ORAL ARGUMENT NOT YET SCHEDULED

No. 22-5325

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

NANCY GIMENA HUISHA-HUISHA, on behalf of herself and others similarly situated, et al.,

Plaintiffs-Appellees,

v.

ALEJANDRO MAYORKAS, et al.,

Defendants-Appellants.

On Appeal from the United States District Court
for the District of Columbia
No. 1:21-cv-100
Hon. Emmet G. Sullivan

PLAINTIFFS-APPELLEES' OPPOSITION TO THE STATES' EMERGENCY MOTION FOR A STAY PENDING APPEAL

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GLOSSARY

Abbreviation	Description
APA	Administrative Procedure Act
CDC	Centers for Disease Control and Prevention
Stay Mot.	States' Emergency Motion for a Stay Pending Appeal (Dec. 12, 2022)

CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1 and Cir. R. 26.1, Counsel for Plaintiffs-Appellees state that they do not have parent corporations. No publicly held corporation owns 10 percent or more of any stake or stock in any of the Counsel for Plaintiffs-Appellees.

INTRODUCTION

The Title 42 policy was never intended to be permanent but has now been in place for nearly three years, resulting in daily expulsions of migrants fleeing horrific danger. Yet even at the time of the first appeal in this case in March 2022, this Court characterized the policy as a "relic from an era with no vaccines, scarce testing, few therapeutics, and little certainty." *Huisha-Huisha v. Mayorkas*, 27 F.4th 718, 734 (D.C. Cir. 2022) (affirming preliminary injunction in part); *see id.* at 735 ("it's far from clear that the CDC's order serves any purpose"). The Court thus pointedly directed the district court to consider "Plaintiffs' claim that the [policy] is arbitrary and capricious." *Id.* at 735.

On remand, the district court rightly found the policy arbitrary and capricious under the APA. ECF No. 165 ("Op."); 2022 WL 16948610 (D.D.C. Nov. 15, 2022). Now, only after the district court rendered judgment, the States have sought to intervene and obtain a stay pending appeal. They seek to keep this purported *public health* policy in place as a means of *immigration control*, abandoning any pretense that expulsions are necessary to address COVID-19.

The States have "not satisfied the stringent requirements" for "the extraordinary relief of a stay pending appeal." *Citizens for Resp. & Ethics in Washington v. Fed. Election Comm'n*, 904 F.3d 1014, 1016-17 (D.C. Cir. 2018) (per curiam) ("*CREW*"). They have "little prospect of success" on the merits. *Id.*

at 1019. As the district court held, the Title 42 policy silently jettisoned CDC's own longstanding policy and practice of using the "least restrictive" public health measures; failed to acknowledge the enormous toll of human suffering inflicted by the policy; and ignored obvious alternatives to expulsion. Contrary to the States' repeated invocations of the prior appeal, these holdings dovetail with this Court's characterization of the policy as a "relic" of the early days of the pandemic, and its directive that on remand the district court consider Plaintiffs' arbitrary-and-capricious claim. *Huisha-Huisha*, 27 F.4th at 734-35.

The equities also weigh decisively against the States. This Court observed in the first appeal that "the record is replete with stomach-churning evidence of death, torture, and rape" inflicted upon Plaintiffs, evidence that "is not credibly disputed." *Id.* at 733. Any further stay would send even more people to "walk the plank" into "extreme" and preventable "violence." *Id.* at 733-34 (cleaned up).

The States assert that ending the policy "will cause an enormous disaster at the border." Stay Mot. 2. But migrants make "complex decisions" based on "myriad economic, social, and political realities," not the mere existence or nonexistence of a particular policy. *Arpaio v. Obama*, 797 F.3d 11, 21 (D.C. Cir. 2015). Indeed, the States repeatedly emphasize the numbers of migrants that have been coming to the country for years *while Title 42 is in place*—which, if anything, indicates that the Title 42 policy has not prevented increased migration. And even

if there is a short-term influx, it is speculative that the result will be either increased undocumented populations, or increased costs for the States, in the long term. In any event, there is no legal basis to use a purported public health measure to displace the immigration laws long after any public health justification has lapsed. *See Huisha-Huisha*, 27 F.4th at 734 ("our system does not permit agencies to act unlawfully even in pursuit of desirable ends") (quoting *Ala. Ass'n of Realtors v. HHS*, 141 S. Ct. 2485, 2490 (2021)).

The States also repeatedly allege that Defendants are "employing strategic surrender to achieve results through collusion" that they could not achieve through rulemaking. Stay Mot. 3. Such allegations of collusion are baseless.[1] To the contrary, the States are seeking to use the pretext of the pandemic to keep the Title 42 policy in place long after any plausible public health justification for it has ended.

[1] The States' motion contains several misstatements. They claim that the district court's five-week stay was in response to a *joint* motion, Stay Mot. i., but the federal government's motion was simply unopposed. And they assert that intervention was fully briefed in district court at the time of their motion, when in fact the court had ordered supplemental briefing which was not yet completed.

ARGUMENT

I. THE STATES LACK STANDING AND ARE NOT LIKELY TO SUCCEED ON INTERVENTION.

Plaintiffs' intervention opposition describes the background of this litigation and explains why the States lack Article III standing and should be denied intervention even if they have standing. Plaintiffs will not repeat those arguments, except to respond to the States' incorrect claim that they do not even need standing for purposes of this motion because the federal government's standing is enough to confer "jurisdiction over this entire appeal." Stay Mot. 13. But standing is a prerequisite for intervention, even for Defendant intervenors, so the federal government's standing is not sufficient. *Deutsche Bank Nat. Trust Co. v. FDIC*, 717 F.3d 189, 193 (D.C. Cir. 2013). And if the States are not likely to succeed in intervening because of a lack of standing—and they are not—they cannot be likely to prevail in merits arguments they will never be permitted to advance as parties. *See United States v. Brit. Am. Tobacco Australia Servs., Ltd.*, 437 F.3d 1235, 1240 (D.C. Cir. 2006). Moreover, even assuming the Court could grant a *sua sponte* stay, Stay Mot. 13, for all the reasons below that would be deeply inequitable here.

II. THE STATES ARE UNLIKELY TO SUCCEED ON THE MERITS.

The district court identified four key defects rendering the Title 42 policy arbitrary and capricious. The States fail to show that any, let alone all, of those conclusions are likely incorrect.

1. First, the district court correctly "conclude[d] that the August 2021 Order is arbitrary and capricious due to CDC's 'failure to acknowledge and explain its departure from past practice'" of applying the least-restrictive-means standard. Op. 27; *see FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009) (rejecting "*sub silentio*" departures).

The States' incorrectly claim that "no such" standard "actually exists." Stay Mot. 14. But prior to instituting Title 42, CDC's declared policy was to impose only the "least restrictive means necessary to prevent spread of disease." *Control of Communicable Diseases*, 82 Fed. Reg. 6890, 6912 (Jan. 19, 2017). That 2017 rule "clarifie[d]" that the agency was to apply this "least restrictive means" standard "in *all* situations involving . . . public health measures," noting "as an example" CDC's actions during the 2014-2016 Ebola epidemic. *Id.* (emphasis added); *see id.* at 6931 (rule intended "to clarify the agency's standard operating procedures and policies").

The district court did not, as the States suggest, apply the 2017 rule's preamble as operative regulatory language. Stay Mot. 16. Moreover, contrary to

the States' assertion, the 2017 rule did not state that the least restrictive standard applied "only" to action taken *under* that rule. Stay Mot. 16. Nor did it "expressly disclaim[]" the standard's more general application. *Id*. Rather, the rule discussed the standard as an existing policy of general application "in *all situations* involving quarantine, isolation, or *other public health measures*." Op. 24-25 (emphasis the district court's) (quoting 82 Fed. Reg. at 6912). The district court thus rightly concluded that the 2017 rule, along with other evidence, established that "the agency's practice was to apply the 'least restrictive means' test more broadly," Op. 24—whether or not an action was taken pursuant the 2017 rule itself, *see Grace v. Barr*, 965 F.3d 883, 902 (D.C. Cir. 2020) (explaining that agency's practice "sets the baseline from which future departures must be explained"). Indeed, CDC has also applied the least-restrictive-means standard with respect to tuberculosis and in

other COVID-19 measures,[2] and included it in a "Public Health Law 101" course for practitioners.[3]

Yet none of CDC's rules or orders authorizing the Title 42 policy even referenced the least-restrictive-means standard, much less explained why it was ignored. *E.g.*, 85 Fed. Reg. 56424 (Final Rule); 86 Fed. Reg. 42828 (August 2021 Order). The agency thus failed even to "display awareness that it [was] changing position." *Fox*, 556 U.S. at 515.

Congressional testimony of two high-ranking, longtime CDC officials—former CDC Principal Deputy Director Dr. Anne Schuchat and Dr. Martin Cetron, Director of CDC's Division of Global Management and Quarantine—confirms the agency's failure to follow its established policy. As the district court noted, Dr. Schuchat testified that CDC's practice was to seek to use the "'least restrictive

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[2] CDC, *Menu of Suggested Provisions For State Tuberculosis Prevention and Control Laws* (last reviewed Sept. 1, 2012), https://www.cdc.gov/tb/programs/laws/menu/appendixa.htm ("Public health officials generally employ a step-wise approach to implementing TB control measures, beginning with the least restrictive measure necessary . . . ."); CDC, *Developing a Framework for Assessing and Managing Individual-Level Risk of Coronavirus Disease 2019 (COVID-19) Exposure in Mobile Populations* (CDC recommendations regarding COVID-19 based on risk level and relative restrictiveness of policy options for arriving travelers) (last updated Oct. 29, 2021), https://www.cdc.gov/immigrantrefugeehealth/exposure-mobile-populations.html.

[3] CDC, *Public Health Law 101: A CDC Foundational Course for Public Health Practitioners*, at 24, https://www.cdc.gov/phlp/docs/phl101/PHL101-Unit-2-16Jan09-Secure.pdf, (last reviewed Apr. 13, 2012, *see* https://www.cdc.gov/phlp/publications/phl_101.html).

means possible to protect public health[.']" Op. 22-23 (quoting ECF No. 153-4 at 8). In testimony made public after summary judgment briefing below concluded, Dr. Cetron confirmed that CDC "should attempt to provide the least restrictive means"—but that in issuing the Title 42 policy, CDC instead "jump[ed] directly to the most restrictive approach." Cetron Tr. 170.[4]

As the district court observed, CDC belatedly acknowledged the least-restrictive-means standard only when *terminating* the Title 42 policy. Op. 23-24. CDC's April 2022 termination order admitted that the policy was "among the most restrictive measures CDC has undertaken" and concluded that "less restrictive means are available." 87 Fed. Reg. 19941, 19951, 19955; *see also* 87 Fed. Reg. 15243, 15252 (Mar. 17, 2022) (stating that "CDC is committed to using the least restrictive means necessary," and concluding that "less restrictive means are available" as to unaccompanied children). CDC's failure to mention the standard

[4] U.S. House of Reps., Tr. of Interview of Martin Cetron, M.D. (May 2, 2022) ("Cetron Tr.") (submitted as exhibit here), https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2022.05.02%20SSCC%20Interview%20of%20Martin%20Cetron%20-%20REDACTED.pdf. This transcript was made public on October 17, 2022. *See* Press Release, Select Subcomm. on the Coronavirus Crisis (Oct. 17, 2022), https://coronavirus.house.gov/news/press-releases/clyburn-trump-cdc-redfield-caputo-report.

As with Dr. Schuchat's testimony, Dr. Cetron's testimony may be considered "to evaluate the existence of a 'least restrictive means' standard with respect to public health measures generally." Op. 22 n.3.

in *issuing* and *maintaining* the Title 42 policy thus constituted an unexplained deviation from this approach.

The States confuse the issues by arguing the APA does not itself require agencies to employ a least-restrictive-means analysis. Stay Mot. 14-15. But as the district court explained, this was the CDC's own established policy, and so under *Fox* CDC had to acknowledge and explain the change. The States' observation that the Title 42 Final Rule contains no mention of the least-restrictive-means standard, *id.* at 15-16, simply illustrates the agency's failure to acknowledge its abandonment of that standard.

And even if the Title 42 policy could be read as silently "*amending*" the least-restrictive-means standard, Stay Mot. 15—in that the policy was obviously not the least restrictive option to address COVID-19 (as the States seemingly concede)—the APA requires agencies to *acknowledge* policy changes. Yet "readers would have no idea that prior to" the Title 42 policy, CDC "generally applied" the least-restrictive-means standard. *Grace*, 965 F.3d at 901; *see Fox*, 556 U.S. at 515 ("*sub silentio*" changes are impermissible).

2. Second, CDC impermissibly disregarded the impact of the Title 42 policy on noncitizens, a "'relevant factor,' or an 'important aspect of the problem,' that CDC should have considered." Op. 28 (quoting *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins.*, 463 U.S. 29, 43 (1983)). Those consequences are familiar to

this Court, which previously noted the "stomach-churning evidence of death, torture, and rape" the Title 42 policy has imposed on noncitizens "forced to walk the plank" into extraordinary harms when summarily expelled. *Huisha-Huisha*, 27 F.4th at 733. Yet the agency entirely failed to acknowledge those extraordinary harms.

The district court correctly explained that "[i]t is unreasonable for the CDC to assume that it can ignore the consequences of any actions it chooses to take in the pursuit of fulfilling its goals, particularly when those actions included the extraordinary decision to suspend the codified procedural and substantive rights of noncitizens seeking safe harbor." Op. 29. "[N]umerous public comments during the Title 42 policy rulemaking informed CDC that implementation of its orders would likely expel migrants to locations with a 'high probability' of 'persecution, torture, violent assaults, or rape.'" *Id*. at 29-30; *see, e.g.*, ECF 154 at 36 (comment citing more than 1,000 publicly reported attacks on migrants in Mexico within a one-year period). CDC failed to grapple with these known and foreseeable consequences of its policy either in its rulemaking or orders, including the operative August 2021 Order.

The States barely address this flaw. And, notably, these very States have elsewhere argued that the APA required the federal government to consider "all important aspects of the problem" in *terminating* Title 42, including supposed

"harms to States" like "healthcare, education, and law-enforcement costs." Appellees' Brief 75, *Louisiana v. CDC*, No. 22-30303 (5th Cir. Aug. 31, 2022). While the harms asserted in that litigation are speculative and contingent, here the record plainly establishes (as this Court previously noted) that the Title 42 policy is routinely subjecting noncitizens to extraordinary danger and harm. As these States aptly put it: The "APA prohibits CDC's refusal to consider" "wanton harms" imposed by the policy and whether those harms "might be avoided or mitigated." *Id*. at 76.

Despite their position elsewhere, the States argue that CDC had no obligation to consider harms to noncitizens because the statute "provides that preventing introduction of persons is warranted when CDC makes the requisite determinations." Stay Mot. 20. But Title 42 is a discretionary authority—one that was never invoked to expel persons until 2020. And it is the antithesis of reasoned decisionmaking for the agency, in deciding as a *policy* matter whether to adopt or maintain the Title 42 policy, to refuse even to *look* at the fact that its policy was subjecting noncitizens, including families with young children, to acts of assault, torture, rape, and murder. The district court was thus right to conclude that CDC's "decision to ignore the harm that could be caused by issuing its Title 42 orders was arbitrary and capricious." Op. 30.

The States' assertion that "CDC did consider such hardships" likewise fails. Stay Mot. 20. Neither CDC's pre-August 2021 orders exempting children, nor its references to case-by-case exemptions, acknowledged the extraordinary harms resulting from expelling migrants. Tellingly, the States' only citation to the record is to CDC's April 2022 *termination* order—which of course postdates the establishment and maintenance of the policy, and where, in any event, the agency only generally acknowledged the "extraordinary" nature of the policy but failed to mention the specific harm it caused. Stay Mot. 20 (citing 87 Fed. Reg. at 19,956).

3. Third, CDC violated the APA requirement to consider reasonable alternatives, particularly those that are "within the ambit of the existing policy." *Dep't of Homeland Sec. v. Regents of the Univ. of Calif.*, 140 S. Ct. 1891, 1913 (2020) (quoting *State Farm*, 463 U.S. at 51).

As the district court explained, CDC "failed to appropriately consider the availability of effective therapeutics that 'reduce[d] the risk of hospitalization' by approximately 70 percent." Op. 35. The original "March 2020 Order listed the lack of vaccines, 'approved therapeutics,' and rapid testing as justifications for the emergency measures." *Id.* at 34-35 (citing 85 Fed. Reg. at 17062). The unavailability of therapeutics treatments was thus a "significant factual predicate" for the policy. *Id.* at 35. However, "the August 2021 Order failed to even mention such treatments or their overall availability." *Id.*; *see also Portland Cement Ass'n*

v. EPA, 665 F.3d 177, 187 (D.C. Cir. 2011) ("Agencies 'have an obligation to deal with newly acquired evidence in some reasonable fashion,' . . . [and] to 'reexamine' their approaches 'if a significant factual predicate changes.'").

