1
2
3 U.S. HOUSE OF REPRESENTATIVES
4
5 WASHINGTON, D.C.
6
7 INTERVIEW OF: MARTIN CETRON, M.D.
8 MONDAY, MAY 2, 2022
9
10 The Interview Commenced at 9:10 a.m.

11 APPEARANCES:

12 FOR THE MAJORITY:

13 [Redacted]

14 [Redacted]

15 [Redacted]

16 [Redacted]

17

18 FOR THE MINORITY:

19 [Redacted]

20 [Redacted]

21 [Redacted]

22 [Redacted]

23

24 FOR HHS:

25 Kevin Barstow

26 Jenn Schmalz

27 JoAnn Martinez

28

29 FOR CDC:

30 Elyssa Malin

31 Erica Portman

32

33 P R O C E E D I N G S

34 [Majority Counsel]. Let's go on the record. The time
35 is now 9:10 a.m. It is May 2, 2022. This is a transcribed
36 interview of Dr. Martin Cetron conducted by the House Select
37 Subcommittee on the Coronavirus Crisis. This interview was
38 requested by Chairman James Clyburn as part of the
39 Committee's oversight of the federal government's response
40 to the coronavirus pandemic.

41 I'd like to ask the witness to state his full name and
42 last name for the record, and please spell your last name.

43 The Witness. Martin Stewart Cetron. Last name is
44 Cetron, C-e-t-r-o-n.

45 [Majority Counsel]. Good morning, Dr. Cetron. Again,
46 my name is [Redacted]. I'm majority counsel for the Select
47 Subcommittee. I want to thank you for appearing virtually
48 today. We recognize that you're here voluntarily, and we
49 appreciate you taking time away from your duties at the CDC.

50 I'll just lay out the ground rules and ask you a few
51 questions.

52 Under the Committee's rules, you're allowed to have an
53 attorney present to advise you during this interview. Do
54 you have an attorney representing you in a personal capacity
55 present with you today?

56 The Witness. I do not.

57 [Majority Counsel]. Is there agency counsel present?

58 The Witness. Yes.

59 [Majority Counsel]. Would agency counsel please

60 identify themselves for the record?

61 Mr. Barstow. Kevin Barstow, senior counsel at HHS.

62 [Majority Counsel]. And could additional agency staff

63 in the room please introduce themselves for the record.

64 We don't have anyone else?

65 Ms. Martinez. Jo Ann Martinez, HHS.

66 Ms. Schmalz. Jen Schmalz, HHS.

67 Ms. Portman. Erica Portman, CDC.

68 Ms. Malin. Elyssa Malin, CDC.

69 [Majority Counsel]. And our colleagues in the minority,

70 could you please identify yourselves for the record.

71 [Minority Counsel]. [Redacted] with the Republican

72 staff.

73 [Minority Counsel]. [Redacted] with the Republican

74 staff.

75 [Minority Counsel]. [Redacted] of the Republican staff.

76 [Minority Counsel]. [Redacted] with the Republican

77 staff.

78 [Majority Counsel]. And my colleagues on the majority,

79 I'd ask you to introduce yourselves as well.

80 [Majority Counsel]. [Redacted] for the majority.

81 [Majority Counsel]. [Redacted] for the majority.

82 [Majority Counsel]. [Redacted] with the majority as

83 well.

84 [Majority Counsel]. Okay. I'd like to go over the
85 ground rules for this interview, and first is the scope. As
86 previously agreed by majority staff and the HHS staff, the
87 scope of this interview is the federal government's response
88 to the coronavirus pandemic from December 1, 2019, through
89 January 20, 2021.

90 The way this interview will proceed is as follows: The
91 majority and minority staffs will alternate asking you
92 questions, one hour per side per round until each side is
93 finished with their questioning. The majority staff will
94 begin and proceed for an hour; the minority staff will then
95 have an hour to ask questions. We'll alternate back and
96 forth in this manner until both sides have no more
97 questions.

98 We've agreed that if we're in the middle of a line of
99 questioning, we may end a few minutes before or go a few
100 minutes past an hour just to wrap up a particular topic.

101 In this interview, while one member of staff may lead
102 questioning, additional staff may ask questions from time to
103 time.

104 There is a court reporter taking down everything I say
105 and everything you say to make a written record of the
106 interview. For the record to be clear, please wait until I
107 finish each question before you begin your answer, and I

108 will wait until you continue your response before asking you
109 the next question.
110 The court reporter cannot read nonverbal answers such as
111 shaking your head, so it is important that you answer each
112 question with an audible verbal answer. Do you understand
113 that?
114 The Witness. I do.
115 By [MAJORITY COUNSEL].
116 Q We want you to answer the questions in the most
117 complete and truthful manner possible, so we're going to
118 take our time. If you have any questions or do not
119 understand any of the questions, please let us know. We
120 will be happy to clarify or rephrase as needed.
121 Do you understand?
122 A I do.
123 Q If I ask you about conversations or events in the
124 past and you're unable to recall the exact words or details,
125 you should testify to the substance of those conversations
126 or events to the best of your recollection. If you can only
127 recall a part of a conversation or event, you should give us
128 your best recollection of those events or parts of
129 conversations that you do recall. Do you understand?
130 A I do.
131 Q If you need to take a break, please let us know.
132 We're happy to accommodate you. Ordinarily we take a

133 five-minute break at the end of each hour of questioning,
134 but if you need a break before that, just let us know. To
135 the extent there's a pending question, I'd ask that you
136 finish answering the question before we take a break.
137 Do you understand that?
138 A I do.
139 Q And although you're here voluntarily and we will
140 not swear you in, you are required by law to answer
141 questions truthfully. This applies to questions posed by
142 congressional staff in an interview.
143 Do you understand?
144 A I do.
145 Q If at any time you knowingly make false statements,
146 you could be subject to criminal prosecution.
147 Do you understand?
148 A I do.
149 Q Is there any reason you are unable to provide
150 truthful answers in today's interview?
151 A There is no reason.
152 Q The Select Subcommittee follows the rules on the
153 Committee of Oversight Reform. Please note if you wish to
154 assert a privilege over any statement today, that assertion
155 must comply with the rules of the Committee on Oversight
156 Reform.
157 Committee Rule 16(c)(1) states for the chair to consider

158 assertions of privilege or testimony or statements,
159 witnesses or entities must clearly state that the specific
160 privilege being asserted and the reason for the assertion on
161 or before the scheduled date of testimony or appearance.
162 Do you understand?
163 A Yes.
164 Q Do you have any questions before we begin?
165 A I do not.
166 Q We really appreciate you being here. We've wanted
167 to sit down with you for some time. We've been looking
168 forward to this. I don't know if you feel the same.
169 But I'd like to start with talking a little bit about
170 your background at the CDC. Can you tell us, walk us
171 through your career path.
172 A Sure. I came to the CDC in 1992 as a commissioned
173 officer in the U.S. Public Health Service. Prior to that, I
174 had 12 years of academic training in internal medicine and
175 residency in infectious disease training.
176 That was Tufts Medical School, University of Virginia
177 internal medicine, and University of Washington in
178 infectious disease. And I joined through the Epidemic
179 Intelligence Service in 1992 in the Division of Parasitic
180 Diseases.
181 Two years after that, I was a staff person in the
182 Division of Bacterial Respiratory Diseases, and in 1996 I

183 joined the Division of Global Migration and Quarantine, and
184 I have been in the Division of Global Migration and
185 Quarantine for the last 26 years. And I have -- I am
186 currently the director of the Division of Global Migration
187 and Quarantine.
188 Q And beginning in January of 2020, were you also
189 serving as director of the Division of Global Migration and
190 Quarantine at that time?
191 A Yes. I have been the director of Global Migration
192 and Quarantine for most of the 26 years of my service in the
193 division.
194 Q Who did you report to at that time?
195 A Prior to the -- my position in the division as
196 director of global migration and quarantine reports to the
197 center director, the National Center for Emerging and
198 Zoonotic Infectious Diseases, NCEZID. That has been Rima
199 Khabbaz in the time you asked about, January 2020.
200 In addition, the COVID Response Activated Emergency
201 Operations Center, and I've been part of the COVID Emergency
202 Response continuously and nonstop since January of 2020, and
203 that has its own incident command structure as well.
204 There's an incident manager who oversees the response
205 activities. That incident manager position has rotated over
206 the course of the two and a half years of the response, so
207 the person in the incident manager position of the COVID

208 response has varied over the course of -- since January 2020
209 to the present.
210 So I have a dual reporting responsibility.
211 Q And who reported to you at that time?
212 A There are members -- there's a task force in the
213 incident response on global -- the global migration task
214 force, and so that task force reports up through the task
215 force lead, and the task force lead reports to me.
216 In addition, the entire staff of the Division of Global
217 Migration and Quarantine reports up through me.
218 Particularly there are a number of branch chiefs in program
219 on leads that report to the division director.
220 Then inside the office of the director in the Division
221 of Global Migration and Quarantine, there's a deputy
222 director, policy lead, each of the program branch chiefs
223 response lead. There are several direct reports, up to 10
224 or so.
225 Q In general terms, can you tell us what your
226 responsibilities were before the emergency response?
227 A Before the emergency response and for the duration
228 of most of my 26 years in the Division of Global Migration
229 and Quarantine, we have the broad responsibility of
230 preventing importation and spread of communicable diseases
231 into the United States.
232 We have a responsibility on the medical side of

233 screening immigrant refugee and migrant health, and we have
234 responsibility for the issuance of guidelines on safe
235 travel. We have a quarantine and border health services
236 branch.
237 We have a U.S.-Mexico unit. We have a travelers health
238 branch. And then we have a number of offices, regulatory
239 and policy, and IMIT -- I think I mentioned that we can
240 provide you the organogram document, but we have fairly
241 broad responsibility which includes overseeing and
242 implementing directly or through partners the regulatory
243 programs of the Division of Global Migration and Quarantine
244 and responsibilities that are delegated through the HHS
245 secretary, the CDC director, and the director of global
246 migration and quarantine regarding a number of different
247 parts of 42CFR parts 70 and 71 on the quarantine regulations
248 and part 34 on the immigration health screening regulations.
249 Q Sticking with this period in January 2020, who were
250 you regularly interacting with, aside from your direct
251 reports, but sort of in the leadership structure of CDC?
252 A Well, with the leadership structure at CDC,
253 including the incident management structure and multiple
254 task force across the response, there were regular
255 interactions with the CDC director as well, particularly on
256 a number of the regulatory issues that are -- that there are
257 delegated responsibilities to the division director of

258 global migration and quarantine from the office of the
259 director, and those would be the intramural CDC
260 interactions.
261 In addition, the position interacts regularly with HHS
262 staff of response and otherwise. And in the interagency,
263 there are regular interactions with the other departments
264 and agencies in the response structure and through the
265 National Security Council.
266 Q And when did you first learn of the novel
267 coronavirus circulating in Wuhan?
268 A Very late in December of 2019, I started getting
269 some incoming signals from my international collaborators
270 and folks about concerns of unexplained severe respiratory
271 illness in Wuhan, China.
272 It would be in the sort of very -- sort of the
273 penultimate days of December. I had been on leave at the
274 time and returned immediately, based on hearing those
275 concerns, to Atlanta, earlier from leave than had been
276 scheduled, and began engaging immediately on return.
277 Prior to the institution of the -- stepping up the
278 emergency response structure, the EOC incident command
279 structure, we had begun engaging in information gathering,
280 fact-finding confirmation events, sort of discussions,
281 planning and so on right from -- I think it was about
282 January 4th across the interagency leadership -- I mean, the

283 inter-CDC leadership with the director of the National
284 Center of Immunization and Respiratory Diseases, with our
285 own national center, and as well as the CDC director at the
286 time.
287 And then the incident command structure was initiated
288 shortly thereafter. I don't remember the exact date in
289 January. And then everything folded into the emergency
290 operation center incident command structure for interactions
291 and coordination.
292 Q It seems like cutting your leave short is a
293 significant step. Why -- what about what you were hearing
294 told you that you needed to immediately get to work back at
295 CDC?
296 A Well, as indicated, I'd been at CDC 30 years, and
297 most of that career has been involved in doing a number of
298 emergency response activities regarding potential global
299 threats. I've participated in nearly all of those
300 infectious disease responses that the agency has been
301 involved in since -- certainly since '96 and some prior to
302 that. And there are features and characteristics which
303 raise red flags, areas of concern which need to be
304 vigorously addressed, fact finding, data gathering.
305 Some of the things that I had heard that were concerning
306 was the type of cases, the severe respiratory cases, the
307 fact that there were healthcare workers also falling ill,

308 the occurrence of deaths, the speed at which the cases may
309 have been changing, so the rate, the type of questions about
310 the route of spread and transmission. And usually these
311 kinds of situations are ones to take very seriously.
312 So we gathered. As soon as we got information, we
313 began -- what we would normally do is try to get as much
314 ground truthing and source of information as possible from
315 multiple sources. I'm also regularly a member of the WHO
316 emergency committee's roster, so I have a number of
317 colleagues and coordinations and collaborations at the World
318 Health Organization, and we began reaching out and trying to
319 get some additional sources of information.
320 But these kinds of situations it's always better to be
321 alert and ready and track things down very vigorously and
322 aggressively rather than waiting for information to
323 passively come to you to -- that was the nature of the
324 engagement.
325 Q You mentioned your international collaborators
326 earlier and you mentioned the WHO. But who else were you
327 talking with in this --
328 A Well, we have CDC staff deployed internationally
329 and around the world. In particular, there are some CDC
330 staff in China, and so we were reaching out to get
331 information from CDC China office as well as what they could
332 filter through the embassy.

333 And this is the kind of thing where your tentacles go up
334 and you try to get triangulated and get multiple sources of
335 input and get a sense of ground truth around the key -- the
336 key kinds of questions: Who's getting sick, how sick,
337 what's the route of spread, how fast is the trajectory of
338 change, are healthcare workers involved, what is the
339 response system, what are the potential sources, what are
340 the natures -- what are the potential natures of the
341 pathogen, is anything known about -- you know, the etiologic
342 agent or the cause of clusters, and piecing together all
343 that kind of material.

344 So multiple inputs. People that are involved and
345 engaged are all reaching out to their own networks, and then
346 we're meeting multiple times a day to coordinate and
347 information share and exchange and try to develop a common
348 operating picture.

349 Q I want to ask you about the CDC staff -- CDC staff
350 in China. Actually, there's been reporting about that and
351 sort of the resources that CDC had.

352 What's your view, given your expertise, in terms of how
353 CDC was resourced in terms of people in China at that time?

354 A This would be secondhand. I don't have the exact
355 date on the numbers of staff over time, but it has been my
356 best understanding that there had been a reduction in the
357 total number of staff in the recent period leading up to

358 that.

359 And, of course, in an event where there's an emergency,
360 you always feel like there's never enough people to get
361 everything you need to know and done. We had some key
362 people still there. I think one could determine, you know,
363 more specifically and factually the numbers of staff over
364 time and -- in the years leading in.

365 There were residual excellent staff there. Whether we
366 would have been better served by having a larger footprint
367 in the CDC China office or not, it's easy to speculate in
368 retrospect but hard to know for sure.

369 Q Do you have a view in terms of that, given what you
370 do?

371 A Given what I do, I think CDC's footprint globally
372 is incredibly important. Its relationships with post
373 governments and ministries of health are incredibly
374 important, and the kinds of networking that are often needed
375 to assess the risk, the nature of the threat to ground truth
376 and to understand what's going on, it is always better to be
377 prepared with a broader footprint than to be working
378 short-staffed.

379 That's a general principle that I would say. And
380 sometimes you never know where and when things are going to
381 happen, but when they do, you really want a competent staff
382 on the ground to be having established relationships and be

383 able to get information and network effectively as quickly
384 as possible.
385 Q What's your assessment of the relationships with
386 your counterparts on the ground at that time when this was
387 first detected?
388 A My relationship to the CDC with my counterparts at
389 CDC on the ground?
390 Q Your assessment of CDC's relationships with their
391 counterparts on the ground at that time.
392 A I probably am not the best one to answer
393 specifically about what the nature of the CDC staff's
394 relationship with host government are or were at that time.
395 And what I can say is it's very important that the
396 communication, you know, be robust and trusted and valuable
397 and information sources be both credible and accurate to the
398 extent that it's possible in the midst of a confusing
399 emerging event.
400 Q And let's take this and move forward a little bit
401 to -- you said January 4 is really when things got
402 organized. The incident management structure, I think, was
403 set up on January 7. Can you broadly explain how your
404 responsibilities changed once that structure was set up.
405 A Well, the incident management structures -- we were
406 organized in a smaller group of a smaller number of the sort
407 of key principals that usually get involved in these types

408 of events for risk assessment, data gathering and so on.
409 As an emergency activation occurs and the EOC has stood
410 up, a more formal structure has come into play, and there
411 are usually more components and folks brought to bear in
412 that regard. And so you would begin to get an additional
413 bench of resources, and the kinds of things, you know, that
414 need to get done are benefited by a broader group of
415 coordination, and different parts of the agency get brought
416 to bear.
417 The incident managers are identified and sort of the
418 regular flow of what we call the rhythm of activities, the
419 scheduling of events, the coordination meetings, the
420 establishment of task force MDs, all of those things happen
421 very broadly from an agency-wide activation approach.
422 Q Can you just tell us maybe about the teams working
423 on global migration quarantine issues? What are the
424 immediate priorities once that is --
425 A The GMTF, the global migration task force, has been
426 a regular fixture in numerous responses over -- as I said,
427 over the last three decades of my time and 26 years in GFMQ,
428 leading activities in DGMQ. And we have some typical types
429 of responsibilities of understanding the scope, the spread,
430 the speed, the nature of the risk, the symptom profile,
431 et cetera.
432 So we were -- at sort of in the opening act of an

433 emerging threat, in addition to characterizing it as quickly
434 as possible, we begin to look at what types of measures
435 would be done to prevent importation and spread or slow the
436 spread. Sometimes prevention of a distribution of a disease
437 is -- in terms of the globalization is not possible, and the
438 idea of looking at the transnational border issues is about
439 trying to buy time to slow spread, think about what could be
440 done.
441 We have a number of plans and exercises around what
442 occurs in the sort of opening act, depending on what the
443 global distribution of disease is, borders, you know,
444 screening, whether they were going to use temperature
445 checking system, questionnaires, risk factors, exposure
446 risks.
447 Mapping out the movement of traffic from potential
448 source or multiple sources into the United States,
449 understanding the ports of entry that might be where there
450 might be direct contact, in this case, with China, Wuhan, or
451 in Wuhan province -- excuse me – Hubei province, the
452 province that Wuhan is in.
453 And so we began doing all of that work. The
454 transportation network infrastructure mapping was one part
455 of our key responsibility.
456 In the pandemic planning back in the early aughts, in,
457 '05 through '07, there was intensive pandemic planning

458 around community mitigation strategies in which our division
459 had a principal role in the use of the community mitigation
460 toolbox: Isolation, quarantine, social distancing, school
461 issues, testing, screening, surveillance, all of that stuff.
462 So we began -- GMTF was a part, although in this type of
463 response there were some dedicated components that were
464 being established on domestic issues. We would also look at
465 some of the interstate spread in addition to international
466 introduction. That's another part of the -- part of our
467 remit is international arrivals and interstate movement.
468 So these were the things we were working on. We quickly
469 mapped some of the air traffic and some of the other means.
470 We would be looking at the context of movements and flows
471 out of the source area where the original cases were being
472 reported.
473 It was notable that Chinese New Year was coming up and
474 there would be a potential travel nexus from, you know,
475 Wuhan to other parts of China, so then we would look at the
476 additional transportation networks that were beyond the
477 nearest -- the closest international airport.
478 Those were some of our key priorities, and very early
479 on, I believe by discussions and then plans for standing up
480 airport entry screening at the three major airports that
481 have direct connections to Wuhan, we were beginning to
482 engage.

483 It always takes a while from getting the green light to
484 go to actually establishing sufficient people to distribute
485 to our quarantine station networks. At first three
486 airports, and then this continued to scale over the course
487 of the next several -- several weeks by looking at both --
488 not only the direct flights to those -- you know, into the
489 country but also the indirect and transit points. We were
490 also engaging with international partners to see what types
491 of screening and approaches might be taken.
492 Again, the pandemic plan looks at some of these border
493 approaches from the perspective for highly communicable
494 respiratory disease of buying time, not from, you know,
495 stopping the spread, but a lot of that needs to be
496 characterized by understanding exactly what the modes of
497 transmission are, how contagious something would be, and
498 what's the symptom profile that you might look for, what
499 tools do you have to detect that.
500 So those would be some of the main things that we were
501 gearing into -- sort of kicking into somewhat standard, you
502 know, roles and responsibilities that follow playbooks as
503 well as that have been exercised from prior events like
504 Ebola in West Africa, Zika, monkey pox. You know, the
505 number of events like this that we've been involved in since
506 '96 are extensive.
507 Q We'll circle back to airport screens in a little

508 bit more detail later.

509 I want to ask you as part of this process and you
510 mentioned the plan involved in the early aughts, 2005. I
511 want to ask you about the interagency processes and when
512 those got started and who were you working with across
513 agencies early on.

514 A Yeah. The interagency process started very
515 quickly. As I'm sure you know, CDC had significant concerns
516 about this emerging threat, and we had been involved in a
517 number of these kinds of things and understand very well the
518 importance of interagency coordination.

519 Especially with the global migration task force, we were
520 intimately involved in the intersections with the Department
521 of Homeland Security, with the Department of Transportation,
522 clearly, obviously, with HHS and its component agencies,
523 including ASPR.

524 So all of the relationships exercised planning of prior
525 events, all of this lead into a rhythm and a tempo that
526 kicks us into familiar space. Sometimes the names of the
527 people occupying the different roles have changed as
528 administrations turn over, but the importance of the
529 coordination is always the same.

530 It always needs to happen early, and in many times there
531 are preexisting agreements that allow things to transcend
532 the individuals who are occupying the specific rolls.

533 Q For the task force you were overseeing, who was
534 doing that coordinating across agencies? And I'm thinking
535 about the period probably before the standup of the White
536 House task force, so throughout January.
537 A I'm not sure I really understand the question. Who
538 was responsible for coordinating --
539 Q Who was leading the interagency interactions? Who
540 was setting the meetings? Who was driving the agenda? What
541 was happening in that period leading up to the creation of
542 the task force?
543 A Again, there are familiar roles. The department
544 has, you know, a standing role in coordination of the
545 interagency meeting, other departments and agencies at
546 various levels, and those coordinations not only occur at
547 the top where they happen out of multiple places, but also
548 then staff become connected, agency-to-agency staff, and
549 we -- you know, the counterparts are assigned to task forces
550 and we begin meeting and, you know, developing shared
551 information, common operating picture, discussing response
552 plans and then policies. We move filters up again and those
553 discussions are happening.
554 So multiple levels of interconnectivity occur, and they
555 are ongoing and they make a part of that rhythm of the
556 emergency operation response, the response structure. So
557 they're scheduled, again, at multiple layers.

558 It's a web. It's not like a single -- it's a very
559 complicated, interdependent web with a lot of information
560 moving at multiple levels, filtering up and down, but also
561 especially across.
562 Q Okay.
563 A That's the way this unfolds.
564 Q Are you able to say who was sort of leading that
565 web and who --
566 A Well, at different -- different departments and
567 agencies, those might be different people. But the roles --
568 for example, the incident manager at CDC would have a major
569 role in sort of coordination.
570 Then there would be, you know, department-wide
571 coordination that involves, you know, agency leads, and plus
572 the people that they want to bring into some of the
573 conversations, so CDC director, other, you know, agency
574 leads and directors.
575 And those would often be coordinated, you know, by HHS
576 setting the schedule for those kinds of things. And then
577 the interagency meetings would have coordination. Very -- I
578 mean, this was the kind of event that very quickly the level
579 of coordination was high in the U.S. government. So there
580 was -- you know, those groups and everything brought
581 together by the HHS secretary's office and other places.
582 And then the interagency meetings would have a

583 coordination, very -- I mean, this was the kind of event
584 that very quickly, the level of coordination was high in the
585 U.S. government. So it was, you know, those groups are
586 being brought together by department, by the HHS secretary's
587 office and other places.
588 But it was quite clear we were going to be dealing with
589 a complex scenario. We had issues to think about -- I mean
590 that "we" collectively -- on American citizens in Wuhan and
591 issues to struggle with around repatriation, and those would
592 involve multiple departments and agencies, state
593 departments, DOD, DHS, of course, CDC HHS.
594 So that network grows very quickly as the number of
595 issues that have to be taken into account arises.
596 Q When did your team start engaging with the White
597 House?
598 A I don't remember the specific date, but very early
599 on through the secretary's office. The secretary of HHS has
600 a lead coordinating responsibility for COVID in the very
601 early days. And the secretary of HHS would bring together
602 the interagency and structuring agendas.
603 I'm not sure what you mean by when the White House task
604 force started. You know, the White House engagement was
605 coordinated initially through the HHS secretary before it
606 was handed over. That would have been sometime in February.
607 But there was engagement with the White House folks very

608 early on, early in January.

609 Q Who at the White House? In what roles?

610 A Different roles. The folks that -- usually there
611 was the senior official from all the cabinets and then
612 senior folks that were identified from the White House. And
613 the secretary, as I said, in the very early days in January,
614 was coordinating -- was responsible for the White House Task
615 Force on COVID. Then that position shifted to White House
616 leadership.

617 But there was -- there were numerous regular meetings in
618 order to bring the entire U.S. government operation together
619 and discuss situational awareness and systems and sort of
620 policies and options, things like that.

621 Q I want to talk about sort of the formal
622 establishment of the White House task force. That was on
623 January 29. The secretary of HHS was to chair it.

624 Did that change your responsibilities in any way in
625 terms of who you were reporting up to or who you were
626 briefing?

627 A Well, the CDC director was part of that task force,
628 and the CDC would often ask me to participate in those
629 meetings as a plus-one subject matter expert, you know, with
630 the CDC director. If that's the question you're asking.
631 I'm not sure exactly what you're asking.

632 Q Sure, that's what I'm asking.

633 I guess around that time, the decisions about travel
634 were starting to be made. I'm wondering if we can first
635 discuss the January 28 advisory to avoid all nonessential
636 travel to China and your involvement in that decision.
637 A So our -- the Division of Global Migration and
638 Quarantine, in addition to the GMTF task force,
639 traditionally has responsibilities to help advise and guide
640 on safe and healthy travel. Our traveler health branch
641 issues routinely peacetime and emergency response time
642 guidance about safe and healthy travel with the best
643 information that we're able to glean.
644 And so we have a series of scaled level of travel
645 advisories that assess risk and appropriate proportionate
646 mitigation measures, and we update that on a constant basis
647 as we better understand the risk assessment -- that is, the
648 scope, the geographic scope, the magnitude, the intensity.
649 So that would be a very standard place for the GMQ to
650 get involved. That is a lot about what recommendations we
651 would make regarding safe and healthy travel from an
652 outbound perspective. People who would be going to,
653 coming -- or American citizens that would be living in those
654 locations, what was the risk assessment of CDC and what were
655 the mitigation recommendations, what legal of concern we
656 had. And they are tiered to four levels, tiered, you know,
657 concerns in terms of risk assessment.

658 So we definitely would be involved in that. That is
659 also an activity where it's peacetime or emergency response
660 time that gets coordinated through the interagency. We get
661 regularly channels of communication involved with the
662 Department of State and all across the interagency in that
663 regard.
664 So those would be the kind of things that the CDC
665 director would rely on our program to do.
666 I want to highlight that distinction between the
667 guidance recommendations around outbound travel or the
668 guidance and recommendations for American citizens in
669 country, the expatriate communities where the risk might be
670 from divisions that get made on the inbound side on the mode
671 of preventing importation is spread clearly.
672 There's an overlap, but they are slightly different and
673 the tools in the tool kit are slightly different, whether
674 the focus is incoming or whether the focus is keeping people
675 who travel healthy and safe on the outbound side.
676 So they are two important parts of a similar piece, but
677 there are different tools available in different ways to
678 approach those questions. We're getting involved in both.
679 So the border screening kinds of activities that I
680 mentioned earlier, the maximum benefits occur from doing
681 exit screening at the source of where the threat is: Having
682 an emergency response plan for illness that might occur in

683 transit, whether it's by air, land, or sea, but the
684 in-transit component; and then the -- sort of the last
685 concentric ring would be what type of border screening might
686 be considered on the arrival side.
687 So you can see the most powerful and impactful way to
688 approach this is understanding clearly where the source or
689 more than one source are; try to get exit screening in place
690 for people that are infected, sick, or exposed are not being
691 put into international or other travel in the first place;
692 and then, you know, a response plan with regard to the
693 conveyances that move, and then, finally, another layer,
694 outer concentric layer of screening on arrival.
695 The reason the efficiency is maximum source control may
696 be obvious. It goes much broader than just controlling
697 direct travel risks to the U.S. But importantly, more often
698 than not there's a lot of indirect movements, and those
699 indirect points of transit are mixed in places in which it's
700 hard to understand -- you know, as opposed to getting a
701 direct flight that's full of 200 passengers right from the
702 international airport, you know, near Wuhan to LAX, for
703 example, or JFK, the more indirect ways people can come, the
704 more sort of diluted and challenging it is to sort out who
705 has actually been in a risk area or not.
706 Q And I guess we can -- in terms of the way you
707 described it, the January 28 advisory was outbound? It was

708 avoiding all nonessential travel into China; is that right?
709 A Yes.
710 Q Why was that recommendation made at that time?
711 A The threat picture that was emerging was a serious
712 respiratory illness, like moving pretty quickly, growing
713 quickly in numbers, as we started to get that data from the
714 first several weeks, and it was clear that it was impacting
715 health in ways that could not easily be circumscribed or
716 defined.
717 And that often at the beginning of a situation like
718 this, where there's a lot of confusion and chaos and the
719 risks are not always exactly clear that somebody can take,
720 you know, one measure to protect themselves, whether it's a
721 vaccine or prevention -- preventive medication or something
722 else that would alleviate their risk and there was community
723 spread and widespread transmission, the best advice we can
724 give until there's much more clarity is for people to avoid
725 an area like that.
726 There was also strain on healthcare systems and hospital
727 delivery. And so it was the combination of the severe
728 threat, the widespread nature, the rapid spread, and the
729 potential impact on healthcare system and delivery that --
730 what would be the options for an American citizen or other
731 persons leaving from the U.S. traveling to the area, if they
732 got sick, in terms of their ability to access care.

