ("LDTs") are a cornerstone of modern personalized medicine: They enable pathologists to appropriately diagnose and provide essential information to tailor treatment plans based on the unique genomic and molecular characteristics of each patient's cancer and to enable optimized treatment efficacy and minimize side effects.

6. The LDTs that I develop and utilize within my laboratory (and which never leave my laboratory) can be divided into four general categories of clinical application: (1) to determine the type or sub-type of cancer a patient may have; (2) for patients with cancers who need systemic therapy, to test for genomic alterations or other biomarkers that can help to direct the best course of treatment; (3) for patients who have been on therapy but have stopped responding to treatment, to assess if there is a genomic basis for treatment resistance and help determine whether a different treatment can be utilized; and (4) to assess for potential genetic predispositions for cancer that can

inform screening and treatment plans for individuals and their families. It is essential to understand the genomic nature of a given patient's cancer in deciding which therapy has the greatest likelihood of success for a particular patient, and without LDTs, it would not be possible to obtain that information in the overwhelming majority of cases.

7. In my practice, I must decide whether an existing, commercially available FDA-approved test (if there even is one) or an in-house LDT—developed in accordance with federal laws and regulations governing clinical laboratories (commonly called "CLIA")—is best-suited to address a patient's clinical need. In so doing, my laboratory colleagues and I assess the current scientific and medical understanding of specific diseases and biomarkers, then evaluate the available diagnostic methods for their limitations and identify areas where new or improved LDTs could significantly improve patient outcomes, such as earlier detection, increased accuracy, or better specificity. In our academic medical center practice, we frequently have introduced new laboratory approaches as LDTs years before any manufactured products are available, and our LDTs often demonstrate superior performance to manufactured options when commercial products are eventually available. We are often called on to consult regarding patients from other local, regional, national, and international institutions who require our laboratory services because the testing they have had up to that point has been unable to answer the relevant clinical question.

8. In cases where there is no FDA-approved test or where existing tests are not adequate, appropriate, or available for use, developing an LDT procedure for in-house use can make a life-or-death difference for my patients. To do so, my colleagues and I review the current scientific and medical literature, medical case studies, and clinical research to identify genomic alterations or other biomarkers known to be associated with the cancer type of interest and evaluate the available technological methods—such as polymerase chain reaction, next-generation

sequencing, or immunohistochemistry—and analytical platforms to determine if they can be used to reliably detect the identified biomarkers of interest and to assess which of those methods is best-suited to doing so. It is important to emphasize that my colleagues and I are not building new machines, hardware, or other implements as part of this process; LDTs leverage pre-existing technical methods on platforms that are widely used for similar purposes in an array of scientific contexts beyond the practice of medicine.

9. Next, we develop the procedure itself—the precise sequence of steps and processes that must be performed in order to reliably, accurately, and replicably extract and analyze information from a given patient sample. We then conduct robust initial testing of the procedure using well-characterized sample sets to evaluate feasibility, and then further optimize the assay conditions and related processes to further enhance the LDT's key performance metrics (e.g., accuracy, precision, and reproducibility). Before any new LDT can be deployed for clinical use, and as required by CLIA, we then conduct extensive and thorough validation testing to determine the process' sensitivity (ability to detect true positives) and specificity (ability to detect true negatives); assess the repeatability and reproducibility of the test; establish the amount of patient sample needed to reliably detect the biomarker or genomic alternation of interest; and evaluate other relevant biological or technical aspects of the LDT based on our medical and scientific expertise. We also undertake clinical validation using appropriate specimens from patients and assess the impact of interfering substances and relevant biological interferences. I personally oversee and review the extensive validation and performance of all LDTs within the laboratory before they can be used to assist in clinical decision-making, and all validations and procedures must be reviewed and approved by the medical director before application to patient care.

10. Unlike FDA-approved or cleared *in vitro* tests and medical devices, CLIA-compliant LDTs offer me and my colleagues the flexibility to rapidly incorporate new scientific and medical advances into our procedures and optimize our processes in light of a patient's particular clinical needs. This adaptability is crucial in the dynamic field of oncology, where timely access to the latest diagnostic information and tools can significantly enhance patient outcomes. It also allows my colleagues and me to continue serving our patients when market developments otherwise would force a procedure offline—for instance, when a given commodity good (*e.g.*, a pipette, a tray, a standard reagent) becomes unavailable due to supply shortages or constraints.

11. The FDA's LDT Rule (the "Final Rule") will drastically change the practice, and seriously undermine the utility, of pathology and laboratory medicine in the United States. That Rule provides that many new or modified testing procedures for wide categories of tests, including those developed in laboratories and expressly authorized by CLIA, cannot be used unless and until it is reviewed and approved or cleared by the FDA after a lengthy and expensive bureaucratic process. In many cases—and particularly for the types of cancer-related LDTs my colleagues and I have been developing for many years—doing so will require me and my colleagues to prepare and submit extensive regulatory filings, satisfy FDA regulatory standards and inspectional requirements, and potentially design and conduct elaborate clinical trials that are intended for manufactured products and not professional medical services. Although these quality standards have some overlap with the ones to which my laboratory and our LDTs already are subject under CLIA, the compliance burden will be much greater, with little evidence of patient benefit.