Further, although the August 2021 Order notes that Title 42 processing was done outdoors, the order "makes no mention of whether Title 8 processing could also take place outdoors, as suggested by at least one commenter as a less drastic measure to expulsion." Op. 33. The States wrongly insist that the cited comment did not "distinctly raise" the possibility of outdoor processing, Stay Mot. 18—but the comment specifically proposed that CDC could address its concern with people "congregating in detention centers" if "individuals could be processed in the field," ECF No. 154 at 9. And, even absent a comment, CDC's own statement that Title 42 processing was safer because it "generally happens outdoors," 86 Fed. Reg. at 42,836, naturally raises the question whether Title 8 processing could likewise occur outdoors. Nor is it "obvious" that outdoor Title 8 processing would not be viable simply because it could take longer than Title 42 processing. Stay Mot. 18. CDC might have found it viable or not, but the agency never addressed the question.

Similarly, despite noting the advent of effective on-site rapid testing and "widely available" vaccines, 86 Fed. Reg. at 42833, CDC's Order lacked "any serious analysis of whether reasonable steps could have been taken to at least begin

instituting vaccination programs" for migrants as an alternative to expulsion, "particularly given that all Americans had been eligible for the vaccine for more than three months by [August 2021]"; or if such steps could be taken toward "increasing the supply of on-site rapid testing." Op. 36-37. Contrary to the States' suggestion, the Order's discussion of lower vaccination rates in some migrants' countries of origin does nothing to address the potential viability or benefits of providing vaccination to migrants upon their arrival in this country. *See* Stay Mot. 19 (citing 86 Fed. Reg. at 42834). Nor can the States' "*post hoc* rationalizations" cure the agency's failure to consider the question. *Regents of the Univ. of Cal.*, 140 S. Ct. at 1909.

Dr. Cetron's testimony confirms the district court's conclusion that CDC repeatedly ignored such alternatives. He testified that by "jumping directly to the most restrictive approach," CDC "bypassed some very fundamental public health principles in terms of going to [the] root cause of the public health concerns," including "cohorting, testing, assessment, use of nonpharmaceutical interventions, masks, et cetera." Cetron Tr. 172. He explained that the risk from migrants "was overstated," such that the Title 42 policy lacked "a commensurate rationale," *id.* at 182–83; and that there was "insufficient evidence that the nature of the threat would warrant [the policy]," which was "not the appropriate tool," *id.* at 202-03.

In short, as this Court previously observed, the Title 42 "order looks in certain respects like a relic from an era with no vaccines, scarce testing, few therapeutics, and little certainty." *Huisha-Huisha*, 27 F.4th at 734. As in *Regents* and *State Farm*, the agency's failure to consider the feasibility of adopting less sweeping alternative measures was arbitrary and capricious.

4. Finally, CDC impermissibly "ignore[d] inconvenient facts" and prior agency "factual determinations." *Fox*, 556 U.S. at 537; *see State Farm*, 463 U.S. at 43 (action is arbitrary and capricious if agency's "explanation for its decision . . . runs counter to the evidence before the agency"). The States do not even address this holding.

CDC ignored evidence that noncitizens subject to Title 42 did not pose any particular risk, and that their numbers were minuscule compared to the overall number of land travelers entering the country. The administrative record established that "during the first seven months of the Title 42 policy, CBP encountered on average just one migrant per day who tested positive for COVID-19"; that "at the time of the August 2021 Order, the rate of daily COVID-19 cases in the United States was almost double the incidence rate in Mexico and substantially higher than the incidence rate in Canada"; and that "Title 42 covered only approximately 0.1% of land border travelers." Op. 39-40.

This evidence bears out Judge Walker's observations during argument on the first appeal that "the order only covers about .1 percent of people who cross the Canadian or Mexican border," and that nothing "suggest[s] that those .1 percent of border crossers are more likely to have COVID than the other 99.9 percent." Oral Argument Tr. at 5, ECF No. 153-2 at 18. Indeed, in July 2021 alone, over 11 million people entered from Mexico by land, including over 8.4 million people in cars, buses, and trains.[5] As Dr. Anthony Fauci explained, immigrants are "absolutely not" a "major reason why COVID-19 is spreading in the US," and "expelling [immigrants] is not the solution." CNN, *Fauci: Expelling immigrants 'not the solution' to stopping Covid-19 spread* (Oct. 3, 2021).[6]

Ignoring this evidence was "especially egregious in view of CDC's previous conclusion [in 2017] that 'the use of quarantine and travel restrictions, in the absence of evidence of their utility, is detrimental to efforts to combat the spread of communicable disease[.]'" Op. 39-40 (citing 82 Fed. Reg. at 6896); *see also* U.S. Dep't of Health and Human Servs., Pandemic Influenza Plan (Nov. 2005) at 307 ("[T]ravel restrictions would need to be about 99% effective to delay introduction

[5] U.S. Bur. of Transp. Stats., Border Crossing Entry Data, https://explore.dot.gov/views/BorderCrossingData/Monthly?%3Aembed=y&%3AisGuestRedirectFromVizportal=y (select July 2021 and "US-Mexico Border").

[6] https://tinyurl.com/5ua5m4bm (2:13 to 4:05 of video).

into a country by one to two months."); *id.* at 369 ("[T]ravel restrictions . . . are likely to be much less effective once the pandemic is widespread.").[7]

As Dr. Cetron testified, once COVID-19 was widespread within the United States, border restrictions generally, and the Title 42 policy specifically, would be ineffective, Cetron Tr. 50, 172-73, 182-83—particularly with a "huge volume" of other travel allowed, *id.* at 53; *see also id.* at 179 (purported risk of migrants importing COVID-19 "did not jibe" with the data, especially in light of infection "hot spots in the U.S. that were much more powerfully overwhelming"); NY Post, *Fauci says US travel bans don't 'make any sense' now given rapid spread of Omicron* (Dec. 20, 2021) ("[W]hen you get to the point when there's enough of a virus in your own country, it doesn't really make any sense of trying to keep it out . . . [I]nput from countries that might even have less infection than we have doesn't give any added value.").[8] The administrative record therefore confirmed this Court's previous observation that "from a public-health perspective, . . . it's far from clear that the CDC's order serves any purpose." *Huisha-Huisha*, 27 F.4th at 735.

For all these reasons, the States fail to show that the district court likely erred in holding the Title 42 policy arbitrary and capricious.

[7] https://www.cdc.gov/flu/pdf/professionals/hhspandemicinfluenzaplan.pdf.
[8] https://tinyurl.com/2ksp2nyk.

III. THE EQUITIES WEIGH DECISIVELY AGAINST A STAY.

The States "fare[] no better on the second 'critical' factor—showing irreparable harm to [their] legal interests." *CREW*, 904 F.3d at 1019 (quoting *Nken v. Holder*, 556 U.S. 418, 434 (2009)). As explained in greater detail in Plaintiffs' intervention opposition, the States' asserted injuries are too unsupported, indirect, and speculative even to establish Article III standing; they certainly do not outweigh the harms to migrants. The States contend that replacement of Title 42 with regular immigration procedures will lead to more undocumented noncitizens in these States, imposing downstream healthcare and educational costs on the States. But "the likelihood of any [such] injury actually being inflicted is too remote to warrant the invocation of judicial power." *Arpaio v. Obama*, 797 F.3d 11, 22 (D.C. Cir. 2015).

Indeed, the States emphasize the high numbers arriving at the border *while Title 42 is in effect*, Stay Mot. 23-24, but that indicates only that the policy is not deterring migration. And while the States cite news articles indicating that Defendants have sought $3 billion from Congress in anticipation of the end of Title 42, little can be read into such budget *requests* by the Executive. And in any event, whether the change will impose any downstream costs on the States is highly contingent and speculative, as explained in Plaintiffs' intervention opposition.

Even if these asserted injuries could satisfy Article III, they do not constitute irreparable harm, which "must be 'both certain and great[,]' and 'actual and not theoretical.'" *CREW*, 904 F.3d at 1019 (quoting *Wisconsin Gas Co. v. FERC*, 758 F.2d 669, 674 (D.C. Cir. 1985)). In particular, the States provide *no* basis to conclude that the lack of a stay *pending appeal* will result in "certain and great" harms in the form of healthcare and education costs which, on the States' own theory, may merely be imposed at *some point* in *some amount* down the road. They suggest that if Title 42 is halted now, there is no way "to unscramble this egg." Stay Mot. 28. But they do not explain why that is so; if the government were later ordered to resume expulsions, it could do so.

By contrast, there can be little doubt that a stay would "substantially injure" Plaintiffs and run counter to "the public interest." *Nken*, 556 U.S. at 434 (cleaned up). As this Court previously noted, "the record is replete with stomach-churning evidence" that "is not credibly disputed." *Huisha-Huisha*, 27 F.4th at 733. In "Mexico alone, recorded incidents of kidnapping, rapes, and other violence against noncitizens subject to Title 42 have spiked from 3,250 cases in June 2021 to over 10,318 in June 2022." Op. 46 (cleaned up); *see also id.* (citing Human Rights First, *The Nightmare Continues: Title 42 Court Order Prolongs Human Rights Abuses, Extends Disorder at U.S. Borders*, at 3-4 (June 2022)). These life-and-death risks far outweigh any speculative indirect budgetary harms that could arise

from a potential eventual increase in undocumented immigrants residing in these states.

In an effort to minimize the harm to migrants subject to the Title 42 policy, the States point to this Court's prior holding that Title 42 expulsions are subject to certain protection screenings. Stay Mot. 25-26. But the District Court reexamined the equities on remand and rightly found that, notwithstanding this Court's mandate, Plaintiffs "continue to face irreparable harm that is beyond remediation." Op. 46. Indeed, the *implementation* of this Court's ruling, which is not currently before the Court, has been deeply flawed, if not illusory. *See* Op. 45-46 (noting federal Defendants cited the existence of screenings but did not even provide evidence of how many such screenings had taken place, even as the rate of expulsions doubled); ECF No. 150 at 31 & n. 2 (explaining noncitizens are not advised of the availability of screenings).

In any event, the States misapprehend the difference between Title 42 expulsions (even with these screenings) and regular immigration processing. Under this Court's prior holding, noncitizens subject to Title 42 may seek screenings only for "withholding of removal" and for claims under the Convention Against Torture. *See Huisha-Huisha*, 27 F.4th at 725, 733. But in Title 8 proceedings, noncitizens are entitled to seek *asylum*, which requires a substantially lower demonstration of "well-founded fear"—or, if considered within the

expedited removal system, the even lower standard of "significant possibility" of asylum eligibility. *See Grace*, 965 F.3d at 888. The Title 42 policy, even as modified by this Court, eliminates access to asylum. *Huisha-Huisha*, 27 F.4th at 730-31 (calling legality of eliminating access to asylum perhaps "the closest question in this case").

More generally, the record demonstrates that the policy is pushing noncitizens (even non-Mexicans) back into extraordinarily dangerous conditions in Mexico, thereby subjecting them "'to unacceptable risks' of 'extreme violence'" and other hardships. *Huisha-Huisha*, 27 F.4th at 734. Even if the withholding and torture screening were adequate, and even if asylum were available, noncitizens unable to make out a case for protection *in Mexico* would still be exposed to those harms as a result of the policy. Regardless of whether subjecting noncitizens to the resulting violence and hardship is a violation of domestic statutes or international law, it is certainly *harm* for purposes of weighing the equities here—and, unlike the States' speculative assertions, that harm is concrete and immediate.

Notably, the States do not try to justify continued Title 42 expulsions on public health grounds in an era of vaccinations, testing, and greater certainty about the disease—circumstances this Court has already recognized. *Huisha-Huisha*, 27 F.4th at 734-35. Indeed, in terminating the policy, CDC "determined that the extraordinary measure of an order under 42 U.S.C. 265 is no longer necessary,

particularly in light of less burdensome measures that are now available." 87 Fed Reg. at 19944; *see also id.* at 19949-50 (discussing "widespread deployment of COVID-19 tests, vaccines, and therapeutics"; and an array of available measures that are "particularly helpful in congregate settings"). That agency determination that Title 42 is unnecessary also eliminated the statutory authority for the policy. 87 Fed Reg. at 19955 (Title 42 legal "authority extends only for such period of time deemed necessary to avert the serious danger of the introduction of a quarantinable communicable disease into the United States") (emphasis omitted).

Rather, the States' entire argument is that Title 42 should be kept in place as an immigration control measure. That these States are transparently interested in Title 42 as a restriction on immigration and asylum rather than a supposed public health measure is unsurprising. These States have long called for ending all other COVID-19 restrictions; nearly all have ended their COVID-19-related public health emergencies, recognizing that vaccines and treatment are widely available;[9] and they have filed lawsuit after lawsuit seeking to stop other COVID-19 measures, including vaccine and mask requirements. *See, e.g.*, *Biden v. Missouri*,

[9] Arizona, Louisiana, Alabama, Alaska, Kentucky, Mississippi, Missouri, Montana, Nebraska, Ohio, Oklahoma, South Carolina, Tennessee, Utah, Virginia, and Wyoming all ended their public health emergencies last year or earlier in 2022. *See* States' COVID-19 Public Health Emergency Declarations and Mask Requirements, National Academy for State Health, https://www.nashp.org /governors-prioritize-health-for-all/.

142 S. Ct. 647, 651 (2022); Complaint, ECF No. 1, *Florida v. Walensky*, No. 22-718 (M.D. Fl. Mar. 29, 2022). Texas has gone so far as to ban local governments, schools, and many private businesses from taking basic precautions to stop COVID-19's spread, and prevented any entity in the State from mandating vaccines for workers or customers.[10] The States are, in other words, doing what several of them recently charged the federal government with: "invoking the COVID-19 pandemic" despite "publicly declar[ing] the pandemic over." *See* Response to Application to Vacate Injunction 1, *Biden v. Nebraska*, No. 22A444 (S. Ct. Nov. 23, 2022) (student loan program).

It is not in the public interest to maintain a public health policy without public health justification, as a pretextual way of circumventing the ordinary immigration and asylum statutes Congress enacted. The "weighing exercise" of equities and public interest in this case is thus "one-sided." *Huisha-Huisha*, 27 F.4th at 734.

[10] Governor Abbott Issues Executive Order Prohibiting Vaccine Mandates By Any Entity, Adds Issue To Special Session Agenda, Off. of the Tex. Gov. (Oct. 11, 2021), https://gov.texas.gov/news/post/governor-abbott-issues-executive-order-prohibiting-vaccine-mandates-by-any-entity-adds-issue-to-special-session-agenda; Texas Executive Order GA-38, https://perma.cc/BGM8-EV6E.

CONCLUSION

This Court should deny the States' motion.

Dated: December 14, 2022

Respectfully Submitted,

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Circuit Rule 28(a)(1), counsel for Plaintiffs-Appellees certify as follows:

A. Parties and Amici

The named Plaintiffs are Nancy Gimena Huisha-Huisha, and her minor child I.M.C.H.; Valeria Macancela Bermejo, and her minor daughter, B.A.M.M.; Josaine Pereira-De Souza, and her minor children H.N.D.S.; E.R.P.D.S.; M.E.S.D.S.; H.T.D.S.D.S.; Martha Liliana Taday-Acosta, and her minor children D.J.Z.; J.A.Z.; Julien Thomas, Fidette Boute, and their minor children D.J.T.-B.; T.J.T.-B.; and Romilus Valcourt, Bedapheca Alcante, and their minor child, B.V.-A.; on behalf of themselves and others similarly situated. The minor children are proceeding under pseudonyms pursuant to Federal Rule of Civil Procedure 5.2(a).

The Defendants are all sued in their official capacities, and are Alejandro Mayorkas, Secretary of Homeland Security; Troy Miller, Acting Commissioner Of U.S. Customs and Border Protection; Pete Flores, Executive Assistant Commissioner, CBP Office of Field Operations; Raul L. Ortiz, Chief of U.S. Border Patrol; Tae D. Johnson, Acting Director of U.S. Immigration and Customs Enforcement; Xavier Becerra, Secretary of the Department of Health and Human Services; and Dr. Rochelle P. Walensky, as Director of the Centers for Disease Control and Prevention.

The Proposed Intervenors are listed in the States' Motion to Intervene (Dec. 9, 2022).