733 Those are all the kinds of factors that lead into a
734 decision like that.
735 Q Do you think that decision should have been made
736 sooner?
737 A We had been providing, you know -- like I said,
738 there are tiers of that, so that avoid all nonessential
739 travel, that's the higher tier short of actually mandating
740 restrictions and closures at the border. So that's a level
741 of guidance.
742 And I'd have to go back and check the record, but I
743 believe we sort of tier through with some geographic
744 specificity before we get to that fourth tier.
745 And certainly, we had concerns earlier, we were setting
746 up our screening, we were setting up surveillance systems,
747 we were gathering data on the nature of the cases, whether
748 it was strong evidence for person-to-person spread, what the
749 incubation period, what the nature of the pathogens would be
750 and whether there were countermeasures known -- that is,
751 treatments -- already, you know, known.
752 So I think by the end of January, we had a reasonable
753 idea that this was a coronavirus in that SARS or MERS
754 family. There were certain things that had been, you know,
755 deduced about that just by the original genomics. I think
756 by the end of January, the emergency committee at WHO had
757 already met at least once, if not more than once in January,

758 to my recollection, that I participated in.
759 So I think as the information was rapidly being
760 acquired, it was clearly a step that needed to be taken.
761 Q Were you advocating for it earlier or was anyone at
762 CDC wanting to do it before the January 28 date?
763 A You know, I can't remember the specifics about
764 that. There was a lot going on in the last two and a half
765 years. I don't remember the specific of dates.
766 But we were -- I can tell you that I and my team and
767 others at CDC were very concerned about this pathogen from
768 very early in January.
769 Q I think what you described was ratcheted up three
770 days later. Secretary Azar announced public health
771 emergency and then the presidential proclamation that entry
772 from China was suspended and the additional screening and
773 quarantine.
774 So that's a ratcheting up in three days. Can you tell
775 us what goes into that and sort of mobilizing the airport
776 screenings and the authority of quarantine?
777 A Yes. So I can say just on the airport screenings,
778 based on what I was hearing in the first week of January, I
779 was making the recommendation we should start doing that
780 even before knowing about all the characteristics of the
781 virus, that heightening surveillance in trying to find cases
782 was going to be important, even if it was only a way to

783 create a better awareness or if we identified cases early in
784 January, whether we had specimens in our hands in the U.S.
785 to be able to begin characterization of the virus.
786 So I'm thinking that by -- I mean, it takes a while to
787 set up and coordinate and get those operations going, but we
788 were doing that in a matter of days rather than -- you know,
789 sometimes it can take longer to mobilize funding and all
790 these other things, get people, discussed at the appropriate
791 perch, develop questionnaires.
792 We wanted to be asking about potential exposures in
793 addition to symptoms, in addition to a temperature
794 screening, and then having the protocol for how to handle
795 those that flip the switch positive.
796 So I'm vaguely recollecting that we had started in the
797 three largest volume hubs receiving direct flights by the
798 middle of January, maybe the second week or toward the end
799 of the second week in January. I'd have to go back and
800 check that record for specifics.
801 And as we characterized the travel network as we learned
802 more about what was going on in terms of travel out of the
803 central locations, the specific hot zone in Wuhan, to other
804 parts of China, and as we were defining the transit hubs and
805 the indirect things, we were expanding that airport program.
806 That, as I said, we were well aware was not designed to
807 prevent importation of a highly contagious respiratory

808 disease. These are about buying time to get better
809 understanding of the risk assessment and what tools are
810 needed, develop diagnostics, develop response plans,
811 characterize things to really understand what's going on.
812 Some of these types of highly contagious respiratory
813 viruses are not going to be stopped by any entry screening
814 program or any, you know, travel bans and all that. It's
815 just not the way it works.
816 Were it true, I would be very happy about that, but that
817 is not the reality of my experience over three decades of
818 doing this kind of work. But it does give you an
819 opportunity to heighten the level of concern.
820 I was hearing from colleagues in the surrounding
821 countries to China that their screening programs were
822 detecting introduced cases. And it's very important to be
823 able to assess whether what's being done at the source is
824 sufficient to prevent exportation and to gear up what type
825 of things could be done at the source to really contain
826 something as close as possible with the source or even, you
827 know, slow it with maximal impact.
828 But I was hearing from colleagues at -- both
829 international colleagues as well as directly from CDC field
830 colleagues in various countries that they were having --
831 they were detecting imported cases through the airport
832 screening programs, and that allowed another path to

833 characterizing the nature of the illness and to understand
834 that things were moving beyond the boundaries of Wuhan and
835 Hubei province as they characterized the itinerary from
836 which the cases are defined.
837 So we began to do that very early, as I said, prior to
838 the end-of-January announcements that you're talking about.
839 Q I think we can take a look at an MMWR by one of
840 your colleagues -- it's Exhibit 1 -- that goes into some of
841 these details very briefly.
842 [Exhibit 1, marked for identification.]
843 A Is this the one that --
844 Q It's by --
845 A -- and others --
846 Q Dr. Patel and Dr. Jernigan.
847 A Dr. Patel and Dr. Jernigan, yeah.
848 So I definitely, you know, participated in providing
849 information into this piece as a member of the response
850 team. And it goes through a little bit of trying to
851 crystallize the level of concern that we had.
852 Q Yes. It seems like your memory is actually pretty
853 good that the enhanced screening started on January 17.
854 I wanted to turn your attention to the first paragraph
855 on page 3, which is also page 142.
856 A Okay. The first -- the initiating paragraph on
857 January 24?

858 Q Yeah. I guess we can start on the bottom. I want
859 to ask you about as of February 1, 2020, and the numbers.
860 Sort of -- it's in the middle of that cut-off paragraph.
861 A Right. "As of 1 February 2020, 3,000 persons on
862 437 flights were screened and then we referred these five
863 symptomatic travelers."
864 Right?
865 Q Right.
866 Why do you think there was such a low number of positive
867 cases detected from the screenings at that time?
868 A I think probably there was some combination. What
869 ultimately we learned more in retrospect than what we knew
870 clearly at this time was that this -- in contrast to the
871 SARS 1 coronavirus and certainly in contrast to MERS, there
872 was a high amount of contagiousness and infectiousness very
873 early in the incubation period, and transmission was
874 occurring from -- and I'm saying this with clarity in
875 hindsight. Transmission could easily occur and was
876 occurring from both presymptomatic and asymptomatic cases.
877 Our screening tools were really -- and our temperature
878 checks and all those things were really focused on looking
879 for febrile cases and people that had active symptoms. And
880 that became very clear early on that we were -- that this
881 program of entry screening that was focused on symptoms and
882 fevers was not going to be very effective in dealing with

883 the asymptomatic or presymptomatic early infection, high
884 viral load, high-risk cases. That probably was the major
885 reason the yield was less than we expected.
886 We did a lot of screening, a tremendous amount of
887 intensity of effort, and it just wasn't panning out the way
888 it should have. That doesn't mean that doing it at the time
889 wasn't something we should do, because, like I said, a lot
890 of this information was gleaned in retrospect.
891 The other possibility -- there was a number of
892 possibilities for why that screening is less efficient than
893 it would be. Some of them include containment at the
894 source, and we have seen that there were some very heavy
895 control measures being put in place first in Wuhan lockdowns
896 and then subsequently in lockdowns in Hubei province. So
897 we're really thinking about that part is the most effective
898 part at filtering.
899 But we were still seeing kind of volume stragglers, but
900 they may not have been coming from areas where they were as
901 exposed to that. That was another explanation.
902 It's possible that the things you're looking for are not
903 consistently positive over the course of an incubation
904 period from exposure to symptom onset if there are going to
905 be symptoms. That is, there's sort of peaks and troughs.
906 It's also possible that people mask symptoms with
907 medication that reduces fever or medication, or they don't

908 directly report. And so it depends on our actual encounter
909 assessment to detect them rather than having people
910 voluntarily acknowledge, well, I don't have a symptom now,
911 but yesterday I had a fever. Now I'm on Tylenol or
912 something.

913 So I think there's a lot of explanations, but it was not
914 lost on me that the yield was low. And as we began to get
915 further into this, I began to gather more information from
916 the WHO emergency committee, reports directly out of China
917 in terms of what they were finding.

918 I became more and more skeptical that our initial border
919 screening protocols would be able to have the kind of yield
920 in preventing importation and spread and the need to move
921 beyond that was becoming clear.

922 I think that's -- you don't know that until you do all
923 the screenings, and part of it is actually doing that to
924 gather the exact data on how much exportation there will be
925 and whether the protocols and tools are working.

926 I will say in contrast, for example, that, things like
927 Ebola, which are maximally contagious late in the illness,
928 in fact, even after death, when some people are just too
929 sick to travel. So this is a totally different scenario.
930 Respiratory nature makes it different in that regard as
931 well. So there's a lot to learn.

932 We decided that we wanted to add the understanding of

933 what would happen for those folks that came in who were not
934 symptomatic or not detected at the airport but still had a
935 14-day rule -- it was emerging as a 14-day incubation
936 period, how we would be able to follow those contacts after
937 arrival and make sure that as soon as someone was
938 identified, they had a way to report to public health during
939 the 14 days after arrival.

940 So contact information, contact tracing, the ability to
941 alert the entire U.S. public health system to travel-related
942 importation, since we weren't getting the yield on
943 airport-based screening that I had hoped, would also be an
944 important component.

945 And incubation period post-arrival surveillance is
946 always important, because not everybody is going to manifest
947 at the time of travel. In fact, most often, for many
948 infectious diseases, there are more retrospectively
949 identified cases in people who had already traveled during
950 the incubation than the ones you would find at the snapshot
951 and point of time at the point of entry.

952 So this has got to be a multilayered, multiple approach
953 to addressing that. There's no one component that's going
954 to solve this. And I think, you know, that's sometimes hard
955 to convey. People want there to be a magic bullet. You
956 know, you get everything as you walk through a thermal
957 scanner or a temperature check.

958 But it isn't like that, and the type of pathogens you're
959 dealing with when people are contagious, if they get
960 symptoms, if they get fever, all play a really important
961 role in terms of how we can all be responsible.
962 Q I want to ask you given what CDC learned later and
963 published its findings about importations from Europe, do
964 you think that screenings should have been expanded to
965 passengers from Europe at this time? Do you think that
966 would have made a difference?
967 A I think -- look: The truth is this has been a
968 rapidly inpatient evolving global pandemic with a pathogen
969 that's got a high reproductive rate. It's highly
970 contagious. It causes symptoms to move quickly.
971 The kinds of roles that we had talked about for airport
972 screening, if you think about pandemic in sort of phases,
973 almost like the Queen's Gambit story or a chess match,
974 you've got an opening act when the pathogen is first
975 emerging and the number of source countries involved could
976 be very narrow, and you've got a lot of focus in that.
977 You've got a point in time at which many countries get
978 involved and there's regional spread or even beyond
979 regional, multi-regions of the globe are having active cases
980 and epidemics. That's a long, long middle game while you
981 have globalization but before you have full characterization
982 of medical countermeasures, treatments, vaccines, all sorts

983 of things.

984 And there's a long period of time of relying on public
985 health measures and community-based mitigation and control,
986 what we call the sort of flattening of the curve.

987 And our group led a lot of this analysis in the 2005
988 pandemic planning -- influenza planning plan, and our
989 planning documents, we published that in '07.

990 But this pandemic moved through regions very, very
991 quickly, both spread in China, regional spread, and into
992 Europe, particularly Italy. And the pandemic moved in some
993 ways faster regionally than others; for example, large West
994 African Ebola pandemic, for a number of reasons: Different
995 pathogen, different mode of transmission, different
996 communicability, different symptom profile, different ebola
997 and Europe became quickly involved, other Asian
998 countries and so on. The U.S. was actually very quickly
999 involved because of our hub connectivity to some locations.

1000 Would we have been able to derive some benefit from
1001 getting screening in various measures done earlier from
1002 Europe? Undoubtedly yes. It would not necessarily, as I
1003 said, have been the things that stopped the globalization of
1004 a pandemic like this, but we may have gotten more cases,
1005 because movement was more open.

1006 There wasn't as much lockdown as there was in China.
1007 That may have allowed us to get specimens from people who

1008 were infected earlier to understand the introduction,
1009 distribution earlier, get tests developed -- all sorts of
1010 things that are really critical about characterizing the
1011 virus when it's on your own soil: Incubation period,
1012 symptom profile, whether people can spread before they get
1013 symptoms.

1014 All of that it's easier to acquire directly from your
1015 own early cases than it is to acquire by derivative, or
1016 trying to understand what another country's epidemiologic
1017 capacity is or exchange.

1018 So I think we could have moved much more quickly had we
1019 been able to expand those types of engagements. But it's
1020 one thing to have a certain response, you know, toward China
1021 and another thing to acknowledge how quickly things are
1022 moving from a global perspective.

1023 Q Is that something you or your team was advocating?
1024 Can you elaborate on that?

1025 A Yes. It was clear to those of us who had been
1026 doing this a long time that we needed a more aggressive
1027 posture, and we were advocating that in a variety of
1028 settings.

1029 And we were also advocating for, you know, different
1030 approaches to the screening. We were advocating for the
1031 need to do follow-on of the travel-related contacts. We
1032 needed good information to do that.

1033 We still didn't have, you know, a very reliable,
1034 sensitive, and specific diagnostic test, which, you know,
1035 hampered the ability -- when you're talking about a common
1036 set of respiratory symptoms, as you're moving into typical
1037 respiratory virus season, particularly flu season, you have
1038 the problem of a -- you know, a pretty common thing with a
1039 lot of volume and a lot of movement and trying to actually
1040 find the thing you're really looking for in order to better
1041 characterize it.

1042 But the only way to do it is -- these things move fast,
1043 and if you wait for systems to sort of, everyone to get on
1044 board and feel like things have to be done, the pathogen is
1045 always chasing you and likely to bite you in the back rather
1046 than you being in front of it in an anticipatory way.

1047 And I think it was very challenging to get that level of
1048 attention and seriousness about what we were dealing with
1049 and the likelihood -- I mean, it's clear to many of us that
1050 this was going to be an emerging pandemic very, very early
1051 by the nature of how it behaved at the source and in a few
1052 other places.

1053 [Majority Counsel]. I want to follow that point, but I
1054 think we're at time, so I wanted to stop there and let my
1055 colleagues in the minority have an opportunity to ask you
1056 questions.

1057 Well, first I'll ask you: Would you like to take a

1058 five-minute break?

1059 The Witness. Maybe a bathroom break would be great, and

1060 I'd be right back, if that's okay.

1061 [Majority Counsel]. We'll return in five minutes.

1062 [Recess]

1063 By [MINORITY COUNSEL].

1064 Q My name is [Redacted]. I'm on the Republican staff

1065 of the Committee on Oversight Reform. I have a few

1066 questions for you.

1067 You testified in the first hour that your title is the

1068 director of global migration and quarantine. How long have

1069 you held that position?

1070 A I came to the division in '96 initially as a

1071 surveillance and epidemiology branch chief. I believe in

1072 2000 I became the deputy director, and I don't remember the

1073 exact year that I became the director, maybe in 2003 or

1074 thereabouts. Roughly been in the role for about 20 years or

1075 just shy of that.

1076 Q I think you might have said this before. Is part

1077 of that job -- does part of that job involve public health

1078 for migration, bringing migration into the United States?

1079 A Part of the job involves the Part 34 regulations

1080 around medical screening for those applying for lawful

1081 permanent residence, and part of our public -- so on the

1082 regulatory side, and part of our job involves the public

1083 health approaches to general migration-related issues.

1084 So in the LPR side, that includes refugee migration and
1085 immigrant applicants. In the public health side, like I
1086 said, we're often asked to consult on migration-related
1087 public health issues.

1088 Q Were you involved in the drafting, execution, or
1089 implementation of the CDC March 20, 2020, order suspending
1090 introduction of certain persons from countries where
1091 communicable disease exists issued under Title 42?

1092 A Not substantially, no.

1093 Q It was reported that you refused to support issuing
1094 that order. Is that report wrong, then?

1095 A You asked if I was involved in the drafting,
1096 writing, and implementation. Did I misunderstand the
1097 question?

1098 Q So what was your involvement in the March 20 order,
1099 then?

1100 A Very little direct involvement.

1101 Q All right.

1102 A I was consulted by the CDC director about issuing
1103 that order, and as has been the case, I provided my advice
1104 to the director, public health advice about the approaches
1105 that should be done to reduce the public health risk.

1106 What was asked was specifically to construct the order
1107 as it was stipulated, not about what public health measures

1108 and risks should be done? I told the director,
1109 respectfully, I thought there were very important
1110 alternative public health measures. So that's -- I think
1111 that's what you're getting at.
1112 Q So is that report, then, overstated? If you
1113 weren't involved in the drafting or execution, there wasn't
1114 a question of whether or not it was your final pen on the
1115 check box?
1116 A No. I don't know how more clear I can be, because
1117 maybe I'm not sure exactly what you're saying.
1118 It's not like we rewrote it. I wrote it with my team
1119 and we -- you know, I refused to sign it. First of all,
1120 these delegations of authorities include the director for
1121 these regulatory authorities as well as the CDC director as
1122 well as the DGMQ director.
1123 But the specific ask about that public health tool that
1124 was posed that the director indicated that was what was
1125 wanted, the director and I, you know, had some conversations
1126 and it was decided that that tool and that use and that
1127 order would be drafted outside of my lane.
1128 Q Would it have normally been drafted within your
1129 division?
1130 A It might have been. Not necessarily, because, like
1131 I said, there's a lot of engagement and involvement around
1132 that. But -- and that was somewhat an unprecedented order

1133 in its scope and magnitude and approach.

1134 So it wouldn't necessarily have been directed by the CDC

1135 director -- I mean, the DGMQ director. In fact, there

1136 hasn't been anything quite like it in a long time, so I

1137 can't tell you what normative might have been for such a

1138 precedent.

1139 Q Did you -- as part of working with Director

1140 Redfield, on that, did you travel to the border?

1141 A I did not. This really was handled out of the

1142 director's office and with others, and I can't speak to

1143 various components.

1144 [Minority Counsel]. Okay. I think that's all we have

1145 for this hour. Thank you.

1146 [Minority Counsel]. I actually have a few.

1147 By [MINORITY COUNSEL]:

1148 Q You mentioned there you thought there were various

1149 alternatives to the order that you were discussing with my

1150 colleague, [Redacted].

1151 What were some of those alternatives?

1152 A As I indicated before, often border measures, hard

1153 core border closures, can be considered, you know, in

1154 appealing or a quick first reach, but often they don't

1155 really work as intended. And the things that are most

1156 needed in terms of the public health readiness are issues

1157 around cohorting -- you know, isolation, quarantine,

1158 detection, various approaches to mitigation, engagements,
1159 use of masking and other types of tools.
1160 And the public health tools that really need to be done
1161 that are shown to work and be more effective are not always
1162 the ones that people think of first, like sealing, you know,
1163 a border that's as long and in a country that's as large.
1164 And those type of approaches have been used in some of
1165 those populations around the border in the past and when
1166 they're used are highly effective, and those other
1167 approaches really don't get at the root cause, and sometimes
1168 they create more public health downstream harm by the nature
1169 than they do good and -- whether that's in terms of
1170 procrastinating on the things that most urgently need to be
1171 done from a public health perspective.
1172 That's been our experience for a while. So lots of
1173 other things have not been tried and were being recommended
1174 and had been recommended in past in similar settings. And
1175 that -- you know, that was my sense.
1176 So there's a lot of known public health tools that work,
1177 you know, to mitigate some of the impact. And then one also
1178 needs to assess where the infection pressure is coming from
1179 and whether it's truly, you know, coming from the perceived
1180 source or an actual source of risk.
1181 Q I guess I don't understand the distinction. So can
1182 you break it down? Like you support -- I guess maybe I

1183 missed it in the last hour. Did you --

1184 A Infection control, identifying cases through

1185 symptoms and cohorting groups where possible.

1186 Q So you favor keeping travel going but having more

1187 robust screening? Is that what I'm understanding you to

1188 say?

1189 A Some aspects of it are related to screening. Some

1190 aspects of it are really focusing on the risk, and some of

1191 the most important things are improving the basic hygiene

1192 circumstances that -- the -- the circumstances that promote

1193 transmission are really important to get at early on and to

1194 try to do, rather than having the impression that somehow

1195 you could actually prevent something from arriving through a

1196 border closure when that's less likely, and also looking at

1197 the relative balance of where is the infection pressure at

1198 the moment and so on.

1199 And we've had very good success with a number of tools

1200 that really mitigate the pressure of transmission, and some

1201 of it's related to age groups and other kinds of things.

1202 So I think that there are public health harms that also

1203 occur when some of the things that were, you know, being

1204 proposed.

1205 Q Okay. So we stopped travel from China; correct?

1206 Do you remember when the president did that?

1207 A I do. I do remember when the president did that in

1208 the end of January.

1209 Q So Dr. Fauci testified before our Committee that he
1210 supported that travel ban, for lack of a better way to put
1211 it, and that he thought that that saved lives.

1212 Do you agree with that or not?

1213 A I think, as I mentioned in my prior testimony, that
1214 there are tools that are appropriate at the onset or the
1215 opening acts of an emerging potential pandemic when there's
1216 single-source involvement, like a concentrated epidemic in
1217 Wuhan. And that as those things change and the sources
1218 become multiple and, to varying degree, globalized, it's
1219 really important to understand where the pathogen is and
1220 where the threat is and where it's not as you design
1221 strategies, and that matters.

1222 And so by March of 2020, we weren't in the situation
1223 that we were in January of 2020 with concentrated cases in
1224 China. There were cases in a number of places. There were
1225 notably very hot spots in the globe, of which the U.S. was
1226 already one of them, and there were notably places in the
1227 globe that did not have that many cases.

1228 And so it's really important to understand how you match
1229 the tools you're going to use with the locus, location of
1230 the source of the movement. And so that goes into that
1231 factor as well.

1232 Q So we were slow to, I think, ban travel from

1233 Europe. In my recollection, Italy was experiencing a large
1234 amount of cases in the spring of 2020.
1235 Would you or did you recommend stopping travel from
1236 Europe sooner than it was actually done?
1237 A I want to be conscious about your term "banning
1238 travel." There weren't hard outright travel bans. There
1239 were selected population. There was still large amounts of
1240 returning travel from Europe even when the 212 proclamations
1241 were put into place, if that's what you're asking about.
1242 And then, again, it's one thing to use a travel ban in
1243 January with a single focus of infection. The continuation
1244 of the use of travel bans as a tool once there's widespread,
1245 you know, infection in the U.S. starts to become diminished,
1246 and the shift in the approach of basically screening,
1247 assessment, isolation, quarantine, infection control,
1248 masking, basic hygiene circumstances becomes more paramount
1249 and more important from the perspective of preventing
1250 importation and spread.
1251 So the tools we take out of a tool kit need to vary by
1252 what the nature of the geographic distribution and scope of
1253 the pandemic is. It's not always going to be appropriate
1254 and sometimes more harm than good will come out of trying to
1255 put into place travel bans, which also have collateral
1256 damage, including the movement of goods and services,
1257 control and preventing the pandemic, the supply chains, many

1258 other things that come into play.

1259 So every situation needs to be evaluated for the context

1260 of the dynamism of the pandemic.

1261 Q Okay. So I want to just try to summarize really

1262 quickly. It sounds like, and is it fair to say, that you

1263 think that impediments to travel, we'll call them, should be

1264 based on -- should be timely and targeted to certain

1265 geographies based on where we're seeing the cases? Is that

1266 a fair summary? And it is a summary.

1267 A I think there's a difference between border

1268 closures and travel bans in one category, and I don't know

1269 what you mean by the term "impediments to travel," like safe

1270 and healthy travel advice, testing, eliminating, isolation

1271 of people that are sick, those kinds of things.

1272 I don't know whether you consider -- are you referring

1273 to those as impediments to travel? Because there's a real

1274 distinction between an outright border closure attempt and

1275 the level of collateral damage from a set of public health

1276 infection control measures that could be used to mitigate

1277 the impact of the transmission and spread.

1278 So if you mean impediments to travel, all those things,

1279 that's sort of one approach, but if you're actually talking

1280 about border closures and travel bans, that's a different

1281 question.

1282 Q Well, let's talk about what was your recommendation

1283 back in -- so most things in America, I think we would
1284 agree, shut down around March 12, 13, in there.
1285 What was your recommendation going back to that time,
1286 March 2020? What was your recommendation vis-a-vis travel,
1287 air travel from foreign countries? Was it based on
1288 geography and where infections were popping up?
1289 A I think what happens is that the focus on broad
1290 border closure measures becomes much, much less effective,
1291 and the need to pivot to a set of community mitigation
1292 strategies becomes much more paramount in having an effect.
1293 Because if you think about it, once the virus is already
1294 here, the real risk is the amplification of our community
1295 spread more than what is contributed by introduced cases.
1296 The volume of travel that was still coming into the
1297 country even under 212, you know, modified border
1298 permissions, which was limited to people who had been in a
1299 certain place within 14 days prior -- it wasn't an outright
1300 travel ban -- but certainly all of the vast -- a huge volume
1301 of that travel was ongoing.
1302 But the pressure of expanding the pandemic in was much
1303 more intrinsically focused and needed to be dealt with the
1304 community mitigation plans that we developed in 2005,
1305 published with full interagency engagement in 2007, and
1306 those infection control practices needed to be the backbone
1307 in this real structure and that there was a certain amount

1308 of false security that would come from focusing on the
1309 border closure aspect as opposed to what we needed to be
1310 doing domestically to get into mitigation.
1311 Q So, then, is it fair to say that you don't support
1312 travel bans at all, ever?
1313 A I don't think I said that. I think I was very
1314 clear that there's an opening act and a place where there's
1315 some uncertainty, where if we have no cases and there's a
1316 single nidus of infection, we're figuring out how to manage
1317 that volume through a whole variety of things, limited on
1318 the volume but also, you know, screening efforts and
1319 awareness.
1320 But, you know, three months into that process in a
1321 different point in the pandemic with a different status of
1322 the epidemic in the United States actually demands an
1323 ability to pivot the focus and the intensity and the
1324 concentration of the resources around control, mitigation,
1325 rather than this idea that it would be contained and you
1326 would stop the cases, because we already had a large number
1327 of U.S. cases at that point.
1328 And then you have to look at what are the collateral
1329 public health consequences of the border closures and how
1330 might they make the situation worse, both globally and
1331 domestically, by where the various, you know, people would
1332 be going, the relocation process of introducing new virus

1333 earlier into limited and constrained resource settings and
1334 great vulnerability.
1335 So there is not one really simple sound bite that is a
1336 perfect fit for all those circumstances.
1337 Q Did you agree with any of the border closures or
1338 travel bans that resulted from this ongoing pandemic?
1339 A I'm not sure there was another border closure. I'm
1340 not sure which border closure you're speaking of other
1341 than --
1342 Q Well, let me go back to my question about
1343 Dr. Fauci. Can you just give me a yes or no to that: Did
1344 you agree or disagree with Dr. Fauci's statement that he
1345 thought that closing off travel from China saved lives?
1346 A In the opening days where the epidemic was
1347 intensely concentrated in a particular city, I think that
1348 taking measures to stem, most importantly, the exit and then
1349 consequently the other things that we could do on entry
1350 around leakage, was very important in both buying time and
1351 saving some lives in that earliest phase where we didn't
1352 know so much about the virus.
1353 I think by March of 2020, we had a lot more
1354 understanding of the global distribution of the virus, the
1355 intensity of the spread, and the pivot away from
1356 geographically-based border closures. Like I said, 212 Act
1357 was not a border closure, unlike the Title 42 specific

1358 aspects were.

1359 The other things that need to be done and need to be

1360 front and center and foremost in terms of the protection of

1361 all the populations in the U.S. need to be pivoted away from

1362 border closure.

1363 I don't know how to say it more clearly.

1364 I do agree with the comment that Dr. Fauci made as they

1365 were appropriate to the context and the situation in early

1366 January. I think the situation was very different by March.

1367 Q So we acted too slowly? Did we act too slowly in

1368 the early days? Should we have banned travel from China

1369 earlier?

1370 A Well, I don't know that we knew the situation. I

1371 mean, I think things moved very quickly once data was being

1372 uncovered. I can't really speak to the specifics of that

1373 timing.

1374 Q Let's move on.

1375 A This was unfolding in a -- you know, the situation

1376 in January was very different from the situation in March in

1377 so many ways.

1378 Q Okay. So you said -- testified earlier that you

1379 came back early from vacation back to work at the CDC.

1380 Would that have been January of 2020?

1381 A Yeah. I think I was back, you know, engaging by

1382 January 4.

1383 Q Were you coming to the office every day?

1384 A Yes.

1385 Q Do you think it's important that CDC personnel come

1386 to the office during public health emergencies?

1387 A Do you mean as a blanket statement, or do you mean

1388 on January 4 of 2020?

1389 Q Well, January -- I mean, we were in a public health

1390 emergency; would you agree?

1391 A The declaration of public health emergency came

1392 later. There was a lot unknown, and in January 4 it was

1393 important for me and my team to be able to convene and

1394 clarify and get as much information to characterize the

1395 risk, the nature of the threat, the speed and mode of

1396 transmission. So that necessitated -- necessitated us being

1397 on site.

1398 Q And you and your team were on site in January of

1399 2020?

1400 A Yeah, and except for the team -- I mean, I had a

1401 large footprint of people that also work at the airports

1402 around the country and some regional international folks.

1403 Those people were at their duty stations.

1404 Q Okay. And did you think that that was -- that was

1405 prudent to have your team on site?

1406 A In January of 2020, the people that were doing the

1407 job that needed to be done were at the duty stations where

1408 they needed to be as we characterized what was going on.

1409 Q Was that in the emergency response center? And we

1410 won't talk about where it is, Kevin.

1411 Were you at the emergency response center at CDC? --

1412 which we don't know where that is.

1413 Is that where you were, or were you at your desk?

1414 Mr. Barstow. We'd ask that be struck and ask that be

1415 redacted from the transcript. I think we've said the

1416 location multiple times in these forums, actually.

1417 By [MINORITY COUNSEL]:

1418 Q Were you working out of the emergency response

1419 center?

1420 A In January of 2020, and except for the people that

1421 were working in their duty stations in the field were

1422 working out of the emergency response center deployed out of

1423 their -- that's where we were.

1424 Q Thank you.

1425 Doctor; is that correct?

1426 A That is correct.

1427 Q Do you consider yourself a virologist or no?

1428 A I'm not a -- specifically a virologist, no.

1429 Q Do you have any opinions that you want to share

1430 with us on the origins of the virus?

1431 A Outside of my expertise, really, to comment.

1432 Q That's what I thought you might say.

1433 You commented on the reduction in CDC China staff
1434 earlier. You just noted that there was a reduction.
1435 Do you have any understanding of why there was a
1436 reduction?
1437 A I do not.
1438 Q Okay. During the prior pandemics that you've
1439 worked on, do you recall recommending any travel-related
1440 measures?
1441 A Travel-related measures like --
1442 Q SARS or MERS or H1N1? I don't know -- was H1N1 a
1443 pandemic? I'm not sure.
1444 A That's 2009. Yes.
1445 So I think that maybe I need to understand better what
1446 you mean by "travel-related measures."
1447 When I mentioned at the opening that our travelers help
1448 branch provides guidance for American citizens traveling
1449 internationally or American citizens living abroad based on
1450 their assessment of the infectious disease health risks and
1451 scalable, sometimes it would be no recommendations and
1452 guidance about it, sometimes it would be at a level 1,
1453 sometimes at a level 4. Sometimes it would be focused on
1454 specific populations.
1455 For example, in Zika, there was a focus on
1456 recommendations for how to stay healthy if you were
1457 traveling during, if you were a pregnant woman is one

1458 example. And all of those things.

1459 So if that's included in what you're asking me about as
1460 a travel health measure, yes, it's important to be able to
1461 provide global situation awareness of threats and
1462 mitigation, you know, mitigation strategies. Those risks
1463 escalate and change, and the mitigations that we recommend
1464 are proportionate to the nature of the threat or focused on
1465 the population that's particularly at risk.