12. While the Final Rule indicates that FDA intends to exercise "enforcement discretion" in some select circumstances, those vague and malleable categories are ill-defined and

there is no guarantee that any of these categories will be applicable. In addition, the Final Rule repeatedly and unambiguously threatens me and my colleagues with criminal prosecution for developing, modifying, and using an LDT that has not been submitted to FDA for premarket review, even when it does qualify for "enforcement discretion" under these vaguely defined, malleable, non-binding, and inherently unreliable forms of administrative grace. 89 Fed. Reg. 37,295 (asserting that LDTs are "illegal"); *id*. at 37,297 (same); *id*. 37,301, 37,304, 37,307 (threatening "to pursue enforcement action … at any time" despite the supposed enforcement discretion).

13. The Final Rule's consequences will be devastating, both for me personally and for my patients. Given the extraordinary costs needed to comply with the FDA's new requirements for LDTs and the FDA's direct threats of criminal prosecution, I already have suspended the development and/or modification of numerous LDTs that were undergoing development and validation—in some cases for many years—because the extraordinary economic and compliance burdens imposed by the Final Rule will make it cost-prohibitive to pursue FDA clearance or approval for those LDTs. This has been particularly heart-breaking for me and my colleagues in the academic medical center context, where we frequently developed LDTs for rare cancers and other diseases or conditions even though the broader market demand for such procedures is highly limited and developing these procedures could not be commercially justified from a strict economic perspective; with the Final Rule in place, my ability to practice medicine and treat my patients now weighs heavily on economic considerations, fear of criminal prosecution, and concerns about job security—not science, my professional and medical judgment, and my patient's needs.

14. To the extent I am able to continue developing new LDTs or modifying existing methods—because it is financially viable or morally essential to do so despite the extraordinary economic, bureaucratic, and compliance burdens imposed by the Final Rule—my practice of medicine will suffer dramatically. As I said earlier, my work is not limited to the laboratory: I currently devote substantial time, at least several hours a day, to consulting with other physicians and participating in molecular tumor boards to discuss and develop individualized patient treatment plans, review patient progress, and optimize patient care. These important interactions will be severely curtailed once the Final Rule takes full effect: While I can still serve on tumor boards, I will have less time to do so because I will be required to spend so much time complying with FDA's new regulatory mandates, and in many cases, my role will be to reinterpret commercial reports rather than contributing data from orthogonal tests or advanced tests to help resolve issues because such LDTs will no longer exist or be available. And, rather than practicing medicine, I will be forced to spend many hours working on regulatory submissions, answering data-driven questions from FDA on strict and immediate timelines, complying with cumbersome bureaucratic requirements, and dealing with additional regulatory inspections beyond those my laboratory already undergoes pursuant to CLIA; with laboratory personnel shortages, I will be doing this work myself rather than treating patients.

15. Most important, the LDT Final Rule will be a death sentence for some of my patients and will unduly prolong and lead to more invasive procedures and treatments for many others. Without the ability to efficiently develop or modify LDTs, as CLIA expressly authorizes, many diseases and conditions will go undiagnosed or will be diagnosed far too late for effective medical interventions to be administered. Others (*e.g.*, a particular cancer variant) are likely to be misdiagnosed (*e.g.*, as a different cancer variant) and patients will receive suboptimal medical

interventions. Needless to say, these missed, delayed, and inaccurate diagnoses will lead to the progression of disease, reducing the likelihood of successful treatment and increasing the risk of poor outcomes. For my patients in particular—typically children and adults with cancer, or importantly, those at risk of cancer—even a short delay can be the difference between receiving care that can put their cancer in remission or even cure it, on the one hand, or only receiving palliative care, on the other.

16. Finally, I note that the significant costs the Final Rule will impose ultimately will be passed on to patients, increasing the already-crushing financial burden that typically accompanies a cancer diagnosis. Many of my patients already struggle to afford the high costs of health care, and with the higher costs that come with FDA regulation, there will be increased disparities in access to essential diagnostic and treatment services—particularly in areas where there is limited access to testing services. This financial strain will not only deter patients from undergoing necessary testing, even if there is an FDA cleared or approved test available, but also may deter physicians from ordering tests because of the possible financially toxic burden they inflict on patients. This additional financial burden will further contribute to delayed or missed diagnoses and suboptimal treatment plans, exacerbate health inequities, and undermine efforts to provide high-quality, accessible cancer care.

17. In short, the FDA's LDT Final Rule has already directly affected me, and will continue to do so, by interfering in my practice of medicine and halting my development and modification of new LDTs—under the explicit threat of criminal prosecution. And it will hurt my patients, by depriving them of access to essential medical services, delaying diagnoses and treatment, increasing their financial burdens, and worsening their health outcomes.

Dated: August 16, 2024

Eric Konnick, MD, MS