B. Rulings under Review

The rulings under review are noted in the States' Motion to Intervene.

C. Related Cases

This case has previously been before this Court on Defendants' appeal of a preliminary injunction entered by the district court. That case resulted in a published opinion. *Huisha-Huisha v. Mayorkas*, 27 F.4th 718 (D.C. Cir. 2022), D.C. Cir. No. 21-5200. The mandate in Case No. 21-5200 issued on May 22, 2022.

P.J.E.S. v. Mayorkas, D.C. Cir. No. 20-5357, did not involve the same parties as this case, but involves a challenge to the U.S. Centers for Disease Control and Prevention's Order under 42 U.S.C. § 265 by a provisionally-certified class consisting of all unaccompanied noncitizen children who (1) are or will be detained in U.S. government custody in the United States, and (2) are or will be subjected to the CDC Order. On October 16, 2022, this Court granted in part the federal government's motion to lift the abeyance in that case, and remanded to the district court for further proceedings.

/s/ *Lee Gelernt*
Lee Gelernt

CERTIFICATE OF COMPLIANCE

This motion response complies with the type-volume limitation of Federal Rule of Appellate Procedure 27(d)(1)(E) and (2)(A) because:

1. It contains 5,174 words.

2. It complies with the typeface and type-style requirements of Federal Rules of Appellate Procedure 32(a)(5) and 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word Professional Plus 2019 in 14-point Times New Roman font.

/s/ *Lee Gelernt*
Lee Gelernt

CERTIFICATE OF SERVICE

I hereby certify that on December 14, 2022, I electronically filed the foregoing with the Clerk for the United States Court of Appeals for the DC Circuit by using the CM/ECF system. A true and correct copy of the foregoing has been served via the Court's CM/ECF system on all counsel of record.

/s/ *Lee Gelernt*
Lee Gelernt

ORAL ARGUMENT NOT YET SCHEDULED

No. 22-5325

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

NANCY GIMENA HUISHA-HUISHA, on behalf of herself and others similarly situated, et al.,

Plaintiffs-Appellees,

v.

ALEJANDRO MAYORKAS, et al.,

Defendants-Appellants.

On Appeal from the United States District Court
for the District of Columbia
No. 1:21-cv-100
Hon. Emmet G. Sullivan

EXHIBIT TO PLAINTIFFS-APPELLEES' OPPOSITION TO THE STATES' EMERGENCY MOTION FOR A STAY PENDING APPEAL:

TRANSCRIPT OF MAY 2, 2022 CONGRESSIONAL TESTIMONY OF MARTIN CETRON, M.D.

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, D.C.

INTERVIEW OF: MARTIN CETRON, M.D.

MONDAY, MAY 2, 2022

The Interview Commenced at 9:10 a.m.

APPEARANCES:

FOR THE MAJORITY:

[Redacted]

[Redacted]

[Redacted]

[Redacted]

FOR THE MINORITY:

[Redacted]

[Redacted]

[Redacted]

[Redacted]

FOR HHS:

Kevin Barstow

Jenn Schmalz

JoAnn Martinez

FOR CDC:

Elyssa Malin

Erica Portman

P R O C E E D I N G S

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

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

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

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

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

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

The Witness. I do not.

[Majority Counsel]. Is there agency counsel present?

The Witness. Yes.

[Majority Counsel]. Would agency counsel please identify themselves for the record?

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

[Majority Counsel]. And could additional agency staff in the room please introduce themselves for the record.

We don't have anyone else?

Ms. Martinez. Jo Ann Martinez, HHS.

Ms. Schmalz. Jen Schmalz, HHS.

Ms. Portman. Erica Portman, CDC.

Ms. Malin. Elyssa Malin, CDC.

[Majority Counsel]. And our colleagues in the minority, could you please identify yourselves for the record.

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

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

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

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

[Majority Counsel]. And my colleagues on the majority, I'd ask you to introduce yourselves as well.

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

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

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

well.

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

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

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

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

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

will wait until you continue your response before asking you the next question.

The court reporter cannot read nonverbal answers such as shaking your head, so it is important that you answer each question with an audible verbal answer. Do you understand that?

The Witness. I do.

By [MAJORITY COUNSEL].

Q We want you to answer the questions in the most complete and truthful manner possible, so we're going to take our time. If you have any questions or do not understand any of the questions, please let us know. We will be happy to clarify or rephrase as needed.

Do you understand?

A I do.

Q If I ask you about conversations or events in the past and you're unable to recall the exact words or details, you should testify to the substance of those conversations or events to the best of your recollection. If you can only recall a part of a conversation or event, you should give us your best recollection of those events or parts of conversations that you do recall. Do you understand?

A I do.

Q If you need to take a break, please let us know. We're happy to accommodate you. Ordinarily we take a

five-minute break at the end of each hour of questioning, but if you need a break before that, just let us know. To the extent there's a pending question, I'd ask that you finish answering the question before we take a break.

Do you understand that?

A I do.

Q And although you're here voluntarily and we will not swear you in, you are required by law to answer questions truthfully. This applies to questions posed by congressional staff in an interview.

Do you understand?

A I do.

Q If at any time you knowingly make false statements, you could be subject to criminal prosecution.

Do you understand?

A I do.

Q Is there any reason you are unable to provide truthful answers in today's interview?

A There is no reason.

Q The Select Subcommittee follows the rules on the Committee of Oversight Reform. Please note if you wish to assert a privilege over any statement today, that assertion must comply with the rules of the Committee on Oversight Reform.

Committee Rule 16(c)(1) states for the chair to consider

assertions of privilege or testimony or statements, witnesses or entities must clearly state that the specific privilege being asserted and the reason for the assertion on or before the scheduled date of testimony or appearance.

Do you understand?

A Yes.

Q Do you have any questions before we begin?

A I do not.

Q We really appreciate you being here. We've wanted to sit down with you for some time. We've been looking forward to this. I don't know if you feel the same.

But I'd like to start with talking a little bit about your background at the CDC. Can you tell us, walk us through your career path.

A Sure. I came to the CDC in 1992 as a commissioned officer in the U.S. Public Health Service. Prior to that, I had 12 years of academic training in internal medicine and residency in infectious disease training.

That was Tufts Medical School, University of Virginia internal medicine, and University of Washington in infectious disease. And I joined through the Epidemic Intelligence Service in 1992 in the Division of Parasitic Diseases.

Two years after that, I was a staff person in the Division of Bacterial Respiratory Diseases, and in 1996 I

joined the Division of Global Migration and Quarantine, and I have been in the Division of Global Migration and Quarantine for the last 26 years. And I have -- I am currently the director of the Division of Global Migration and Quarantine.

Q And beginning in January of 2020, were you also serving as director of the Division of Global Migration and Quarantine at that time?

A Yes. I have been the director of Global Migration and Quarantine for most of the 26 years of my service in the division.

Q Who did you report to at that time?

A Prior to the -- my position in the division as director of global migration and quarantine reports to the center director, the National Center for Emerging and Zoonotic Infectious Diseases, NCEZID. That has been Rima Khabbaz in the time you asked about, January 2020.

In addition, the COVID Response Activated Emergency Operations Center, and I've been part of the COVID Emergency Response continuously and nonstop since January of 2020, and that has its own incident command structure as well.

There's an incident manager who oversees the response activities. That incident manager position has rotated over the course of the two and a half years of the response, so the person in the incident manager position of the COVID

response has varied over the course of -- since January 2020 to the present.

So I have a dual reporting responsibility.

Q And who reported to you at that time?

A There are members -- there's a task force in the incident response on global -- the global migration task force, and so that task force reports up through the task force lead, and the task force lead reports to me.

In addition, the entire staff of the Division of Global Migration and Quarantine reports up through me. Particularly there are a number of branch chiefs in program on leads that report to the division director.

Then inside the office of the director in the Division of Global Migration and Quarantine, there's a deputy director, policy lead, each of the program branch chiefs response lead. There are several direct reports, up to 10 or so.

Q In general terms, can you tell us what your responsibilities were before the emergency response?

A Before the emergency response and for the duration of most of my 26 years in the Division of Global Migration and Quarantine, we have the broad responsibility of preventing importation and spread of communicable diseases into the United States.

We have a responsibility on the medical side of

screening immigrant refugee and migrant health, and we have responsibility for the issuance of guidelines on safe travel. We have a quarantine and border health services branch.

We have a U.S.-Mexico unit. We have a travelers health branch. And then we have a number of offices, regulatory and policy, and IMIT -- I think I mentioned that we can provide you the organogram document, but we have fairly broad responsibility which includes overseeing and implementing directly or through partners the regulatory programs of the Division of Global Migration and Quarantine and responsibilities that are delegated through the HHS secretary, the CDC director, and the director of global migration and quarantine regarding a number of different parts of 42CFR parts 70 and 71 on the quarantine regulations and part 34 on the immigration health screening regulations.

Q Sticking with this period in January 2020, who were you regularly interacting with, aside from your direct reports, but sort of in the leadership structure of CDC?

A Well, with the leadership structure at CDC, including the incident management structure and multiple task force across the response, there were regular interactions with the CDC director as well, particularly on a number of the regulatory issues that are -- that there are delegated responsibilities to the division director of

global migration and quarantine from the office of the director, and those would be the intramural CDC interactions.

In addition, the position interacts regularly with HHS staff of response and otherwise. And in the interagency, there are regular interactions with the other departments and agencies in the response structure and through the National Security Council.

Q And when did you first learn of the novel coronavirus circulating in Wuhan?

A Very late in December of 2019, I started getting some incoming signals from my international collaborators and folks about concerns of unexplained severe respiratory illness in Wuhan, China.

It would be in the sort of very -- sort of the penultimate days of December. I had been on leave at the time and returned immediately, based on hearing those concerns, to Atlanta, earlier from leave than had been scheduled, and began engaging immediately on return.

Prior to the institution of the -- stepping up the emergency response structure, the EOC incident command structure, we had begun engaging in information gathering, fact-finding confirmation events, sort of discussions, planning and so on right from -- I think it was about January 4th across the interagency leadership -- I mean, the

inter-CDC leadership with the director of the National Center of Immunization and Respiratory Diseases, with our own national center, and as well as the CDC director at the time.

And then the incident command structure was initiated shortly thereafter. I don't remember the exact date in January. And then everything folded into the emergency operation center incident command structure for interactions and coordination.

Q It seems like cutting your leave short is a significant step. Why -- what about what you were hearing told you that you needed to immediately get to work back at CDC?

A Well, as indicated, I'd been at CDC 30 years, and most of that career has been involved in doing a number of emergency response activities regarding potential global threats. I've participated in nearly all of those infectious disease responses that the agency has been involved in since -- certainly since '96 and some prior to that. And there are features and characteristics which raise red flags, areas of concern which need to be vigorously addressed, fact finding, data gathering.

Some of the things that I had heard that were concerning was the type of cases, the severe respiratory cases, the fact that there were healthcare workers also falling ill,

the occurrence of deaths, the speed at which the cases may have been changing, so the rate, the type of questions about the route of spread and transmission. And usually these kinds of situations are ones to take very seriously.

So we gathered. As soon as we got information, we began -- what we would normally do is try to get as much ground truthing and source of information as possible from multiple sources. I'm also regularly a member of the WHO emergency committee's roster, so I have a number of colleagues and coordinations and collaborations at the World Health Organization, and we began reaching out and trying to get some additional sources of information.

But these kinds of situations it's always better to be alert and ready and track things down very vigorously and aggressively rather than waiting for information to passively come to you to -- that was the nature of the engagement.

Q You mentioned your international collaborators earlier and you mentioned the WHO. But who else were you talking with in this --

A Well, we have CDC staff deployed internationally and around the world. In particular, there are some CDC staff in China, and so we were reaching out to get information from CDC China office as well as what they could filter through the embassy.

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

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

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

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

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

that.

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

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

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

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

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

able to get information and network effectively as quickly as possible.

Q What's your assessment of the relationships with your counterparts on the ground at that time when this was first detected?

A My relationship to the CDC with my counterparts at CDC on the ground?

Q Your assessment of CDC's relationships with their counterparts on the ground at that time.

A I probably am not the best one to answer specifically about what the nature of the CDC staff's relationship with host government are or were at that time. And what I can say is it's very important that the communication, you know, be robust and trusted and valuable and information sources be both credible and accurate to the extent that it's possible in the midst of a confusing emerging event.

Q And let's take this and move forward a little bit to -- you said January 4 is really when things got organized. The incident management structure, I think, was set up on January 7. Can you broadly explain how your responsibilities changed once that structure was set up.

A Well, the incident management structures -- we were organized in a smaller group of a smaller number of the sort of key principals that usually get involved in these types

of events for risk assessment, data gathering and so on.

As an emergency activation occurs and the EOC has stood up, a more formal structure has come into play, and there are usually more components and folks brought to bear in that regard. And so you would begin to get an additional bench of resources, and the kinds of things, you know, that need to get done are benefited by a broader group of coordination, and different parts of the agency get brought to bear.

The incident managers are identified and sort of the regular flow of what we call the rhythm of activities, the scheduling of events, the coordination meetings, the establishment of task force MDs, all of those things happen very broadly from an agency-wide activation approach.

Q Can you just tell us maybe about the teams working on global migration quarantine issues? What are the immediate priorities once that is --

A The GMTF, the global migration task force, has been a regular fixture in numerous responses over -- as I said, over the last three decades of my time and 26 years in GFMQ, leading activities in DGMQ. And we have some typical types of responsibilities of understanding the scope, the spread, the speed, the nature of the risk, the symptom profile, et cetera.

So we were -- at sort of in the opening act of an

emerging threat, in addition to characterizing it as quickly as possible, we begin to look at what types of measures would be done to prevent importation and spread or slow the spread. Sometimes prevention of a distribution of a disease is -- in terms of the globalization is not possible, and the idea of looking at the transnational border issues is about trying to buy time to slow spread, think about what could be done.

We have a number of plans and exercises around what occurs in the sort of opening act, depending on what the global distribution of disease is, borders, you know, screening, whether they were going to use temperature checking system, questionnaires, risk factors, exposure risks.

Mapping out the movement of traffic from potential source or multiple sources into the United States, understanding the ports of entry that might be where there might be direct contact, in this case, with China, Wuhan, or in Wuhan province -- excuse me – Hubei province, the province that Wuhan is in.

And so we began doing all of that work. The transportation network infrastructure mapping was one part of our key responsibility.

In the pandemic planning back in the early aughts, in, '05 through '07, there was intensive pandemic planning

around community mitigation strategies in which our division had a principal role in the use of the community mitigation toolbox: Isolation, quarantine, social distancing, school issues, testing, screening, surveillance, all of that stuff.

So we began -- GMTF was a part, although in this type of response there were some dedicated components that were being established on domestic issues. We would also look at some of the interstate spread in addition to international introduction. That's another part of the -- part of our remit is international arrivals and interstate movement.

So these were the things we were working on. We quickly mapped some of the air traffic and some of the other means. We would be looking at the context of movements and flows out of the source area where the original cases were being reported.

It was notable that Chinese New Year was coming up and there would be a potential travel nexus from, you know, Wuhan to other parts of China, so then we would look at the additional transportation networks that were beyond the nearest -- the closest international airport.

Those were some of our key priorities, and very early on, I believe by discussions and then plans for standing up airport entry screening at the three major airports that have direct connections to Wuhan, we were beginning to engage.

It always takes a while from getting the green light to go to actually establishing sufficient people to distribute to our quarantine station networks. At first three airports, and then this continued to scale over the course of the next several -- several weeks by looking at both -- not only the direct flights to those -- you know, into the country but also the indirect and transit points. We were also engaging with international partners to see what types of screening and approaches might be taken.

Again, the pandemic plan looks at some of these border approaches from the perspective for highly communicable respiratory disease of buying time, not from, you know, stopping the spread, but a lot of that needs to be characterized by understanding exactly what the modes of transmission are, how contagious something would be, and what's the symptom profile that you might look for, what tools do you have to detect that.

So those would be some of the main things that we were gearing into -- sort of kicking into somewhat standard, you know, roles and responsibilities that follow playbooks as well as that have been exercised from prior events like Ebola in West Africa, Zika, monkey pox. You know, the number of events like this that we've been involved in since '96 are extensive.

Q We'll circle back to airport screens in a little

bit more detail later.

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

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

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

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

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

Q For the task force you were overseeing, who was doing that coordinating across agencies? And I'm thinking about the period probably before the standup of the White House task force, so throughout January.

A I'm not sure I really understand the question. Who was responsible for coordinating --

Q Who was leading the interagency interactions? Who was setting the meetings? Who was driving the agenda? What was happening in that period leading up to the creation of the task force?