1466 Q What prior pandemic would you say most closely, now
1467 that you have hindsight, mirrors COVID-19?

1468 A None.

1469 Q So it's just completely extraordinary?

1470 A The last time we had anything like this was over
1471 100 years ago. And this scale, scope, magnitude, speed of
1472 transmission, nature of all of society types of impacts --
1473 I've been doing this, as I said, for almost 30 years and
1474 studying infectious threats for many years prior to the CDC.

1475 This is truly -- has been, in my experience, an
1476 unprecedented event. I studied in depth the history of the
1477 1918 pandemic and published extensively on the lessons and
1478 the tools and approach, looking at the impact of the 1918
1479 pandemic across 43 cities in the United States in a
1480 different context of movement.

1481 That's about as close as I can imagine. But I did not
1482 live through that other than reading the historical record

1483 and analyzing the details of data. This has truly been an
1484 unprecedented event for over 100 years.
1485 [Minority Counsel]. Okay.
1486 I don't have any other questions.
1487 [Redacted], do you?
1488 [Minority Counsel]. I've got one or two clarifying
1489 ones.
1490 By [MINORITY COUNSEL]:
1491 Q So just to be clear, I asked you if you ever
1492 traveled to the southern border during the scope of this
1493 interview, and you said no; correct?
1494 A I don't know if you asked if I had ever traveled at
1495 any time to the southern border. I think you asked if I
1496 traveled to the southern border as a part of this pandemic
1497 response. Is that --
1498 Q Yes. Whatever the scope is today, December 2019 to
1499 whatever.
1500 So no, you've never traveled for this pandemic?
1501 A That is correct. I did not go to the border
1502 directly. I have a -- you know, that's correct.
1503 Q Did anyone from DGMQ go to the border during the
1504 pandemic?
1505 A Yes. I have a U.S.-Mexico unit office that's based
1506 out of San Diego, and there are staff, you know, in our
1507 quarantine station at Texas, and there are folks from my

1508 team in Atlanta that visited the border periodically during
1509 the pandemic --
1510 Q Did anyone --
1511 A -- at headquarters.
1512 Q Did -- was one of the purposes to examine the
1513 practicality of Title 42 expulsion?
1514 A We traveled there before the Title 42
1515 conversations, and, in fact, before the pandemic started in
1516 terms of recommendations to mitigate the impacts of other
1517 migration experiences on the border and the risk of
1518 infectious disease outbreaks and have made recommendations
1519 on these infection control approaches in the past.
1520 Q Was there any memo or report generated based on
1521 those travels through the pandemic specific to Title 42?
1522 A Specific to Title 42. I don't recall. I mean, we
1523 traveled at the request of the -- the team traveled at the
1524 request of the CDC director to assess the kinds of
1525 recommendations that we have been made -- making for border
1526 facilities for many, many months in terms of infection
1527 control changes and ability to use traditional public health
1528 measures. And those -- that advice was provided back to the
1529 CDC director internally.
1530 Q Dr. Anne Schuchat, the former deputy director of
1531 the CDC, testified that it was your view in March 2020 that
1532 "the facts on the ground didn't call for this from a public

1533 health perspective."

1534 Do you think that was characterized accurately?

1535 A Did you say my view or her view?

1536 Q Your view.

1537 A My view -- that does characterize my view, which is

1538 that there were a number of things that were more

1539 important -- just as I talk about the pivot, there are much

1540 more important things that needed to be done that we had

1541 been, you know, talking about that were going to be critical

1542 regardless.

1543 And that the collateral public health damage that might

1544 occur through the approach that was being -- at least as it

1545 was being explained to me from the CDC director, potentially

1546 could do more harm than good.

1547 And it was important to not be distracted by some of the

1548 views with which that concept would come across without

1549 realizing what the failure to address the infection control

1550 situation might ultimately create.

1551 So that was my view.

1552 Q Did you -- how did you communicate those facts to

1553 the CDC director? Did you just call Dr. Redfield and have a

1554 meeting with Dr. Redfield? Did it escalate to Secretary

1555 Azar? Did it escalate to the White House?

1556 A Yeah. I mean, I don't want to speak to specific

1557 deliberations or, you know, there was an -- what's now, but

1558 my views were communicated internally when asked.
1559 Q Dr. Schuchat continued that you thought Title 42
1560 was being initiated for "other purposes."
1561 Could you expound on what those other purposes were, in
1562 your mind?
1563 A I don't know specifically what all the other
1564 purposes were. My concerns were that the proportionality
1565 and the approach of using a public health authority at a
1566 time when we have a lot of intrinsic disease in the U.S. and
1567 the reported threat that was being, quote/unquote, addressed
1568 to prevent importation in that approach was not consistent,
1569 and it potentially risked the misuse of a public health
1570 authority that was not going to actually control or be used
1571 in place of the public health tools that we knew were
1572 important to do.
1573 And, you know, pandemics can be difficult times, and,
1574 you know, sometimes the epidemic of disease can be followed
1575 by an epidemic -- an inappropriate epidemic of stigma and
1576 misrepresentation of where the problem is.
1577 And we had the problem to be addressed internally that
1578 was very important and that needed to be specifically
1579 handled over the perception that a border closure at that
1580 time when we had so much disease was actually going to, you
1581 know, solve the problem and would not actually create other
1582 problems that were consequential.

1583 Q So it was reported that Stephen Miller at the time,
1584 who was a senior advisor to President Trump, was pushing for
1585 Title 42 on March 17, 2022. A month ago, former CDC
1586 director Robert Redfield testified to us under oath that
1587 he's not aware of any involvement by Mr. Miller in Title 42.
1588 Did you have any communications with Stephen Miller
1589 regarding Title 42?
1590 A I was on phone calls in which he was speaking.
1591 Q Okay. Specific to Title 42?
1592 A I'm not going to discuss the content of the
1593 internal deliberations.
1594 Q Okay. Current DHS secretary Alejandro Mayorkas
1595 said about Title 42, "We're doing this to identify a public
1596 health need, not an immigration policy."
1597 Do you disagree?
1598 Mr. Barstow. It's outside the scope of the interview,
1599 [Redacted].
1600 By [MINORITY COUNSEL].
1601 Q I'll say it.
1602 If we're doing Title 42 out of a public health and not
1603 an immigration policy, do you agree with me?
1604 A What? I don't understand what you just asked.
1605 Mr. Barstow. If you want to ask about during the time
1606 period from December 1, 2019, through January 20, 2021,
1607 about the use of Title 42, you may do so.

1608 But you can answer the question.

1609 By [MINORITY COUNSEL].

1610 Q Are you aware that the Biden administration has
1611 been in court defending Title 42 up until last month?

1612 Mr. Barstow. That's outside the scope of the interview,
1613 [Redacted].

1614 By [MINORITY COUNSEL].

1615 Q On February 17, 2021, the Biden administration
1616 filed a legal brief in federal court opposing an effort to
1617 end Title 42.

1618 Were you involved in any way with assisting or advising
1619 on that brief?

1620 Mr. Barstow. That's also outside the scope of the
1621 interview.

1622 By [MINORITY COUNSEL].

1623 Q On August 2, 2021, the Biden administration filed
1624 another brief defending Title 42 with accompanying
1625 declarations.

1626 Were you involved in any way in assisting or advising on
1627 that brief?

1628 Mr. Barstow. That's outside the scope of the interview.

1629 By [MINORITY COUNSEL]:

1630 Q That particular brief notes record and strained DHS
1631 operations and caused border facilities to be filled beyond
1632 their normal operating capacity, impacting their ability to

1633 employ social distancing in congregate settings.

1634 From a public health perspective, does COVID-19 transmit

1635 indoor in non-socially-distanced or congregate settings?

1636 A I didn't catch the opening piece. You're asking me

1637 the general question, is COVID-19 -- is the risk of

1638 transmission in congregate settings greater than in

1639 noncongregate settings --

1640 Q Yes.

1641 A -- that have cohorting and social distancing?

1642 Q Yes.

1643 A Yes, especially unmitigated, but are there ways to

1644 mitigate, and CDC has made recommendations on mitigating

1645 risks in various settings.

1646 Q That brief also asserts that DHS lacks sufficient

1647 capacity to safely hold and process all individuals seeking

1648 to enter the United States during the global pandemic.

1649 If the U.S. government were restricted in its ability to

1650 implement the CDC order, again, from a public health

1651 perspective -- not commenting on Title 42 itself -- does

1652 COVID-19 transmit more to individuals in any congregate

1653 setting for a longer period of time than they have for

1654 mitigation?

1655 A When you say "that brief," what are you referring

1656 to? You opened it by saying "that brief." I don't know

1657 what brief you're talking about.

1658 Q There was a brief submitted by Biden administration
1659 on August 2, 2021, to a federal court defending the use of
1660 Title 42.
1661 A Now what's your question? Does COVID-19 transmit
1662 in congregate settings more easily if unmitigated? The
1663 answer is yes.
1664 Q Okay.
1665 The same brief says "DHS would effectively need to
1666 release a growing number of families in the border
1667 communities, which risks overwhelming the local testing,
1668 isolation, and quarantine infrastructure DHS has worked to
1669 create and will thus burden local healthcare systems and
1670 strain healthcare resources."
1671 Is straining healthcare resources and overwhelming
1672 hospitals a public health concern with COVID-19?
1673 A COVID-19 has shown us the potential to strain
1674 healthcare resources, and in the settings in which that has
1675 occurred have been -- as I indicated before, have been due
1676 to the COVID transmission that's already occurring inside
1677 our borders and communities in that regard. And those
1678 circumstances, you know, are important to mitigate, as CDC
1679 has recommended.
1680 Q So you agree with all three assertions from the
1681 Biden administration's brief that Title 42, in fact, had
1682 public health benefits?

1683 A That's not what I said at all. You asked me very
1684 specifically about COVID-19 under a set of assumptions that
1685 were articulated by the secretary of DHS, not articulated by
1686 me. You asked me about the principles of can we and should
1687 we be addressing COVID-19's risk for straining healthcare
1688 settings and what can be done about that. And that's what
1689 you asked.

1690 And yes, those are risks. Those were risks in our
1691 pandemic planning. They involved the community mitigation
1692 strategies that I talked about to flatten the curve. And
1693 those community mitigation strategies to flatten the curve
1694 that we talked about do not include border closures.

1695 So I don't know how to be more clear of the distinction
1696 and the intensity of the times in which COVID-19 has
1697 stressed healthcare resources in this country being very
1698 specific to different phases of the internal domestic
1699 situation with COVID-19, omicron and delta responses being
1700 some examples.

1701 So it feels like you're trying to make some link and
1702 make extensions to a policy about border closure, and that's
1703 not what I'm saying here.

1704 Q So you actually disagree with the Biden
1705 administration's stance that Title 42 is a public health
1706 benefit?

1707 Mr. Barstow. Outside the scope of the interview,

1708 [Redacted].

1709 Q Again, on September 17, 2021, for the fourth time

1710 the Biden administration filed another appeal on a motion to

1711 stay a lower court order to keep Title 42 in place.

1712 Were you involved in drafting or advising that order at

1713 all?

1714 Mr. Barstow. That's outside the scope.

1715 Q On October 21, 2021, the Biden administration filed

1716 another legal brief in federal appeals court arguing that

1717 the court should keep Title 42 order in place.

1718 Were you involved in that at all?

1719 Mr. Barstow. That is also outside the scope.

1720 Q On November 29, 2021, the Biden administration

1721 filed another brief in federal appeals court arguing the

1722 Court should keep Title 42 in place. Were you involved in

1723 that?

1724 Mr. Barstow. That's also outside of the scope of the

1725 interview.

1726 Q On January 19, 2022, the Biden administration sent

1727 government attorneys to argue in front of the Federal

1728 Appeals Court that the court should keep Title 42 in place.

1729 Were you involved in that at all?

1730 Mr. Barstow. That's outside the scope.

1731 Q So when the Trump administration put Title 42 in

1732 place, you said you voiced your displeasure with CDC

1733 director Redfield. The Biden administration has been in
1734 court for 15 months arguing Title 42 should stay in place.
1735 Did you voice your displeasure?
1736 Mr. Barstow. That's outside the scope of your
1737 interview.
1738 Q Do you continue to disagree that -- or do you
1739 continue to -- is it your continued stance that Title 42 is
1740 not a public health measure?
1741 Mr. Barstow. That's outside the scope of the interview.
1742 Q Dr. Cetron, if HHS counsel was not objecting to all
1743 these questions, would you be willing to voluntarily answer
1744 them?
1745 A The supposition doesn't apply.
1746 Q Minority party didn't agree to the scope of these
1747 interviews. I'm asking if we were to call an interview with
1748 a different scope, would you be willing to answer the
1749 questions that I'm asking you?
1750 A I don't know. It depends on the questions.
1751 Q I just asked them.
1752 A I can't answer that at this time.
1753 [Minority Counsel]. Okay. Thank you. That's all we
1754 have.
1755 [Majority Counsel]. I think we can take a five-minute
1756 break and start back up at 11:05.
1757 [Recess]

1758 [Majority Counsel]. Back on the record.

1759 By [MAJORITY COUNSEL]:

1760 Q Dr. Cetron, I wanted to follow up and return your
1761 attention to this period around the -- I guess it was the
1762 first proclamation, January 31 when entry from China was
1763 suspended.

1764 You mentioned a number of the tools that were being used
1765 to enhance screening, and part of that was also contact
1766 tracing for people who came in.

1767 I'm wondering if you could tell us what tools you had
1768 and what the government had at its disposal to conduct
1769 contact tracing at that time.

1770 A We were more limited in the ability to do -- to get
1771 accurate, complete, reliable, and timely information
1772 regarding especially air travelers' contact information, and
1773 have been. And this has been a gap that I have been dealing
1774 with and working on and trying to get closed for a number of
1775 years, going back to SARS 2003, SARS 1 and others.

1776 And that's because the data systems have been
1777 constrained. And, you know, we need -- we need to know the
1778 who, what, when, where in a very quick way to be moved
1779 through digital means for an infection that can move rapidly
1780 and spread rapidly so it could be traced and followed,
1781 either retrospectively or if we were told about an
1782 infectious case that was in the travel corridor while

1783 infectious or in order to follow proactively infectious
1784 cases through an incubation period after arrival so that
1785 information can be rapidly acted on by public health
1786 officials and used to mitigate around cases -- you know, the
1787 case finding, the contact notifications, the isolation of a
1788 case, the implementation of mitigation strategies,
1789 quarantine household contacts and so on.
1790 And you need to do that quickly before the generation
1791 times pass and a disease like SARS-CoV-2, which has a high
1792 reproductive rate, every generation that goes by that you
1793 can't effectively contact trace is missed opportunities for
1794 a rapidly amplifying spread.
1795 And those data are not -- as I said, it needs to be
1796 timely, accurate, complete, and, you know, readily
1797 available. It's not something that you have to go back and
1798 forth and extract and it comes two weeks later when, you
1799 know, it gets out -- the horse is out of the barn.
1800 Q Was this something you were pushing for at that
1801 time, additional data?
1802 A Prior.
1803 Q Prior. Okay.
1804 A Beginning of January, I began raising this and just
1805 said, you know, looking at the potential volume, we really
1806 need you to get this in place. I don't remember the
1807 specific dates, but we had -- I had found the struggle to be

1808 problematic in prior epidemics.

1809 I also found that when it could be obtained in the
1810 course of Ebola, which couldn't be done with the advance
1811 notification or collection of the information that was
1812 necessary for public health purposes, we had to deploy large
1813 numbers of people to actually capture that information
1814 literally at the points of arrival and get it into digital
1815 systems immediately.

1816 But it was used to do -- and this was -- you know, Ebola
1817 was a slower-moving disease, nonrespiratory spread, more
1818 contact, droplet, fewer people were able to travel when they
1819 were highly contagious because it was an airborne illness.
1820 And it was a longer incubation period, 21 days.

1821 And -- but during the large West African Ebola outbreak,
1822 the public health system was -- and, again, the numbers were
1823 smaller. It was arrivals from the three countries affected
1824 in West Africa. They were around 35,000 a year, much
1825 different in a number constraint.

1826 But proactive following of people who had arrived from a
1827 risk area could be done in the public health systems, but we
1828 had to capture all that relevant information by setting up
1829 an infrastructure at the airport and then moving that data
1830 flow from the collection point into state and local public
1831 health departments in this pure manner. For a rapidly
1832 interpreting respiratory viral disease with the

1833 characteristics of this virus, that type of system would
1834 not -- would not work.
1835 So in -- I forget the specific days in January, we had
1836 an interim final rule on the contact data fields and had
1837 issued an order to airlines identifying the data
1838 requirements.
1839 Q And did you get that data from the airlines that
1840 you requested?
1841 A We asked for it before the regulatory process could
1842 keep up. It was a struggle. The quality of information
1843 wasn't where it needed to be in terms of complete, accurate,
1844 and timely and in a digital format, and we continued to try
1845 to close the gap on those things.
1846 Q Did you get it? I'm asking specifically about sort
1847 of the basic contact information -- cell phone, address --
1848 A So the basic steps -- there are a number of data
1849 elements that are collected by DHS and others in the system,
1850 but the information that's needed to do the job of public
1851 health contact tracing included these additional data
1852 elements. That's the only way to actually do that.
1853 It has to be up to date, timely, accurate, and complete
1854 and move digitally in order to move at the speed of the
1855 pandemic, and we weren't getting -- you know, we weren't
1856 getting those kind of things. And we kept pushing on them.
1857 They involved systemwide kinds of changes in order to do

1858 that.

1859 Q Two follow-ups. Who were you pushing? And what

1860 were you told about why you weren't getting it?

1861 A I think we were making the plea in general. I was

1862 having meetings with airlines in general about the need and

1863 why and how and the processes that they required to get --

1864 you know, the regulatory processes that they required to go

1865 to work. We were trying to move through on the regulatory

1866 processes as well. Ultimately, we got these emergency

1867 orders, and then the systems would come into place and then

1868 we would evaluate the quality of the information.

1869 But, you know, all the different obstacles that would

1870 come up, the pressure points that we would use to try to

1871 make sure all these different pieces could get rolling

1872 logistically, regulatory, operationally, et cetera,

1873 et cetera.

1874 I think the speed and urgency of this issue had been

1875 identified. We had directions from many prior events. It

1876 just really -- we really wanted it to be moving, moving very

1877 fast with great intent.

1878 Q It seems like certain agencies like DHS, FAA have

1879 that data. And -- is that accurate?

1880 A I think there's a distinction. There are data that

1881 are available in AFIS and other systems and there's some

1882 data that are available in airlines, such as frequent flyer

1883 systems.

1884 But often the kinds of data that we need are not readily
1885 available in preexisting systems or require cumbersome
1886 intersectivity in mapping and manual, you know, bridge
1887 building in order to get them linked, in order for them to
1888 be current.

1889 Just as an example, an airline might have a phone number
1890 or an email address from a frequent flyer data set that was
1891 set up 10 or 15 years ago and it actually would not be
1892 accurate, reliable information to be used in the moment.

1893 That's the kind of thing where a legacy data system --
1894 some fields were generally not captured in those systems or
1895 in multiple places in different systems. And some fields
1896 needed to be updated, and many fields needed to be moved
1897 into an electronic format so that they are available in an
1898 emergency without having to, you know, reconstruct and build
1899 and create new databases that don't happen in the time frame
1900 that are needed for response.

1901 Q Once the regulatory process started, was there any
1902 pushback from within government?

1903 A I don't recall, really, where all the different
1904 delays were, and I'm not even sure I'm characterizing it as
1905 pushback or delays or whatever. But in an emergency, it's
1906 just not the time to try to get the kinds of momentum that
1907 are needed on processes, and the amnesia that occurs after

1908 an emergency sometimes isn't enough to close the gap. And
1909 this has been a frustration and a problem from my
1910 perspective on the readiness side for a while.
1911 Q Did your request for that data have the support of
1912 the White House?
1913 A I don't recall all the specifics about where the
1914 support or where the barriers were on that. I think it
1915 was -- it ended up being a bigger and harder problem to
1916 solve, but most people who were involved at the moment
1917 appreciated it.
1918 And having the continuity of three decades of public
1919 health experience around this issue and then reeducating it
1920 every time there's an administration change about the
1921 urgency of that is difficult. I'm not --
1922 Yeah. And then obviously there are privacy issues that
1923 come up around it and who is going to have access to the
1924 data and how it's going to be protected and how do we make
1925 sure it's used only for the intended purposes.
1926 So a lot of that stuff turns over anew in every sitting,
1927 whether it's departments and agencies or whether it's, you
1928 know, administrations, you know, at the White House level.
1929 But these are hard problems to solve. They're important
1930 problems to solve.
1931 And we need to not go through these cycles about looking
1932 at the same problems over and over again in the middle of a

1933 crisis, but just have a commitment that is part of readiness
1934 and a response that would solve these sort of basic public
1935 health gaps.
1936 Q I want to --
1937 A The arguments are familiar that you mentioned, and
1938 they happen often. We need to solve them.
1939 Q I want to take us forward into February and the
1940 decision-making that led to further proclamations and
1941 restrictions and focus our attention on Europe.
1942 So maybe you can take us to February and just generally
1943 walk us through what you were working on as it relates to
1944 travel from Europe.
1945 A Yeah. Well, the epicenters of the pandemic were
1946 shifting, certainly, by February, and more of what we were
1947 learning was being uncovered. And the ability to engage and
1948 deal with a variety of the issues as the epicenter was
1949 shifting became more challenging than sort of the single
1950 notice -- single locus and issues around the emergency in
1951 Wuhan and Hubei province in China.
1952 And whether it was putting up travel advisories, that
1953 is, the outbound recommendations, or getting the screening
1954 issues expanded or the 212F proclamations, as you were
1955 mentioning, on the expanding geographic scope and the
1956 utility on how that would work as opposed to other kinds of
1957 tools -- all of that became -- you know, the volume became a

1958 bigger deal.

1959 The nature of the engagements and the connectivity and
1960 the relationships between the Schengen zone in the U.S. all
1961 came into play. Those were hard. We saw the shift
1962 happening with the epicenter faster than -- the virus was
1963 moving faster in some places like that than we could
1964 navigate the change in approach.

1965 Q And when did you first start working on
1966 restrictions involving travelers from Europe?

1967 A Do you mean the advice to people traveling to
1968 Europe, or do you mean the issues around the 212F
1969 proclamation from the Schengen zone?

1970 Q The 212F proclamation that came later in March.

1971 A Yeah. I would say we were trying to gain traction
1972 for the concept that the pandemic was expanding in
1973 geographic scope in certain areas, and the kinds of tools
1974 that we would need, we would need to look at that volume and
1975 mitigation strategies that we needed to be putting in place.

1976 And, again, the things that I talked about earlier about
1977 moving from border and geography alone and the optimism that
1978 was had about portion border restrictions but not really
1979 border closures, but not having the kinds of other
1980 mitigation, both in regard to advice around travel, but
1981 especially around understanding the need to move into
1982 mitigation components.

1983 Since the border was being, perhaps, overly relied on at
1984 the expense of thinking about the level of domestic
1985 mitigation that was going to be necessary -- those were the
1986 kinds of things that we felt were really difficult, just the
1987 reality of what was going on, what we were going to be
1988 facing. This thing was becoming very, very clear by
1989 February.

1990 Q Can you give us a little bit of a practical
1991 explanation on what you mean by trying to gain traction on
1992 these ideas?

1993 A Lots of different things. So, you know, the work
1994 that I'd been involved in and I mentioned about the
1995 historical review of 1918 and the pandemic response plan
1996 that came out in '07, preparedness plan, the role of border
1997 restrictions versus mitigation and the need to look at what
1998 was necessary to flatten the curve, it was -- a couple
1999 things were quite, quite clear.

2000 One is that you wanted to change the shape of the curve.
2001 You didn't want the spikes to be very high where they
2002 overwhelmed healthcare systems. You didn't want them to
2003 happen so fast that you didn't have other systems ready. So
2004 goal one is to get the peaks down.

2005 Goal two was to shift the epidemic to the right to buy
2006 time so that you could come back with all the tools you
2007 needed to be ready, including rapid development of

2008 antivirals, vaccines, diagnostics, et cetera.
2009 And the third is you wanted the total area under that
2010 curve to be lower in sort of a more manageable way while you
2011 understood risk factors, who was at risk, while you focused
2012 on mitigation.
2013 The key part is that you had to intervene early, because
2014 once things begin an exponential escalation, that phase, you
2015 had to be there at that inflection point when things were
2016 starting to escalate, because they would move fast with a
2017 high reproductive rate. They were going to grow
2018 exponentially, not linearly, and you could quickly
2019 overwhelm.
2020 So the kinds of things that had to be done had to be
2021 done in advance, I would say in some ways earlier than most
2022 people would think is necessary, and they had to be
2023 sustained for slightly longer than most people thought they
2024 could handle. So it wasn't just about getting to the peak
2025 and at the first downturn you could lift those measures, but
2026 they had to be modulated and pulsed.
2027 That started early. Later there's multiple strategies
2028 that I have described in a Swiss cheese-like model, that any
2029 one layer was going to have some holes in it, but combined
2030 multiple mitigation strategies would be more robust and more
2031 protective, and they had to be sustained for periods of time
2032 in the pulse until you were in a comfortable place.

2033 And that overreliance on border measures alone as a
2034 single layer were not likely to get you that kind of impact.
2035 So although it was necessary to consider what that enhanced
2036 screening looked like, the contact tracing, case finding,
2037 all those kinds of things, you still, had to be able to
2038 prepare for testing, isolation, quarantine, cohorting, mask
2039 use, all of that other stuff.

2040 And as the epidemic started to quickly move in February,
2041 globalize and have big sort of pockets of waves, we could
2042 see some of that as being a herald of an event, and we
2043 looked at the volume of connectivity and the speed of
2044 connectivity by air from Europe and the outbreaks that were
2045 occurring there and anticipate by the arrival that it wasn't
2046 very long before those would be major sources of -- you
2047 know, of outbreaks across the United States.

2048 And we couldn't wait for them to happen in order to be
2049 prepared to manage them. It just felt like it was too hard
2050 to get that kind of anticipatory reality of what was
2051 unfolding through all of the navigating the policy
2052 processes, whether it was surveillance or expanding, you
2053 know, testing options, you know, distribution of masks,
2054 isolation, quarantine.

2055 All the kinds of things that were in that '07 playbook,
2056 you know, were -- in addition to how we could understand the
2057 movements at the border -- one, border closures alone

2058 wouldn't necessarily do it, and, two, the need to sort of
2059 have all these tools available and, you know, early
2060 detection of arrival was going to be critical. And that was
2061 hard.

2062 Q And who were you and your team making this case to
2063 at that point?

2064 A Well, it was my responsibility, sitting on a lot of
2065 the interagency things. But first internally making the
2066 case, you know, into the response structure and into what --
2067 you know, in the conversations with the division director
2068 and in the meetings that we would have with HHS, just
2069 understanding the nature of what was going on. And then
2070 there are other forums to make those presentations, other
2071 settings in which to do that.

2072 And so there were multiple places where we could
2073 articulate this framing.

2074 Q Pointing you to the interagency settings, who were
2075 you making that argument to and how was it being received in
2076 this period? Because, you know, the restrictions didn't
2077 come into play until March 11 from these countries. So I'm
2078 wondering about this critical period.

2079 A Yeah. No. These -- you know, I think we were
2080 invited to attend and make presentations. CDC was the
2081 interagency, the task force. Just looking at some of the
2082 exhibits you sent with some agendas, I don't remember the

2083 details of the dates and stuff, but --

2084 Q Sure. Let's look at them. I think they're

2085 Exhibits 2, 3, and 4. 2, 3, and 4 --

2086 A There were meetings that were occurring in February

2087 as well while the HHS was still chairing the task force, and

2088 then there were meetings that were occurring when the task

2089 force -- we switched over from the HHS secretary to the

2090 White House directly.

2091 And we were at the table. CDC was at the table and

2092 presenting sort of the forecasting of the significance of

2093 the potential severity of this virus and its characteristics

2094 in particular.

2095 Q And looking at these agendas -- and you might not

2096 recall them specifically -- but Italy was on the agenda, the

2097 screening update from Italy. You and Dr. Cetron [sic] were

2098 briefing the task force.

2099 I'm wondering if you can characterize how your

2100 presentation of these concepts that you've been talking

2101 about was received at that point.

2102 A I think you mean Dr. Jernigan and I. If I'm

2103 correct in this, I think he was the incident manager of --

2104 the incident lead of the response structure, and a lot of

2105 these components were in my area of expertise. And so Dan

2106 and I were presenting kind of regularly at some of these

2107 meetings.

2108 And I described basically, you know, as I'm saying in
2109 terms of the general content was that this is significant.
2110 Both Dr. Jernigan and -- he had been an NIH officer of mine
2111 many, many years ago in respiratory diseases. He had a lot
2112 of experience as well, and we could both see the writing on
2113 the wall here.
2114 There were a lot of red flags, and we were trying to,
2115 you know, demonstrate the trajectory of the case occurrence
2116 as they were being defined globally. And in particular
2117 Dr. Jernigan asked what the domestic situation was looking
2118 like.
2119 I would be asked to describe some of the travel issues
2120 and volume and the potential for, you know, what was being
2121 missed in the screening modes and how -- what was the
2122 importance of getting things ready for these waves that we
2123 had seen. It was pretty devastating, the other places where
2124 they had occurred.
2125 So I guess I would say that CDC had a much greater level
2126 of concern about what this -- how this pandemic would
2127 unfold. That's what we were -- that's what we were asked to
2128 express and brief on.
2129 Q And generally what was the reaction from meetings
2130 like this, the White House task force?
2131 A It varied, to be honest, depending on different
2132 perspectives. We were offering a science-based public

2133 health perspective. Others were offering, you know,
2134 different perspectives and process.
2135 Q Dr. Schuchat said that the CDC has been pushing for
2136 this restriction from the Schengen countries and it had been
2137 delayed for a period of time.
2138 Is that accurate?
2139 A That is fair.
2140 Q Okay. Can you talk about that delay and what
2141 caused that delay?
2142 A In general, it just was all the other parallel
2143 factors of concerns regarding the connectivity, impact, you
2144 know, on things other than the public health impact. Just
2145 the general -- you know, sort of the general tone.
2146 And as I said, you know, this concept of multilayered
2147 strategies and tools. We needed a multiple approach in
2148 here. It wasn't that the point was to rely exclusively on a
2149 212F, which seemed to be one of the things the
2150 administration had seemed to value in that regard, but also
2151 to ready the domestic situation for, you know, preparing to
2152 be able to implement mitigation strategies that had been in
2153 the response plan and the seriousness of what we would
2154 likely be anticipating in a very short period of time.
2155 So, again, there was just this general overall concern
2156 that maybe public health was overplaying the concerns and
2157 the significance and that there were all these other factors

2158 that need to be brought to bear. I think that was the
2159 general.
2160 Q Who was expressing that, without getting into
2161 specific conversations?
2162 A No, no. I'm just trying to give you a flavor. I'm
2163 not going to go down the "who said what, when, and where"
2164 and stuff like that.
2165 Q Okay.
2166 A These were internal deliberations. I'm trying to
2167 give you a sense of where the balance of thinking was about
2168 this.
2169 Q Sure. Understood.
2170 Our colleagues mentioned that part of our interview with
2171 Director Redfield, and he described you as being extremely
2172 frustrated during this period. I can review what he said.
2173 "One of the areas that was particularly frustrating was
2174 the area you're bringing up about escalating the order of
2175 travel. At the time, CDC felt that travel alerts should be
2176 alerted. So if you ever bring in Marty Cetron -- I don't
2177 know if he's one of the people he interviewed -- I'm sure
2178 he'll go into this in enormous detail, because he was
2179 extremely frustrated."
2180 Tell us your frustrations.
2181 A Okay. I think Dr. Redfield's sentiment accurately
2182 describes my frustrations. Things weren't being taken

2183 seriously enough. They weren't moving quickly enough. It
2184 was being underplayed and perhaps at a risk of what I -- and
2185 not I alone, but I and others at CDC were seeing as the
2186 inevitable consequences of delay.
2187 I had been one to study this in detail in the lead-up to
2188 the U.S. response plan in 2005 to 2007. I had seen what
2189 happens when there are delays in implementing multiple
2190 measures at an appropriate time, how quickly things can get
2191 overwhelming, and I had done a lot of analytic work on the
2192 toll of the delays and the shape of the way the epidemic
2193 would occur.
2194 I've seen the comparisons between Philadelphia and
2195 St. Louis, and I knew that you could flatten the curve. I
2196 knew you could mitigate the impact. I knew you could
2197 alleviate the strain on healthcare systems. I knew you
2198 could save lives.
2199 And I just didn't feel like -- I just didn't feel like
2200 there was enough listening going on. So it was very
2201 frustrating, and that's a fair -- his comments are a fair
2202 characterization.
2203 It required bold responses earlier than might be
2204 tolerable, and I know that those responses wouldn't be easy
2205 and would have some of their own consequences to weigh, but
2206 it felt clear to me that the failure to act in a timely way
2207 could really be significant for the country.

2208 Q And I think you just articulated this, but it's
2209 been said and we've heard from witnesses that this period in
2210 February was a lost month where things should have been done
2211 that weren't.
2212 Would you agree with that assessment as well?
2213 A More should have and could have been done, and the
2214 CDC was really, really pushing for more. It would have -- I
2215 think it would have helped significantly alleviate a lot
2216 of -- a lot more suffering and death.
2217 Q I want to change gears and talk briefly about
2218 messaging to the public. And you, along with other leaders,
2219 participated in telebriefings, providing updates to the
2220 public. I think you spoke January 17, January 21,
2221 January 24, and January 31 in telebriefings with others.
2222 Can you talk about those communications in the general
2223 sense and the importance of that.
2224 A Well, I can say that having also having been part
2225 of a lot of epidemic and other pandemic responses, the
2226 technical expertise is necessary; that is, the CDC technical
2227 expertise is necessary but insufficient.
2228 And communication is a huge part of it. And a big part
2229 of the communication has to be about public trust and that
2230 in settings where -- even where there was technical
2231 expertise, if there was for whatever reason -- and those
2232 reasons vary across the globe and, you know, on rationale,

2233 but where there's a bankruptcy of public trust or a
2234 bankruptcy of trust in the various institutions that are
2235 involved, you can't get -- you can't get an effective public
2236 health response when there's not a lot of trust.
2237 And that trust comes from timely, honest, transparent,
2238 regular, repetitive communication, including honest
2239 uncertainties about what's ahead, what you know, what you
2240 don't know, what you're doing to fill in the gaps, when
2241 we'll come back and tell you more.
2242 And that has been sort of a mantra training process for
2243 all CDC leaders who are involved in public communication.
2244 And I think it's very much true today. And there are many
2245 factors that are involved that erode trust. But it is so
2246 important to getting effective response to a public health
2247 crisis in an emergency.
2248 It's absolutely critical. Even the best technical
2249 solutions and technical agencies or plans or know-hows will
2250 crumble under the lack of effective communication and
2251 trustability.
2252 Q Was that mantra followed in moving forward past
2253 January and February?
2254 A I think it – there was a lot left to be desired.
2255 Q Why?
2256 A You know, one of the things -- there were so many
2257 factors and reasons in why this all evolved the way it did.

2258 But a lot of the way in which CDC would normally be
2259 regularly out there communicating, whether it's the CDC
2260 director or the senior leaders who are involved in the
2261 response, you know, shifted between probably when
2262 Dr. Messonnier and I were no longer doing those briefings.
2263 There was sort of a shift in the level of the briefings
2264 occurring in different settings and spaces.
2265 So I don't know. Again, there's probably a lot of
2266 reasons. But there was -- that was somewhat atypical from
2267 the way CDC responses had previously been done, whether it
2268 was the Ebola response or other kinds of things.
2269 Q Can you describe that shift and what it meant in
2270 terms of public health?
2271 A I think there was a de-emphasizing of communication
2272 from CDC directly, and more of the communication around the
2273 pandemic was coming, you know, outside the realm of public
2274 health officials or the government communication was
2275 occurring in different settings.
2276 Not that it's not appropriate for there to be whole of
2277 government communication, but there was not the level of
2278 communication that CDC would normally participate in as a
2279 component of overall communication. That's my sense, but
2280 that's -- again, there are many factors.
2281 Q What about the -- do you have a view on the quality
2282 of the communications coming from those other places?

2283 A I didn't -- I didn't think it met our standards for
2284 scientific accuracy. But that's my opinion. The principles
2285 and the teachings about how to communicate in a public
2286 health emergency and a crisis, what do we know and what do
2287 we not know, what are we doing to find out, coming back
2288 regularly, what can you do in the interim until we know
2289 more, what is the sort of factual scientific credible, both
2290 risk assessment, things that can be done to attenuate risk,
2291 scope, and magnitude.

2292 Those would be normally the places which CDC would fill
2293 in the way that we're more accustomed to. I think that that
2294 role was being fulfilled in the same way when the
2295 communication sort of didn't include as much of the CDC
2296 perspective.

2297 Q Anything that stands out to you specifically in
2298 terms of not meeting those ideals and principles?

2299 A I think there's -- I think there's a number of
2300 examples about, you know, what therapeutics work and don't
2301 work, what the approach is, what the perspective was on the
2302 trajectory, how long things would be until everything was
2303 over, you know. There's a lot of different areas which I
2304 just don't think was consistent with the science of what we
2305 were actually seeing.

2306 I'm sure you've heard numerous aspects about this by
2307 communication experts.

2308 Q Sure. And I won't get into specifics, but I want
2309 to ask you about the impact, and you mentioned this
2310 bankruptcy of trust. How did those communications
2311 contribute to that idea?
2312 A Well, information -- misinformation or information
2313 that's not factually accurate really erodes that, because if
2314 there is disinformation, misinformation, whether by intent
2315 or by accident that is not true, people wonder, you know, if
2316 anything that is being said is true.
2317 So -- or if it's, you know, contrary to what people can
2318 see in their own lives or out their door and it doesn't
2319 jibe, it erodes the credibility of the government's
2320 response, and it calls into question all sorts of things.
2321 It calls into question motives and all sorts of other stuff.
2322 And it's just not a time where those things should be --
2323 it's a time where that kind of trust building and
2324 communication integrity is so important in order for people
2325 to be well informed, in order for people to be able to take
2326 the right steps, in order for people to anticipate what the
2327 impact on their lives will be.
2328 So it's -- it was very difficult.
2329 Q What was the public health impact of sort of those
2330 failures, as you articulated them?
2331 A I think a lot of confusion is one of them. A lot
2332 of uncertainty, a lot of questioning sources of authority, a

2333 lot of questioning what's true and what's counterfactual,
2334 you know. Calling into question the kinds of measures that
2335 might be needed and in what ways.
2336 And that kind of, you know, inability to grasp the
2337 circumstances you're in and take the right steps and protect
2338 yourself and your family, protect the most vulnerable people
2339 in your communities.
2340 All of that gets thrown into confusion and chaos, and it
2341 becomes really difficult. And that void gets filled by a
2342 whole variety of folks that are talking with various degrees
2343 of expertise, of various degrees of agendas or intent that
2344 may be different from the Public Health Service concept.
2345 And so it just becomes really, really hard.
2346 And a lot of, you know, false narratives get created, a
2347 lot of excessive blame and stigma. All of those kind of
2348 things are consequences of the failure both to build trust
2349 and accurate, timely, and credible information delivery.
2350 Q Do you think that the president adding to that
2351 confusion contributed to those problems, as you articulated
2352 them?
2353 A I'll leave it to you and others to judge.
2354 Q Given your expertise -- and I know you've done
2355 extensive work on looking at nonpharmaceutical interventions
2356 in the past -- do you think communications around those
2357 measures would have changed what we saw transpire over this

2358 year?

2359 A I do. That middle game before you have medical
2360 countermeasures, good treatments and good vaccines, and even
2361 when you do, the virus has the ability to mutate and escape.
2362 And so overreliance on waiting for the magic bullet has been
2363 a repeated, you know, lesson observed.

2364 I wouldn't even call it lessons learned. And the
2365 importance and value of nonpharmaceutical interventions in
2366 flattening the curve have been very well demonstrated
2367 scientifically.

2368 And I think the inability to communicate, one, that we
2369 need multiple tools for a pandemic of this degree of
2370 seriousness, that this long middle game -- I talked about
2371 the opening act and the middle game when you don't really
2372 have the medical countermeasure tools and you have public
2373 health measures, pharmaceutical measures, they need to be
2374 conveyed really accurately.

2375 Because that's what is going to make a difference on
2376 whether we can avoid an overwhelming surge in the healthcare
2377 system where we can protect those that are most vulnerable.
2378 We understood that we were using those things like masks not
2379 just as a matter of personal protection, but as source
2380 control for, you know, an unseen virus that spreads very
2381 rapidly and can quickly, you know, take out a large portion
2382 of vulnerable populations.

2383 I think proper communication on the why and the how and
2384 the impact of those things could have had a tremendous
2385 difference in mitigating the pandemic. While we awaited
2386 some of our most powerful tools, which have been the
2387 vaccines and more recently the antivirals, but also
2388 acknowledging that the toolkit has got to be mixed, and it
2389 takes a while to develop immunity and the virus is -- you
2390 know, while we may be sick and tired of the virus, at times
2391 the virus was not tired of making us sick.
2392 And in that setting, the virus is mutating and changing,
2393 and it may render some of our medical countermeasures less
2394 effective than others, although by and large they are really
2395 powerful. They are super important.
2396 But I think that the failure to appreciate the
2397 seriousness of the threat and the intensity of the virus's
2398 capacity to constantly throw us curveballs kind of
2399 undermines our ability to reduce suffering and save lots and
2400 lots of lives.
2401 Q I'll close with this: Given your expertise in this
2402 area and the research that you've done on these measures, do
2403 you think consistent messaging on nonpharmaceutical
2404 interventions -- what do you think the difference would have
2405 been in terms of the impact that we saw from the virus in
2406 the first year?
2407 A Yeah. I think honest and accurate messaging about

2408 the potential impact and how to empower people to take care
2409 of themselves, their family, and their neighbors and their
2410 community could have had a huge impact in keeping the mask
2411 as a measure of hygiene and less as a political signal or
2412 statement.

2413 And I'm saddened by the way an instrument of hygiene,
2414 sanitation, you know, lost its real meaning as an instrument
2415 of, you know, some type of other agenda signaling. So that
2416 saddens me.

2417 "Consistency" is a difficult term to use in that
2418 setting. I mean, honest and transparent and accurate and up
2419 to date, because things change during a pandemic. We've
2420 learned more all the time, and it may be that, you know, the
2421 messaging deviates a little bit in terms of what we know and
2422 what we've learned, whether what type of mask and what
2423 settings and actual impact of transmission reduction,
2424 disease reduction and so on.

2425 But the general principles of being very up front in
2426 conveying the scientific information to the power of these
2427 nonpharmaceutical mitigations and how they can shape the
2428 experience of this pandemic in terms of suffering and death,
2429 you know, was -- is clearly -- was lacking, you know. And I
2430 think that hurt. That hurt all of us. It hurts all of us
2431 and our families.

2432 And there are people, you know, who are no longer with

2433 us that would have benefited from that kind of very clear
2434 messaging.
2435 Q One last question in this area, and it's, you know,
2436 you mentioned the times that you were out there in
2437 telebriefings in January. We didn't really hear from you
2438 that much after that. It was reported in CNN that CDC
2439 officials said they had been muzzled and that their agency's
2440 efforts to coordinate -- to mount a coordinated response
2441 were hamstrung by the White House.
2442 You're a subject matter expert. You were out there in
2443 front of the public. Did you feel muzzled?
2444 A It was clear -- there was clearly a change in
2445 February in terms of how the communication would go. That's
2446 all -- that's all I can say. I mean, I think it was
2447 unfortunate change in -- not saying that it should have been
2448 all one way or all another way or whether it should have
2449 been me or other folks from the agency, but I don't think
2450 CDC was able to effectively communicate its messaging, as
2451 had been sort of the more normal approach to responding to
2452 public health crises, and I think that ultimately undermined
2453 an effective response. It's not about me.
2454 [Majority Counsel]. I want to move forward to talk
2455 about -- well, actually, rather than opening another huge
2456 topic, I will cede my time to my colleagues, but ask you if
2457 you want a five-minute break.

2458 Mr. Barstow. [Redacted], it depends how long you're
2459 going to go here. If you know.
2460 [Minority Counsel]. I think we probably just have a few
2461 minutes. Are you ready, Dr. Cetron?
2462 By [MINORITY COUNSEL]:
2463 Q So my colleague [Redacted] asked you some questions
2464 about CDC telebriefings. Do you know how many were given
2465 under the Trump administration?
2466 A I don't. Do you mean how many CDC telebriefings?
2467 No, I don't.
2468 Q So it was 27 over the 12 months, January to -- 11
2469 months, January to December.
2470 Do you know how many were given during the Biden
2471 administration?
2472 A I don't.
2473 Q Six over 17 months.
2474 You said the Trump administration messaging left a lot
2475 to be desired. There were 21 more CDC telebriefings. Does
2476 your statement apply to the Biden administration as well?
2477 Mr. Barstow. Outside the scope of the interview,
2478 [Redacted].
2479 Q You were also talking about disinformation and how
2480 it "erodes credibility in the CDC."
2481 President Biden said, "If you're vaccinated, you're not
2482 going to be hospitalized, you're not going to be in the ICU

2483 unit, and you're not going to die."

2484 Dr. Cetron, have vaccinated Americans been hospitalized

2485 for COVID-19?

2486 A Yes. Certainly different proportions,

2487 significantly different proportions.

2488 Q Okay. Have vaccinated Americans been in the ICU

2489 for COVID-19?

2490 A Yes, I believe so.

2491 Q Have vaccinated Americans died from COVID-19?

2492 [Majority Counsel]. Just one quick point. The vaccines

2493 were rolled out in January of 2021.

2494 [Minority Counsel]. [Redacted], I don't think it's your

2495 time. And we've objected to many majority questions before,

2496 and you won't entertain our objections, so I won't entertain

2497 yours.

2498 [Majority Counsel]. It's outside the scope.

2499 [Minority Counsel]. You said July 2, 2021. But I'm

2500 asking health-oriented questions, not specific to that

2501 statement.

2502 Mr. Barstow. What was your question, [Redacted]?

2503 [Minority Counsel]. I'll just start over.

2504 Q So I read you President Biden's statement. I want

2505 to ask you three yes-or-no questions.

2506 Have vaccinated Americans been hospitalized with

2507 COVID-19?

2508 A So --

2509 Q The question is a yes-or-no question.

2510 A What do you mean by vaccinated? A single dose or

2511 fully vaccinated or boosted. What do you mean by the term

2512 "vaccinated"?

2513 Q Fully vaccinated. People who were fully vaccinated

2514 by the time the statement was made.

2515 A Have there been people who are fully vaccinated

2516 that have been hospitalized?

2517 Q Yes, correct.

2518 A Not all fully vaccinated people respond.

2519 Q Have there been fully vaccinated people who have

2520 been in the ICU unit for COVID-19?

2521 A Probably with the same caveats, many fewer, but not

2522 everybody is responding the same way to the vaccine based

2523 on --

2524 Q And have many vaccinated people died from COVID-19?

2525 A Again, with the same caveats, depending on their

2526 ability to mount a response or be protected by vaccine and

2527 whether they have been boosted and how long it's been.

2528 Q So, generally speaking, if I say if you're

2529 vaccinated, you're not going to be hospitalized, you're not

2530 going to be in the ICU, and you're not going to die, is that

2531 a true statement?

2532 Mr. Barstow. [Redacted], you're trying to take that

2533 into the presidency and a lot of the context. We've allowed
2534 some questions here, but I'm going to instruct you not to
2535 answer the question.
2536 Q Okay. President Biden also said the vaccines
2537 "cover the highly transmissible delta variant" and "you're
2538 not going to get COVID if you have these vaccinations."
2539 Have people caught COVID while being vaccinated?
2540 Mr. Barstow. That's outside the scope. We've allowed
2541 some questions in this phase. I don't think we're going to
2542 get any further.
2543 [Minority Counsel]. How is it outside the scope? COVID
2544 has been around since October, November of 2019.
2545 Q So I'll ask you this question: The first vaccine
2546 rolled out in, what, early December of 2020?
2547 Have people caught the virus between December 2020 and
2548 January 20, 2021, that were vaccinated?
2549 A The question you're asking really has to do with
2550 what the purpose of the vaccine has been, and the purpose --
2551 Q No, that's not what I'm asking. I'm asking if a
2552 vaccinated person can catch COVID-19.
2553 A But the vaccines -- the purpose --
2554 Q It doesn't matter --
2555 A -- is not whether you're infected or not. It's
2556 designed to attenuate the severity of the infection, and
2557 this is an example where nuanced messaging matters.

2558 So the vaccinations, being fully vaccinated and boosted
2559 are some of the best protection possible to avert severe
2560 disease, hospitalization, ICU admission, and death, point
2561 blank, and all the data support that.
2562 It does not actually say that everyone and anyone who
2563 gets a vaccine won't catch COVID. That's not the way that
2564 it's worked.
2565 Q Okay. You said nuance matters. So if I say that
2566 you're not going to be hospitalized, you're not going to go
2567 into the ICU, and you're not going to die, that's not very
2568 nuanced.
2569 A What I'm saying is the end point of the vaccination
2570 depends on who's being vaccinated, how much vaccine has
2571 given since, the time since the last dose.
2572 The point of the message is will the vaccine make a
2573 significant impact on what events as they emerge, whether
2574 they will circumvent some of the protection of the vaccine.
2575 That is nuanced. So, again, I thought I was very clear
2576 about the word on consistency of messaging. It's not about
2577 consistency; it's about being able to clearly explain what
2578 we know and what we learn as we learn it and not always
2579 saying the same thing that applies at every state when the
2580 new variant emerges and it escapes some of the effect of the
2581 vaccine or an elderly person doesn't respond or someone on
2582 cancer chemotherapy whose immune system is damaged by both

2583 disease and treatment, you're not going to get the same
2584 response.
2585 But the point of the message is will the vaccine make a
2586 significant difference on the proportion of people that are
2587 hospitalized, that die of COVID. There is no doubt that
2588 that's a true statement. Could that be messaged more
2589 clearly and can that occur in the proper setting?
2590 Absolutely. But it's not about perfect consistency and
2591 simplicity; it's about the accuracy of the message. And it
2592 matters.
2593 And the truth about the power of the vaccine to change
2594 the shape and the trajectory of the pandemic are quite
2595 important. But it depends on how many doses, how they're
2596 used, in what populations, who's being exposed and who's
2597 not, and what variant is emerging.
2598 That's the honest truth, [Redacted]. That's the way it
2599 works.
2600 Q And I'm not disputing any of it.
2601 A It feels like a little bit of a "gotcha" game here,
2602 and I think it's a big --
2603 Q Dr. Cetron, I'm not disputing any of what you just
2604 said. I'm just saying you were asked in the last hour about
2605 disinformation. You were asked about consistency of
2606 messaging --
2607 A I think there's a difference between disinformation

2608 and --

2609 Q It's wrong information. It doesn't matter if you

2610 disagree with it.

2611 A No, there is a difference. There's a difference in

2612 whether it's about intent, about how off it is. Variations

2613 around the predominance of truth and acknowledged certain

2614 amount of uncertainty of variants is one thing than offering

2615 up a counterfactual.

2616 Those are different types of disinformation. One may be

2617 done innocently, and it may be done by intent. Those are

2618 different types of disinformation. They are not all the

2619 same thing.

2620 And I was speaking in general that things that are --

2621 where the counterfactual is portrayed as equivalent to the

2622 facts themselves, not these minor variants, that matters.

2623 When people can equally believe a complete counterfactual

2624 rather than understanding that this is true in the majority

2625 of times with 5 percent uncertainty is not the same as

2626 saying that this is completely counterfactual to everything

2627 we know. Those are not equivalent.

2628 And I'm sorry it's not convenient, but that's the truth.

2629 Q All right. Then I'm going to ask these again and

2630 you can just give me yes or no.

2631 If I say if you're fully vaccinated you will not be

2632 hospitalized, am I lying?

2633 Mr. Barstow. [Redacted], he already answered these
2634 questions. He's not going to answer them again.
2635 The Witness. I'm not going to keep playing.
2636 [Minority Counsel]. We have no more questions then,
2637 thank you.
2638 [Majority Counsel]. Dr. Cetron, I wanted to check in
2639 with you if you wanted to take a break or if you wanted to
2640 keep going.
2641 The Witness. Yes. Is this the break we take for lunch,
2642 or is this a five-minute break?
2643 [Majority Counsel]. It can be either. If you discuss
2644 with Kevin what your preference would be, we'll decide
2645 amongst ourselves as well.
2646 [Discussion held off the record.]
2647 Mr. Barstow. I think a longer break now would be good
2648 and then we can power through.
2649 [Majority Counsel]. That's fine with me.
2650 Mr. Barstow. 12:35?
2651 [Majority Counsel]. Is that okay with you, [Redacted]?
2652 [Minority Counsel]. Yes.
2653 [Majority Counsel]. We'll be back on the record at
2654 12:35.
2655 [Recess]
2656 By [MAJORITY COUNSEL]:
2657 Q All right. Back on the record.

2658 Dr. Cetron, I'd like to move to another topic that was
2659 occupying a lot of your time, and that's cruise ships. I
2660 want to discuss how your team handled decisions around the
2661 outbreaks on cruise ships in the February-March period going
2662 forward.
2663 Let's start -- can you tell us how you first came to
2664 learn about coronavirus outbreaks on cruise ships.
2665 A Sure. Our first exposure had to do with the
2666 Diamond Princess docked off the coast of Japan reporting an
2667 outbreak of cases, and trying to understand the
2668 circumstances in that situation.
2669 I mentioned to you that my group, Global Migration and
2670 Quarantine, has some international field staff. We had the
2671 head of our office program that was based out of Bangkok,
2672 Thailand, Dr. Barbara Knust, and both from requests that
2673 were coming in from different places, including from the
2674 embassy in Japan, from, you know, State Department, from a
2675 variety of interests, we were trying to get a better handle
2676 on what was happening, because there were a number of
2677 American citizens on the Diamond Princess when it was
2678 ultimately docked in the harbor in Japan.
2679 And Barbara Knust was closest to the area, so I had
2680 asked her to deploy in support of the U.S. interests in
2681 coordination with the Japanese, you know, public health
2682 authorities. That's how we were sort of started trying to

2683 understand the circumstances.

2684 Again, it was really early in the COVID experience, but
2685 it was very -- sort of heralding a scenario where you have a
2686 closed environment with a prolonged stay. So when you look
2687 at these things, we look at the person, place, time, and
2688 space as variables which impact the risk for an outbreak,
2689 whether the -- what people are on board and what their
2690 vulnerability or risk for getting sick would be if they
2691 become infected.

2692 Place, what's the nature of the location, what are sort
2693 of the environmental constructs of the situation,
2694 indoor/outdoor, enclosed, ventilated poorly, well
2695 ventilated. Those would be the sort of characteristics
2696 around place, location. Is it in the middle of a hot zone?
2697 Is it an emerging area? Is it pretty far from the presence
2698 of the virus.

2699 Person, place, time. How much time were people spending
2700 in a setting of risk.

2701 And then space, what is the nature of the actual space
2702 in the environment.

2703 A lot of it -- as one can imagine, a lot of cruise
2704 ships, you know, would be ticking a lot of those boxes as a
2705 risk environment for a respiratory virus that spreads
2706 efficiently and quickly from person to person. They tend to
2707 be very crowded, large populations, very mixed international

2708 populations.

2709 The passengers, in general, are skewed more toward the
2710 elderly and more toward vulnerable, although that is not
2711 uniformly true across all the ships and all the lines, but
2712 as a generalization.

2713 And they're served by a large number of crew, which tend
2714 to be younger and more international, from particular areas
2715 in the world that haven't had some early impact of the
2716 virus.

2717 The passengers rotate generally around a week and the
2718 crew tend to carry over from vessel to vessel.

2719 So, as you can tell from what I'm describing, it is not
2720 surprising, perhaps, that cruise ships became one of the
2721 early sources of an outbreak, given how confined they were.

2722 And this was a really important outbreak, not only
2723 because of the size and the magnitude of those people who
2724 quite vulnerable on board, the impact, but, in fact, it sort
2725 of was an opportunity of a passenger population to
2726 understand some of the characteristics of the virus by what
2727 the attack rate what is, what the submission period was.
2728 How things were being interpret. So it was a really
2729 critical time to understand COVID in a maritime setting.

2730 Q And in terms of what your team learned, what were
2731 some of the things that had to be done to prevent this from
2732 happening on other ships?

2733 A It was -- well, so there's a lot that we were
2734 trying to understand. One is how could those -- how could
2735 we mitigate the outbreak on board. What would be the impact
2736 of disembarking the passengers on the local port communities
2737 and the introduction and spread.
2738 The ship had some challenges finding the harbor. Once
2739 it was identified as a place of having an outbreak, how
2740 would we safely identify who on board was infected, who
2741 needed to be triaged and taken to a local hospital for
2742 medical care, what was the attack rate, how could we get
2743 testing done in that setting.
2744 How many people got sick relative to how many people got
2745 infected? Was there evidence of asymptomatic or
2746 presymptomatic spread? Was there clustering of infection by
2747 a cabin or by area on the ship. What would that tell us
2748 about the level of infectivity?
2749 What types of measures were being put into place? Was
2750 there surface contamination issues that represented a
2751 particular transmission risk, or was it all moving through
2752 air and droplets?
2753 It was a lot to try to understand. And then it was an
2754 international setting and the whole issues about
2755 repatriation of citizens from multiple countries came into
2756 play, how could that be done safely, how would you
2757 repatriate people from an intense outbreak epicenter. And

2758 so on.

2759 So it was an international incident, obviously, and at
2760 times early in the pandemic the cruise ship itself, Diamond
2761 Princess, became a place that had more reported and
2762 confirmed cases than many other places outside of China, per
2763 se.

2764 So it was sort of a herald event and in -- what we have
2765 come to learn as a high-risk event. We had an outbreak
2766 investigation SWAT team that was involved and much
2767 engagement, international-coordinated engagement.

2768 And then it informed things about CDC guidance and
2769 recommendations about maritime safety in that environment
2770 and what COVID would mean -- what challenges were faced and
2771 what COVID would mean to high-risk persons that might be
2772 joining other cruise ships.

2773 And ultimately we had developed a dedicated maritime
2774 unit separate from the global migration task force just
2775 because of the scale and magnitude of that problem, the
2776 number of ships, the number of ships that were demonstrating
2777 infection where outbreaks were occurring and escalating that
2778 were at sea in all regions, you know, of the world that were
2779 having challenges finding a port harbor and evacuation
2780 issues and many, many other things that were unfolding in
2781 relation to this.

2782 So it was not a one-off incident, and it was an incident

2783 with a lot of global significance and had a big intersection
2784 with the global sort of travel and trade components.
2785 Q It's been reported that the Diamond Princess and
2786 then the Grand Princess after that occupied a lot of time of
2787 the White House task force in terms of the decisions that
2788 had to be made around those two.
2789 Is that accurate? And what was your experience?
2790 A It is accurate, because, as I said, the Diamond
2791 Princess, as a herald event, barely unfolded and the
2792 circumstances that led to that event and the growing, more
2793 globalized nature of the presence of the virus as well as
2794 the fact that cruise ships served as large mixing vessels,
2795 if you will. That is to say that in the course of
2796 introducing even a single or small number of cases, given
2797 the prolonged stay the living quarters, that the
2798 transmission would amplify very quickly in that setting, and
2799 then people after that period would scatter globally and
2800 become seeds and sources of introduction.
2801 So it was pretty important to understand the niche of
2802 the cruise ship environment in not only its role that one
2803 would play if you tried to contain a specific outbreak on a
2804 specific vessel, but that this pattern would likely be
2805 repeated over and over again across multiple vessels at sea.
2806 And such was the case. We had our own essentially
2807 domestic experience with an international cruise ship

2808 infection with the Grand Princess that went, came in out of
2809 California. And so -- and they're large population bases.
2810 I think when you mix passengers and crew, you're talking
2811 about thousands of people on board that are living, eating,
2812 you know, recreating, vacating, vacationing, all sorts of
2813 things that are together in common indoor spaces, some of
2814 which are very poorly ventilated and could be very crowded.
2815 So they were like floating cities of populations that were
2816 intensely intermingling at close risk.
2817 And it did take a lot of time not only to figure out how
2818 to define the risk of introduction and then amplification,
2819 mitigate it on board, mitigate its impact when people were
2820 embarking and disembarking and its impact on port
2821 communities and their healthcare systems.
2822 The transportation -- once people come back to a port
2823 and they have to get on to other commercial transport in
2824 order to get to where they're going and what the risk that
2825 that would entail.
2826 So it was kind of a microcosm of understanding multiple
2827 factors in managing the COVID pandemic in a maritime
2828 environment as a source of not only introduction,
2829 amplification, but also distribution and seeding and setting
2830 up new loci of infection in other places along the
2831 trajectory of that movement. It would take a lot of time.
2832 Q Who was making the ultimate decisions on this in

2833 terms of the task force?

2834 A Again, I think, as I indicated to you earlier,
2835 there are multiple levels of decision-making around --
2836 depending on the type of problem that was being solved. But
2837 they were significant because of the scale of which the
2838 number of ships at sea, the number of passengers, crew
2839 members, number of countries that are implicated by the
2840 itineraries, there were many complex issues and complex
2841 policy issues which elevated up and down the sort of layered
2842 chains of responsibility.

2843 So there were definitely engagements in the White House
2844 task force. There were engagements in the interagency.
2845 There were engagements with state and local communities.
2846 There were port communities. There was a lot going on.

2847 And, of course, there were economic interests outside of
2848 the specific -- the public health interest, stuff outside
2849 but nested inside and interdependent in terms of how to
2850 manage the risk.

2851 Q Was there opposition -- sticking with the Diamond
2852 Princess and I guess the first 14 passengers who arrived in
2853 the U.S. from Japan, was there opposition to that decision
2854 to repatriate the sick passengers?