A Again, there are familiar roles. The department has, you know, a standing role in coordination of the interagency meeting, other departments and agencies at various levels, and those coordinations not only occur at the top where they happen out of multiple places, but also then staff become connected, agency-to-agency staff, and we -- you know, the counterparts are assigned to task forces and we begin meeting and, you know, developing shared information, common operating picture, discussing response plans and then policies. We move filters up again and those discussions are happening.

So multiple levels of interconnectivity occur, and they are ongoing and they make a part of that rhythm of the emergency operation response, the response structure. So they're scheduled, again, at multiple layers.

It's a web. It's not like a single -- it's a very complicated, interdependent web with a lot of information moving at multiple levels, filtering up and down, but also especially across.

Q Okay.

A That's the way this unfolds.

Q Are you able to say who was sort of leading that web and who --

A Well, at different -- different departments and agencies, those might be different people. But the roles -- for example, the incident manager at CDC would have a major role in sort of coordination.

Then there would be, you know, department-wide coordination that involves, you know, agency leads, and plus the people that they want to bring into some of the conversations, so CDC director, other, you know, agency leads and directors.

And those would often be coordinated, you know, by HHS setting the schedule for those kinds of things. And then the interagency meetings would have coordination. Very -- I mean, this was the kind of event that very quickly the level of coordination was high in the U.S. government. So there was -- you know, those groups and everything brought together by the HHS secretary's office and other places.

And then the interagency meetings would have a

coordination, very -- I mean, this was the kind of event that very quickly, the level of coordination was high in the U.S. government. So it was, you know, those groups are being brought together by department, by the HHS secretary's office and other places.

But it was quite clear we were going to be dealing with a complex scenario. We had issues to think about -- I mean that "we" collectively -- on American citizens in Wuhan and issues to struggle with around repatriation, and those would involve multiple departments and agencies, state departments, DOD, DHS, of course, CDC HHS.

So that network grows very quickly as the number of issues that have to be taken into account arises.

Q When did your team start engaging with the White House?

A I don't remember the specific date, but very early on through the secretary's office. The secretary of HHS has a lead coordinating responsibility for COVID in the very early days. And the secretary of HHS would bring together the interagency and structuring agendas.

I'm not sure what you mean by when the White House task force started. You know, the White House engagement was coordinated initially through the HHS secretary before it was handed over. That would have been sometime in February. But there was engagement with the White House folks very

early on, early in January.

Q Who at the White House? In what roles?

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

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

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

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

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

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

I guess around that time, the decisions about travel were starting to be made. I'm wondering if we can first discuss the January 28 advisory to avoid all nonessential travel to China and your involvement in that decision.

A So our -- the Division of Global Migration and Quarantine, in addition to the GMTF task force, traditionally has responsibilities to help advise and guide on safe and healthy travel. Our traveler health branch issues routinely peacetime and emergency response time guidance about safe and healthy travel with the best information that we're able to glean.

And so we have a series of scaled level of travel advisories that assess risk and appropriate proportionate mitigation measures, and we update that on a constant basis as we better understand the risk assessment -- that is, the scope, the geographic scope, the magnitude, the intensity.

So that would be a very standard place for the GMQ to get involved. That is a lot about what recommendations we would make regarding safe and healthy travel from an outbound perspective. People who would be going to, coming -- or American citizens that would be living in those locations, what was the risk assessment of CDC and what were the mitigation recommendations, what legal of concern we had. And they are tiered to four levels, tiered, you know, concerns in terms of risk assessment.

So we definitely would be involved in that. That is also an activity where it's peacetime or emergency response time that gets coordinated through the interagency. We get regularly channels of communication involved with the Department of State and all across the interagency in that regard.

So those would be the kind of things that the CDC director would rely on our program to do.

I want to highlight that distinction between the guidance recommendations around outbound travel or the guidance and recommendations for American citizens in country, the expatriate communities where the risk might be from divisions that get made on the inbound side on the mode of preventing importation is spread clearly.

There's an overlap, but they are slightly different and the tools in the tool kit are slightly different, whether the focus is incoming or whether the focus is keeping people who travel healthy and safe on the outbound side.

So they are two important parts of a similar piece, but there are different tools available in different ways to approach those questions. We're getting involved in both.

So the border screening kinds of activities that I mentioned earlier, the maximum benefits occur from doing exit screening at the source of where the threat is: Having an emergency response plan for illness that might occur in

transit, whether it's by air, land, or sea, but the in-transit component; and then the -- sort of the last concentric ring would be what type of border screening might be considered on the arrival side.

So you can see the most powerful and impactful way to approach this is understanding clearly where the source or more than one source are; try to get exit screening in place for people that are infected, sick, or exposed are not being put into international or other travel in the first place; and then, you know, a response plan with regard to the conveyances that move, and then, finally, another layer, outer concentric layer of screening on arrival.

The reason the efficiency is maximum source control may be obvious. It goes much broader than just controlling direct travel risks to the U.S. But importantly, more often than not there's a lot of indirect movements, and those indirect points of transit are mixed in places in which it's hard to understand -- you know, as opposed to getting a direct flight that's full of 200 passengers right from the international airport, you know, near Wuhan to LAX, for example, or JFK, the more indirect ways people can come, the more sort of diluted and challenging it is to sort out who has actually been in a risk area or not.

Q And I guess we can -- in terms of the way you described it, the January 28 advisory was outbound? It was

avoiding all nonessential travel into China; is that right?

A Yes.

Q Why was that recommendation made at that time?

A The threat picture that was emerging was a serious respiratory illness, like moving pretty quickly, growing quickly in numbers, as we started to get that data from the first several weeks, and it was clear that it was impacting health in ways that could not easily be circumscribed or defined.

And that often at the beginning of a situation like this, where there's a lot of confusion and chaos and the risks are not always exactly clear that somebody can take, you know, one measure to protect themselves, whether it's a vaccine or prevention -- preventive medication or something else that would alleviate their risk and there was community spread and widespread transmission, the best advice we can give until there's much more clarity is for people to avoid an area like that.

There was also strain on healthcare systems and hospital delivery. And so it was the combination of the severe threat, the widespread nature, the rapid spread, and the potential impact on healthcare system and delivery that -- what would be the options for an American citizen or other persons leaving from the U.S. traveling to the area, if they got sick, in terms of their ability to access care.

Those are all the kinds of factors that lead into a decision like that.

Q Do you think that decision should have been made sooner?

A We had been providing, you know -- like I said, there are tiers of that, so that avoid all nonessential travel, that's the higher tier short of actually mandating restrictions and closures at the border. So that's a level of guidance.

And I'd have to go back and check the record, but I believe we sort of tier through with some geographic specificity before we get to that fourth tier.

And certainly, we had concerns earlier, we were setting up our screening, we were setting up surveillance systems, we were gathering data on the nature of the cases, whether it was strong evidence for person-to-person spread, what the incubation period, what the nature of the pathogens would be and whether there were countermeasures known -- that is, treatments -- already, you know, known.

So I think by the end of January, we had a reasonable idea that this was a coronavirus in that SARS or MERS family. There were certain things that had been, you know, deduced about that just by the original genomics. I think by the end of January, the emergency committee at WHO had 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

create a better awareness or if we identified cases early in January, whether we had specimens in our hands in the U.S. to be able to begin characterization of the virus.

So I'm thinking that by -- I mean, it takes a while to set up and coordinate and get those operations going, but we were doing that in a matter of days rather than -- you know, sometimes it can take longer to mobilize funding and all these other things, get people, discussed at the appropriate perch, develop questionnaires.

We wanted to be asking about potential exposures in addition to symptoms, in addition to a temperature screening, and then having the protocol for how to handle those that flip the switch positive.

So I'm vaguely recollecting that we had started in the three largest volume hubs receiving direct flights by the middle of January, maybe the second week or toward the end of the second week in January. I'd have to go back and check that record for specifics.

And as we characterized the travel network as we learned more about what was going on in terms of travel out of the central locations, the specific hot zone in Wuhan, to other parts of China, and as we were defining the transit hubs and the indirect things, we were expanding that airport program.

That, as I said, we were well aware was not designed to prevent importation of a highly contagious respiratory

disease. These are about buying time to get better understanding of the risk assessment and what tools are needed, develop diagnostics, develop response plans, characterize things to really understand what's going on.

Some of these types of highly contagious respiratory viruses are not going to be stopped by any entry screening program or any, you know, travel bans and all that. It's just not the way it works.

Were it true, I would be very happy about that, but that is not the reality of my experience over three decades of doing this kind of work. But it does give you an opportunity to heighten the level of concern.

I was hearing from colleagues in the surrounding countries to China that their screening programs were detecting introduced cases. And it's very important to be able to assess whether what's being done at the source is sufficient to prevent exportation and to gear up what type of things could be done at the source to really contain something as close as possible with the source or even, you know, slow it with maximal impact.

But I was hearing from colleagues at -- both international colleagues as well as directly from CDC field colleagues in various countries that they were having -- they were detecting imported cases through the airport screening programs, and that allowed another path to

characterizing the nature of the illness and to understand that things were moving beyond the boundaries of Wuhan and Hubei province as they characterized the itinerary from which the cases are defined.

So we began to do that very early, as I said, prior to the end-of-January announcements that you're talking about.

Q I think we can take a look at an MMWR by one of your colleagues -- it's Exhibit 1 -- that goes into some of these details very briefly.

[Exhibit 1, marked for identification.]

A Is this the one that --

Q It's by --

A -- and others --

Q Dr. Patel and Dr. Jernigan.

A Dr. Patel and Dr. Jernigan, yeah.

So I definitely, you know, participated in providing information into this piece as a member of the response team. And it goes through a little bit of trying to crystallize the level of concern that we had.

Q Yes. It seems like your memory is actually pretty good that the enhanced screening started on January 17.

I wanted to turn your attention to the first paragraph on page 3, which is also page 142.

A Okay. The first -- the initiating paragraph on January 24?

Q Yeah. I guess we can start on the bottom. I want to ask you about as of February 1, 2020, and the numbers. Sort of -- it's in the middle of that cut-off paragraph.

A Right. "As of 1 February 2020, 3,000 persons on 437 flights were screened and then we referred these five symptomatic travelers."

Right?

Q Right.

Why do you think there was such a low number of positive cases detected from the screenings at that time?

A I think probably there was some combination. What ultimately we learned more in retrospect than what we knew clearly at this time was that this -- in contrast to the SARS 1 coronavirus and certainly in contrast to MERS, there was a high amount of contagiousness and infectiousness very early in the incubation period, and transmission was occurring from -- and I'm saying this with clarity in hindsight. Transmission could easily occur and was occurring from both presymptomatic and asymptomatic cases.

Our screening tools were really -- and our temperature checks and all those things were really focused on looking for febrile cases and people that had active symptoms. And that became very clear early on that we were -- that this program of entry screening that was focused on symptoms and fevers was not going to be very effective in dealing with

the asymptomatic or presymptomatic early infection, high viral load, high-risk cases. That probably was the major reason the yield was less than we expected.

We did a lot of screening, a tremendous amount of intensity of effort, and it just wasn't panning out the way it should have. That doesn't mean that doing it at the time wasn't something we should do, because, like I said, a lot of this information was gleaned in retrospect.

The other possibility -- there was a number of possibilities for why that screening is less efficient than it would be. Some of them include containment at the source, and we have seen that there were some very heavy control measures being put in place first in Wuhan lockdowns and then subsequently in lockdowns in Hubei province. So we're really thinking about that part is the most effective part at filtering.

But we were still seeing kind of volume stragglers, but they may not have been coming from areas where they were as exposed to that. That was another explanation.

It's possible that the things you're looking for are not consistently positive over the course of an incubation period from exposure to symptom onset if there are going to be symptoms. That is, there's sort of peaks and troughs.

It's also possible that people mask symptoms with 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

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

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

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

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

But it isn't like that, and the type of pathogens you're dealing with when people are contagious, if they get symptoms, if they get fever, all play a really important role in terms of how we can all be responsible.

Q I want to ask you given what CDC learned later and published its findings about importations from Europe, do you think that screenings should have been expanded to passengers from Europe at this time? Do you think that would have made a difference?

A I think -- look: The truth is this has been a rapidly inpatient evolving global pandemic with a pathogen that's got a high reproductive rate. It's highly contagious. It causes symptoms to move quickly.

The kinds of roles that we had talked about for airport screening, if you think about pandemic in sort of phases, almost like the Queen's Gambit story or a chess match, you've got an opening act when the pathogen is first emerging and the number of source countries involved could be very narrow, and you've got a lot of focus in that.

You've got a point in time at which many countries get involved and there's regional spread or even beyond regional, multi-regions of the globe are having active cases and epidemics. That's a long, long middle game while you have globalization but before you have full characterization of medical countermeasures, treatments, vaccines, all sorts

of things.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

five-minute break?

The Witness. Maybe a bathroom break would be great, and I'd be right back, if that's okay.

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

[Recess]

By [MINORITY COUNSEL].

Q My name is [Redacted]. I'm on the Republican staff of the Committee on Oversight Reform. I have a few questions for you.

You testified in the first hour that your title is the director of global migration and quarantine. How long have you held that position?

A I came to the division in '96 initially as a surveillance and epidemiology branch chief. I believe in 2000 I became the deputy director, and I don't remember the exact year that I became the director, maybe in 2003 or thereabouts. Roughly been in the role for about 20 years or just shy of that.

Q I think you might have said this before. Is part of that job -- does part of that job involve public health for migration, bringing migration into the United States?

A Part of the job involves the Part 34 regulations around medical screening for those applying for lawful permanent residence, and part of our public -- so on the regulatory side, and part of our job involves the public

health approaches to general migration-related issues.

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

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

A Not substantially, no.

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

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

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

A Very little direct involvement.

Q All right.

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

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

and risks should be done? I told the director, respectfully, I thought there were very important alternative public health measures. So that's -- I think that's what you're getting at.

Q So is that report, then, overstated? If you weren't involved in the drafting or execution, there wasn't a question of whether or not it was your final pen on the check box?

A No. I don't know how more clear I can be, because maybe I'm not sure exactly what you're saying.

It's not like we rewrote it. I wrote it with my team and we -- you know, I refused to sign it. First of all, these delegations of authorities include the director for these regulatory authorities as well as the CDC director as well as the DGMQ director.

But the specific ask about that public health tool that was posed that the director indicated that was what was wanted, the director and I, you know, had some conversations and it was decided that that tool and that use and that order would be drafted outside of my lane.

Q Would it have normally been drafted within your division?

A It might have been. Not necessarily, because, like I said, there's a lot of engagement and involvement around that. But -- and that was somewhat an unprecedented order

in its scope and magnitude and approach.

So it wouldn't necessarily have been directed by the CDC director -- I mean, the DGMQ director. In fact, there hasn't been anything quite like it in a long time, so I can't tell you what normative might have been for such a precedent.

Q Did you -- as part of working with Director Redfield, on that, did you travel to the border?

A I did not. This really was handled out of the director's office and with others, and I can't speak to various components.

[Minority Counsel]. Okay. I think that's all we have for this hour. Thank you.

[Minority Counsel]. I actually have a few.

By [MINORITY COUNSEL]:

Q You mentioned there you thought there were various alternatives to the order that you were discussing with my colleague, [Redacted].

What were some of those alternatives?

A As I indicated before, often border measures, hard core border closures, can be considered, you know, in appealing or a quick first reach, but often they don't really work as intended. And the things that are most needed in terms of the public health readiness are issues around cohorting -- you know, isolation, quarantine,

detection, various approaches to mitigation, engagements, use of masking and other types of tools.

And the public health tools that really need to be done that are shown to work and be more effective are not always the ones that people think of first, like sealing, you know, a border that's as long and in a country that's as large.

And those type of approaches have been used in some of those populations around the border in the past and when they're used are highly effective, and those other approaches really don't get at the root cause, and sometimes they create more public health downstream harm by the nature than they do good and -- whether that's in terms of procrastinating on the things that most urgently need to be done from a public health perspective.

That's been our experience for a while. So lots of other things have not been tried and were being recommended and had been recommended in past in similar settings. And that -- you know, that was my sense.

So there's a lot of known public health tools that work, you know, to mitigate some of the impact. And then one also needs to assess where the infection pressure is coming from and whether it's truly, you know, coming from the perceived source or an actual source of risk.

Q I guess I don't understand the distinction. So can you break it down? Like you support -- I guess maybe I

missed it in the last hour. Did you --

A Infection control, identifying cases through symptoms and cohorting groups where possible.

Q So you favor keeping travel going but having more robust screening? Is that what I'm understanding you to say?