2855 A Some of the sick passengers were disembarked and
2856 cared for locally in Japanese healthcare facilities. Some
2857 of them who were not too sick to travel could be

2858 repatriated. Some of them who were not yet sick but may
2859 have been incubating or exposed possibly were part of the
2860 cohort that was repatriated.
2861 I think the idea of whether to repatriate American
2862 citizens from the Diamond Princess was not as -- not
2863 controversial, per se, in that setting. How to do it, how
2864 to do it safely and how to do it in an international
2865 context, those were challenging problems to solve, but I
2866 don't think there was a debate about whether to do it.
2867 Q It was reported in the New York Times that the
2868 president was "furious" when those 14 passengers were flown
2869 into the U.S.
2870 Was that position something that was articulated down to
2871 you, and did that change any of the decisions going forward?
2872 A We were aware by the media reports of the comments
2873 that the president was making. I would say that I think --
2874 I don't remember exactly what was on the schedule of people
2875 that were, you know, quite busy around this, but the
2876 decisions about to repatriate or not in advance of those
2877 decisions, I don't think got raised there, so I can't speak
2878 to the specifics of what the degree were.
2879 But the planning around repatriation proceeded and
2880 perhaps proceeded prior to his comments. I don't remember
2881 the specific details on timing.
2882 Q Did his comments affect these decisions going

2883 forward, moving on to the Grand Princess and other ships?

2884 A As opposed to the decision to repatriate from the

2885 Diamond Princess?

2886 Q Moving forward.

2887 A Yeah. It's hard to know. I think the problem was

2888 is that there were many, many thousands of Americans at sea

2889 on ships during COVID, and ships -- and the number of

2890 outbreaks on ships was increasing very regularly, both in

2891 scale and magnitude.

2892 Outbreaks that involved significant morbidity and

2893 mortality as well as global distribution, and it created

2894 some challenges in terms of how to manage them, how those

2895 cases would be counted, whether they're counted, you know,

2896 in some type of -- against some type of international

2897 setting or whether they would be counted as U.S. domestic

2898 cases based on their citizenship. There was a lot of

2899 confusion handling that.

2900 I tend to see those kind of questions come up pretty

2901 regularly in outbreaks in globally mobile settings. So it's

2902 hard. It complicates policy as what the ledger of the cases

2903 going to be.

2904 But really the issue is how do you safely manage those

2905 cases to reduce harms, hospitalizations and deaths, to

2906 reduce transmission, to reduce the trajectory of impact as -

2907 -

2908 [Technical interruption]

2909 [Recess]

2910 The Witness. I think you were asking -- maybe if you
2911 can repeat your question, [Redacted]. Not from the
2912 beginning.

2913 Q You said something interesting about ledgers and
2914 the issue of case counting. I wanted to ask you about that
2915 and sort of what the discussions were about case counting
2916 when it came to the next cruise ship crisis, the Grand
2917 Princess.

2918 A I think that -- I think that it's always confusing
2919 when outbreaks are occurring among globally mobile
2920 populations and occurring in places that are outside of the
2921 nation's domestic territory.

2922 How those cases get attributed, whether it's by place of
2923 exposure, whether it's by place of diagnosis, whether it's -
2924 - you know, if the state that the person is resident of or
2925 the state, you know, if the exposure occurred at work.
2926 These are not uncommon challenges.

2927 And so the surveillance issues, you know, came -- those
2928 cases are cases that happen on cruise ships, and that always
2929 gets defined a little bit. That's not an uncommon problem.

2930 The bigger problem from the public health perspective is
2931 how to actually contain an outbreak in a globally mobile or
2932 internationally mixed setting, especially one that happens,

2933 perhaps, in international waters.

2934 And how do you safely intervene in the outbreak, make
2935 recommendations. How do you get the people who need medical
2936 care that's beyond the capacity of the vessel to safely give
2937 medical care. How do you move all the other people who may
2938 be infected and exposed but don't know it or incubating and
2939 it's not clear, how do you get them safely home.

2940 Those are the kinds of things that Diamond Princess
2941 opened that can by showing us that this is going to be a
2942 problem moving forward. Grand Princess reaffirmed that this
2943 was not a single vessel type unique circumstance.

2944 And then as we stood up a maritime unit and began a
2945 surveillance system to track cases that were out at sea or,
2946 you know, among recently embarked or disembarked persons or
2947 in support communities at ports, we realized that we were
2948 having to deal with a whole gamut of these international
2949 microcosms of high-risk events, high-risk settings that
2950 could basically be sources of introduction, amplification
2951 and distribution and seeding.

2952 And that is a challenge of these kind of floating
2953 international cities that periodically visit multiple
2954 countries in port calls, et cetera. It's a unique,
2955 difficult situation to manage.

2956 Q I want to get into the substance of the actions
2957 that were taken, but I wanted to ask you one last question

2958 about this sort of ledger issue.

2959 The president said publicly on March 6, when he was
2960 actually at the CDC, and he was asked about the infected
2961 passengers on the Grand Princess, and he said, "I don't
2962 have" -- "I don't need to have the numbers doubled because
2963 of one ship."

2964 First question is: How did the president weighing in on
2965 these decisions affect your work on the ground?

2966 A We do what we have to do to define, characterize,
2967 control an outbreak, you know. We just have to move on.

2968 Q Did that desire to keep numbers down, was that
2969 articulated to you or your team at any point?

2970 A The problem that I've been describing was
2971 articulated. It didn't stop -- it didn't stop me from
2972 telling my team we need to do good surveillance. We need to
2973 count. How we count and label them as to where they
2974 occurred was less important to me than that we understood
2975 fully what the scope and magnitude and the extent of the
2976 problem was and how we would solve it.

2977 To say we just -- you know, our division has been
2978 dealing with cruise ship outbreaks of infectious diseases
2979 before COVID and after, and we'll continue to do what we
2980 need to do and let other people worry about whose ledger
2981 they sit on.

2982 Q I want to dive into the substance of the problem

2983 and what was proposed. So your team, your maritime team was
2984 tracking all of the Americans on cruise ships.
2985 Can you give us a sense of the scope of the problem as
2986 you found it?
2987 A Yeah, I think -- I don't want to misquote the
2988 actual numbers. Most of these are available in published
2989 reports.
2990 The kind of counting the number of ships that were
2991 involved in outbreaks, the size of the outbreaks, and we
2992 counted cases whether they were in American citizens or in
2993 crew members or in foreign nationals.
2994 We tried to define the scope and magnitude and the
2995 severity of an outbreak in the transmission settings
2996 independent of, as I said, what ledger you would count --
2997 hold as to the accounting.
2998 They occurred on a ship. We did, you know, count the
2999 data, whether it was in crew members or passengers. We did
3000 look at the data based on severity and how many people were
3001 requiring infirmary visits or intensive support or maybe
3002 oxygen support on the small medical capabilities that are
3003 available in the infirmaries on ships. How many
3004 evacuations, those kinds of things that we were getting
3005 called in about that might need some assistance beyond the
3006 capacity of the ship?
3007 And then we would be looking at how fast the trajectory

3008 was, whether the carryover infections were occurring from
3009 new introductions in seeding, new passengers coming on
3010 board, or whether the existing crew members that stayed over
3011 week to week and continued to support a vessel, whether the
3012 infections in crew members were creating these carryover
3013 outbreaks, whether it was the same ship repeatedly involved.
3014 Those are the kinds of things that our maritime team was
3015 intensively engaged in. And from those experiences, we were
3016 realizing the scope and magnitude and the problem that COVID
3017 would place in a maritime environment at sea sometimes miles
3018 and miles away from land-based medical care were going to be
3019 quite significant and that these weren't one-off events that
3020 occurred sporadically, but that these were the types of
3021 environments that were uniquely, you know, at risk and
3022 needed specific management, attention, very, you know,
3023 complicated guidelines for control, screening, surveillance,
3024 testing before embarkation, how many days when, testing at
3025 embarkation, testing periodically passengers and crew during
3026 that, beefing up infirmary capabilities, you know, defining
3027 the level of medical support that was available compared to
3028 the number of passengers and crew on board and the
3029 vulnerabilities.
3030 Having emergency response evacuation plans, having
3031 agreements with port cities as to where people could be
3032 brought, disembarking persons who were infected and how to

3033 manage them for a period of isolation and their close
3034 contacts for quarantine periods, arranging private, safe
3035 travel for people that were infected and not very sick and
3036 need to go from the disembarking port to their homes, which
3037 would involve -- normally involve commercial travel and not
3038 wanting to exacerbate this infection spread along the entire
3039 travel corridor trajectory. So having a plan for private
3040 movement of infected people from one location to another.

3041 So it was -- these were very complicated problems, and
3042 there were multiple outbreaks like this, scores, if not
3043 more, of settings like this.

3044 And complicating that further, there were many countries
3045 which did not allow any of these ships to come into their
3046 ports or receive any assistance from the national
3047 authorities and those other governments.

3048 So we had to deal with all of those aspects of trying to
3049 deal with, you know, a highly transmissible respiratory
3050 pathogen in a setting that was uniquely risky.
3051 Accommodation of household-type risk factors with
3052 hoteling-like risk factors with -- in the restaurant
3053 services.

3054 All of those different settings that create the risk for
3055 transmission and spread are sort of cohabitating on the
3056 vessel in that regard. And all the transportation corridor
3057 risks were really a difficult problem, and it did occupy the

3058 full attention of a large team in the maritime unit for
3059 many, many weeks and months.
3060 Q It sounds like a massive and complex problem. Can
3061 you talk about some of the tools that you were talking about
3062 using and how that led to an emergency order.
3063 A Well, we brought to bear everything we knew about
3064 containing sort of a high-risk land-based outbreak and
3065 extended it within the context of how that might happen at
3066 sea, where resources were more constrained because they
3067 needed to be all available in situ at a distance.
3068 And so developing a safe plan for defining surveillance
3069 plan, a testing plan, a monitoring plan, the proper scaling
3070 of healthcare resources on board, the proper agreements that
3071 people would know in an emergency where very sick people
3072 would be evacuated to, what port would be able to be brought
3073 to bear by Coast Guard or other emergency services, how to
3074 achieve isolation and quarantine for passengers and crew.
3075 Meals, obviously, meal service, the congregate,
3076 aggregate setting kind of things. Those are the kinds of
3077 things that had to be worked out.
3078 We -- on the very front end, once we understood the risk
3079 in this setting, we tried to issue travel-related guidance,
3080 eventually looking at the ship as if it were a geographic
3081 destination and advising people not to travel on cruise
3082 ships because of the increased risk and the limited

3083 resources, much the way we would do if there was an outbreak
3084 in a particular country. We would alert people in advance
3085 to not engage in an activity where it was difficult to both
3086 prevent and respond.
3087 Our travel guidance was initially focused regionally
3088 where we saw the outbreaks, but as the epidemic and the
3089 pandemic spread geographically, the advisories involved in
3090 that engaging in cruise ship travel anywhere on the globe,
3091 not just in the southeast Asia area -- that transmission
3092 happened very quickly, but certainly our experience with the
3093 Grand Princess off California was clear about that.
3094 We learned for that carryover passengers and carryover
3095 crew, particularly the entertainment and other kind of crew,
3096 were responsible for breaching outbreaks sequentially on
3097 some of these vessels, so that's something that came to
3098 play.
3099 Eventually it was also clear that we were not going to
3100 get the kinds of COVID control that were needed by doing
3101 this sort of one vessel at a time and that the plans to
3102 really prevent, contain, prevent, respond to outbreaks was
3103 going to be very broad and somewhat industry-wide in these
3104 large population settings.
3105 And so that led to the recommendation to go beyond the
3106 travel-related guidance, which was actually insufficient to
3107 prevent embarkation and any vessels from taking off fully

3108 loaded.

3109 And so we were discussing the need until further notice
3110 to have a no-sail order, a no-sail order in order to get a
3111 better handle on how to contain these outbreaks and create a
3112 situation where hundreds of thousands of passengers were
3113 stranded at sea in high-risk settings in many ports around
3114 the globe. Many countries would not allow them the safety
3115 of harbor and disembarking and so on.

3116 Q And just set us in a time frame. When was the --
3117 when was your team proposing the no-sail order? I guess the
3118 first one was on March 14, and on March 7 there was an
3119 announcement of a plan amongst the industry.

3120 A Yeah. So I think things were getting out of hand
3121 between Diamond Princess and Grand Princess by the end of
3122 January into February, and our surveillance team was just
3123 hearing about vessel after vessel, line after line that were
3124 being plagued by these outbreaks.

3125 We were having, you know, the discussions about this
3126 no-sail concept. It was obviously a big deal, and it was
3127 one of those kind of items which would escalate quickly into
3128 the entire interagency with the task force and certainly had
3129 the attention of senior administration officials.

3130 And the approach to issuing the order versus having an
3131 industry come up with its own plan and then running that
3132 plan by the public health -- our public health maritime unit

3133 to see if it was feasible, operational, implementable and
3134 all of those kind of -- so that was all going on in this
3135 time frame through February and into early March.
3136 Q Let's start with March 7. And then it is Vice
3137 President Pence, Director Redfield, a number of Florida
3138 politicians. They met with the cruise industry executives
3139 in Ft. Lauderdale.
3140 Did you participate in that meeting in Ft. Lauderdale?
3141 A I did not. I did not.
3142 Q Did you have discussions with Director Redfield
3143 about your position in terms of --
3144 A Director Redfield was representing CDC along with
3145 other members of the White House task force. He was briefed
3146 regularly on our team on the scope and magnitude and the
3147 challenges of the problem and was aware that we were going
3148 to need to elevate to regulatory actions, because we weren't
3149 able to control this with things short of that.
3150 Incrementality and the proportionality was insufficient to
3151 stem the scope of the problem.
3152 Q It seems like the -- at least at that announcement,
3153 it wasn't a regulatory action that was being rolled out; it
3154 was a plan that would be announced in 72 hours that the
3155 industry was proposing. Is that right?
3156 A That's what -- that's what -- I wasn't at the
3157 meeting, but my understanding is that's what was agreed to

3158 between the administration and the CEOs or whoever attended
3159 the meeting.
3160 Q Given what your team was seeing, was that adequate
3161 to deal with the problem as you measured it?
3162 A I was -- I would fairly characterize my assessment
3163 was, it was I was skeptical, because there wasn't sufficient
3164 public health expertise within the industry to actually
3165 understand the characteristics of the virus, the scope, the
3166 risks.
3167 And I was skeptical that they would have adequate and
3168 sufficient plans, but I agreed with -- or I went along with
3169 the decision that was reached. That wasn't my call to make.
3170 It was above me to make that call for them to submit plans.
3171 And the plans that were submitted were reviewed by our
3172 team, and some I would describe as overly aspirational and
3173 not feasible and not implementable and others were wholly
3174 inadequate in terms of really appreciating the scope and the
3175 magnitude.
3176 So plans were developed, they were submitted, they were
3177 reviewed, and I did not think that they would be able to
3178 address the problems. By aspirational, I mean they were
3179 assuming the availability of certain things that were pretty
3180 difficult to get, assuming a major scale-up in their
3181 on-board laboratory capacity or their medical capacity, all
3182 sorts of things they didn't necessarily include in these

3183 agreements for managing an acute response. Evacuation for
3184 port agreements. So they were missing a lot of components
3185 and they had a number of gaps.
3186 But I commend -- an issue for making that effort. I
3187 don't think it was their fault that they lacked the public
3188 health resources in order to fully comprehend and manage
3189 this kind of a problem. It was an unprecedented problem in
3190 scope and magnitude.
3191 Q And Vice President Pence at that meeting said
3192 publicly that Americans could travel on cruise ships safely.
3193 Did you agree with that assessment at that time based on
3194 what you were seeing?
3195 A I don't know what specific time frame he was
3196 referring to in that, whether that was in the future,
3197 whether that was in the moment, whether that was in the
3198 past. I'm not sure what he was specifically referring to.
3199 My experience leading to that meeting was there was not
3200 a safe, healthy way to continue to travel on cruise ships in
3201 that moment without trying to control the huge number of
3202 outbreaks that were already ongoing and, you know, literally
3203 hundreds of thousands of people that were kind of stranded
3204 at sea in the midst of outbreaks that had also to be sort of
3205 managed in that setting concurrently.
3206 So to me, the scope and the magnitude of the problem far
3207 exceeded what I would describe as safe and healthy cruise

3208 ship travel until a much better handle could be gotten on
3209 the problem, per se.
3210 Q Were you concerned about this delay in getting to a
3211 no-sail order and the impact --
3212 A I was definitely of the opinion that we needed to
3213 push, push in that direction, that given the amount of
3214 consultation that was being required of my team and the
3215 entire maritime unit, which stood up and needed emergency
3216 managing all of the incoming on the outbreaks and the
3217 problems and the challenges, I was quite, quite concerned
3218 that we needed to have a pause and we needed to deal with
3219 all of the folks.
3220 Like I said, in the course of time there were, you know,
3221 counting passengers and crew, there were an enormous number
3222 of people that were still out at sea that needed to be
3223 safely repatriated without creating an extension of the
3224 epidemic.
3225 And so, like I said before, on other things this is the
3226 kind of virus that's very unforgiving in the mode at which
3227 it spreads and the speed at which it spreads and its stealth
3228 nature at times. And I thought we needed stronger action
3229 earlier in order to be able to get a handle on it and get in
3230 front of it. It was not a situation in control.
3231 Q This has been reported. I'll just ask you: Did
3232 you call this situation unconscionable in the conversation

3233 with Dr. Schuchat?

3234 A I did.

3235 Q And why?

3236 A Because I did not think it was being addressed with
3237 the sense of urgency that was needed to protect people, to
3238 reduce morbidity, and reduce fatalities.

3239 Q It was also reported that this was a stressful time
3240 for you personally and that you had expressed your
3241 frustration and you were working around the clock. Is that
3242 accurate?

3243 A That's accurate.

3244 Q Can you describe -- I guess you sort of went into
3245 it, but in terms of getting this done, what was blocking
3246 you, blocking your team, from getting this done?

3247 A I think, like I've said about other things, this
3248 system wasn't either appropriately assessing the risk and
3249 the magnitude of the problem, nor acting with sufficient
3250 urgency in order to save lives, and that was tremendously
3251 frustrating to someone who's spent, you know, decades with
3252 that as a principal goal.

3253 Q Did the administration's relationship with the
3254 industry and that announcement add to your frustrations
3255 about the issue?

3256 A The slowness of reacting really augmented my
3257 frustration, yeah.

3258 Q Do you think Americans died as a result of that
3259 delay?
3260 A I think the delay had significant impact on the
3261 morbidity and mortality.
3262 Q I want to move to the first iteration of the order,
3263 and that's on March 14, and that's Exhibit Number 5.
3264 [Exhibit 5 was marked for identification.]
3265 Q I want to ask you about specific parts of this
3266 order. And starting the first part, Applicability, and it
3267 had a big exception, the exception that "this order shall
3268 not apply to any cruise ship that voluntarily suspends
3269 operations for the period of this order."
3270 Can you talk about how that came to be and why that
3271 exception was in this order?
3272 A I think that, as you've mentioned, there was some
3273 confidence by the industry and perhaps others in support of
3274 that confidence that they could manage this problem on their
3275 own and -- or that they would see voluntarily when they got
3276 the feedback from us on their proposed plans that they
3277 couldn't manage the problem, so they would voluntarily agree
3278 to suspend operations short of having the regulatory
3279 authority and impose some of those restrictions and
3280 operations.
3281 So I think what you see in there is the regulation would
3282 only apply if you didn't voluntarily suspend, and there was

3283 some cascading momentum among certain parts of the industry
3284 that they would suspend until they were able to get their
3285 planning in place and then they would see.
3286 Q It seems to me that this is not the most direct way
3287 of dealing with a massive problem in allowing industry to
3288 regulate itself when people are dying.
3289 What was your view in terms of the adequacy of doing it
3290 this way?
3291 A In the end, my biggest concern was that there was a
3292 suspension in operations, because we had to stop, you know,
3293 pouring gasoline on the fire of the outbreaks at sea, which
3294 was a lot of risk.
3295 And whether they agreed to voluntarily suspend or those
3296 that didn't were going to be suspended by regulation, we
3297 just needed to get this paused and we needed to have sort of
3298 a major rethinking about how safe and healthy travel could
3299 and if it could and how it would resume in setting up a
3300 COVID pandemic of this magnitude, which, as I said, cascaded
3301 well beyond the ship itself. It had impact and implications
3302 for really accelerating the pandemic across the globe and in
3303 many communities.
3304 So how we got there was less important to me than that
3305 it happened and it happened quickly.
3306 Q Did this order get us there?
3307 A It made a huge -- the order made a huge -- things,

3308 as you will note, need to be modified along the way, but,
3309 you know, taking the accelerant away by not embarking new
3310 passengers and beginning new cruises made a big difference.
3311 We still had to manage the existing multiple outbreaks at
3312 sea across tens, if not hundreds of thousands of persons
3313 that were impacted either directly or by contact.
3314 So the first step was stop adding fuel to the fire of
3315 the outbreak, and the second one was managing the existing
3316 outbreaks that were still ongoing. And that was my goal and
3317 our goal at CDC.
3318 Q And moving down in the order, I just want to point
3319 to the section that reads "Coordination efforts with the
3320 cruise ship industry."
3321 And in that section, it says "the federal government
3322 recognizes the enormity and importance of this action taken
3323 by CRIA" -- that's the Cruise Lines International
3324 Association -- "and the commitment it demonstrates in
3325 protecting the health of both cruise ship passengers and the
3326 public at large."
3327 Who drafted this order?
3328 A The initial draft of the order was originated at
3329 CDC with my team and our general counsel. The order
3330 circulated in the interagencies, as was common for anything
3331 of this magnitude. Went through OIRA and OMB and the
3332 various interagency partners of people at the White House as

3333 well as in DHS and other departments and agencies that are a
3334 part of it. And the language was refined and drafted and
3335 modified and edited and so on as it moved through those
3336 processes.

3337 Q Was this language amending the industry group part
3338 of the original CDC draft?

3339 A I can't remember the specifics.

3340 Q Okay. So as you described, this was stopping the
3341 accelerant. What about the ongoing fires, the ships that
3342 were already at sea?

3343 A Our maritime unit and team, together with DHS and
3344 Coast Guard and public health practitioners in port
3345 communities and many others, had to manage the safe
3346 evacuation from all of these ships down to a skeleton level
3347 of crew only to keep maintenance and other basic things
3348 going.

3349 And that took many weeks to months in order to safely
3350 get people home. That involved finding the ports to enter
3351 in the United States, evaluate, test sort of infected,
3352 exposed, from not involved, and working to have isolation
3353 quarantine locations and then safe means of getting non-U.S.
3354 nationals who were coming into the U.S. ports repatriated
3355 with the assistance of foreign governments, whether they
3356 were Canadians or other nationalities.

3357 And reciprocal, the other way, where American citizens

3358 who were at sea coming into a port in other countries would
3359 have to be equally evaluated, sorted, and safely repatriated
3360 to the U.S. without extending the infection or seeding new
3361 communities.

3362 And that took a long time. But that was occurring
3363 during the cessation, during the no-sail period, so that you
3364 weren't continuing adding the accelerant to the problem.
3365 But it took a lot of intense coordination and public health
3366 resources to mitigate the impact of the extraction of people
3367 that were infected that were still out there at large.

3368 Q And the CLIA plan, those that had voluntarily
3369 undertaken the plan, how was it addressing those issues,
3370 sort of in between --

3371 A As I mentioned, the CLIA plan alone was inadequate
3372 and insufficient, but the engagement between the CDC
3373 requirements that were put into place in the setting of
3374 no-sail and the recognition broadly of the need to relate,
3375 not just stop adding accelerant to the fire of these
3376 outbreaks, but actually to put the fires out in multiple
3377 settings around the world, you know, came about in this
3378 phase of the no-sail issuance.

3379 This was what was collectively necessary in order to
3380 really get it down to a level at which people weren't
3381 getting infected, amplifying it, getting severely ill or
3382 dying. And so that took a fair amount of time, but it

3383 happened under the pause of the no-sail order.

3384 Q And the -- it's been reported that the industry

3385 had -- the plan had included that the carriers would hire a

3386 global rescue team of special ops veterans who would extract

3387 passengers and bring them into medical facilities without

3388 burden on the U.S. government.

3389 Did that happen?

3390 A I can't -- I can't say. But generally the

3391 extraction process happened with the intense engagement of

3392 our team at USG. Whether some of the vessels had

3393 independently contracted with other means, I don't really --

3394 I don't really know. I only know about the ones that we

3395 were intensely involved in, which was the U.S. government.

3396 And largely the ones that we were intensely involved in

3397 had to do with ships that were going to be permitted into

3398 U.S. ports for this process. Whether the industry, you

3399 know, got or didn't get the level of public health support

3400 from some of these other countries or whether they were

3401 navigating it through other procedures internationally, I

3402 can't really speak to that.

3403 But I know that there was just intensive involvement of

3404 the CDC, U.S. public health and some of the other

3405 interagency coordination and support in order to safely

3406 evacuate, I believe -- and don't hold me to the numbers, but

3407 somewhere in the range of 300,000 people were disembarked

3408 and then moved without accelerating the spread to the
3409 maximum extent possible through the CDC guidance and
3410 involvement and the assistance of the maritime unit.
3411 Q I want to show you Exhibit Number 6, which is an
3412 email that you sent during this period between the first
3413 no-sail and the -- I guess we'll call it the first
3414 extension.
3415 [Exhibit 6 was marked for identification.]
3416 A Okay. Got it.
3417 Q First, I guess, "BLUF" means bottom line up front;
3418 right?
3419 A Yes.
3420 Q Can you tell us what led you to write this email
3421 and what this represented at the time?
3422 A I knew that Dr. Redfield was preparing for a White
3423 House task force meeting in which this was going to be --
3424 the order was going to be added to the agenda. I wanted to
3425 make sure that he was very well prepared with all the
3426 efforts that we were doing collectively and the rationale
3427 for the order, which was significant one, and make sure that
3428 he was prepared to answer any questions or articulate why
3429 this was necessary.
3430 This was my attempt to make sure the director was well
3431 informed to face that conversation or to be prepared for
3432 that conversation.

3433 Q I want to ask you about the fourth bullet that
3434 starts with "poor planning."
3435 A What would you like to know?
3436 Q What was your basis or finding there was "poor
3437 planning by the industry" and "failure to adhere to
3438 recommendations and unsafe transport"?
3439 A Just actual experience that the team was finding
3440 that, you know, the kinds of things -- it's one thing to
3441 have a set of guidance and provide that to industry, but a
3442 plan is insufficient unless it's actionable, and we had
3443 members of the maritime unit that were overseeing and
3444 monitoring the adherence to the plan.
3445 We were receiving emails, photos, other kinds of
3446 material from people on the vessels and describing
3447 situations which were not consistent with saying that there
3448 was adherence to the plan and were continuing to expose gaps
3449 in the ability to execute a plan, even though it was pretty
3450 clearly articulated.
3451 And, like I said, you asked earlier about the confidence
3452 I had in the industry to execute on a mission, a public
3453 health mission of this degree of complexity. I think it's
3454 not necessarily to the fault of an industry that has a
3455 different purpose to be able to execute a very complicated
3456 public health plan.
3457 But my feeling was that they had not had adequate

3458 assistance on -- they were indicating that they would be
3459 commissioning some private public health assistance to
3460 provide the kind of support they needed it, and it was not
3461 evident that that was sufficiently being executed.
3462 And so I did want Dr. Redfield to be aware that we were
3463 trying to do our best to have this happen in the absence of
3464 a regulatory order, which I knew was not very popular, and
3465 that we weren't getting where we needed to be, and I thought
3466 the order was quite important. And I wanted him to be able
3467 to articulate that if he was questioned in the White House
3468 task force meeting.
3469 Q And at this moment, what was the state of, just
3470 generally, outbreaks on the ships? You know, we had no new
3471 embarkations, but I guess the ships were still out there?
3472 A Yeah, they were out there. And, I mean, I think
3473 more than 100 ship capacities ran anywhere from 2,000
3474 passengers and 2,000 crew. That wouldn't have been
3475 uncommon. So we're talking about thousands of people on at
3476 least 100 different vessels that were out there. At any one
3477 point in time, any number of them were experiencing large
3478 outbreaks or in the early parts of new outbreaks.
3479 So, again, this was a pretty big -- and that's with the
3480 idea that new embarkations had already -- were going to be
3481 able to be ceased and there was voluntary suspension of new
3482 additions. But there was still a really big problem to get

3483 the existing outbreaks under control.

3484 [Majority Counsel]. If I may.

3485 A moment ago, Dr. Cetron, you mentioned that the order
3486 wasn't popular. What did you mean by that? Who wasn't it
3487 popular with?

3488 The Witness. For sure it was very unpopular with the
3489 industry. They didn't want to be regulated and they didn't
3490 think it was necessary. And, you know, pretty confident
3491 among some of them that they had this ability to get this
3492 under control in their home. I think the industry had a
3493 very strong voice in its opposition and was using that voice
3494 quite loudly.

3495 By [MAJORITY COUNSEL]:

3496 Q I wanted to talk about the interagency process in
3497 this. And you wrote in the beginning of the email, "All
3498 interagency members of NSC, PCC are supportive."

3499 What was the interagency process?

3500 A I think I described -- so basically it's a CDC
3501 order. We formulated it, had written extensive -- both the
3502 rationale, the background, the existing status, the
3503 outbreaks, everything we could to make it very clear what
3504 the state of play was, and then we would move that up
3505 through CDC clearance process.

3506 We go to HHS for clearance and then it would move into
3507 the interagency. There would be discussions with the

3508 interagency through the -- the White House convening the
3509 National Security Council and other pieces of the policy
3510 process. And then regulators of these kinds of sorts would
3511 go.
3512 So there would be an informal play of providing inputs
3513 from the interagency, and then it would be more formally
3514 submitted up the wire, and then they would send it out for
3515 further clearance across the interagency. More edits and
3516 other things would come the way of the drafters and CDC, and
3517 we would try to achieve broad concurrence across the White
3518 House and the interagency.
3519 And then the order would be -- amended versions of the
3520 order would then be sent up to the CDC director for
3521 signature.
3522 So that would be the process by which this occurred.
3523 Q One quick question. What does PCC mean in this
3524 context?
3525 A Policy Coordinating Committee. Each administration
3526 has a different acronym or definition for what those
3527 processes would be. There's a place for the interagency,
3528 and all of those with equities in these decisions would have
3529 policy coordination.
3530 Q Do you recall any agencies with equities in this
3531 decision that were opposed to the order, refused to sign
3532 off?

3533 Mr. Barstow. What order are we talking about?

3534 [Majority Counsel]. We're talking about --

3535 Mr. Barstow. There's the March order and there's the

3536 April order. This email is in April.

3537 [Majority Counsel]. We're talking about the movement

3538 from the March 19 order to the April order. That's what I'm

3539 talking about. This particular period of time.

3540 Mr. Barstow. Okay.

3541 The Witness. As I described the process, there were --

3542 the deliberations involved inputs and edits and all sorts of

3543 things and concerns to be addressed and so on. Is that what

3544 you're asking?

3545 Q Yes. I'll be more specific. So it's been reported

3546 that in the lead-up to this order, the -- and this was --

3547 and I'm quoting an article in ProPublica -- Department of

3548 Homeland Security refused to sign off and that the

3549 Department of Homeland Security "disagreed with CDC's

3550 narrative describing the actions of the cruise line

3551 industry."

3552 Is that an accurate report?

3553 A There were definitely discussions of the general

3554 nature you're describing as part of the interagency

3555 deliberative process.