A Some aspects of it are related to screening. Some aspects of it are really focusing on the risk, and some of the most important things are improving the basic hygiene circumstances that -- the -- the circumstances that promote transmission are really important to get at early on and to try to do, rather than having the impression that somehow you could actually prevent something from arriving through a border closure when that's less likely, and also looking at the relative balance of where is the infection pressure at the moment and so on.

And we've had very good success with a number of tools that really mitigate the pressure of transmission, and some of it's related to age groups and other kinds of things.

So I think that there are public health harms that also occur when some of the things that were, you know, being proposed.

Q Okay. So we stopped travel from China; correct? Do you remember when the president did that?

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

the end of January.

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

Do you agree with that or not?

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

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

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

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

Europe. In my recollection, Italy was experiencing a large amount of cases in the spring of 2020.

Would you or did you recommend stopping travel from Europe sooner than it was actually done?

A I want to be conscious about your term "banning travel." There weren't hard outright travel bans. There were selected population. There was still large amounts of returning travel from Europe even when the 212 proclamations were put into place, if that's what you're asking about.

And then, again, it's one thing to use a travel ban in January with a single focus of infection. The continuation of the use of travel bans as a tool once there's widespread, you know, infection in the U.S. starts to become diminished, and the shift in the approach of basically screening, assessment, isolation, quarantine, infection control, masking, basic hygiene circumstances becomes more paramount and more important from the perspective of preventing importation and spread.

So the tools we take out of a tool kit need to vary by what the nature of the geographic distribution and scope of the pandemic is. It's not always going to be appropriate and sometimes more harm than good will come out of trying to put into place travel bans, which also have collateral damage, including the movement of goods and services, control and preventing the pandemic, the supply chains, many

other things that come into play.

So every situation needs to be evaluated for the context of the dynamism of the pandemic.

Q Okay. So I want to just try to summarize really quickly. It sounds like, and is it fair to say, that you think that impediments to travel, we'll call them, should be based on -- should be timely and targeted to certain geographies based on where we're seeing the cases? Is that a fair summary? And it is a summary.

A I think there's a difference between border closures and travel bans in one category, and I don't know what you mean by the term "impediments to travel," like safe and healthy travel advice, testing, eliminating, isolation of people that are sick, those kinds of things.

I don't know whether you consider -- are you referring to those as impediments to travel? Because there's a real distinction between an outright border closure attempt and the level of collateral damage from a set of public health infection control measures that could be used to mitigate the impact of the transmission and spread.

So if you mean impediments to travel, all those things, that's sort of one approach, but if you're actually talking about border closures and travel bans, that's a different question.

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

back in -- so most things in America, I think we would agree, shut down around March 12, 13, in there.

What was your recommendation going back to that time, March 2020? What was your recommendation vis-a-vis travel, air travel from foreign countries? Was it based on geography and where infections were popping up?

A I think what happens is that the focus on broad border closure measures becomes much, much less effective, and the need to pivot to a set of community mitigation strategies becomes much more paramount in having an effect. Because if you think about it, once the virus is already here, the real risk is the amplification of our community spread more than what is contributed by introduced cases.

The volume of travel that was still coming into the country even under 212, you know, modified border permissions, which was limited to people who had been in a certain place within 14 days prior -- it wasn't an outright travel ban -- but certainly all of the vast -- a huge volume of that travel was ongoing.

But the pressure of expanding the pandemic in was much more intrinsically focused and needed to be dealt with the community mitigation plans that we developed in 2005, published with full interagency engagement in 2007, and those infection control practices needed to be the backbone in this real structure and that there was a certain amount

of false security that would come from focusing on the border closure aspect as opposed to what we needed to be doing domestically to get into mitigation.

Q So, then, is it fair to say that you don't support travel bans at all, ever?

A I don't think I said that. I think I was very clear that there's an opening act and a place where there's some uncertainty, where if we have no cases and there's a single nidus of infection, we're figuring out how to manage that volume through a whole variety of things, limited on the volume but also, you know, screening efforts and awareness.

But, you know, three months into that process in a different point in the pandemic with a different status of the epidemic in the United States actually demands an ability to pivot the focus and the intensity and the concentration of the resources around control, mitigation, rather than this idea that it would be contained and you would stop the cases, because we already had a large number of U.S. cases at that point.

And then you have to look at what are the collateral public health consequences of the border closures and how might they make the situation worse, both globally and domestically, by where the various, you know, people would be going, the relocation process of introducing new virus

earlier into limited and constrained resource settings and great vulnerability.

So there is not one really simple sound bite that is a perfect fit for all those circumstances.

Q Did you agree with any of the border closures or travel bans that resulted from this ongoing pandemic?

A I'm not sure there was another border closure. I'm not sure which border closure you're speaking of other than --

Q Well, let me go back to my question about Dr. Fauci. Can you just give me a yes or no to that: Did you agree or disagree with Dr. Fauci's statement that he thought that closing off travel from China saved lives?

A In the opening days where the epidemic was intensely concentrated in a particular city, I think that taking measures to stem, most importantly, the exit and then consequently the other things that we could do on entry around leakage, was very important in both buying time and saving some lives in that earliest phase where we didn't know so much about the virus.

I think by March of 2020, we had a lot more understanding of the global distribution of the virus, the intensity of the spread, and the pivot away from geographically-based border closures. Like I said, 212 Act was not a border closure, unlike the Title 42 specific

aspects were.

The other things that need to be done and need to be front and center and foremost in terms of the protection of all the populations in the U.S. need to be pivoted away from border closure.

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

I do agree with the comment that Dr. Fauci made as they were appropriate to the context and the situation in early January. I think the situation was very different by March.

Q So we acted too slowly? Did we act too slowly in the early days? Should we have banned travel from China earlier?

A Well, I don't know that we knew the situation. I mean, I think things moved very quickly once data was being uncovered. I can't really speak to the specifics of that timing.

Q Let's move on.

A This was unfolding in a -- you know, the situation in January was very different from the situation in March in so many ways.

Q Okay. So you said -- testified earlier that you came back early from vacation back to work at the CDC. Would that have been January of 2020?

A Yeah. I think I was back, you know, engaging by January 4.

Q Were you coming to the office every day?
A Yes.
Q Do you think it's important that CDC personnel come to the office during public health emergencies?
A Do you mean as a blanket statement, or do you mean on January 4 of 2020?
Q Well, January -- I mean, we were in a public health emergency; would you agree?
A The declaration of public health emergency came later. There was a lot unknown, and in January 4 it was important for me and my team to be able to convene and clarify and get as much information to characterize the risk, the nature of the threat, the speed and mode of transmission. So that necessitated -- necessitated us being on site.
Q And you and your team were on site in January of 2020?
A Yeah, and except for the team -- I mean, I had a large footprint of people that also work at the airports around the country and some regional international folks. Those people were at their duty stations.
Q Okay. And did you think that that was -- that was prudent to have your team on site?
A In January of 2020, the people that were doing the job that needed to be done were at the duty stations where

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

Q Was that in the emergency response center? And we won't talk about where it is, Kevin.

Were you at the emergency response center at CDC? -- which we don't know where that is.

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

Mr. Barstow. We'd ask that be struck and ask that be redacted from the transcript. I think we've said the location multiple times in these forums, actually.

By [MINORITY COUNSEL]:

Q Were you working out of the emergency response center?

A In January of 2020, and except for the people that were working in their duty stations in the field were working out of the emergency response center deployed out of their -- that's where we were.

Q Thank you.

Doctor; is that correct?

A That is correct.

Q Do you consider yourself a virologist or no?

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

Q Do you have any opinions that you want to share with us on the origins of the virus?

A Outside of my expertise, really, to comment.

Q That's what I thought you might say.

You commented on the reduction in CDC China staff earlier. You just noted that there was a reduction.

Do you have any understanding of why there was a reduction?

A I do not.

Q Okay. During the prior pandemics that you've worked on, do you recall recommending any travel-related measures?

A Travel-related measures like --

Q SARS or MERS or H1N1? I don't know -- was H1N1 a pandemic? I'm not sure.

A That's 2009. Yes.

So I think that maybe I need to understand better what you mean by "travel-related measures."

When I mentioned at the opening that our travelers help branch provides guidance for American citizens traveling internationally or American citizens living abroad based on their assessment of the infectious disease health risks and scalable, sometimes it would be no recommendations and guidance about it, sometimes it would be at a level 1, sometimes at a level 4. Sometimes it would be focused on specific populations.

For example, in Zika, there was a focus on recommendations for how to stay healthy if you were traveling during, if you were a pregnant woman is one

example. And all of those things.

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

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

A None.

Q So it's just completely extraordinary?

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

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

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

and analyzing the details of data. This has truly been an unprecedented event for over 100 years.

[Minority Counsel]. Okay.

I don't have any other questions.

[Redacted], do you?

[Minority Counsel]. I've got one or two clarifying ones.

By [MINORITY COUNSEL]:

Q So just to be clear, I asked you if you ever traveled to the southern border during the scope of this interview, and you said no; correct?

A I don't know if you asked if I had ever traveled at any time to the southern border. I think you asked if I traveled to the southern border as a part of this pandemic response. Is that --

Q Yes. Whatever the scope is today, December 2019 to whatever.

So no, you've never traveled for this pandemic?

A That is correct. I did not go to the border directly. I have a -- you know, that's correct.

Q Did anyone from DGMQ go to the border during the pandemic?

A Yes. I have a U.S.-Mexico unit office that's based out of San Diego, and there are staff, you know, in our quarantine station at Texas, and there are folks from my

team in Atlanta that visited the border periodically during the pandemic --

Q Did anyone --

A -- at headquarters.

Q Did -- was one of the purposes to examine the practicality of Title 42 expulsion?

A We traveled there before the Title 42 conversations, and, in fact, before the pandemic started in terms of recommendations to mitigate the impacts of other migration experiences on the border and the risk of infectious disease outbreaks and have made recommendations on these infection control approaches in the past.

Q Was there any memo or report generated based on those travels through the pandemic specific to Title 42?

A Specific to Title 42. I don't recall. I mean, we traveled at the request of the -- the team traveled at the request of the CDC director to assess the kinds of recommendations that we have been made -- making for border facilities for many, many months in terms of infection control changes and ability to use traditional public health measures. And those -- that advice was provided back to the CDC director internally.

Q Dr. Anne Schuchat, the former deputy director of the CDC, testified that it was your view in March 2020 that "the facts on the ground didn't call for this from a public

health perspective."

Do you think that was characterized accurately?

A Did you say my view or her view?

Q Your view.

A My view -- that does characterize my view, which is that there were a number of things that were more important -- just as I talk about the pivot, there are much more important things that needed to be done that we had been, you know, talking about that were going to be critical regardless.

And that the collateral public health damage that might occur through the approach that was being -- at least as it was being explained to me from the CDC director, potentially could do more harm than good.

And it was important to not be distracted by some of the views with which that concept would come across without realizing what the failure to address the infection control situation might ultimately create.

So that was my view.

Q Did you -- how did you communicate those facts to the CDC director? Did you just call Dr. Redfield and have a meeting with Dr. Redfield? Did it escalate to Secretary Azar? Did it escalate to the White House?

A Yeah. I mean, I don't want to speak to specific deliberations or, you know, there was an -- what's now, but

my views were communicated internally when asked.

Q Dr. Schuchat continued that you thought Title 42 was being initiated for "other purposes."

Could you expound on what those other purposes were, in your mind?

A I don't know specifically what all the other purposes were. My concerns were that the proportionality and the approach of using a public health authority at a time when we have a lot of intrinsic disease in the U.S. and the reported threat that was being, quote/unquote, addressed to prevent importation in that approach was not consistent, and it potentially risked the misuse of a public health authority that was not going to actually control or be used in place of the public health tools that we knew were important to do.

And, you know, pandemics can be difficult times, and, you know, sometimes the epidemic of disease can be followed by an epidemic -- an inappropriate epidemic of stigma and misrepresentation of where the problem is.

And we had the problem to be addressed internally that was very important and that needed to be specifically handled over the perception that a border closure at that time when we had so much disease was actually going to, you know, solve the problem and would not actually create other problems that were consequential.

Q So it was reported that Stephen Miller at the time, who was a senior advisor to President Trump, was pushing for Title 42 on March 17, 2022. A month ago, former CDC director Robert Redfield testified to us under oath that he's not aware of any involvement by Mr. Miller in Title 42.

Did you have any communications with Stephen Miller regarding Title 42?

A I was on phone calls in which he was speaking.

Q Okay. Specific to Title 42?

A I'm not going to discuss the content of the internal deliberations.

Q Okay. Current DHS secretary Alejandro Mayorkas said about Title 42, "We're doing this to identify a public health need, not an immigration policy."

Do you disagree?

Mr. Barstow. It's outside the scope of the interview, [Redacted].

By [MINORITY COUNSEL].

Q I'll say it.

If we're doing Title 42 out of a public health and not an immigration policy, do you agree with me?

A What? I don't understand what you just asked.

Mr. Barstow. If you want to ask about during the time period from December 1, 2019, through January 20, 2021, about the use of Title 42, you may do so.

But you can answer the question.

By [MINORITY COUNSEL].

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

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

By [MINORITY COUNSEL].

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

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

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

By [MINORITY COUNSEL].

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

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

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

By [MINORITY COUNSEL]:

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

employ social distancing in congregate settings.

From a public health perspective, does COVID-19 transmit indoor in non-socially-distanced or congregate settings?

A I didn't catch the opening piece. You're asking me the general question, is COVID-19 -- is the risk of transmission in congregate settings greater than in noncongregate settings --

Q Yes.

A -- that have cohorting and social distancing?

Q Yes.

A Yes, especially unmitigated, but are there ways to mitigate, and CDC has made recommendations on mitigating risks in various settings.

Q That brief also asserts that DHS lacks sufficient capacity to safely hold and process all individuals seeking to enter the United States during the global pandemic.

If the U.S. government were restricted in its ability to implement the CDC order, again, from a public health perspective -- not commenting on Title 42 itself -- does COVID-19 transmit more to individuals in any congregate setting for a longer period of time than they have for mitigation?

A When you say "that brief," what are you referring to? You opened it by saying "that brief." I don't know what brief you're talking about.

Q There was a brief submitted by Biden administration on August 2, 2021, to a federal court defending the use of Title 42.

A Now what's your question? Does COVID-19 transmit in congregate settings more easily if unmitigated? The answer is yes.

Q Okay.

The same brief says "DHS would effectively need to release a growing number of families in the border communities, which risks overwhelming the local testing, isolation, and quarantine infrastructure DHS has worked to create and will thus burden local healthcare systems and strain healthcare resources."

Is straining healthcare resources and overwhelming hospitals a public health concern with COVID-19?

A COVID-19 has shown us the potential to strain healthcare resources, and in the settings in which that has occurred have been -- as I indicated before, have been due to the COVID transmission that's already occurring inside our borders and communities in that regard. And those circumstances, you know, are important to mitigate, as CDC has recommended.

Q So you agree with all three assertions from the Biden administration's brief that Title 42, in fact, had public health benefits?

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

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

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

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

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

Mr. Barstow. Outside the scope of the interview,

[Redacted].

Q Again, on September 17, 2021, for the fourth time the Biden administration filed another appeal on a motion to stay a lower court order to keep Title 42 in place.

Were you involved in drafting or advising that order at all?

Mr. Barstow. That's outside the scope.

Q On October 21, 2021, the Biden administration filed another legal brief in federal appeals court arguing that the court should keep Title 42 order in place.

Were you involved in that at all?

Mr. Barstow. That is also outside the scope.

Q On November 29, 2021, the Biden administration filed another brief in federal appeals court arguing the Court should keep Title 42 in place. Were you involved in that?

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

Q On January 19, 2022, the Biden administration sent government attorneys to argue in front of the Federal Appeals Court that the court should keep Title 42 in place.

Were you involved in that at all?

Mr. Barstow. That's outside the scope.

Q So when the Trump administration put Title 42 in place, you said you voiced your displeasure with CDC

director Redfield. The Biden administration has been in court for 15 months arguing Title 42 should stay in place.

Did you voice your displeasure?

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

Q Do you continue to disagree that -- or do you continue to -- is it your continued stance that Title 42 is not a public health measure?

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

Q Dr. Cetron, if HHS counsel was not objecting to all these questions, would you be willing to voluntarily answer them?

A The supposition doesn't apply.

Q Minority party didn't agree to the scope of these interviews. I'm asking if we were to call an interview with a different scope, would you be willing to answer the questions that I'm asking you?

A I don't know. It depends on the questions.

Q I just asked them.

A I can't answer that at this time.

[Minority Counsel]. Okay. Thank you. That's all we have.

[Majority Counsel]. I think we can take a five-minute break and start back up at 11:05.

[Recess]

[Majority Counsel]. Back on the record.

By [MAJORITY COUNSEL]:

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

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

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

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

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

infectious or in order to follow proactively infectious cases through an incubation period after arrival so that information can be rapidly acted on by public health officials and used to mitigate around cases -- you know, the case finding, the contact notifications, the isolation of a case, the implementation of mitigation strategies, quarantine household contacts and so on.

And you need to do that quickly before the generation times pass and a disease like SARS-CoV-2, which has a high reproductive rate, every generation that goes by that you can't effectively contact trace is missed opportunities for a rapidly amplifying spread.

And those data are not -- as I said, it needs to be timely, accurate, complete, and, you know, readily available. It's not something that you have to go back and forth and extract and it comes two weeks later when, you know, it gets out -- the horse is out of the barn.

Q Was this something you were pushing for at that time, additional data?

A Prior.

Q Prior. Okay.

A Beginning of January, I began raising this and just said, you know, looking at the potential volume, we really need you to get this in place. I don't remember the specific dates, but we had -- I had found the struggle to be

problematic in prior epidemics.

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

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

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

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

characteristics of this virus, that type of system would not -- would not work.

So in -- I forget the specific days in January, we had an interim final rule on the contact data fields and had issued an order to airlines identifying the data requirements.

Q And did you get that data from the airlines that you requested?

A We asked for it before the regulatory process could keep up. It was a struggle. The quality of information wasn't where it needed to be in terms of complete, accurate, and timely and in a digital format, and we continued to try to close the gap on those things.

Q Did you get it? I'm asking specifically about sort of the basic contact information -- cell phone, address --

A So the basic steps -- there are a number of data elements that are collected by DHS and others in the system, but the information that's needed to do the job of public health contact tracing included these additional data elements. That's the only way to actually do that.

It has to be up to date, timely, accurate, and complete and move digitally in order to move at the speed of the pandemic, and we weren't getting -- you know, we weren't getting those kind of things. And we kept pushing on them. They involved systemwide kinds of changes in order to do

that.

Q Two follow-ups. Who were you pushing? And what were you told about why you weren't getting it?

A I think we were making the plea in general. I was having meetings with airlines in general about the need and why and how and the processes that they required to get -- you know, the regulatory processes that they required to go to work. We were trying to move through on the regulatory processes as well. Ultimately, we got these emergency orders, and then the systems would come into place and then we would evaluate the quality of the information.

But, you know, all the different obstacles that would come up, the pressure points that we would use to try to make sure all these different pieces could get rolling logistically, regulatory, operationally, et cetera, et cetera.

I think the speed and urgency of this issue had been identified. We had directions from many prior events. It just really -- we really wanted it to be moving, moving very fast with great intent.

Q It seems like certain agencies like DHS, FAA have that data. And -- is that accurate?

A I think there's a distinction. There are data that are available in AFIS and other systems and there's some data that are available in airlines, such as frequent flyer

systems.

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

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

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

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

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

an emergency sometimes isn't enough to close the gap. And this has been a frustration and a problem from my perspective on the readiness side for a while.

Q Did your request for that data have the support of the White House?

A I don't recall all the specifics about where the support or where the barriers were on that. I think it was -- it ended up being a bigger and harder problem to solve, but most people who were involved at the moment appreciated it.

And having the continuity of three decades of public health experience around this issue and then reeducating it every time there's an administration change about the urgency of that is difficult. I'm not --

Yeah. And then obviously there are privacy issues that come up around it and who is going to have access to the data and how it's going to be protected and how do we make sure it's used only for the intended purposes.

So a lot of that stuff turns over anew in every sitting, whether it's departments and agencies or whether it's, you know, administrations, you know, at the White House level. But these are hard problems to solve. They're important problems to solve.

And we need to not go through these cycles about looking at the same problems over and over again in the middle of a

crisis, but just have a commitment that is part of readiness and a response that would solve these sort of basic public health gaps.

Q I want to --

A The arguments are familiar that you mentioned, and they happen often. We need to solve them.

Q I want to take us forward into February and the decision-making that led to further proclamations and restrictions and focus our attention on Europe.

So maybe you can take us to February and just generally walk us through what you were working on as it relates to travel from Europe.

A Yeah. Well, the epicenters of the pandemic were shifting, certainly, by February, and more of what we were learning was being uncovered. And the ability to engage and deal with a variety of the issues as the epicenter was shifting became more challenging than sort of the single notice -- single locus and issues around the emergency in Wuhan and Hubei province in China.

And whether it was putting up travel advisories, that is, the outbound recommendations, or getting the screening issues expanded or the 212F proclamations, as you were mentioning, on the expanding geographic scope and the utility on how that would work as opposed to other kinds of tools -- all of that became -- you know, the volume became a

bigger deal.

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

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

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

Q The 212F proclamation that came later in March.

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

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

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

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

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

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

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

antivirals, vaccines, diagnostics, et cetera.

And the third is you wanted the total area under that curve to be lower in sort of a more manageable way while you understood risk factors, who was at risk, while you focused on mitigation.

The key part is that you had to intervene early, because once things begin an exponential escalation, that phase, you had to be there at that inflection point when things were starting to escalate, because they would move fast with a high reproductive rate. They were going to grow exponentially, not linearly, and you could quickly overwhelm.

So the kinds of things that had to be done had to be done in advance, I would say in some ways earlier than most people would think is necessary, and they had to be sustained for slightly longer than most people thought they could handle. So it wasn't just about getting to the peak and at the first downturn you could lift those measures, but they had to be modulated and pulsed.

That started early. Later there's multiple strategies that I have described in a Swiss cheese-like model, that any one layer was going to have some holes in it, but combined multiple mitigation strategies would be more robust and more protective, and they had to be sustained for periods of time in the pulse until you were in a comfortable place.

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

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

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

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

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

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

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

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

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

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

details of the dates and stuff, but --

Q Sure. Let's look at them. I think they're Exhibits 2, 3, and 4. 2, 3, and 4 --

A There were meetings that were occurring in February as well while the HHS was still chairing the task force, and then there were meetings that were occurring when the task force -- we switched over from the HHS secretary to the White House directly.

And we were at the table. CDC was at the table and presenting sort of the forecasting of the significance of the potential severity of this virus and its characteristics in particular.

Q And looking at these agendas -- and you might not recall them specifically -- but Italy was on the agenda, the screening update from Italy. You and Dr. Cetron [sic] were briefing the task force.

I'm wondering if you can characterize how your presentation of these concepts that you've been talking about was received at that point.

A I think you mean Dr. Jernigan and I. If I'm correct in this, I think he was the incident manager of -- the incident lead of the response structure, and a lot of these components were in my area of expertise. And so Dan and I were presenting kind of regularly at some of these meetings.

And I described basically, you know, as I'm saying in terms of the general content was that this is significant. Both Dr. Jernigan and -- he had been an NIH officer of mine many, many years ago in respiratory diseases. He had a lot of experience as well, and we could both see the writing on the wall here.

There were a lot of red flags, and we were trying to, you know, demonstrate the trajectory of the case occurrence as they were being defined globally. And in particular Dr. Jernigan asked what the domestic situation was looking like.

I would be asked to describe some of the travel issues and volume and the potential for, you know, what was being missed in the screening modes and how -- what was the importance of getting things ready for these waves that we had seen. It was pretty devastating, the other places where they had occurred.

So I guess I would say that CDC had a much greater level of concern about what this -- how this pandemic would unfold. That's what we were -- that's what we were asked to express and brief on.

Q And generally what was the reaction from meetings like this, the White House task force?

A It varied, to be honest, depending on different perspectives. We were offering a science-based public

health perspective. Others were offering, you know, different perspectives and process.

Q Dr. Schuchat said that the CDC has been pushing for this restriction from the Schengen countries and it had been delayed for a period of time.

Is that accurate?

A That is fair.

Q Okay. Can you talk about that delay and what caused that delay?

A In general, it just was all the other parallel factors of concerns regarding the connectivity, impact, you know, on things other than the public health impact. Just the general -- you know, sort of the general tone.

And as I said, you know, this concept of multilayered strategies and tools. We needed a multiple approach in here. It wasn't that the point was to rely exclusively on a 212F, which seemed to be one of the things the administration had seemed to value in that regard, but also to ready the domestic situation for, you know, preparing to be able to implement mitigation strategies that had been in the response plan and the seriousness of what we would likely be anticipating in a very short period of time.

So, again, there was just this general overall concern that maybe public health was overplaying the concerns and the significance and that there were all these other factors

that need to be brought to bear. I think that was the general.

Q Who was expressing that, without getting into specific conversations?

A No, no. I'm just trying to give you a flavor. I'm not going to go down the "who said what, when, and where" and stuff like that.

Q Okay.

A These were internal deliberations. I'm trying to give you a sense of where the balance of thinking was about this.

Q Sure. Understood.

Our colleagues mentioned that part of our interview with Director Redfield, and he described you as being extremely frustrated during this period. I can review what he said.

"One of the areas that was particularly frustrating was the area you're bringing up about escalating the order of travel. At the time, CDC felt that travel alerts should be alerted. So if you ever bring in Marty Cetron -- I don't know if he's one of the people he interviewed -- I'm sure he'll go into this in enormous detail, because he was extremely frustrated."

Tell us your frustrations.

A Okay. I think Dr. Redfield's sentiment accurately describes my frustrations. Things weren't being taken

seriously enough. They weren't moving quickly enough. It was being underplayed and perhaps at a risk of what I -- and not I alone, but I and others at CDC were seeing as the inevitable consequences of delay.

I had been one to study this in detail in the lead-up to the U.S. response plan in 2005 to 2007. I had seen what happens when there are delays in implementing multiple measures at an appropriate time, how quickly things can get overwhelming, and I had done a lot of analytic work on the toll of the delays and the shape of the way the epidemic would occur.

I've seen the comparisons between Philadelphia and St. Louis, and I knew that you could flatten the curve. I knew you could mitigate the impact. I knew you could alleviate the strain on healthcare systems. I knew you could save lives.

And I just didn't feel like -- I just didn't feel like there was enough listening going on. So it was very frustrating, and that's a fair -- his comments are a fair characterization.

It required bold responses earlier than might be tolerable, and I know that those responses wouldn't be easy and would have some of their own consequences to weigh, but it felt clear to me that the failure to act in a timely way could really be significant for the country.

Q And I think you just articulated this, but it's been said and we've heard from witnesses that this period in February was a lost month where things should have been done that weren't.

Would you agree with that assessment as well?

A More should have and could have been done, and the CDC was really, really pushing for more. It would have -- I think it would have helped significantly alleviate a lot of -- a lot more suffering and death.

Q I want to change gears and talk briefly about messaging to the public. And you, along with other leaders, participated in telebriefings, providing updates to the public. I think you spoke January 17, January 21, January 24, and January 31 in telebriefings with others.

Can you talk about those communications in the general sense and the importance of that.

A Well, I can say that having also having been part of a lot of epidemic and other pandemic responses, the technical expertise is necessary; that is, the CDC technical expertise is necessary but insufficient.

And communication is a huge part of it. And a big part of the communication has to be about public trust and that in settings where -- even where there was technical expertise, if there was for whatever reason -- and those reasons vary across the globe and, you know, on rationale,

but where there's a bankruptcy of public trust or a bankruptcy of trust in the various institutions that are involved, you can't get -- you can't get an effective public health response when there's not a lot of trust.

And that trust comes from timely, honest, transparent, regular, repetitive communication, including honest uncertainties about what's ahead, what you know, what you don't know, what you're doing to fill in the gaps, when we'll come back and tell you more.

And that has been sort of a mantra training process for all CDC leaders who are involved in public communication. And I think it's very much true today. And there are many factors that are involved that erode trust. But it is so important to getting effective response to a public health crisis in an emergency.

It's absolutely critical. Even the best technical solutions and technical agencies or plans or know-hows will crumble under the lack of effective communication and trustability.

Q Was that mantra followed in moving forward past January and February?

A I think it - there was a lot left to be desired.

Q Why?

A You know, one of the things -- there were so many factors and reasons in why this all evolved the way it did.

But a lot of the way in which CDC would normally be regularly out there communicating, whether it's the CDC director or the senior leaders who are involved in the response, you know, shifted between probably when Dr. Messonnier and I were no longer doing those briefings. There was sort of a shift in the level of the briefings occurring in different settings and spaces.

So I don't know. Again, there's probably a lot of reasons. But there was -- that was somewhat atypical from the way CDC responses had previously been done, whether it was the Ebola response or other kinds of things.

Q Can you describe that shift and what it meant in terms of public health?

A I think there was a de-emphasizing of communication from CDC directly, and more of the communication around the pandemic was coming, you know, outside the realm of public health officials or the government communication was occurring in different settings.

Not that it's not appropriate for there to be whole of government communication, but there was not the level of communication that CDC would normally participate in as a component of overall communication. That's my sense, but that's -- again, there are many factors.

Q What about the -- do you have a view on the quality of the communications coming from those other places?

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

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

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

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

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

Q Sure. And I won't get into specifics, but I want to ask you about the impact, and you mentioned this bankruptcy of trust. How did those communications contribute to that idea?

A Well, information -- misinformation or information that's not factually accurate really erodes that, because if there is disinformation, misinformation, whether by intent or by accident that is not true, people wonder, you know, if anything that is being said is true.

So -- or if it's, you know, contrary to what people can see in their own lives or out their door and it doesn't jibe, it erodes the credibility of the government's response, and it calls into question all sorts of things. It calls into question motives and all sorts of other stuff.

And it's just not a time where those things should be -- it's a time where that kind of trust building and communication integrity is so important in order for people to be well informed, in order for people to be able to take the right steps, in order for people to anticipate what the impact on their lives will be.

So it's -- it was very difficult.

Q What was the public health impact of sort of those failures, as you articulated them?

A I think a lot of confusion is one of them. A lot of uncertainty, a lot of questioning sources of authority, a

lot of questioning what's true and what's counterfactual, you know. Calling into question the kinds of measures that might be needed and in what ways.

And that kind of, you know, inability to grasp the circumstances you're in and take the right steps and protect yourself and your family, protect the most vulnerable people in your communities.

All of that gets thrown into confusion and chaos, and it becomes really difficult. And that void gets filled by a whole variety of folks that are talking with various degrees of expertise, of various degrees of agendas or intent that may be different from the Public Health Service concept. And so it just becomes really, really hard.

And a lot of, you know, false narratives get created, a lot of excessive blame and stigma. All of those kind of things are consequences of the failure both to build trust and accurate, timely, and credible information delivery.

Q Do you think that the president adding to that confusion contributed to those problems, as you articulated them?

A I'll leave it to you and others to judge.

Q Given your expertise -- and I know you've done extensive work on looking at nonpharmaceutical interventions in the past -- do you think communications around those measures would have changed what we saw transpire over this

year?

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

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

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

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

I think proper communication on the why and the how and the impact of those things could have had a tremendous difference in mitigating the pandemic. While we awaited some of our most powerful tools, which have been the vaccines and more recently the antivirals, but also acknowledging that the toolkit has got to be mixed, and it takes a while to develop immunity and the virus is -- you know, while we may be sick and tired of the virus, at times the virus was not tired of making us sick.

And in that setting, the virus is mutating and changing, and it may render some of our medical countermeasures less effective than others, although by and large they are really powerful. They are super important.

But I think that the failure to appreciate the seriousness of the threat and the intensity of the virus's capacity to constantly throw us curveballs kind of undermines our ability to reduce suffering and save lots and lots of lives.

Q I'll close with this: Given your expertise in this area and the research that you've done on these measures, do you think consistent messaging on nonpharmaceutical interventions -- what do you think the difference would have been in terms of the impact that we saw from the virus in the first year?

A Yeah. I think honest and accurate messaging about

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

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

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

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

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

us that would have benefited from that kind of very clear messaging.

Q One last question in this area, and it's, you know, you mentioned the times that you were out there in telebriefings in January. We didn't really hear from you that much after that. It was reported in CNN that CDC officials said they had been muzzled and that their agency's efforts to coordinate -- to mount a coordinated response were hamstrung by the White House.

You're a subject matter expert. You were out there in front of the public. Did you feel muzzled?

A It was clear -- there was clearly a change in February in terms of how the communication would go. That's all -- that's all I can say. I mean, I think it was unfortunate change in -- not saying that it should have been all one way or all another way or whether it should have been me or other folks from the agency, but I don't think CDC was able to effectively communicate its messaging, as had been sort of the more normal approach to responding to public health crises, and I think that ultimately undermined an effective response. It's not about me.