3556 Q Do you recall what the disagreement was over the

3557 CDC's narrative of the actions of the cruise line industry?

3558 Mr. Barstow. [Redacted], I think that's deliberative,
3559 so I'm going to instruct Dr. Cetron not to answer that
3560 question.
3561 [Majority Counsel]. Okay. I'll just note for the
3562 record that I'm quoting a publicly available news article.
3563 This decision has been reported in the news. The specific
3564 point that the agency articulated was in the news, and its
3565 disagreement with CDC's narrative was reported publicly.
3566 Noting that objection for the record and asking that we
3567 perhaps revisit it at some point.
3568 Q Beyond what the agencies were saying, what was your
3569 position in this process? So moving from the order that was
3570 applicable to really a small subset and now moving to a
3571 full-scale order no-sail order.
3572 A I thought it was necessary. It was unclear what
3573 voluntary participation would mean in terms of full
3574 compliance. It was unclear whether those that were
3575 voluntarily participating believed they had a sufficient
3576 plan or not. And so I thought that we needed a more
3577 uniform, consistent, clear set of instructions on what
3578 public health meant in terms of things that had to be done,
3579 and that may or may not have been the things that all the
3580 lines were either equally wanting to do or equally able to
3581 do.
3582 So that's how the piece was sort of evolving to be more

3583 directive and more clear on what was necessary and more
3584 consistent across the board. And not subjected to either
3585 the variability or the decision to opt in for some days and
3586 then opt out for another and tracking all that.
3587 I think one of the problems was there needed to be a
3588 very clear set of public health expectations and objectives
3589 in order to continue this process safely.
3590 Q And the "why" question: Why in terms of what you
3591 were seeing that was happening?
3592 A I said was there variability in understanding and
3593 intent. There was variability in capacity or completeness.
3594 There was variability in the aspirational nature from what
3595 was actually executable. We were getting a number of
3596 reports of the groups that said we're in, we're voluntarily
3597 in, we don't need to be regulated, but on the sort of -- the
3598 checks of what was going on, we weren't seeing that level of
3599 effectuation of the intent plan.
3600 Q Before moving on to the next order, I think it's a
3601 good time for us to take our five-minute break and turn it
3602 over to our colleagues.
3603 [Minority Counsel]. We have no questions for the next
3604 hour, so when you come back, just roll.
3605 [Majority Counsel]. Thanks, [Redacted]. I'll just ask
3606 the witness and Kevin if you want to keep going or if you
3607 want to take a break.

3608 [Recess]

3609 [Majority Counsel]. So back on the record.

3610 By [MAJORITY COUNSEL]:

3611 Q So we were reviewing the lead-up to the April 9
3612 order. Now I wanted to review the April 9 order with you,
3613 and it's Exhibit Number 7.

3614 [Exhibit 7 was marked for identification.]

3615 A Okay. I have it open.

3616 Q And moving to the Applicability section, I think
3617 this is on the second page, first paragraph, second page.

3618 It reads that "this order shall additionally apply to
3619 any cruise ship that was excluded from the March order."

3620 So is this what you were describing in the need to --

3621 A Yes.

3622 Q Okay. Why was this critical at this moment?

3623 A As I had said earlier, it's because there was
3624 insufficient clarity and understanding and expectations and
3625 execution of the -- and too much variability.

3626 And voluntary, temporary suspension with or without some
3627 of the things that were part of the CDC requirements for
3628 safe operation and disembarkation were incompletely
3629 practiced. So I just felt it needed to be very clear that
3630 this needed to be industry-wide.

3631 Q I want to move down to the section that reads
3632 "Critical need for further cooperation and response

3633 planning."

3634 A Can you tell me which page we're talking about?

3635 Q It is page 4.

3636 A Uh-huh. I think this is -- most of what I'm

3637 reading on page 4 comports with what I described to you, is

3638 that there was some combination of the industry coming

3639 together to create a response planning framework, CDC

3640 developing its own internal plans and expectations, and

3641 trying to tease out what was aspirational from what was

3642 feasible and what was -- no matter how it was stated, what

3643 was actually being practiced.

3644 That's what this "Critical need for further cooperation

3645 and response planning" means, essentially getting on the

3646 same page.

3647 Q Who drafted this section of the order?

3648 A I don't recall specifically. But I think it was

3649 intended to be, you know, some -- some clarity about why

3650 there was a need to go beyond a voluntary approach to

3651 getting into this. This clearly represented a perspective

3652 that the cruise industry was looking for, obviously.

3653 They were looking for more of an engagement in the

3654 process so that they could, you know, have their

3655 perspectives shared.

3656 How this -- the actual words came about, I can't

3657 remember the details at the time.

3658 Q What about --

3659 A But we obviously weren't on the same page, just
3660 speaking in generalities, and we had some things that needed
3661 to be done and some things that weren't being done, and
3662 there were perspectives, you know, from the industry on, you
3663 know, wanting to have a say in this stuff and -- so there
3664 you have it.

3665 Q Sure.

3666 A The details of who wrote what words and which group
3667 represented getting those words in or interests really
3668 escape me at the time. My goal was to get another order
3669 clearly done with -- again, we were really focused on
3670 outcome and not on blame.

3671 We were really trying to get what needed to be done get
3672 done and get approval and get the orders out and make sure
3673 there was absolute clarity on what was needed from a public
3674 health perspective.

3675 Q Sure.

3676 A That's -- that was the goal.

3677 Q I think -- and looking back, we were trying to
3678 assess process. And I want to ask you about --

3679 A This was not an easy process.

3680 Q What about the title? Was that the original title?

3681 A I really honestly -- I really honestly don't
3682 remember. I don't.

3683 Q Let me try to jog your memory. It was reported in
3684 ProPublica that this section was originally titled "Failure
3685 of cruise ship industry to develop and implement a response
3686 plan."
3687 Is that accurate?
3688 A I don't know. I never spoke to ProPublica. I
3689 don't know where they got their information.
3690 The document, as I told you about process was
3691 significantly revised, amended, and churned through a
3692 deliberative process in the interagency. And, you know,
3693 it's entirely possible that who said what to whom where in
3694 the deliberative process is really kind of beyond -- beyond
3695 my memory and beyond my goals, which is to get an effective
3696 public health response out. That's where we needed to be.
3697 It was not easy. It was a big order, and it involved an
3698 entire industry. That doesn't -- you know, that doesn't
3699 escape me. It doesn't escape me that there were people not
3700 happy about it, but --
3701 Q I'll ask one last question on this and we'll move
3702 on.
3703 Did that change in title from "Recognizing the failures"
3704 to "the need for cooperation," did that come from CDC?
3705 A Yeah. I really don't want to get into that in the
3706 speculation. All this stuff -- again, I read the ProPublica
3707 article. I had nothing to do with it. It's not the way I

3708 work.

3709 I think I've stated my position, basically. We needed
3710 to get something done that was important, and it was hard
3711 work, and there were a lot of perspectives on this problem.
3712 And I'm going to leave it there.

3713 Q Okay.

3714 [Majority Counsel]. I apologize. Kevin, to the extent
3715 that you're planning to make an objection, could you just
3716 put that on the record that -- I saw that you may have been
3717 providing direction to the witness.

3718 Mr. Barstow. We had a conversation, but I think it's
3719 Dr. Cetron's position that he doesn't want to get further
3720 into the process. If you'd like to, I'm happy to put an
3721 objection on the record that it was his decision that he
3722 didn't want to get into it further. But I won't speak for
3723 him.

3724 [Majority Counsel]. I do think that a clarification --
3725 For the record, Dr. Cetron, are you refusing to answer
3726 the question on the basis of an instruction from agency
3727 counsel?

3728 The Witness. No. It's not refusing to answer the
3729 question on the basis of objection from agency counsel. It
3730 is the sense that I can't remember every detail, number one.
3731 I don't want to speculate about who drafted what words, and
3732 I really don't want to, you know, compromise what is a

3733 deliberative process and it needs to be one where there is
3734 lots of inputs.
3735 And my goal here is to try to explain what the public
3736 health problems were, what weren't being met by the
3737 voluntary program, why the need for an additional order was
3738 there. And, you know, that's my rationale.
3739 I don't want to go out there and I have no -- you know,
3740 have no intention here of trying to pass judgments other
3741 than giving my professional judgment that this was
3742 necessary, whatever was necessary to get the job done and
3743 accomplish our public health goals is what I was trying to
3744 achieve.
3745 And whether or not the idea was mine or somebody else's
3746 and whose it was and how it came to be, I totally respect
3747 that there's a need for a deliberative process and there are
3748 many points of view that come to bear in addressing the
3749 pandemic.
3750 It's not one that -- one perfect right answer, but we
3751 need to be pulling in the same direction and get the job
3752 done. That's how I feel. That's why I've chosen to answer
3753 that way.
3754 [Majority Counsel]. Thank you. I just wanted to make
3755 sure the record was clear, so I made that clarification.
3756 Thank you.
3757 Q Okay. I have another question like this, but

3758 focused on your words.

3759 It was reported that in this period and the delay that
3760 led to getting to the April order that you told Olivia
3761 Troye, a member of the vice president's staff, “we’re going
3762 to kill Americans.” Did you make that statement?

3763 A I believe -- I don't know if that's exactly the
3764 specific words, but I believe the sentiment and the
3765 frustration that I was feeling about the delays and not able
3766 to really get to things that needed to be done had
3767 consequences on the lives of Americans and others, people
3768 that were at sea.

3769 Q Do you think Americans died because of this delay?

3770 A I think, as I've said earlier, that pandemics of
3771 this nature that move quickly with big consequences that
3772 there's a necessity to take early and bold action on --
3773 sometimes even unpopular action with other consequences.

3774 But it is necessary to save lives and not have regrets.

3775 And yes, I do think the delays or the frustration were
3776 some of the challenges that we had in getting to where we
3777 needed to in public health. I believe some of those things
3778 have cost lives, and I'm saddened by it.

3779 Q Moving forward, let's -- I'll just call it the
3780 second extension. We'll talk in terms of extensions.
3781 That's the July 16, 2020, order, and that's Exhibit 8.

3782 [Exhibit 8 was marked for identification.]

3783 Q Can you tell us the process that led to this
3784 extension in July?
3785 A So, first of all, the need for the order was
3786 ongoing because of the nature of the pandemic, the status of
3787 the pandemic. As I mentioned to you, there was -- after the
3788 order that prevented new embarkations from the U.S. ports,
3789 there was still an enormous challenge to deal with the
3790 ongoing outbreaks that were at sea that neither the COVID
3791 threat itself, the virus specifically, had been mitigated
3792 sufficiently to remove that threat, nor had the challenges
3793 of the ongoing outbreaks been sufficiently met to have a
3794 sort of a pause and a reset. And so the order needed to be
3795 extended.
3796 In addition, it was clear that the industry would need
3797 -- or it was our opinion that the industry may be engaging
3798 in expanding its own public health advice and authorities
3799 from an independent -- separate from the -- from CDC and
3800 that that work would be ongoing and that work would involve
3801 public health consultants, former CDC people and other
3802 public health consultants, to address a whole series of
3803 issues. And that would be an ongoing process through the
3804 summer.
3805 So I think that was some of the genesis. One, the
3806 threat hadn't mitigated sufficiently; two, we weren't in a
3807 position to resume normal sailing; three, there were

3808 inadequate, you know, controls still being put in place to
3809 mitigate the outbreaks that were already out there, that
3810 were still challenges of folks with COVID at sea, and there
3811 needed to be much more engagement in the planning process,
3812 you know, that would happen somewhat independently to the
3813 other mechanisms that we became aware of.
3814 So those were -- I think I'm just trying to remember
3815 this point in time and what was going on and why another
3816 extension was needed and that we couldn't go back to this
3817 idea of the industry alone can handle it on its own through
3818 voluntary processes and would have ample -- both experience,
3819 guidance, and paths to follow.
3820 Q And I wanted to ask you about the third paragraph
3821 and the information included there.
3822 A Yes. I think that's basically the very crisp
3823 summary of some of the data that supports what I just shared
3824 with you verbally.
3825 Q So this was --
3826 A This was an ongoing issue, and, quite honestly,
3827 those were just the ones we knew about where people were
3828 within a sufficient U.S. jurisdiction to have -- to actually
3829 be reporting, as was required in the no-sail order, to have
3830 a regular reporting frequency, but it would not necessarily
3831 account for all of the outbreaks that didn't involve vessels
3832 with a U.S.-based itinerary for port calls.

3833 So, you know, at the least, this is the kind of tip of
3834 the iceberg issue that we were seeing for what eventually
3835 got reported to the CDC maritime unit, but not necessarily
3836 the totality of the experience, which was likely larger.
3837 And I believe we have -- further, after this July date,
3838 I think we have a further series of summary publications
3839 that included, you know, broader assessments of the various
3840 magnitudes. We can make those available through Kevin at
3841 another time.
3842 Q Sure. And let's just talk about the scope of the
3843 problem at this point. It's at 38,000 hours managing
3844 outbreaks, almost 3,000 cases, 34 deaths.
3845 Can you tell us about how these things were happening?
3846 And we had basically the stop at embarkations and then the
3847 April order. What were you seeing at this point in July in
3848 terms of --
3849 A I think this is mostly focusing on that -- on that
3850 time period where even with the orders in place, without
3851 adding new people to the journeys, to the cruising journeys,
3852 the residual effect between March and July was that these
3853 outbreaks were continuing and amplifying and extending and
3854 it was, you know -- it was not under control.
3855 And it was not a time to lower the guard and roll back
3856 and resume normal cruising at this point in the pandemic,
3857 but rather, really significant processes need to be in place

3858 at -- quite honestly, a lot of this because of so many other
3859 things that were accelerating in the pandemic in its early
3860 time frame and well before the availability of vaccines, for
3861 example, and other medical countermeasures, CDC wasn't going
3862 to be in the capacity to provide all the consultative
3863 support alone that the industry would need to be able to
3864 handle these decisions in an unregulated environment.
3865 And I was encouraged by the fact that the
3866 recommendations that I was making is that they were going to
3867 need some independent public health experts that would be
3868 actively commissioned to get engaged. And such a panel, the
3869 healthy sail panel, was actually not just contemplated but
3870 created and led by a former HHS secretary, Levitt, with a
3871 number of former CDC publication health folks and other
3872 non-CDC public health folks that were really tasked or
3873 requested by the industry or at least two of the lines with
3874 some representation from other parts of the industry to help
3875 engage in some really deep and difficult and technical
3876 conversations about how to move into a potentially safe
3877 sailing space, what would be some of the requirements to do
3878 that before there could be resumption.
3879 And so that panel started, and that was important. I
3880 think part of this paragraph was intended to reflect that
3881 the problem was still very much ongoing and part of it was
3882 to reflect that the enormous challenge that was posed by the

3883 problem for CDC that was also dealing with a huge number of
3884 domestic outbreaks around the country at that scale.
3885 It was going to require that this other process that
3886 they really wanted to move into a "what's the future look
3887 like for safe and healthy sailing" was going to require a
3888 very deep engagement process with public health.
3889 Q And moving forward to the -- what we'll call the
3890 third extension. That's Exhibit 9. That's the
3891 September 20, 2020, order.
3892 Obviously this one is different. Can you tell us about
3893 the process that led up to this order?
3894 [Exhibit 9 was marked for identification.]
3895 A Some of the things that were different were that
3896 summer healthy sail panel that was commissioned did
3897 intensive work. I think -- don't hold me to the dates, but
3898 roughly over that summer, a three-month period, you know,
3899 July, August, and moving into September, and they were
3900 coming up with a series of a more concrete, very specific
3901 set of plans and recommendations.
3902 CDC had two liaisons that were requested and cleared by
3903 our general counsel to sit as liaison members on the healthy
3904 sail panel that participated and listened in on some of the
3905 conversations and were available as a resource to answer
3906 questions in that regard to provide technical input or
3907 answer specific questions about the surveillance data or

3908 things that were being learned about the virus.

3909 And that process had been ongoing over that summer

3910 period. And it was chaired by, I believe, former Secretary

3911 Levitt.

3912 You're muted.

3913 Q In terms of the legal authorities, this was a

3914 conditional order as opposed to the prior orders. Do you

3915 recall why that was?

3916 A You're referring now to the --

3917 Q September 20, Exhibit 9.

3918 A Okay. So the discussion was, you know, you take

3919 one perspective and what sort of -- when are we going to be

3920 in a better place. The recommendations and the other kinds

3921 of inputs that were coming, and then the desire from the

3922 industry is what is it going to take in the future in order

3923 for us to resume the business and have safer sailing; right?

3924 And so the flavor here was, you know, whether we

3925 extended the no-sail order through the winter, it was a big

3926 winter sailing season that was upcoming and that how long it

3927 might take to get to a better place both in the perspective

3928 of the virus, the perspective of the planning, and the

3929 perspective of proof -- going beyond plans but proof of

3930 concept in a safe, iterative way. And that's how this piece

3931 evolved.

3932 And so rather than an outright no-sail order, what you

3933 see here is a conditional sail order that laid out a series
3934 of phases and that by achieving each phase successfully --
3935 so it's not just having the plan for a phase but getting
3936 through it, having some oversight and documenting the
3937 ability to execute in that phase, take lessons learned from
3938 phase one, phase two, and phase three and incorporate them
3939 and incrementally scale up before full resumption of
3940 commercial passenger services could be done safely. That's
3941 where the framing of the conditional sail order came from.
3942 And the concept of what would it take, what conditions
3943 would need to be met, you know, from CDC in order to plan
3944 toward a future resumption of commercial sailing.
3945 Q Did you think the industry was going to comply and
3946 get to a position where people could sail again?
3947 A You know, I have not prognosticated with any
3948 certainty what this virus will do, what the curveball is
3949 going to look like. I know when we weren't there. I knew
3950 how hard it would be to get to that place.
3951 And I knew there would be a number of contingencies and
3952 uncertainties that, if fulfilled, might bring us closer.
3953 For example, there was beginning to be a lot of discussion
3954 about the eventual availability of an effective vaccine.
3955 That would be a potential game changer in the way we looked
3956 at the pandemic.
3957 I knew that there were evolutions in the types of

3958 testing that were available that we would gain that capacity
3959 and some of the other nonpharmaceutical and mitigation
3960 measures. The surveillance components, the portable -- you
3961 know, the rapid test would play into this picture.
3962 And the understanding would be not to pretend we knew
3963 the outcome with some certainty, but to have both a set of
3964 incremental measures in the phases and then documentation
3965 that those would actually work.
3966 And so that was the thinking behind it. I thought it
3967 was a very good sign that at least some of the lines had
3968 commissioned the healthy sail panel and they were beginning
3969 to develop a more earnest and realistic sense of the
3970 magnitude of the challenges that the virus was posing and
3971 imposing on their industry.
3972 I thought that there were people really coming to grips
3973 to how hard this problem was. I also thought that we were
3974 making potential progress on the pharmaceutical and
3975 nonpharmaceutical front.
3976 And this seemed to be a way to provide both what the
3977 government thought would be necessary to assure a safer
3978 pathway, a healthier pathway, in addition to providing some
3979 future clear direction to an industry.
3980 And so that's how this ended. And the recommendations
3981 coming out of the healthy sail panel were validating and
3982 aligning very well with CDC's perspective, so that that gap

3983 that I talked about earlier, the disconnect between an
3984 industry that was largely not getting independent public
3985 health input and not just saying "we got this, we can do it
3986 all on our own," which I felt was really unrealistic.
3987 And the kinds of input that they were getting from
3988 experts that were not regulators from the CDC side was a
3989 very encouraging process. That's how we ended up here in
3990 this new space.
3991 Q The public reporting has been that Director
3992 Redfield wanted to extend the order into the winter, as you
3993 discussed, but there was an intervention from the White
3994 House.
3995 Did you work with Director Redfield on this particular
3996 conditional order?
3997 A Yes.
3998 Q And he --
3999 A We basically -- the statement is true. Our initial
4000 draft was another extension. We didn't see the vaccine
4001 really for the other things we're discussing were going to
4002 happen. They wanted to be able to clearly forecast what to
4003 do, what to tell about passengers who were booking in the
4004 winter sailing season.
4005 It seemed unrealistically that full commercial sailing
4006 would be doable in a safe and healthy way until several more
4007 months, and progress on the vaccinations, progress on all

4008 the other fronts were needed. The healthy sail
4009 recommendations were a report, but not necessarily with
4010 demonstrable impact.
4011 So there were many ways to go, and this idea of creating
4012 a conditional sail with spelling out criteria on steps along
4013 the way was another way to get there.
4014 Q And can you describe what that intervention was
4015 sort of around the time that this order was expiring?
4016 A Which intervention are you talking about?
4017 Q From the White House that's been reported.
4018 A I don't know what specific reporting source you're
4019 using in that regard, but they were very engaged, as they
4020 had been in this topic all along since the beginning, as
4021 you're aware.
4022 And so I'm not sure. I'm not exactly sure what you're
4023 asking.
4024 Q Sure. And there's an exhibit, if you want to refer
4025 back to the reporting. I will just get the exhibit number.
4026 It is Exhibit 15.
4027 [Exhibit 15 was marked for identification.]
4028 A So I wasn't in the meetings that were being
4029 discussed in this New York Times piece by Sheila Kaplan.
4030 And, like I said, I don't talk to reporters on these kinds
4031 of topics, and this seems like a more appropriate question
4032 for Dr. Redfield, who is obviously here and quoted. I don't

4033 know what to say about that.

4034 Q We spoke to Dr. Redfield, and here's what he said

4035 about that. He said -- and I'm going to quote him from our

4036 interview:

4037 "In October they gave me an extension to October 31, and

4038 I wanted an extension to like March. And, to be honest, I

4039 was prepared to step down as CDC director if that issue got

4040 prevented, because I felt so strongly about the no-sail

4041 order. And I came through with the idea of a conditional

4042 sail order and we wrote that guidance, and that guidance --

4043 actually, the rigor of the debate against me subsided after

4044 that."

4045 And he made the point that this conditional order was a

4046 compromise position that the industry wouldn't actually meet

4047 and it effectively served as a no-sail order.

4048 Is that accurate?

4049 A Well, all I can say is when Dr. Redfield came back

4050 from these meetings, what he said to me was “let's work on a

4051 conditional sail order that provided an incremental

4052 pathway.” I didn't -- he didn't give me all the things he

4053 just said to you, and I wasn't privy to this interview with

4054 the New York Times.

4055 But he said that's where we landed, and can you do

4056 everything possible to rewrite everything and make it work

4057 this way, and we set about doing that.

4058 Q And effectively, is that what happened? Did this,
4059 essentially, in effect, act as a de facto no-sail order?
4060 A Well, if you're asking the question did commercial
4061 sailing resume with full complement of passengers on board
4062 in October, November, or December or even January, you know,
4063 of 2020 and '21, the answer is no, it did not -- there
4064 were -- it did not resume. The answer is no, it didn't
4065 resume.
4066 And because the steps that were required to go through
4067 the phases of conditional sailing to demonstrate that there
4068 was the ability to effectively sail with this pandemic with
4069 the tools that were on hand had not been met, but it did
4070 provide a pathway toward what needed to be done.
4071 And then as we moved into '21 and vaccines started to
4072 become available, in addition to the stipulations that we
4073 had in our three phases of the conditional sail order. We
4074 then began to incorporate by amendment and modification
4075 criteria on the proportion of passengers and crew that would
4076 have to be fully vaccinated in addition to being tested to
4077 embark and tested at disembarking.
4078 So we had another tool in the tool kit which essentially
4079 made the difference. And it wasn't really until that
4080 vaccine tool was added to the tool kit did the contemplation
4081 of resuming commercial sailing take place. And that
4082 actually -- I don't remember exactly when that happened, but

4083 it was into -- closer to the summer sailing season of '21.
4084 I don't know exactly what you mean by -- it was
4085 basically trying to stipulate what would be required not
4086 only in the phases, but oversight and proof of concept. In
4087 sailing, for example, there were phases where you had to
4088 have a plan, where you had to certify the capacity, the
4089 number of tests, the various port agreements. Those were
4090 all built into the conditional phasing.
4091 And then there would be periods of essentially test
4092 sails that did not involve any commercial passengers. First
4093 crew would come back and resume without passengers at all.
4094 There would be simulated voyages in which they would be able
4095 to detect early and contain any COVID outbreaks, and these
4096 simulated voyages did not involve paying commercial
4097 passengers. And then there would be a scale-up in volume
4098 and so on.
4099 So that halfway process of getting there and then, in
4100 effect, really scaling up a safe and healthy sailing process
4101 also really became very contingent upon having a highly
4102 vaccinated cohort of passengers and crew, like over
4103 95 percent.
4104 Ultimately, it was all of those things in the evolution
4105 really in the months of '21 that led to the resumption of
4106 commercial sailing voyages. And so I think we ended up with
4107 a very deliberative, calculated, measured, safer process.

4108 But in terms of -- if there would have been a no-sail
4109 order through the winter -- and the winter season always
4110 proves to be a little bit more challenging with COVID --
4111 versus this approach, essentially commercial sailing would
4112 not have been resumed. So there you have it.
4113 Q Okay.
4114 A That's how it evolved.
4115 Q I wanted to move on from cruise ships and ask you
4116 generally and briefly about CDC's quarantine powers and in
4117 an emergency response, how they can be exercised. So maybe
4118 you can give us just a brief overview of how that works.
4119 A Yeah, that's a tall order. I'll just say in
4120 general the federal quarantine authorities come in with
4121 regard to preventing importation and spread of -- a series
4122 of communicable disease come into areas of scope and
4123 conditionality.
4124 So in terms of scope, the federal jurisdiction is
4125 international arrival, interstate movement. It includes the
4126 territories, for example, and whether that movement poses a
4127 risk, you know, air, land, and sea kind of thing, and
4128 whether it's the movement of people, animal, or inanimate
4129 things.
4130 So that's the general scope that derives from the Public
4131 Health Service Act of 1944. The authorities are then --
4132 that statute has been clarified in regulations. Part 70 is

4133 usually what we call the domestic component, 71 the
4134 international component, and it specifies the circumstances
4135 under which the federal government would be able to -- the
4136 legal language in there is "detain, apprehend, and
4137 conditionally release" in that framing.
4138 And for human movement, the criteria is specified around
4139 a set of specific disease conditions that are enumerated,
4140 and the list of those unique conditions has been augmented
4141 and added over time as we face different epidemic and
4142 pandemic threats, whether it be SARS, Severe Acute
4143 Respiratory Disease, MERS, Middle East Respiratory Syndrome,
4144 and those kinds of conditions covered under SARS rubric, and
4145 so on and so on. Diseases have been added to the list of
4146 which human movement can be added to the apprehension,
4147 detention, and conditional release.
4148 With regard to inanimate products or animate or
4149 animals --
4150 Q Just --
4151 A -- it's more broad.
4152 Q -- for brevity, let's stick with human beings.
4153 A Okay. So that's the setting on the human aspects
4154 of it under the quarantine authorities. By statute, they go
4155 to the secretary, and I believe maybe in the older statutes
4156 the surgeon general before, the CDC, and then the HHS
4157 secretary, the secretary -- the director of the CDC and, by

4158 further delegation, to the director of global migration and
4159 quarantine. That's the general sense of where those sit.
4160 It is notable that there are a number of these
4161 jurisdictions which -- that is interstate movement
4162 transportation corridors, you know, surface transport as
4163 well as air and even sea transport have some specific
4164 mentions.
4165 And some of those jurisdictional authorities are
4166 overlapping. Particularly complicated are sort of airports
4167 and train and bus stations, which have interstate or
4168 international touch point as well as a local touch point.
4169 So there are places in which that happens in
4170 coordination with the state and local. That's basically the
4171 broad sense of that. And there are some specific measures
4172 that are mentioned and a general reference to other measures
4173 that are appropriate to control introductions.
4174 Q I'm going to look back to the interstate
4175 authorities later.
4176 But I would say that the exercise of these authorities
4177 has been a big part of your life's work; safe to say?
4178 A Yes. Both when I first came into the division in
4179 '96 and we looked at the existing authorities and determined
4180 an overhaul, what needed a modernization and regulatory
4181 change, as well as in pandemic planning process.
4182 And then particularly in the COVID response where we had

4183 a whole different scale in terms of the level of need, as I
4184 mentioned, a threat that we haven't seen in quite this
4185 magnitude in over 100 years.
4186 So yeah, that has been a huge part of my life's work.
4187 Q And you have probably -- and this is probably hard
4188 to agree with, but one of the foremost experts in the
4189 exercise of these authorities in the federal government?
4190 A I've spent a lot of time in deep assessment of
4191 these authorities, but historically in mathematical modeling
4192 and actual practice in over dozens of epidemics, local and
4193 global, over my 30-year career. So I'm heavily invested.
4194 I'm sure there are other very smart people as well.
4195 Q I wanted to ask you about the principles that
4196 should guide your use when it comes to human beings.
4197 A Well, I think my staff has heard me say and one of
4198 the things that I have tried to study and learn along the
4199 way is the importance of asking some really key questions in
4200 these kinds of settings and also learning from historical
4201 mistakes when some of the questions weren't asked.
4202 Frequently it's asked may we do it, can we do it, should
4203 we do it. And sometimes there's a short circuit between
4204 what we may do and what we can do, and sometimes that's a
4205 disconnect. Sometimes there's a disconnect between the most
4206 important question is what should we do, what's the right
4207 thing to do in terms of reducing morbidity and mortality and

4208 saving lives.

4209 I think it's important to ask that question first. And
4210 if we may or may not, I think it's important to look for if
4211 those authorities may be needed and if they need help in
4212 implementing capacity to look for other places.
4213 Implementing capacity is bigger and greater in certainly
4214 more operational positions of the U.S. government.

4215 So at the borders, there's CBP, there's DHS, et cetera,
4216 in terms of operation and implementation. And that kind of
4217 coordination that we have in the interagency is very
4218 important in that regard.

4219 When we get to the question of what should we do, I
4220 think there's a number of principles that are also very
4221 important to have in play. And that is in terms of equity
4222 and proportionality that the measures that are taken are
4223 proportionate to the risks and the threat, that they could
4224 be scaled if the threat escalates and the measures need to
4225 escalate, that we should attempt to provide the least
4226 restrictive means in accomplishing the same public health
4227 outcome. We shouldn't go to the most restrictive approach
4228 if lesser restrictive means that have fewer collateral
4229 consequences and damages and unintended consequences would
4230 suffice.

4231 And so those are some of the important principles.
4232 Proportionality, ethical considerations, the equity

4233 considerations, and frankly, the opportunity for appeal in
4234 terms of the process and opportunity to be heard and to
4235 limit the time.
4236 If we're in an assessment phase and we don't know or we
4237 have reason to believe that there's an infectious threat
4238 being represented that we have a conditional approach for a
4239 short period of time and reassess the evidence as more is
4240 needed and confirm whether that person is infected or not or
4241 there's a true exposure or not and then take kind of a
4242 stepwise approach.
4243 So those have been the framing principles in which I've
4244 tried to both respect and understand the magnitude of having
4245 these types of authorities where we balance the interests of
4246 the public good. And sometimes doing what we need to do,
4247 that if it meets all those criteria can be resource
4248 intensive and requires investing in order to meet the bar on
4249 all those things.
4250 That's kind of how I've approached my responsibilities
4251 with this job since being in this role since 1996.
4252 Q Thank you for that context.
4253 One thing that you said -- and I'm now referring to the
4254 March 20 order commonly referred to as the Title 42 order
4255 that my colleagues in the minority asked you about.
4256 You called this order unprecedented, and I wanted to
4257 give you an opportunity to elaborate why.