[Majority Counsel]. I want to move forward to talk about -- well, actually, rather than opening another huge topic, I will cede my time to my colleagues, but ask you if you want a five-minute break.

Mr. Barstow. [Redacted], it depends how long you're going to go here. If you know.

[Minority Counsel]. I think we probably just have a few minutes. Are you ready, Dr. Cetron?

By [MINORITY COUNSEL]:

Q So my colleague [Redacted] asked you some questions about CDC telebriefings. Do you know how many were given under the Trump administration?

A I don't. Do you mean how many CDC telebriefings? No, I don't.

Q So it was 27 over the 12 months, January to -- 11 months, January to December.

Do you know how many were given during the Biden administration?

A I don't.

Q Six over 17 months.

You said the Trump administration messaging left a lot to be desired. There were 21 more CDC telebriefings. Does your statement apply to the Biden administration as well?

Mr. Barstow. Outside the scope of the interview, [Redacted].

Q You were also talking about disinformation and how it "erodes credibility in the CDC."

President Biden said, "If you're vaccinated, you're not going to be hospitalized, you're not going to be in the ICU

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

Dr. Cetron, have vaccinated Americans been hospitalized for COVID-19?

A Yes. Certainly different proportions, significantly different proportions.

Q Okay. Have vaccinated Americans been in the ICU for COVID-19?

A Yes, I believe so.

Q Have vaccinated Americans died from COVID-19?

[Majority Counsel]. Just one quick point. The vaccines were rolled out in January of 2021.

[Minority Counsel]. [Redacted], I don't think it's your time. And we've objected to many majority questions before, and you won't entertain our objections, so I won't entertain yours.

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

[Minority Counsel]. You said July 2, 2021. But I'm asking health-oriented questions, not specific to that statement.

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

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

Q So I read you President Biden's statement. I want to ask you three yes-or-no questions.

Have vaccinated Americans been hospitalized with COVID-19?

A So --
Q The question is a yes-or-no question.
A What do you mean by vaccinated? A single dose or fully vaccinated or boosted. What do you mean by the term "vaccinated"?
Q Fully vaccinated. People who were fully vaccinated by the time the statement was made.
A Have there been people who are fully vaccinated that have been hospitalized?
Q Yes, correct.
A Not all fully vaccinated people respond.
Q Have there been fully vaccinated people who have been in the ICU unit for COVID-19?
A Probably with the same caveats, many fewer, but not everybody is responding the same way to the vaccine based on --
Q And have many vaccinated people died from COVID-19?
A Again, with the same caveats, depending on their ability to mount a response or be protected by vaccine and whether they have been boosted and how long it's been.
Q So, generally speaking, if I say if you're vaccinated, you're not going to be hospitalized, you're not going to be in the ICU, and you're not going to die, is that a true statement?
Mr. Barstow. [Redacted], you're trying to take that

into the presidency and a lot of the context. We've allowed some questions here, but I'm going to instruct you not to answer the question.

Q Okay. President Biden also said the vaccines "cover the highly transmissible delta variant" and "you're not going to get COVID if you have these vaccinations."

Have people caught COVID while being vaccinated?

Mr. Barstow. That's outside the scope. We've allowed some questions in this phase. I don't think we're going to get any further.

[Minority Counsel]. How is it outside the scope? COVID has been around since October, November of 2019.

Q So I'll ask you this question: The first vaccine rolled out in, what, early December of 2020?

Have people caught the virus between December 2020 and January 20, 2021, that were vaccinated?

A The question you're asking really has to do with what the purpose of the vaccine has been, and the purpose --

Q No, that's not what I'm asking. I'm asking if a vaccinated person can catch COVID-19.

A But the vaccines -- the purpose --

Q It doesn't matter --

A -- is not whether you're infected or not. It's designed to attenuate the severity of the infection, and this is an example where nuanced messaging matters.

So the vaccinations, being fully vaccinated and boosted are some of the best protection possible to avert severe disease, hospitalization, ICU admission, and death, point blank, and all the data support that.

It does not actually say that everyone and anyone who gets a vaccine won't catch COVID. That's not the way that it's worked.

Q Okay. You said nuance matters. So if I say that you're not going to be hospitalized, you're not going to go into the ICU, and you're not going to die, that's not very nuanced.

A What I'm saying is the end point of the vaccination depends on who's being vaccinated, how much vaccine has given since, the time since the last dose.

The point of the message is will the vaccine make a significant impact on what events as they emerge, whether they will circumvent some of the protection of the vaccine. That is nuanced. So, again, I thought I was very clear about the word on consistency of messaging. It's not about consistency; it's about being able to clearly explain what we know and what we learn as we learn it and not always saying the same thing that applies at every state when the new variant emerges and it escapes some of the effect of the vaccine or an elderly person doesn't respond or someone on cancer chemotherapy whose immune system is damaged by both

disease and treatment, you're not going to get the same response.

But the point of the message is will the vaccine make a significant difference on the proportion of people that are hospitalized, that die of COVID. There is no doubt that that's a true statement. Could that be messaged more clearly and can that occur in the proper setting? Absolutely. But it's not about perfect consistency and simplicity; it's about the accuracy of the message. And it matters.

And the truth about the power of the vaccine to change the shape and the trajectory of the pandemic are quite important. But it depends on how many doses, how they're used, in what populations, who's being exposed and who's not, and what variant is emerging.

That's the honest truth, [Redacted]. That's the way it works.

Q And I'm not disputing any of it.

A It feels like a little bit of a "gotcha" game here, and I think it's a big --

Q Dr. Cetron, I'm not disputing any of what you just said. I'm just saying you were asked in the last hour about disinformation. You were asked about consistency of messaging --

A I think there's a difference between disinformation

and --

Q It's wrong information. It doesn't matter if you disagree with it.

A No, there is a difference. There's a difference in whether it's about intent, about how off it is. Variations around the predominance of truth and acknowledged certain amount of uncertainty of variants is one thing than offering up a counterfactual.

Those are different types of disinformation. One may be done innocently, and it may be done by intent. Those are different types of disinformation. They are not all the same thing.

And I was speaking in general that things that are -- where the counterfactual is portrayed as equivalent to the facts themselves, not these minor variants, that matters. When people can equally believe a complete counterfactual rather than understanding that this is true in the majority of times with 5 percent uncertainty is not the same as saying that this is completely counterfactual to everything we know. Those are not equivalent.

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

Q All right. Then I'm going to ask these again and you can just give me yes or no.

If I say if you're fully vaccinated you will not be hospitalized, am I lying?

Mr. Barstow. [Redacted], he already answered these questions. He's not going to answer them again.

The Witness. I'm not going to keep playing.

[Minority Counsel]. We have no more questions then, thank you.

[Majority Counsel]. Dr. Cetron, I wanted to check in with you if you wanted to take a break or if you wanted to keep going.

The Witness. Yes. Is this the break we take for lunch, or is this a five-minute break?

[Majority Counsel]. It can be either. If you discuss with Kevin what your preference would be, we'll decide amongst ourselves as well.

[Discussion held off the record.]

Mr. Barstow. I think a longer break now would be good and then we can power through.

[Majority Counsel]. That's fine with me.

Mr. Barstow. 12:35?

[Majority Counsel]. Is that okay with you, [Redacted]?

[Minority Counsel]. Yes.

[Majority Counsel]. We'll be back on the record at 12:35.

[Recess]

By [MAJORITY COUNSEL]:

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

understand the circumstances.

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

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

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

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

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

populations.

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

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

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

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

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

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

A It was -- well, so there's a lot that we were trying to understand. One is how could those -- how could we mitigate the outbreak on board. What would be the impact of disembarking the passengers on the local port communities and the introduction and spread.

The ship had some challenges finding the harbor. Once it was identified as a place of having an outbreak, how would we safely identify who on board was infected, who needed to be triaged and taken to a local hospital for medical care, what was the attack rate, how could we get testing done in that setting.

How many people got sick relative to how many people got infected? Was there evidence of asymptomatic or presymptomatic spread? Was there clustering of infection by a cabin or by area on the ship. What would that tell us about the level of infectivity?

What types of measures were being put into place? Was there surface contamination issues that represented a particular transmission risk, or was it all moving through air and droplets?

It was a lot to try to understand. And then it was an international setting and the whole issues about repatriation of citizens from multiple countries came into play, how could that be done safely, how would you repatriate people from an intense outbreak epicenter. And

so on.

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

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

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

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

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

with a lot of global significance and had a big intersection with the global sort of travel and trade components.

Q It's been reported that the Diamond Princess and then the Grand Princess after that occupied a lot of time of the White House task force in terms of the decisions that had to be made around those two.

Is that accurate? And what was your experience?

A It is accurate, because, as I said, the Diamond Princess, as a herald event, barely unfolded and the circumstances that led to that event and the growing, more globalized nature of the presence of the virus as well as the fact that cruise ships served as large mixing vessels, if you will. That is to say that in the course of introducing even a single or small number of cases, given the prolonged stay the living quarters, that the transmission would amplify very quickly in that setting, and then people after that period would scatter globally and become seeds and sources of introduction.

So it was pretty important to understand the niche of the cruise ship environment in not only its role that one would play if you tried to contain a specific outbreak on a specific vessel, but that this pattern would likely be repeated over and over again across multiple vessels at sea.

And such was the case. We had our own essentially domestic experience with an international cruise ship

infection with the Grand Princess that went, came in out of California. And so -- and they're large population bases.

I think when you mix passengers and crew, you're talking about thousands of people on board that are living, eating, you know, recreating, vacating, vacationing, all sorts of things that are together in common indoor spaces, some of which are very poorly ventilated and could be very crowded. So they were like floating cities of populations that were intensely intermingling at close risk.

And it did take a lot of time not only to figure out how to define the risk of introduction and then amplification, mitigate it on board, mitigate its impact when people were embarking and disembarking and its impact on port communities and their healthcare systems.

The transportation -- once people come back to a port and they have to get on to other commercial transport in order to get to where they're going and what the risk that that would entail.

So it was kind of a microcosm of understanding multiple factors in managing the COVID pandemic in a maritime environment as a source of not only introduction, amplification, but also distribution and seeding and setting up new loci of infection in other places along the trajectory of that movement. It would take a lot of time.

Q Who was making the ultimate decisions on this in

terms of the task force?

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

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

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

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

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

repatriated. Some of them who were not yet sick but may have been incubating or exposed possibly were part of the cohort that was repatriated.

I think the idea of whether to repatriate American citizens from the Diamond Princess was not as -- not controversial, per se, in that setting. How to do it, how to do it safely and how to do it in an international context, those were challenging problems to solve, but I don't think there was a debate about whether to do it.

Q It was reported in the New York Times that the president was "furious" when those 14 passengers were flown into the U.S.

Was that position something that was articulated down to you, and did that change any of the decisions going forward?

A We were aware by the media reports of the comments that the president was making. I would say that I think -- I don't remember exactly what was on the schedule of people that were, you know, quite busy around this, but the decisions about to repatriate or not in advance of those decisions, I don't think got raised there, so I can't speak to the specifics of what the degree were.

But the planning around repatriation proceeded and perhaps proceeded prior to his comments. I don't remember the specific details on timing.

Q Did his comments affect these decisions going

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

A As opposed to the decision to repatriate from the Diamond Princess?

Q Moving forward.

A Yeah. It's hard to know. I think the problem was is that there were many, many thousands of Americans at sea on ships during COVID, and ships -- and the number of outbreaks on ships was increasing very regularly, both in scale and magnitude.

Outbreaks that involved significant morbidity and mortality as well as global distribution, and it created some challenges in terms of how to manage them, how those cases would be counted, whether they're counted, you know, in some type of -- against some type of international setting or whether they would be counted as U.S. domestic cases based on their citizenship. There was a lot of confusion handling that.

I tend to see those kind of questions come up pretty regularly in outbreaks in globally mobile settings. So it's hard. It complicates policy as what the ledger of the cases going to be.

But really the issue is how do you safely manage those cases to reduce harms, hospitalizations and deaths, to reduce transmission, to reduce the trajectory of impact as --

[Technical interruption]

[Recess]

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

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

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

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

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

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

perhaps, in international waters.

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

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

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

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

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

about this sort of ledger issue.

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

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

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

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

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

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

Q I want to dive into the substance of the problem

and what was proposed. So your team, your maritime team was tracking all of the Americans on cruise ships.

Can you give us a sense of the scope of the problem as you found it?

A Yeah, I think -- I don't want to misquote the actual numbers. Most of these are available in published reports.

The kind of counting the number of ships that were involved in outbreaks, the size of the outbreaks, and we counted cases whether they were in American citizens or in crew members or in foreign nationals.

We tried to define the scope and magnitude and the severity of an outbreak in the transmission settings independent of, as I said, what ledger you would count -- hold as to the accounting.

They occurred on a ship. We did, you know, count the data, whether it was in crew members or passengers. We did look at the data based on severity and how many people were requiring infirmary visits or intensive support or maybe oxygen support on the small medical capabilities that are available in the infirmaries on ships. How many evacuations, those kinds of things that we were getting called in about that might need some assistance beyond the capacity of the ship?

And then we would be looking at how fast the trajectory

was, whether the carryover infections were occurring from new introductions in seeding, new passengers coming on board, or whether the existing crew members that stayed over week to week and continued to support a vessel, whether the infections in crew members were creating these carryover outbreaks, whether it was the same ship repeatedly involved.

Those are the kinds of things that our maritime team was intensively engaged in. And from those experiences, we were realizing the scope and magnitude and the problem that COVID would place in a maritime environment at sea sometimes miles and miles away from land-based medical care were going to be quite significant and that these weren't one-off events that occurred sporadically, but that these were the types of environments that were uniquely, you know, at risk and needed specific management, attention, very, you know, complicated guidelines for control, screening, surveillance, testing before embarkation, how many days when, testing at embarkation, testing periodically passengers and crew during that, beefing up infirmary capabilities, you know, defining the level of medical support that was available compared to the number of passengers and crew on board and the vulnerabilities.

Having emergency response evacuation plans, having agreements with port cities as to where people could be brought, disembarking persons who were infected and how to

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

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

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

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

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

full attention of a large team in the maritime unit for many, many weeks and months.

Q It sounds like a massive and complex problem. Can you talk about some of the tools that you were talking about using and how that led to an emergency order.

A Well, we brought to bear everything we knew about containing sort of a high-risk land-based outbreak and extended it within the context of how that might happen at sea, where resources were more constrained because they needed to be all available in situ at a distance.

And so developing a safe plan for defining surveillance plan, a testing plan, a monitoring plan, the proper scaling of healthcare resources on board, the proper agreements that people would know in an emergency where very sick people would be evacuated to, what port would be able to be brought to bear by Coast Guard or other emergency services, how to achieve isolation and quarantine for passengers and crew.

Meals, obviously, meal service, the congregate, aggregate setting kind of things. Those are the kinds of things that had to be worked out.

We -- on the very front end, once we understood the risk in this setting, we tried to issue travel-related guidance, eventually looking at the ship as if it were a geographic destination and advising people not to travel on cruise ships because of the increased risk and the limited

resources, much the way we would do if there was an outbreak in a particular country. We would alert people in advance to not engage in an activity where it was difficult to both prevent and respond.

Our travel guidance was initially focused regionally where we saw the outbreaks, but as the epidemic and the pandemic spread geographically, the advisories involved in that engaging in cruise ship travel anywhere on the globe, not just in the southeast Asia area -- that transmission happened very quickly, but certainly our experience with the Grand Princess off California was clear about that.

We learned for that carryover passengers and carryover crew, particularly the entertainment and other kind of crew, were responsible for breaching outbreaks sequentially on some of these vessels, so that's something that came to play.

Eventually it was also clear that we were not going to get the kinds of COVID control that were needed by doing this sort of one vessel at a time and that the plans to really prevent, contain, prevent, respond to outbreaks was going to be very broad and somewhat industry-wide in these large population settings.

And so that led to the recommendation to go beyond the travel-related guidance, which was actually insufficient to prevent embarkation and any vessels from taking off fully

loaded.

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

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

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

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

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

to see if it was feasible, operational, implementable and all of those kind of -- so that was all going on in this time frame through February and into early March.

Q Let's start with March 7. And then it is Vice President Pence, Director Redfield, a number of Florida politicians. They met with the cruise industry executives in Ft. Lauderdale.

Did you participate in that meeting in Ft. Lauderdale?

A I did not. I did not.

Q Did you have discussions with Director Redfield about your position in terms of --

A Director Redfield was representing CDC along with other members of the White House task force. He was briefed regularly on our team on the scope and magnitude and the challenges of the problem and was aware that we were going to need to elevate to regulatory actions, because we weren't able to control this with things short of that. Incrementality and the proportionality was insufficient to stem the scope of the problem.