4258 A That kind of wholesale border closure restriction
4259 and not only closure against admission, but also active
4260 deportation and the suspension of other types of rights that
4261 come -- that are protected under -- not under the public
4262 health side, I don't think, to my knowledge, have -- we have
4263 seen going back a very, very long way under our public
4264 health rationale.
4265 I'm not speaking to immigration authorities, Title 8 and
4266 all other kinds of authorities that exist in the front war
4267 on terrorism, whatever. I'm talking specifically about the
4268 responsibilities derived under the Public Health Service Act
4269 and the orders that would be -- the regulation and orders
4270 that would be generated under a specific public health
4271 threat.
4272 So it's unprecedented. It would require jumping
4273 directly to the most restrictive approach rather than
4274 looking at lesser restrictive approaches to whether they
4275 could achieve the same goals.
4276 And I think it also bypassed some very fundamental
4277 public health principles in terms of going to root cause of
4278 the public health concerns. I think I mentioned this in the
4279 beginning when we talked about this topic -- cohorting,
4280 testing, assessment, use of nonpharmaceutical interventions,
4281 masks, et cetera.
4282 Understanding that the threat that was being addressed

4283 was a real and present danger, so what is the risk of
4284 importation into a setting where the reported burden of the
4285 virus was very low in the groups that were being targeted
4286 but the amount of virus that was already present in the
4287 United States was substantial and the tools that would be in
4288 place to mitigate the threat, you know, domestically were
4289 available to be used.
4290 And so on balance, in looking at all of those things, I
4291 didn't feel that this approach met the responsibilities that
4292 we had taken on for using public health authorities
4293 appropriately, judiciously, most widely, and with the least
4294 public health collateral damage. I thought some of these
4295 kinds of consequences that were not being realized would end
4296 up having greater both COVID consequences and other public
4297 health damaging consequences.
4298 Leaving unaccompanied minor children in camps at the
4299 mercy of many other both diseases and other consequential
4300 health risks.
4301 So on balance, it didn't meet, you know, the thresholds
4302 for -- that we have -- you know, I've expressed and held in
4303 high regard, particularly at that March 2020 moment when
4304 this was being contemplated.
4305 You're muted.
4306 Q I want to follow up on a number of things you just
4307 articulated. Before I do that, I want to ask you about

4308 process in terms of how this particular order fit into the
4309 process, as you understood it, of exercising this kind of
4310 authority.
4311 A I'm not sure I really follow your question. Sorry.
4312 Q The idea for this order, where did it originate
4313 from? I'll start with that question.
4314 A It did not originate from CDC.
4315 Q Where did it originate? How did you first learn
4316 about it?
4317 A I was informed by the director that this was
4318 something that was being discussed. I had also been on a
4319 few conversations with the director in which this -- you
4320 know, interagency conversations in which this was actively
4321 being discussed. And as I told the director, he sought my
4322 advice and that I would offer him my advice as a career
4323 public health official. But ultimately this was a decision
4324 that was his to make, not mine to make.
4325 But I offered him my risk assessment, the factors that
4326 are aligned with the principles that I just described.
4327 Q Those interagency discussions have been reported on
4328 publicly. I wanted to ask you about the involvement of the
4329 president's senior advisor, Stephen Miller. Specifically,
4330 it's been reported that on March 17 there was a group call
4331 where Mr. Miller reportedly urged CDC to use its authorities
4332 to close the border immediately.

4333 Is that true?

4334 A I was on -- I was on calls at the request of the
4335 director, Tillerson, and heard some of those ideas
4336 mentioned. But I'm not at liberty to discuss who said what
4337 where.

4338 Q Sure. I want to ask you about what's publicly been
4339 released. Well, I'll start with did your team -- after
4340 these discussions, did your teams look at the public health
4341 rationale for such an order?

4342 A So we looked -- we looked at the rationale. As I
4343 said to you earlier, we had trips to the border prior to
4344 assess situations. We had -- my team have had requests and
4345 participated in trips to the border prior to COVID looking
4346 at, you know, influenza and other diseases, communicable
4347 diseases there, and made a number of recommendations on
4348 improving the sanitary conditions. This is, again, prior to
4349 COVID.

4350 And so if that answers your question, we looked at the
4351 rationale. We gathered data on the reported incidents of
4352 the disease in these populations. We scoured international
4353 available data.

4354 My team that works physically on the border, including
4355 the U.S.-Mexico unit and others with a lot of experience, we
4356 could not substantiate that the threat was, quote/unquote,
4357 being addressed by this for importation and spread was

4358 consistent with taking these kinds of unprecedented actions.

4359 And that there were other very important sanitary
4360 measures and changes in capacities and cohorting and other
4361 tools that can and should be used and had been recommended
4362 many times in the past around this. And so that was our
4363 assessment.

4364 Q That call in March where Mr. Miller discussed what
4365 I mentioned, who else was on that emergency call?

4366 A Yeah. I think that I'm not going to get into the
4367 "who said what when to whom."

4368 Q Not asking you about anything that was said.

4369 A Just representation?

4370 Q Exactly.

4371 A Department? There were many departments with the
4372 obvious ones that had equity in this issue, you know, that
4373 participated in a lot of these kinds of conversations.

4374 Q And so who was represented there?

4375 A Homeland Security has equities in this.
4376 Occasionally the CBP commissioner would be involved.
4377 Representatives from some of the component agencies of
4378 Homeland Security.

4379 Q Was this a call that was organized by the White
4380 House?

4381 A I don't recall definitively, but it wouldn't have
4382 been uncommon in that regard. And whether it was

4383 originating at the White House at some times or whether NSC
4384 separately or some of the departments and agencies -- there
4385 were, you know, a number of ways in which they could be
4386 initiated and CDC would be asked to participate.
4387 Q And who from CDC was on the call?
4388 A To my knowledge, it was Dr. Redfield and I. I
4389 don't know that there was anyone else. I can't be a hundred
4390 percent sure of that.
4391 Q Aside from Mr. Miller, was anyone else on the call
4392 representing the White House?
4393 A I don't know for sure, but my best recollection is
4394 probably so. But I really can't remember. These were --
4395 one, it's a long time ago, and, two, you know, there were
4396 people that were on -- that might have been on or weren't
4397 announced or whatever. I don't really know all the
4398 participants.
4399 Q Was this a one-off call or a series of calls?
4400 A There were a number of deliberations about this
4401 topic, and to my knowledge, it was not a one-off call.
4402 Dr. Redfield was the normal -- would be the normal invitee
4403 from CDC. He had asked me to join him on occasion with some
4404 of these conversations, whether it was with the White House
4405 directly or folks from Homeland Security or a call with the
4406 CBP commissioner.
4407 Q And because you've -- your team looked into the

4408 rationale -- let me ask you: Do you recall any other
4409 specific names of people who were working on these issues?
4410 A I don't know, but if I did, that would be
4411 information -- sort of privileged information that I
4412 wouldn't be comfortable talking about.
4413 Q So what was discussed is -- may be privileged, but
4414 who participated is not privileged. We can check with
4415 Kevin, but that's our position.
4416 [Majority Counsel]. Kevin, if you'd like to put an
4417 objection on the record, please feel --
4418 Mr. Barstow. I think if Dr. Cetron remembers who was on
4419 the calls or some of these deliberations, he's allowed to
4420 say so. I think he's saying that he doesn't remember.
4421 The Witness. I don't remember specifically enough to
4422 call in or out specific individuals named by omission or
4423 commission. I just remember there were commissions around
4424 this that involved sort of the normal folks who have
4425 equities in these kind of policy deliberations. That's
4426 where I'm uncomfortable in terms of my memory of these
4427 topics.
4428 [Majority Counsel]. Just to be clear, have you limited
4429 any of your answers based on instruction from Kevin?
4430 The Witness. You mean just now?
4431 [Majority Counsel]. Yes.
4432 The Witness. No.

4433 [Majority Counsel]. Thank you.
4434 Q So following this discussion, the interagency
4435 discussion, your teams looked at this risk; is that right?
4436 A Yes. We made some assessment trying to gather data
4437 to look at the strength of -- argument about the risk of
4438 importing this from -- from some folks, migration, and
4439 didn't -- it did not jibe.
4440 And like I said, there were hot spots in the pandemic
4441 that were clearly very apparent, and there were hot spots in
4442 the U.S. that were much more powerfully overwhelming at the
4443 moment and some, as I also mentioned in terms of at sea,
4444 with repatriating, you know, American citizens.
4445 This was a -- this was out of proportion to the risk,
4446 and there were many sanitary measures and nonpharmaceutical
4447 interventions that needed to be done to improve those
4448 settings, you know, very much as a first step, and there
4449 were some significant collateral damages and consequences
4450 from a public health perspective.
4451 The problem doesn't go away simply because those people,
4452 you know, that have a legitimate fear of persecution from
4453 where they are or where they're staying and so on, COVID
4454 concerns wouldn't be addressed by these other settings on
4455 top of other public health risks that might be encountered.
4456 So that was our assessment.
4457 Q I want to ask you about the piece of paper itself,

4458 the order. It's been reported that a Department of Health
4459 and Human Services attorney sent your team the proposed
4460 order following a call with Mr. Miller; is that accurate?
4461 A The order -- the proposed order was not drafted by
4462 me or my team. And there was one handed to us. As I said,
4463 you know, my job was to advise Dr. Redfield. That's been my
4464 experience as a career public health official, and I offered
4465 that advice when that order came.
4466 I asked him if I could be excused from that process in
4467 that this was going to be a decision for the director and it
4468 should be handled by folks in the office of the director.
4469 And he respected that -- my position on that.
4470 And I don't know specifically who had first pen or edit
4471 or who was all involved in crafting it, but to the best of
4472 my knowledge and understanding right now, certainly it
4473 wasn't members of my team, and it came from outside the CDC
4474 subject matter experts.
4475 Where the inputs came and how it derived and all of
4476 those things, we were excused from that process, and it was
4477 managed between the CDC office of the director and other
4478 officials in the administration, the HHS or beyond.
4479 Q I'll get into some of the reactions of your team.
4480 They've been published in the press. And specifically I'm
4481 referring to the ProPublica article. According to that
4482 article, a team member working under you said that the

4483 proposed order included a “misrepresented and incomplete
4484 piece of data” to overstate the public health risk at the
4485 border. Is that accurate?

4486 A I don't know who said that or whatever. As I told
4487 you, I don't speak to reporters on these internal matters.
4488 And -- but what is accurate is the general sentiment that
4489 you're describing. It was not my feeling alone, but other
4490 members, other CDC folks in addition to members of my team,
4491 were concerned about that.

4492 We were concerned that that misrepresentation could
4493 create more harms than benefits, and there were many other
4494 things that should be prioritized in terms of addressing the
4495 COVID threat at the border.

4496 And that is notwithstanding operational -- you know, the
4497 issues around the policymaking authority and regulations and
4498 ability with respect to Homeland Security and mitigation and
4499 immigration notwithstanding. The issue here was whether
4500 this was warranted under a public health intervention.

4501 Q Were there efforts to overstate the risk that you
4502 were aware of?

4503 A I do feel that the risk assessment was overstated
4504 in comparison to all of the data that we had in terms of the
4505 infection rate that was -- and so on.

4506 So, yeah.

4507 [Majority Counsel]. Okay. I'm out of time, but I'll

4508 check in with you, Kevin and colleagues in the minority, if
4509 you have any questions. But we're getting closer to
4510 wrapping up.
4511 [Minority Counsel]. We'll have a few questions. Are
4512 you done with your hour?
4513 [Majority Counsel]. Yes. This makes sense in terms of
4514 the time to stop.
4515 [Minority Counsel]. If the witness is okay, the
4516 minority would like to request a five-minute break. Or four
4517 minutes, like 3:00.
4518 [Recess].
4519 BY Mr. Barstow.
4520 Q You said that the risk COVID 19 at the border was
4521 overstated. If you explained it, pardon my reiteration of
4522 the question, but can you explain that again, why it was
4523 overstated?
4524 A I think a lot of the argument was the -- made that
4525 there was a lot of COVID coming in and crossing the border
4526 and represented a risk for introduction and -- and spread.
4527 And based on all the data that we were sort of able to
4528 gather, that was the part that was overstated.
4529 And the other aspect of it was that COVID was well
4530 established in the United States, and there were a number of
4531 hot spots, and we were also learning about the types of
4532 tools that were available in terms of nonpharmaceutical

4533 interventions and hygiene.
4534 And, quite honestly, those were things that had been
4535 recommended before with regard to other lesser threats, and
4536 those were the kinds of things that we thought were
4537 appropriate for the context at the time and that there was
4538 not a commensurate rationale and that there were significant
4539 harms that would come of the proposed actions that were
4540 taken.
4541 So there was a lack of proportionality, there was a lack
4542 of legitimate threat coming in, and that there were other
4543 potential consequential harms in terms of both COVID and
4544 other public health consequences that would come with the
4545 manner in which was proposed to resolve the problem that was
4546 already well established in the United States.
4547 Q And I'm not a medical doctor, but with an
4548 exponential disease like COVID, does stopping even one case
4549 pose its benefits?
4550 A The benefits of stopping one case when you're
4551 already in exponential spread in widespread communities, you
4552 know, in different places across the U.S. has a differential
4553 impact, marginal impact relative to the risk of essentially
4554 repeated consequential exposures in that regard.
4555 So yeah, I don't think stopping one case is the same
4556 when your day one January 1, 2020, as it is when you're in
4557 March.

4558 Q Would that same logic apply to a testing
4559 requirement for Americans coming back from abroad that
4560 stopping one case isn't necessarily the end-all deal?
4561 A So the testing requirement for -- the predeparture
4562 testing requirement had -- it's not about -- it's not about
4563 one case. We're talking about sort of the millions in terms
4564 of volume. An idea of the predeparture testing requirement
4565 is to prevent its introduction in the travel corridor and
4566 not so it's creating a safe and healthy travel corridor so
4567 that the movements and the benefits of engaging in
4568 international travel, as stipulated in the international
4569 health recommendations, can be maintained, because there's a
4570 lot of important activity that occurs with regard to
4571 maintaining the international exchange of goods and services
4572 in the case of travel, for example, and not having, you
4573 know, airlines take down the conduit that can move reagents,
4574 supply chain items for vaccine development, medical
4575 ingredients for pharmaceutical production, all of those
4576 things. So the calculus is different in that regard; right?
4577 So I think that it's not about stopping every case or
4578 only one case. We know that there's a certain amount of
4579 leakiness being tolerated. We had a testing requirement
4580 for -- first none, then 72 hours in advance. Then it was,
4581 with Omicron it was moved closer to the time.
4582 So these are all tailored to the circumstances and the

4583 goals, and they're not amenable to -- by analogy, to simple,
4584 you know, generalizations, because the context matters in
4585 terms of the issues and the consequences.
4586 Q So the testing requirement to reenter the country,
4587 that same fear doesn't apply at ports of entry? I mean, I
4588 was at the border a month ago and saw miles long of people
4589 trying to walk across that, to me, poses a congregate
4590 setting similar to --
4591 A Right, but it is not quite the same. It's a
4592 different kind of engagement. So, for example, we don't
4593 have a testing requirement at the land crossing. We do have
4594 one in the international airspace. And it's for the very --
4595 you know, some of that very reason, right, is that it's a
4596 different setting and so on.
4597 So we do have adapted COVID measures that are contingent
4598 on the specific context and looking at the collateral
4599 damages versus those kinds of things.
4600 So in order to maintain the movement of trucks that are
4601 bringing required goods for infrastructure, for medicines
4602 and all of those things and that kind of exchange, the
4603 testing requirement is not done in that setting.
4604 So all of these different settings are a little bit
4605 different in trying to balance those kinds of benefits, and
4606 that's why they aren't the same in that regard.
4607 Our requirements at sea are based on the unique

4608 environment of a cruise ship and what's available, and even
4609 with the vaccination requirement, when we had the vaccines
4610 that aren't necessarily working as well in that setting, we
4611 might have, you know, a testing requirement in that space
4612 when there's a structure to do that.
4613 So it's very, very much, you know, contextually derived.
4614 Q The assertions that you said that the COVID-19
4615 threat at the border, was that overstated, is that based on
4616 your team's visits and, I imagine, briefings back to you?
4617 A There are a number of factors that came into place,
4618 including some of the team's visits, including some of the
4619 team's work with other organizations that had the ability to
4620 test and report on the incidence of infection that they were
4621 discovering and testing.
4622 BY [MINORITY COUNSEL].
4623 Q Did you have any data on this? Did you guys
4624 conduct any studies at the border? Were you testing --
4625 like, you know, sampling and doing -- did you have any
4626 studies or data to back up all these assertions you're
4627 making?
4628 A Actually, let me just reframe. Partner
4629 organizations that have been involved in some of these
4630 locations did have data, as did community organizations that
4631 were involved in testing migrants in different settings.
4632 So yeah, there were data on this in regard to -- that

4633 informed that the COVID infection rates were not justified
4634 to try to, you know, stop an entire set of movements based
4635 on the COVID risk in that setting.
4636 And then there were other things that could be done that
4637 might be able to mitigate that or when the situation was
4638 more manageable, that illness could be assessed and
4639 cohorting could occur. There were different rates of COVID
4640 that were occurring in different -- it was a lot of
4641 different --
4642 Q Could you provide those studies to us? Of the
4643 third-party partners.
4644 A I don't know about how quickly or whether we can
4645 get that information to you.
4646 Q You're sort of comparing flights and people
4647 crossing at land ports of entry, and you're making judgments
4648 based on, you know, the values of burdening and not
4649 burdening travel through those two means.
4650 And I'm just wondering is that -- whose job is it to --
4651 is it your job -- you know, is there some sort of HHS
4652 directive that says it's your job to make those value
4653 judgments, that it makes sense to test air -- people
4654 repatriating via air, but not people repatriating and
4655 sometimes migrating across land borders?
4656 A It's our job to bring the public health data that
4657 are available and the perspectives into these discussions

4658 and provide guidance and advice. It is the job of, you
4659 know, the folks that are appointed, that are in charge of
4660 various agencies to set and make policy based on the input
4661 that they're getting.

4662 Q Is that Dr. Redfield at the time?

4663 A The CDC director has the ultimate responsibility
4664 for deciding what the policy of the agency will be. And, as
4665 we indicated when I first met him, I would faithfully give
4666 him my best assessment, my best opinion based on career
4667 experience in this role. But I understood and accepted that
4668 the responsibility for making these decisions sat with him.

4669 And that's what I've been doing, no matter who is in the
4670 CDC director role, and that's just kind of how we work. I
4671 give the best data available for him to make those
4672 decisions.

4673 Q I think it's come up over the course of the
4674 interview that you disagreed at certain points with some of,
4675 you know, the direction that Dr. Redfield was going in, and
4676 you voiced that to him; is that correct?

4677 A I always gave Dr. Redfield my best and honest and
4678 nonpartisan advice based on the public health assessment of
4679 risk and the consequences of various approaches to
4680 mitigation. I've been committed to doing that with every
4681 CDC director since I've joined this agency and will continue
4682 to do so.

4683 Q Over the course of, you know -- I mean, the Select
4684 Subcommittee is conducting this investigation based on lots
4685 of media reports, and I think you've discussed some of those
4686 media reports with [Redacted]. There's a reporter named Dan
4687 Diamond who has written a series of articles on political
4688 interference at CDC.
4689 Are you familiar with Dan Diamond's work?
4690 A Not off the top of my head based on your question
4691 right now. But in general my policy is not to talk to
4692 reporters about these kind of things or do background or off
4693 the record or anything else. Everything -- every engagement
4694 with reporters that I would do is cleared through the
4695 channels with the director and HHS and others.
4696 Q Is there an HHS or CDC policy on engaging with
4697 reporters?
4698 A I don't know what the CDC policy is, but in general
4699 the practice of people like me when there's an outreach for
4700 any of that stuff is to tell the folks to talk to the people
4701 in public affairs and public relations, and they will scope
4702 it out and they will get the clearance that's necessary. I
4703 don't do that.
4704 Q There was a letter that one of the prior directors
4705 wrote to Dr. Redfield about -- criticizing some of his
4706 decisions, and I think that letter got leaked.
4707 Are you familiar with that letter?

4708 A Are you talking about the letter that Dr. Foege --
4709 Q Yes.
4710 A I was familiar with it after the fact. I was
4711 unfamiliar with it at the time.
4712 Q Are you concerned that there's lots of folks at CDC
4713 that talked to the media on or off the record, but
4714 anonymously? Does that concern you?
4715 A In general, I think what we do as career folks is
4716 dependent on having the integrity of a deliberative process
4717 and providing our best advice and respecting the privacy of
4718 those deliberative processes so people who are in charge of
4719 decision-making make the best informed decisions.
4720 And I wouldn't want to see anything that chilled that
4721 process. I don't think leaks or all these other things are
4722 healthy for the way we need to operate. And it's been my
4723 practice to avoid that at every setting unless I was asked
4724 and cleared to speak.
4725 Q Do you have any recommendations for going forward
4726 what the agency should do to sort of stop what some may view
4727 as insubordination through leaks to the press? Do you have
4728 any recommendation? Should there be a policy?
4729 I'm just asking based on your experience, your 20-plus
4730 years of experience.
4731 A No. I'm trying to understand exactly what you're
4732 asking me. I think you're asking whether I thought it was a

4733 good idea that people speak off the record or anonymously.
4734 I don't think it's a good idea and I don't do it. Are you
4735 asking me whether --
4736 Q I'm asking going forward like what could CDC do
4737 differently to prevent, you know, these leaks that I think
4738 chip away at the American public's trust in our public
4739 health officials. But that's my personal opinion. You may
4740 not believe that, and I wouldn't want -- I'm not putting
4741 words in your mouth. I'm just asking for recommendations
4742 for going forward.
4743 A I didn't actually -- I wasn't prepared to come here
4744 with a thoughtful answer to that question. I certainly can
4745 provide some thinking about that. It's probably not a
4746 straightforward question.
4747 I think there's all sorts of things that need to happen
4748 to improve the quality of communication, the integrity of
4749 communication, the protecting the deliberative process. You
4750 know, I don't think leaks serve our public health purposes
4751 in that regard.
4752 I'm -- you know, there may be people who have a
4753 different point of view on that, but you won't find me
4754 participating in that process, I can assure you of that.
4755 [Minority Counsel]. Okay. [Redacted], do you want to
4756 take over? I might have a few more, but go ahead.
4757 By [MINORITY COUNSEL].

4758 Q So you talked a little bit about -- and I agree
4759 with you it should be the goal to use the least restrictive
4760 means possible to achieve the desired end of -- in this
4761 case, as few deaths and hospitalizations in cases as
4762 possible.
4763 Were you involved in -- I'm asking you a question about
4764 deliberations after you just said you don't want to talk
4765 about deliberations, but were you involved in any other
4766 decisions to close businesses or close schools?
4767 A Yeah, that has generally not been the purview of my
4768 scope in this response. I had mentioned that, you know, in
4769 the development of planning, going back to the early aughts,
4770 we looked at what was in the purview of when and if border
4771 measures were appropriate and how and what would be the
4772 benefits and consequences and what point of time it would
4773 work and how much could they achieve, and then what were the
4774 benefits of looking at 1918 in models and contemporary
4775 experiences around the globe in flattening the curve.
4776 It turns -- as it's unfolded in the scale of this
4777 pandemic outside of the preparedness realm, the actual
4778 guidance and responsibilities about the areas you're asking
4779 were taking place in another set of the response, another
4780 task force in the response on the timing of those decisions
4781 on schools and businesses and so on.
4782 I believe that some of the decision or the preparedness

4783 work that we did informed that, but as was quite clear,
4784 multiple layers had different types of contribution. If you
4785 think of them as Swiss cheese, some have bigger holes than
4786 others. Some have more collateral consequences than others
4787 and have to be carefully selected and evaluated and looked
4788 at in that regard.
4789 So the simple answer was I wasn't involved.
4790 Q Considering your history in infectious disease, I'm
4791 going to ask you your opinion on it. Do you think there
4792 were less restrictive means to achieving the end than
4793 closing businesses?
4794 A Do you mean in January of 2020 to January of '21?
4795 Is that what you're saying? Or are you talking about a
4796 particular point in time? Are you talking about the March
4797 --
4798 Q I think the mid one was March 2020 until -- and I
4799 think some were still at least operating at marginal
4800 capacities until recently.
4801 A It would be hard for me to give you a really
4802 specific opinion. What I can say is while we're awaiting
4803 for the vaccine development and medical countermeasures,
4804 et cetera, a wholesale unmitigated pandemic would have
4805 really, really grave consequences.
4806 And I do not espouse to that philosophy of what some
4807 would call the sort of "let her rip." And I don't think

4808 that if you take the kind of zero COVID policies that we've
4809 seen in certain Asian countries and you keep things, you
4810 know, down and suppressed for a very long time that you
4811 maintain a totally susceptible population.
4812 But you're buying time with those types of policies, and
4813 you aren't prepared to come back with a very robust use of
4814 effective medical countermeasures when they're available.
4815 You're setting up a vulnerability.
4816 So the answer about where is the sweet spot in trying to
4817 attenuate the more severe impacts, once the healthcare
4818 system becomes overwhelmed, the collateral damage across
4819 broadly beyond COVID is enormous.
4820 And I think that that -- you know, attenuating those
4821 kind of severe spikes that you saw with Omicron in late fall
4822 and Thanksgiving through something like January, those can
4823 be devastating when the entire healthcare systems are
4824 brought to the brink and surgeries that are needed can't be
4825 performed and response, ICU for a car accident isn't
4826 available.
4827 Now you're really talking about serious consequences.
4828 You've got to find a sweet spot, and in some ways that
4829 depends on what's working in different settings. And it's
4830 not an easy thing to answer.
4831 This is why we spend so much time studying it in
4832 history, studying it in models and theories, studying it in

4833 practice, looking at the impacts of other countries as they
4834 took on different policies, and constantly trying to
4835 navigate and find effective approach.
4836 And that approach also changes over the course of the
4837 pandemic when the virus issues a curveball and mutates or
4838 when population immunity does build up in a less vulnerable
4839 group, so they constantly have to be looked at and reflected
4840 on.
4841 And I don't think there's a simple answer of all on or
4842 all off. I think it's actually neither of those two. It's
4843 much more delicate to figure out the right balance.
4844 Q Do you recall who ran -- or, first of all, what was
4845 the name of the task force within CDC that was in charge of
4846 that kind of stuff and who ran it?
4847 A I don't recall. It was a big issue, and it was
4848 broken up into a lot of different settings. There were some
4849 that focused a lot on schools and were gathering data on
4850 schools. There were some that were collecting data on the
4851 use of masks and what impact masks would use. We have
4852 modeling and forecasting group that's assessing these kinds
4853 of things theoretically and doing projections.
4854 So it's a pretty widespread set of responsibilities.
4855 Q You brought up how mitigation measures evolve and
4856 medical countermeasures evolve.
4857 As more vaccines have been brought to market, more

4858 antivirals have been brought to market, we've learned the
4859 efficacy or non-efficacy of various nonpharmaceutical
4860 interventions, has CDC altered public health policy to kind
4861 of flow with it?
4862 A If you're asking my opinion as not the person
4863 that's responsible --
4864 Q Yes.
4865 A -- I think there's been an evolution of CDC
4866 guidance and recommendations that are adapting to the stages
4867 of the pandemic and the availability of interventions. I
4868 think it would be pretty apparent if you looked at the
4869 course of our guidance over time and from that opening act
4870 to -- in early January to where we are now.
4871 Examples include the length of time for isolation and
4872 quarantine, availability of tests, types of use,
4873 availability of using masking both as personal protection
4874 and importantly, very importantly, source of control and the
4875 different settings of risk, yes, I think CDC has attempted
4876 to be adaptive.
4877 Q In your opinion -- so we've seen how effective
4878 vaccines can be and how effective the antivirals can be, how
4879 much we've learned from like early processes in hospital
4880 care, in at-home care, but unfortunately more likely to
4881 continue to see significant deaths, more people dying in
4882 2021 when we have all these things in 2020.

4883 Why do you think that is?

4884 A First, I want to be sort of careful about the
4885 scope. We're talking about largely vaccines. The emergence
4886 and use of the vaccines have been after the scope of this
4887 conversation.

4888 That said, I would say that even that is not a fixed
4889 answer. I tried to give you that indication earlier when we
4890 talked about the power of vaccines. They're influenced by -
4891 - one is how vaccinated somebody is, which vaccine is in
4892 use.

4893 We've seen dramatic differences between vaccine
4894 platforms in terms of their effectiveness. Looking at
4895 vaccines against what end point? Is it against infection?
4896 Is it against hospitalizations? Is it against death? How
4897 many vaccine doses have people had?

4898 Whether they've been boosted and are fully up to date or
4899 never boosted, and most importantly, the risk factors of
4900 who's most vulnerable and who's likely to die and also who's
4901 likely to benefit from vaccine.

4902 So even vaccine effectiveness varies across the age
4903 structure of the population, varies across a host of
4904 underlying conditions.

4905 I will say in principle -- and this is based on my
4906 experience for several decades -- pandemics and epidemics
4907 are really complicated interactions between a pathogen, the

4908 host, the type of host, and the milieu or the environment or
4909 the social context to structure the engagement, the
4910 policies, the behavior aspects, whether it's, you know --
4911 and one setting differs so much from another, as we've seen
4912 sort of zero COVID policies in China with the Omicron.
4913 The high -- the complex circumstances of pathogen hosts
4914 and the environment can have the perception of one pathogen,
4915 similar pathogen having either low severity overall impact
4916 or having a high-severity impact, depending on that
4917 interaction.
4918 The truth is this is what keeps people who do this for a
4919 living constantly engaged because we're always trying to
4920 figure out what's the balance of that interaction between
4921 the pathogen we see as it evolves, host of the populations
4922 that are at risk and the policies, behaviors, and the milieu
4923 and the context and the population and the setting where it
4924 occurs. That is a pretty holy trinity principle in
4925 infectious disease, public health.
4926 Q Knowing a significant portion of the population is
4927 fully vaccinated and another significant portion is not and
4928 there's at least another portion that has some level of
4929 natural immunity, Dr. Fauci said on TV last week that we're
4930 nearing the end of the pandemic phase of the virus. He said
4931 it's pretty much moving to endemic. Do you agree?
4932 A Yeah, I think that's a little bit out of scope

4933 here. But the other, you know -- you know, thing about this
4934 is, I think there's a lot of misunderstanding about the
4935 various terminologies and so on.
4936 Q It's just --
4937 A I'm not going to -- I'm not going to share here and
4938 I think it's a much more complicated question than perhaps
4939 even you realize.
4940 [Minority Counsel]. [Redacted], do you have anything
4941 more?
4942 [Minority Counsel]. No. I just hope that we can get
4943 some of that data from the third parties that were testing
4944 people at the border in those land crossing areas that
4945 helped you solidify your opinion on, you know, the land
4946 crossings versus flights coming into America and, you know,
4947 those opinions.
4948 Mr. Barstow. As always, we're happy to consider any
4949 request that is made by the Committee.
4950 [Minority Counsel]. Thank you, Kevin.
4951 [Minority Counsel]. I think we're good for our hour,
4952 then.
4953 [Majority Counsel]. Dr. Cetron, do you want to take
4954 five minutes or do you want to keep going? I anticipate
4955 having less than an hour left.
4956 The Witness. Let's keep going. It's a long day. So --
4957 [Majority Counsel]. I appreciate that, and I appreciate

4958 your patience.

4959 By [MAJORITY COUNSEL].

4960 Q I wanted to circle back to our discussion and

4961 clarify a few things for the record.

4962 Where did this proposed order come from?

4963 A Which proposed order? Which order are you talking

4964 about?

4965 Q That March 20, what became the March 20 order.

4966 A I don't know, to be honest with you. I can't say

4967 definitively one place. You're talking about the written

4968 order, the draft?

4969 Q The draft, yes.

4970 A I can't say with any certainty. I can just say

4971 that neither I nor my team were involved in drafting it.

4972 Q Was CDC considering anything like that in terms of

4973 restrictions at the land border?

4974 A Do you mean the wholesale closure of the land

4975 border to a certain population? Is that what you're talking

4976 about?

4977 Q Right.

4978 A As opposed to the other kinds of things that I

4979 mentioned?

4980 Q Right.

4981 A I think that we -- you know, I think we've looked

4982 at the people that have talked about it. We've discussed

4983 how those types of border closures have worked or not worked
4984 or failed in the past and what were the goals and what would
4985 be the effective means of trying to address it.
4986 And if the circumstances changed, it's a different
4987 situation, but that was not -- it was not deemed to be the
4988 appropriate tool or the appropriate use of that authority
4989 for that purpose, given all of the totality of
4990 circumstances.
4991 Q I want to ask you about another quote that's in the
4992 ProPublica piece. And it comes from -- it's attributed to
4993 someone reporting to you, and it is an email where this
4994 person wrote, "I'm also not a fan of trying to make the case
4995 that Canada and Mexico represent a big risk on the land
4996 border based on what we believe" -- and "believe" is in
4997 quotes -- "is occurring versus what we know about the number
4998 of cases, which are far fewer than the number of cases in
4999 the U.S. now due to community spread."
5000 Is that an accurate assessment of the data as it was
5001 known at that time?
5002 A Yes, I can't speak to every single word of a quote
5003 that somebody else offered on my behalf. But I think, as
5004 you've heard me say, you know, a number of times, that
5005 comports with the assessment.
5006 Q Okay. The quote is -- starts with "I'm also not a
5007 fan of trying to make the case that Canada and Mexico

5008 represent a big risk on the land border."

5009 Was your team asked to make a case for the public health

5010 rationale?

5011 A I think that's what was -- I think that's what was

5012 being asked by this proposal that came to us, you know, to

5013 invoke that kind of authority is to, you know, see whether

5014 that was a justifiable public health action based on the

5015 circumstances at the time. I don't know if you would call

5016 that making the case. But, in any event...

5017 Q Sure. And you mentioned that you chose to excuse

5018 yourself from the ultimate decision to authorize the order.

5019 When did that happen?

5020 A I don't know. I think whenever Dr. Redfield said,

5021 you know, said to me, this is the decision that's being

5022 taken, and I said to him, I think, that there are

5023 potentially significant harms in that decision, and I would

5024 appreciate it, if that's your decision, if you guys handled

5025 it out of the office of the director, which he accepted.

5026 I'd given him my advice on the issue earlier, and from

5027 past experiences in other epidemics in other settings, that

5028 I thought it might propose a false sense of security about

5029 what really needed to be done and should be done first and

5030 foremost, and it could be much more effective in addressing

5031 this and that it was not a least restrictive means approach.

5032 It was not generated -- insufficient evidence that the

5033 nature of the threat would warrant it and that it might be
5034 misperceived as -- you know, really using a public health
5035 rationale for a different -- you know, a different type of a
5036 need.

5037 And I wasn't taking issue with the questions around the
5038 overall policies with regard to immigration. I was actually
5039 concerned that the public health order, as it was being
5040 proposed, was not the appropriate tool to deal with that
5041 problem.

5042 Q Had you ever excused yourself from a decision like
5043 this in the past?

5044 A I don't recall ever having to -- having to do that.
5045 But I felt pretty strongly about it, and I felt pretty
5046 strongly about the potential negative downstream
5047 consequences of -- of that.

5048 Q One of the consequences that you mentioned -- I
5049 guess it was in our second hour in response to [Redacted]'s
5050 question -- was stigma.

5051 Can you explain what you meant by that.

5052 A Well, you know, I've been part of a number of
5053 epidemic and pandemic responses over time, and I think it's
5054 fair to say that epidemics -- there's the epidemic of
5055 disease.

5056 There's an epidemic of fear in how to deal with the fear
5057 about that disease, and then there's often an epidemic of

5058 stigma in which there's scapegoating or blaming or assigning
5059 the problem of the epidemic, perhaps inappropriately
5060 assigning it to a particular group of individuals or
5061 particular settings. And this is not an uncommon phenomenon
5062 in epidemics.

5063 The epidemics of fear and stigma, the best vaccine
5064 against those epidemics is truth, honesty, education,
5065 information, maintaining integrity about the nature of what
5066 the threat is and isn't, and not treating victims as vectors
5067 and not assigning, you know, to individuals as vectors when
5068 there's -- you know, when there's not evidence that supports
5069 that.

5070 And that's what I was referring to with stigma. I think
5071 there's some significant harmful consequences to allowing
5072 stigmatization, and I think that there is -- it veers away
5073 from the principles that I articulated about transparency
5074 and integrity and clarifying and informing and then adapting
5075 and being -- using good scientific and public health
5076 principles to address things.

5077 And authorities, our public health authorities, are
5078 really important to have at hand and use them when they're
5079 totally appropriate. So if we don't take a very fair and
5080 balanced approach to using them in that way, then the trust
5081 that we've built up on our ability to use those public
5082 health authorities begins to erode.

5083 Those were some of the things I was very concerned about
5084 in addition to the negative public health conditions of
5085 misidentifying the source of the problem and not addressing
5086 things that were more important and more impactful.
5087 Q And I know you've studied this and the exercise of
5088 these authorities throughout history.
5089 What sort of impact has that stigma had in the past in
5090 American history?
5091 A I think we've seen a number of examples where, you
5092 know, individuals or groups of individuals were blamed for a
5093 problem as if that allowed for an explanation that
5094 marginalized the problem and kept it at bay or contributed
5095 to either a sense of denial -- as long as I listen to that
5096 individual or that person, the problem didn't -- wouldn't
5097 and didn't impact me, so on, that kind of thing.
5098 That creation of a concept of "other," and "other" is
5099 where the risk is and "other" is where the consequences
5100 would be. I think that not only has harms in terms of
5101 creating the stigma, but it allows for a false sense of
5102 security about what an individual may or may not be part of
5103 that group need to be doing in order to play a role both in
5104 protecting myself and in my responsibilities toward handling
5105 the problem.
5106 And there are many examples in history, you know, that
5107 would comport with that, whether it's HIV stigmatizations

5108 or, you know, internment camps or other kinds of things.

5109 So I think that there's a risk there, and the risk is
5110 creating a false narrative and therefore avoiding the kinds
5111 of things that we all need to be doing collectively to
5112 address the risk as opposed to trying to comfort ourselves
5113 by distancing us from the risk as long as we're not part of
5114 that stigmatized group.

5115 Q In explaining your decision to excuse yourself,
5116 it's been reported that you told colleagues, "I will not be
5117 part of this. It is just morally wrong, and to use public
5118 authority that has never, ever been used this way, it's to
5119 keep Hispanics out of the country and it's wrong."

5120 Did you say that?

5121 A Again, I can't account for every word as it was
5122 quoted in somebody else's secondhand and so on, but I think
5123 what I'm describing to you here today is that the tone and
5124 the sentiment of that quote is consistent with some of the
5125 concerns that I had. And that would be fair to say, but I
5126 can't attest to specifics of every word there.

5127 And I would have never actually -- as I had told you, I
5128 would not have made that direct quote to a reporter in the
5129 public -- in the public setting. So that is -- what you're
5130 quoting back is the source from another individual, and I
5131 can't attest to that.

5132 Q Sure. Did you believe that the authority was being

5133 used to keep Hispanics out of the country?

5134 A I can't -- I can't specifically say why all the

5135 decisions that have been made around these kinds of things

5136 are being done. That's not for me to say what the

5137 intentions always were.

5138 What I can say is that the evidence to use the authority

5139 did not seem to be sufficient or justifiable, that there

5140 were less restrictive means. There was a potential that

5141 misrepresenting the situation would create stigma and would

5142 create a distraction from doing some of the things that were

5143 more important and absolutely necessary and that might

5144 create additional public health harms and consequences.

5145 I can't make judgment on, you know, what's in the minds

5146 and hearts of other people who are promoting those

5147 priorities.

5148 Q Were you concerned that keeping Hispanics out of

5149 the country might be the rationale?

5150 A Was I concerned that there might be more than a

5151 public health agenda involved and I don't know all the

5152 aspects of it? Yes, I was concerned that there may be a

5153 motivation that was beyond the specific public health

5154 agenda.

5155 But, again, that is for other people who are proponents

5156 of the policy to, you know, articulate, not for me.

5157 Q Do you think -- and you can limit your answer to

5158 the period that we're talking about.

5159 Do you think that the order created stigma against
5160 certain groups?

5161 A Yeah, you know, again, I don't want to -- I don't
5162 want to speculate. There's all sorts of things that gets
5163 said and there's all sorts of information that's moving
5164 around, and how people receive that information and, you
5165 know, what it means, different people hear it, that's not
5166 for me to say.

5167 My concern is to, again, kind of try to stay very clear
5168 about what are the justifiable uses, what's the evidence in
5169 support of it, how do we weigh the risks and benefits, what
5170 could be done.

5171 Q It's clear that this was a moment that you took a
5172 moral stand. Do you have anything else you'd like to say
5173 about the decision?

5174 A No. I think it's very important to realize that
5175 this -- that responding to a pandemic is a whole of society
5176 response, and it is an interaction between the pathogen and
5177 the host and the context in the environment. And what we
5178 say and what we do and our actions should reflect, you know,
5179 our sense of honest, you know, concern and care for one
5180 another.

5181 The people whose movements are restricted, who are
5182 restricting movements for the good -- when individual

5183 liberties are restricted for the benefit of the whole, we
5184 should be thinking and be very grateful for those people who
5185 make that effort and we should try to support in all ways
5186 possible mitigating the impact, you know, on these folks,
5187 because they are making, you know, compromises.
5188 And the best way to instill that collective spirit in
5189 this sense is to actually try to always stay a little bit,
5190 you know, above the fray and create a sense of balanced
5191 decision-making that's grounded in good science and good
5192 practice and with a sense of dignity and honesty and so on.
5193 I've tried to adhere to that, you know, my entire
5194 career. It can be very challenging in a pandemic. But I
5195 think it gets back to what we really understood to do
5196 collectively in terms of battling these problems and not
5197 just consider what our own individual perspective is, but
5198 consider the perspective of all involved.
5199 Q I want to move on and ask you -- you mentioned that
5200 the authorities include interstate authorities. I'll first
5201 ask you: At any point during this period did CDC consider
5202 any other uses of that authority? I'll ask -- in terms of
5203 --
5204 A I'm not sure I understand. I'm not sure I
5205 understand the question.
5206 Q That's a bad question.
5207 I'll ask you specifically, it was reported that CDC was

5208 considering a mask requirement on public transportation.

5209 Were you involved in that discussion?

5210 A Absolutely, yes.

5211 Q Okay. And tell us a little bit about what the

5212 authorities are in this in terms of that requirement.

5213 A Again, there were a lot of conversations happening

5214 jointly in the interagency about how do we mitigate the

5215 impacts of the pandemic while minimizing the interference

5216 with travel and trade. How do we create safe travel and

5217 healthier travel experiences?

5218 How do we maintain the ability for international

5219 exchange of goods and services to continue in parts of the

5220 economy, you know, in that regard that are critical or

5221 important and to continue, how do we move supplies of

5222 vaccine and antivirals and critical supply chain reagents

5223 around.

5224 And there was a joint interagency effort discussing

5225 what's in our tool kit. As I indicated to you, there was a

5226 time which this concept of geographic 212F proclamations

5227 where we tried to, you know, shut the borders or ban

5228 movement.

5229 Could be that wasn't actually going to be sufficient and

5230 no longer had the same kind of place in the phasing of where

5231 the pandemic as it was globalizing would be, but would have

5232 a chilling effect on keeping, you know, flights going and

5233 international exchange.

5234 This is also in keeping with the spirit of the
5235 international health regulations to which the U.S. is a
5236 signatory member, something that I have worked on for a
5237 number of years. From 2005 -- you know, 2003 to 2005 when
5238 the charter was proposed and signed.

5239 We were looking at the tool kit and the idea of
5240 individualized risk assessment in trying to create a safe
5241 travel corridor by keeping infections out of the area of
5242 transportation space, by doing everything that we could to
5243 -- if infections were getting in, because this was a
5244 contagious virus that could be asymptomatic and sometimes
5245 even testing negative 72 hours in advance wouldn't guarantee
5246 an infected person might not be boarding.

5247 And the large-scale volume mixing and movement of the
5248 virus, that masks would actually be one of those very
5249 important layers of Swiss cheese that was a lot more cheese
5250 than hole and that, if used properly as source control and
5251 personal protection and it was a community-wide commitment
5252 that the travel corridor safety could be markedly improved
5253 by masks and that was there an agreement that there was
5254 appropriate federal authority to create a mask for
5255 international air travel.

5256 Again, things may need to be adapted in different
5257 settings about the transportation corridor could safely be

5258 markedly improved by having people wear masks. And there
5259 were obviously caveats and exceptions and age limits and all
5260 of those things.
5261 But the evidence was scientifically there. We modeled
5262 the issue in terms of the risk on its potential
5263 contribution, which was significant in risk reduction. And
5264 these things were -- you know, this idea was generated out
5265 of CDC but discussed in interagency deliberations, and I had
5266 talked about it with CDC director and so on.
5267 And there was a general support for that, and we began
5268 working on that problem beginning in that July time frame of
5269 2020, and these conversations were ongoing over the course
5270 of the summer and the summer travel season in 2020.
5271 So -- and we drafted -- we drafted that -- that order.
5272 Yes, I think it was a potentially important tool in the
5273 tool kit that could make a big difference. I know
5274 Dr. Redfield was very supportive and has given testimony on
5275 the record the tremendous power of masks in reducing
5276 transmission, especially if worn properly and worn by
5277 everyone and that it wasn't just about what you were doing
5278 for yourself to protect yourself; it was also a way of
5279 controlling the unknown asymptomatic infection and
5280 containing it so that you weren't actively spreading that.
5281 So if everybody participated in these various settings
5282 of density and mixing and so on, it would have a tremendous

5283 reduction effect. And it was written into some of the
5284 guidance and recommendations in the document that FAA led on
5285 putting out -- called "the ramp to recovery" or something of
5286 that sort. The CDC section reflected a lot of this work as
5287 well.

5288 Q In general terms, in terms of the reduction, what
5289 were your models telling you?

5290 A Significant impact in reduction. And they were
5291 also being borne out by data that were gathered in other use
5292 of community masks used in indoor poorly ventilated and
5293 dense settings.

5294 So if you take that parameter as I was talking about
5295 where transmissions would go way up and you look at the
5296 person, place, time, and space, the use of masking in these
5297 settings, especially community-wide, both source control and
5298 personal protection, really attenuated all of the risks of
5299 having, for high-risk persons, for places in which risk, you
5300 know, would be amplified, the time that people were
5301 spending, the choice they had about their ability to leave
5302 such a place or space or not, the place, whether indoor or
5303 outdoor, were well ventilated or not.

5304 So all of those things were impacted significantly in
5305 terms of risk reduction by a general mask use.

5306 And there was some emergence of decisions around this
5307 that were much more patchwork. It could be a particular

5308 state or a particular jurisdiction or the risk of one
5309 airport versus another or one, you know, entity versus
5310 another creating a lot of confusion.
5311 And so this was a -- seemed to be a very good space for
5312 a coordinated, unified set of efforts that were guided by
5313 best practices in some of the scientific evidence and the
5314 public health evidence was emerging.
5315 That was our thinking in developing that order was in
5316 that spirit of getting a handle on control, especially in
5317 the pre-vaccine era, but not exclusively. Even beyond, it's
5318 very important.
5319 Q Can you give us the contours of the order? Where
5320 would it have applied, what were the enforcement mechanisms,
5321 and --
5322 A Interstate and international arrival transport
5323 corridors. That would include both the hubs, the airports
5324 as well as on the conveyances, for example; also surface
5325 transport with interstate linkages and movements.
5326 So which is the buses, terminals and the buses that
5327 moved, you had linkages that would be transporting
5328 interstate passengers. You know, that was one of the
5329 overall framing of this.
5330 And that there were carve-outs for places on the grounds
5331 that were either, you know, outdoors and well ventilated or
5332 wholly private nonpublic-facing and so on. They were framed

5333 in those regards.

5334 There were carve-outs for folks with certain

5335 disabilities that had medical authorization and inability to

5336 use a mask or children under a certain age that couldn't be

5337 expected to regularly, you know, use masks in that regard.

5338 But yeah, aside from the sort of carve-out issues, it

5339 was meant to be that jurisdictional space within the federal

5340 government where the federal government had interstate

5341 movement on the international level.

5342 Q You said your team drafted it in July?

5343 A We began the discussions and we began evolution of

5344 the drafts and interagency deliberations and building the

5345 argument and presenting the data. And then we were moving

5346 it up.

5347 We had, as I indicated, support of our director and the

5348 secretary, and it was being moved into those kinds of

5349 decision-making processes for White House task force and the

5350 interagency and so on.

5351 Q So what happened with that order?

5352 A Despite what seemed like a fairly broad consensus,

5353 ultimately that decision was made and we were told that

5354 there would be no such use of federal authority for masking

5355 in a transportation corridor, mask requirements in the

5356 transportation corridor, and that that would not happen.

5357 Q Were you given a reason why that wouldn't happen?

5358 A Not specifically. There was all sorts of
5359 speculation, but I don't care to speculate. But it wasn't
5360 -- it wasn't going to happen, and we needed to look for
5361 alternatives to being able to use that tool.
5362 Q It was reported in October of 2020 that the White
5363 House blocked that order. We have an article there that
5364 covers it. I think it's the last exhibit, but let me check.
5365 Hold on one second.
5366 Yes, Exhibit 16.
5367 [Exhibit 16 was marked for identification.]
5368 A Okay. What's your question?
5369 Q It says there that "the White House Coronavirus
5370 Task Force, led by Vice President Mike Pence, declined to
5371 even discuss it."
5372 Is that accurate?
5373 A I think that that's also a question for
5374 Dr. Redfield. It sounds like meetings that he was involved
5375 in that I wasn't at.
5376 But I think it sounds like Dr. Redfield, you know,
5377 interviewed with Sheila Kaplan on this article, and maybe
5378 you asked him the same question. I'm not sure.
5379 Q Do you think that -- and I think you went into
5380 this.
5381 Do you think that such an order would have been in the
5382 best interest of public health at the time?

5383 A I do.
5384 Q We saw a very deadly surge of the virus in the
5385 winter of 2020. Do you think that implementation of this
5386 order could have saved lives?
5387 A I think it would have helped. Just like I said,
5388 multiple layers implemented early effectively, you know,
5389 makes a difference. And I think this would have -- I'm not
5390 saying it would have stopped the surge or the waves.
5391 I think it would have affected the shape of the surge,
5392 along with many other things that needed to be done, and I
5393 think the risk of both importation and spread, I think
5394 especially the risks of spread, travel of the many waves
5395 that we've now seen over two and a half years has been
5396 tightly correlated with resurging waves.
5397 It's been correlated with the introduction of variants,
5398 and it's been correlated with the shape of surges. As
5399 travel volume has gone up, it has amplified and extended and
5400 accelerated the shape of those curves, and I think that, you
5401 know, masking in the transportation corridor could have made
5402 a significant contribution.
5403 And I was disappointed when we were unable to use that
5404 tool. And in my opinion, it was well within the scope of
5405 the federal public health authority that the CDC was given.
5406 Q Apart from the episodes that we've discussed, did
5407 CDC seek to institute any other orders in this time period

5408 that didn't happen?

5409 A I don't recall that off the top of my head in that
5410 regard. But I think this is one I was very much directly
5411 involved in. That probably is something that others may be
5412 able to ask.

5413 But we sought, you know, the testing components and the
5414 kinds of tools that we thought would really make a
5415 difference and we were looking for -- to use this to help
5416 mitigate the impact of the pandemic. These are some of the
5417 nonpharmaceutical tools that are really important in that
5418 jurisdiction.

5419 Q What I'd ask you also, the decision you took in
5420 regards to the March 20 order, were there any other
5421 incidents where you felt you had to take a moral stand in
5422 that way, any other decisions involving public health during
5423 this period?

5424 A I think if you're asking the question were there
5425 decisions that I felt were important to bring to the table
5426 around these types of issues, you know, I'd like to think
5427 that they inform and infuse aspects, as I've said before,
5428 the general principles.

5429 This was a, you know, the March '20 order was a clear
5430 space, but I think as I present the data, I try to present a
5431 set of principles, the science, the equity, the
5432 considerations, the balance and the tradeoff, and provide my

5433 best advice to -- whether it's the director who's asking or
5434 anybody else in an agency discussion. I think it's
5435 important to understand the larger picture at play.
5436 So I think we're responsible for all of the -- you know,
5437 the authorities and the advice that's given to us as leaders
5438 and to use it with a strong moral compass.
5439 Q Were there any other times where your moral compass
5440 was challenged in that way?
5441 A You know, this has been a difficult pandemic on so
5442 many grounds, and it has been challenging to make hard
5443 decisions in a lot of places. I think suffice it to say
5444 that, you know, I looked and tried to consult the framing of
5445 all the decision that I make that is infused by a set of
5446 principles.
5447 I've served -- you know, the integrity of the science,
5448 communication, honesty of process, the balance of the
5449 equities, the least restrictive means, the opportunity to
5450 appeal given the decisions, the proportionality.
5451 I don't know if you call that a collection of moral
5452 assumptions or just, you know, parts of trying to execute my
5453 job faithfully and with responsibility and integrity.
5454 Q There has been a great deal of public reporting
5455 about political interference in the CDC scientific work by
5456 Trump administration officials. Do you think political
5457 pressure was a problem for the CDC in 2020?

5458 A I think that, yes, I think it was a problem in
5459 various aspects. I think that's, you know, not much in
5460 dispute in that regard.
5461 You know, pandemics are whole of society events. They
5462 involve taking into perspectives the political, public
5463 health, private sector population. There's lots of
5464 perspectives that they should all be as part of what we need
5465 to do as whole of society is rather than seeing all these
5466 things as a battle and a fight and false dichotomies that
5467 it's either public health or, you know, a private interest
5468 or a population desire or, you know, a political interest,
5469 it's all of those things.
5470 If we constantly are finger-pointing and blaming
5471 somebody else for things, we lose the fact that the real
5472 enemy here was the virus and its ability to cause just a
5473 tremendous amount of suffering, harms, morbidity, mortality,
5474 death, mental health consequences, missed opportunity, and
5475 collateral damages across multiple sectors.
5476 We are all best served if we're going to battle
5477 pandemics if we can find a way for those things to not be in
5478 false dichotomy, but to find a win/win where it's not an
5479 either/or but it's a both/and. How do we comprehensively
5480 work together to battle the threat of this virus, because at
5481 stake here is risk to all of us, no matter which lens we're
5482 using to look at the problem.

5483 And I think we could have had a better outcome and
5484 continue to have a better outcome if we kind of avoid these
5485 false dichotomies and try to find, you know, collective
5486 solutions.
5487 I think the virus doesn't really care about our
5488 politics. It doesn't care about, you know, our business
5489 interests and our financial bottom lines. It's really doing
5490 what it does best. We needed to be our better selves if
5491 we're going to effectively battle the next pandemic.
5492 Q What impact do you think this political pressure
5493 had on CDC and its ability to control its mission?
5494 A I think when there's all these tensions, as I said,
5495 I think that technical expertise alone is not going to be --
5496 it's essential but not sufficient, and doesn't guarantee
5497 success. And building an established bank account of trust
5498 in institutions and individuals and our collective interests
5499 that we trust one another to have each other's back and have
5500 the best interest of all of us at stake, we will be able to
5501 do better off.
5502 So I think the erosion of credibility and trust really
5503 harms the ability to persuade people to take sometimes
5504 difficult steps that's in our joint collective interest.
5505 That's tough. It's tough.
5506 Q What can be done to sort of reverse that bankruptcy
5507 of trust that you've talked about?

5508 A Never too late to start. Better communication,
5509 better listening, better understanding. You know, truth and
5510 honesty, quelling the act of disinformation, fair
5511 representation of the circumstances and situation at hand,
5512 acknowledging uncertainty, living in difficult spaces but
5513 knowing that there are better and less well paths forward
5514 and trying to find those solutions jointly.
5515 I think that will help restoring the integrity of our
5516 institutions and our leaders, but also having more
5517 collective responsibility for one another at the individual
5518 local level as well.
5519 Q One final question: Are there any policies or
5520 procedures that you wish had been in place and could have
5521 protected the CDC or could have protected the public?
5522 A I think that's a really long answer, and I think
5523 that we'll -- we'll need to sit back and take time and tease
5524 this apart and do, you know, a full dissection and we will
5525 come up with recommendations and interim actions.
5526 My only hope is that we can do that with a sense of
5527 collective fairness for what's at stake and respect for one
5528 another and that we deliberate around that with a sense of
5529 integrity rather than a sense of divisiveness, because
5530 there's a lot at stake if we don't.
5531 And I would like to see some of the lessons observed
5532 really turn into lessons learned in a very honest way,

5533 self-reflection and reflection on others. And too often I
5534 think there's lessons that are observed that are never
5535 really learned and mistakes that are repeated.
5536 I know that when I look back at the 1918 pandemic in
5537 detail, it feels like there were lessons there that were
5538 missed and ignored as we came into this pandemic, and I hope
5539 we can do a better job in that reflection in the future.
5540 Q Any specific lessons top of mind?
5541 A There are going to be many, and I'd hate to leave
5542 some out at the end of a very long day. Probably that will
5543 take some time, but I just hope we commit to honestly
5544 engaging in that instead of blaming, finger-pointing.
5545 I really hope that we actually can see our way
5546 collectively to looking at what worked and what didn't and
5547 what we might do differently and have some genuine
5548 conversation around that.
5549 Q Is there anything else that you'd like to put on
5550 the record before we close?
5551 A No.
5552 [Majority Counsel]. On behalf of the majority staff, I
5553 want to thank you for your decades of service to this
5554 country and particularly the sacrifices you've made over the
5555 last couple of years, and I want to thank you for taking the
5556 time to speak with us today.
5557 The Witness. Thank you. Thank you to all the members

5558 here.

5559 [Minority Counsel]. Thank you, Dr. Cetron.

5560 [Proceedings adjourned at 4:10 PM]

Dr Cetron's Transcript Review of Oversight Committee Interview on Covid19 Pandemic Response

25May2022 09:10am

P3, L43- STUART not STEWART

P8, L174- internal medicine residency and infectious disease fellowship

P10, L213-GMTF

P10, L218- branch chiefs and program leads

P10, L218 I, as the Director of DGMQ,

P11, L233 immigrants, refugees, and other migrants applying for lawful permanent residence entering the US.

P11, L239-IDEA= Innovation, Development, Evaluation, and Analytics

P16, L372 host

P18, L427 DGMQ

P22, L524 exercises, and planning , responses from prior events

P23, L552 we elevate our discussions upward, and receive input and feedback from top down

P25, L593 State department

P26, L628 CDC Director

P27, L653 coming home from

P28 L660-61 we have regular channels of communication

P28, L670 decisions

P28-29, L681-686 1- at the source, 2- response in transit, 3- response on arrival, 4- response after travel. at ports of entry and post arrival at final destinations during the incubation period

P30 L714 impacting health broadly and severely across different populations ie wide spectrum of illness

P31 L742-3 I believe for China we tiered through very rapidly to the highest levels with some geographic specificity (Wuhan -> Hubei ->all China)

P37 L899 large volume and stragglers, but they may have been coming from areas not yet exposed to the virus

P39 L934 potential risk during the incubation period

P39 L952 multiple attack approach

P40 L968-970 rapidly evolving global pandemic with a pathogen with a high reproductive rate, spreads fast. It's highly contagious. It causes severe symptoms which can evolve quickly

P41 L997-999 move to prior graf.

"Ebola stayed regionally constrained., much more so than Covid. There is no comparison." end graf

P41 l 999 new graf "In a matter of weeks, Covid spread out of China and the SE Asia region. Italy...

p43 L1052 and the likelihood of a very serious pandemic, the worst in 100 years…

p46 L1121 It's also NOT like I wrote it with my team nor did my team write it

p47 L1137 So it wouldn't necessarily have been delegated by the CDC Director to the DGMQ Director

p47 L1153 can be considered an appealing approach

p48 L1162 public health mitigation strategies as opposed to outright border closures

p48 L1164 (ie border closures)

p49 L1203 in Title 42

p50 L1226 (ie in Mexico and among the migrants crossing the border)

p53 L1301 in the United States

p53 L1306 new sentence break Those infection control practices needed to be the backbone of the response structure until medical counter measures were available. There was a certain amount of false security..

p54 L1317 limiting or discouraging the volume of travel in/out

p55 L1356 212F

p59 L1444 health

p72 L1765-1766 contact tracing and post arrival monitoring

p74 L1823-1824 engaged heavily in post arrival monitoring for all arrivals from W Africa,… ~35,000 arrivals annually, orders of magnitude smaller than COVID.

P75 L1848 Not really, No

P76 L1861 and with specific groups, industry and the WH/NSC

P76 L1875 by CDC but not at the higher levels of USG

P76, L1903 & 1911 In retrospect I was being too cautious here, the actual answer is there was significant pushback from the top of DHS Acting S1 and WH Sr Officials.

P78 L1913 In the end insufficiently at the higher levels of WH officials.

P80 L1977 unrealistic optimism that 212F and border measures would alleviate the ensuing crisis

P82 L2010 cases and hospitalizations and deaths (ie infections, morbidity and mortality)

P84 L2064-67 interagency and WH policy meetings, … conversations with the CDC Director

P84 L2079 These were Sr level interagency meetings run by WH Officials

P90 L2216 morbidity and mortality, lot more suffering and death

P93 L2293-96 should read “ I don't think that communication role was being filled in the same way as prior pandemics. The communication on Covid didn't include as much of the CDC perspective

P93- L110 single corrective word edits

P110 L2725 to discover key feature of the pandemic, a captive passenger population...

P114 L2812 embarking/disembarking in port communities for daytrips,...

P123 L3051 A combination

P125 L3089 evolved

p125 L3096 bridging

P125 L3102 detect

P126 L3111 avoid

P135 L3339 Not that I recall but remember the specifics of the sequence of edits offered outside cdc

P171 L4246 added “individual liberties and the interests of”

P172 L4262 been used this extensively before from a public health perspective. We have not seen this going back a …

P173 L4296-99 (ie human trafficking, gender and sexual violence etc.)

P173 L4302 proportionality, least restrictive means, equity, - principles that I've ...

P193 L4804-4815 Multiple edits to clarify the threrd of mine response which were poorly captured in the original transcript.

P205 L? avoid

P209 L5184 thanking

P212 L5261 scientifically not electronically

MSC

5/25/2022 5:26pm