Q It seems like the -- at least at that announcement, it wasn't a regulatory action that was being rolled out; it was a plan that would be announced in 72 hours that the industry was proposing. Is that right?

A That's what -- that's what -- I wasn't at the meeting, but my understanding is that's what was agreed to

between the administration and the CEOs or whoever attended the meeting.

Q Given what your team was seeing, was that adequate to deal with the problem as you measured it?

A I was -- I would fairly characterize my assessment was, it was I was skeptical, because there wasn't sufficient public health expertise within the industry to actually understand the characteristics of the virus, the scope, the risks.

And I was skeptical that they would have adequate and sufficient plans, but I agreed with -- or I went along with the decision that was reached. That wasn't my call to make. It was above me to make that call for them to submit plans.

And the plans that were submitted were reviewed by our team, and some I would describe as overly aspirational and not feasible and not implementable and others were wholly inadequate in terms of really appreciating the scope and the magnitude.

So plans were developed, they were submitted, they were reviewed, and I did not think that they would be able to address the problems. By aspirational, I mean they were assuming the availability of certain things that were pretty difficult to get, assuming a major scale-up in their on-board laboratory capacity or their medical capacity, all sorts of things they didn't necessarily include in these

agreements for managing an acute response. Evacuation for port agreements. So they were missing a lot of components and they had a number of gaps.

But I commend -- an issue for making that effort. I don't think it was their fault that they lacked the public health resources in order to fully comprehend and manage this kind of a problem. It was an unprecedented problem in scope and magnitude.

Q And Vice President Pence at that meeting said publicly that Americans could travel on cruise ships safely.

Did you agree with that assessment at that time based on what you were seeing?

A I don't know what specific time frame he was referring to in that, whether that was in the future, whether that was in the moment, whether that was in the past. I'm not sure what he was specifically referring to.

My experience leading to that meeting was there was not a safe, healthy way to continue to travel on cruise ships in that moment without trying to control the huge number of outbreaks that were already ongoing and, you know, literally hundreds of thousands of people that were kind of stranded at sea in the midst of outbreaks that had also to be sort of managed in that setting concurrently.

So to me, the scope and the magnitude of the problem far exceeded what I would describe as safe and healthy cruise

ship travel until a much better handle could be gotten on the problem, per se.

Q Were you concerned about this delay in getting to a no-sail order and the impact --

A I was definitely of the opinion that we needed to push, push in that direction, that given the amount of consultation that was being required of my team and the entire maritime unit, which stood up and needed emergency managing all of the incoming on the outbreaks and the problems and the challenges, I was quite, quite concerned that we needed to have a pause and we needed to deal with all of the folks.

Like I said, in the course of time there were, you know, counting passengers and crew, there were an enormous number of people that were still out at sea that needed to be safely repatriated without creating an extension of the epidemic.

And so, like I said before, on other things this is the kind of virus that's very unforgiving in the mode at which it spreads and the speed at which it spreads and its stealth nature at times. And I thought we needed stronger action earlier in order to be able to get a handle on it and get in front of it. It was not a situation in control.

Q This has been reported. I'll just ask you: Did you call this situation unconscionable in the conversation

with Dr. Schuchat?

A I did.

Q And why?

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

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

A That's accurate.

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

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

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

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

Q Do you think Americans died as a result of that delay?

A I think the delay had significant impact on the morbidity and mortality.

Q I want to move to the first iteration of the order, and that's on March 14, and that's Exhibit Number 5.

[Exhibit 5 was marked for identification.]

Q I want to ask you about specific parts of this order. And starting the first part, Applicability, and it had a big exception, the exception that "this order shall not apply to any cruise ship that voluntarily suspends operations for the period of this order."

Can you talk about how that came to be and why that exception was in this order?

A I think that, as you've mentioned, there was some confidence by the industry and perhaps others in support of that confidence that they could manage this problem on their own and -- or that they would see voluntarily when they got the feedback from us on their proposed plans that they couldn't manage the problem, so they would voluntarily agree to suspend operations short of having the regulatory authority and impose some of those restrictions and operations.

So I think what you see in there is the regulation would only apply if you didn't voluntarily suspend, and there was

some cascading momentum among certain parts of the industry that they would suspend until they were able to get their planning in place and then they would see.

Q It seems to me that this is not the most direct way of dealing with a massive problem in allowing industry to regulate itself when people are dying.

What was your view in terms of the adequacy of doing it this way?

A In the end, my biggest concern was that there was a suspension in operations, because we had to stop, you know, pouring gasoline on the fire of the outbreaks at sea, which was a lot of risk.

And whether they agreed to voluntarily suspend or those that didn't were going to be suspended by regulation, we just needed to get this paused and we needed to have sort of a major rethinking about how safe and healthy travel could and if it could and how it would resume in setting up a COVID pandemic of this magnitude, which, as I said, cascaded well beyond the ship itself. It had impact and implications for really accelerating the pandemic across the globe and in many communities.

So how we got there was less important to me than that it happened and it happened quickly.

Q Did this order get us there?

A It made a huge -- the order made a huge -- things,

as you will note, need to be modified along the way, but, you know, taking the accelerant away by not embarking new passengers and beginning new cruises made a big difference. We still had to manage the existing multiple outbreaks at sea across tens, if not hundreds of thousands of persons that were impacted either directly or by contact.

So the first step was stop adding fuel to the fire of the outbreak, and the second one was managing the existing outbreaks that were still ongoing. And that was my goal and our goal at CDC.

Q And moving down in the order, I just want to point to the section that reads "Coordination efforts with the cruise ship industry."

And in that section, it says "the federal government recognizes the enormity and importance of this action taken by CRIA" -- that's the Cruise Lines International Association -- "and the commitment it demonstrates in protecting the health of both cruise ship passengers and the public at large."

Who drafted this order?

A The initial draft of the order was originated at CDC with my team and our general counsel. The order circulated in the interagencies, as was common for anything of this magnitude. Went through OIRA and OMB and the 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

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

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

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

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

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

happened under the pause of the no-sail order.

Q And the -- it's been reported that the industry had -- the plan had included that the carriers would hire a global rescue team of special ops veterans who would extract passengers and bring them into medical facilities without burden on the U.S. government.

Did that happen?

A I can't -- I can't say. But generally the extraction process happened with the intense engagement of our team at USG. Whether some of the vessels had independently contracted with other means, I don't really -- I don't really know. I only know about the ones that we were intensely involved in, which was the U.S. government.

And largely the ones that we were intensely involved in had to do with ships that were going to be permitted into U.S. ports for this process. Whether the industry, you know, got or didn't get the level of public health support from some of these other countries or whether they were navigating it through other procedures internationally, I can't really speak to that.

But I know that there was just intensive involvement of the CDC, U.S. public health and some of the other interagency coordination and support in order to safely evacuate, I believe -- and don't hold me to the numbers, but somewhere in the range of 300,000 people were disembarked

and then moved without accelerating the spread to the maximum extent possible through the CDC guidance and involvement and the assistance of the maritime unit.

Q I want to show you Exhibit Number 6, which is an email that you sent during this period between the first no-sail and the -- I guess we'll call it the first extension.

[Exhibit 6 was marked for identification.]

A Okay. Got it.

Q First, I guess, "BLUF" means bottom line up front; right?

A Yes.

Q Can you tell us what led you to write this email and what this represented at the time?

A I knew that Dr. Redfield was preparing for a White House task force meeting in which this was going to be -- the order was going to be added to the agenda. I wanted to make sure that he was very well prepared with all the efforts that we were doing collectively and the rationale for the order, which was significant one, and make sure that he was prepared to answer any questions or articulate why this was necessary.

This was my attempt to make sure the director was well informed to face that conversation or to be prepared for that conversation.

Q I want to ask you about the fourth bullet that starts with "poor planning."

A What would you like to know?

Q What was your basis or finding there was "poor planning by the industry" and "failure to adhere to recommendations and unsafe transport"?

A Just actual experience that the team was finding that, you know, the kinds of things -- it's one thing to have a set of guidance and provide that to industry, but a plan is insufficient unless it's actionable, and we had members of the maritime unit that were overseeing and monitoring the adherence to the plan.

We were receiving emails, photos, other kinds of material from people on the vessels and describing situations which were not consistent with saying that there was adherence to the plan and were continuing to expose gaps in the ability to execute a plan, even though it was pretty clearly articulated.

And, like I said, you asked earlier about the confidence I had in the industry to execute on a mission, a public health mission of this degree of complexity. I think it's not necessarily to the fault of an industry that has a different purpose to be able to execute a very complicated public health plan.

But my feeling was that they had not had adequate

assistance on -- they were indicating that they would be commissioning some private public health assistance to provide the kind of support they needed it, and it was not evident that that was sufficiently being executed.

And so I did want Dr. Redfield to be aware that we were trying to do our best to have this happen in the absence of a regulatory order, which I knew was not very popular, and that we weren't getting where we needed to be, and I thought the order was quite important. And I wanted him to be able to articulate that if he was questioned in the White House task force meeting.

Q And at this moment, what was the state of, just generally, outbreaks on the ships? You know, we had no new embarkations, but I guess the ships were still out there?

A Yeah, they were out there. And, I mean, I think more than 100 ship capacities ran anywhere from 2,000 passengers and 2,000 crew. That wouldn't have been uncommon. So we're talking about thousands of people on at least 100 different vessels that were out there. At any one point in time, any number of them were experiencing large outbreaks or in the early parts of new outbreaks.

So, again, this was a pretty big -- and that's with the idea that new embarkations had already -- were going to be able to be ceased and there was voluntary suspension of new additions. But there was still a really big problem to get

the existing outbreaks under control.

[Majority Counsel]. If I may.

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

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

By [MAJORITY COUNSEL]:

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

What was the interagency process?

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

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

interagency through the -- the White House convening the National Security Council and other pieces of the policy process. And then regulators of these kinds of sorts would go.

So there would be an informal play of providing inputs from the interagency, and then it would be more formally submitted up the wire, and then they would send it out for further clearance across the interagency. More edits and other things would come the way of the drafters and CDC, and we would try to achieve broad concurrence across the White House and the interagency.

And then the order would be -- amended versions of the order would then be sent up to the CDC director for signature.

So that would be the process by which this occurred.

Q One quick question. What does PCC mean in this context?

A Policy Coordinating Committee. Each administration has a different acronym or definition for what those processes would be. There's a place for the interagency, and all of those with equities in these decisions would have policy coordination.

Q Do you recall any agencies with equities in this decision that were opposed to the order, refused to sign off?

Mr. Barstow. What order are we talking about?

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

Mr. Barstow. There's the March order and there's the April order. This email is in April.

[Majority Counsel]. We're talking about the movement from the March 19 order to the April order. That's what I'm talking about. This particular period of time.

Mr. Barstow. Okay.

The Witness. As I described the process, there were -- the deliberations involved inputs and edits and all sorts of things and concerns to be addressed and so on. Is that what you're asking?

Q Yes. I'll be more specific. So it's been reported that in the lead-up to this order, the -- and this was -- and I'm quoting an article in ProPublica -- Department of Homeland Security refused to sign off and that the Department of Homeland Security "disagreed with CDC's narrative describing the actions of the cruise line industry."

Is that an accurate report?

A There were definitely discussions of the general nature you're describing as part of the interagency deliberative process.

Q Do you recall what the disagreement was over the CDC's narrative of the actions of the cruise line industry?

Mr. Barstow. [Redacted], I think that's deliberative, so I'm going to instruct Dr. Cetron not to answer that question.

[Majority Counsel]. Okay. I'll just note for the record that I'm quoting a publicly available news article. This decision has been reported in the news. The specific point that the agency articulated was in the news, and its disagreement with CDC's narrative was reported publicly.

Noting that objection for the record and asking that we perhaps revisit it at some point.

Q Beyond what the agencies were saying, what was your position in this process? So moving from the order that was applicable to really a small subset and now moving to a full-scale order no-sail order.

A I thought it was necessary. It was unclear what voluntary participation would mean in terms of full compliance. It was unclear whether those that were voluntarily participating believed they had a sufficient plan or not. And so I thought that we needed a more uniform, consistent, clear set of instructions on what public health meant in terms of things that had to be done, and that may or may not have been the things that all the lines were either equally wanting to do or equally able to do.

So that's how the piece was sort of evolving to be more

directive and more clear on what was necessary and more consistent across the board. And not subjected to either the variability or the decision to opt in for some days and then opt out for another and tracking all that.

I think one of the problems was there needed to be a very clear set of public health expectations and objectives in order to continue this process safely.

Q And the "why" question: Why in terms of what you were seeing that was happening?

A I said was there variability in understanding and intent. There was variability in capacity or completeness. There was variability in the aspirational nature from what was actually executable. We were getting a number of reports of the groups that said we're in, we're voluntarily in, we don't need to be regulated, but on the sort of -- the checks of what was going on, we weren't seeing that level of effectuation of the intent plan.

Q Before moving on to the next order, I think it's a good time for us to take our five-minute break and turn it over to our colleagues.

[Minority Counsel]. We have no questions for the next hour, so when you come back, just roll.

[Majority Counsel]. Thanks, [Redacted]. I'll just ask the witness and Kevin if you want to keep going or if you want to take a break.

[Recess]

[Majority Counsel]. So back on the record.

By [MAJORITY COUNSEL]:

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

[Exhibit 7 was marked for identification.]

A Okay. I have it open.

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

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

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

A Yes.

Q Okay. Why was this critical at this moment?

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

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

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

planning."

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

Q It is page 4.

A Uh-huh. I think this is -- most of what I'm reading on page 4 comports with what I described to you, is that there was some combination of the industry coming together to create a response planning framework, CDC developing its own internal plans and expectations, and trying to tease out what was aspirational from what was feasible and what was -- no matter how it was stated, what was actually being practiced.

That's what this "Critical need for further cooperation and response planning" means, essentially getting on the same page.

Q Who drafted this section of the order?

A I don't recall specifically. But I think it was intended to be, you know, some -- some clarity about why there was a need to go beyond a voluntary approach to getting into this. This clearly represented a perspective that the cruise industry was looking for, obviously.

They were looking for more of an engagement in the process so that they could, you know, have their perspectives shared.

How this -- the actual words came about, I can't remember the details at the time.

Q What about --

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

Q Sure.

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

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

Q Sure.

A That's -- that was the goal.

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

A This was not an easy process.

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

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

Q Let me try to jog your memory. It was reported in ProPublica that this section was originally titled "Failure of cruise ship industry to develop and implement a response plan."

Is that accurate?

A I don't know. I never spoke to ProPublica. I don't know where they got their information.

The document, as I told you about process was significantly revised, amended, and churned through a deliberative process in the interagency. And, you know, it's entirely possible that who said what to whom where in the deliberative process is really kind of beyond -- beyond my memory and beyond my goals, which is to get an effective public health response out. That's where we needed to be.

It was not easy. It was a big order, and it involved an entire industry. That doesn't -- you know, that doesn't escape me. It doesn't escape me that there were people not happy about it, but --

Q I'll ask one last question on this and we'll move on.

Did that change in title from "Recognizing the failures" to "the need for cooperation," did that come from CDC?

A Yeah. I really don't want to get into that in the speculation. All this stuff -- again, I read the ProPublica article. I had nothing to do with it. It's not the way I

work.

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

Q Okay.

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

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

[Majority Counsel]. I do think that a clarification --

For the record, Dr. Cetron, are you refusing to answer the question on the basis of an instruction from agency counsel?

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

deliberative process and it needs to be one where there is lots of inputs.

And my goal here is to try to explain what the public health problems were, what weren't being met by the voluntary program, why the need for an additional order was there. And, you know, that's my rationale.

I don't want to go out there and I have no -- you know, have no intention here of trying to pass judgments other than giving my professional judgment that this was necessary, whatever was necessary to get the job done and accomplish our public health goals is what I was trying to achieve.

And whether or not the idea was mine or somebody else's and whose it was and how it came to be, I totally respect that there's a need for a deliberative process and there are many points of view that come to bear in addressing the pandemic.

It's not one that -- one perfect right answer, but we need to be pulling in the same direction and get the job done. That's how I feel. That's why I've chosen to answer that way.

[Majority Counsel]. Thank you. I just wanted to make sure the record was clear, so I made that clarification. Thank you.

Q Okay. I have another question like this, but

focused on your words.

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

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

Q Do you think Americans died because of this delay?

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

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

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

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

[Exhibit 8 was marked for identification.]

Q Can you tell us the process that led to this extension in July?

A So, first of all, the need for the order was ongoing because of the nature of the pandemic, the status of the pandemic. As I mentioned to you, there was -- after the order that prevented new embarkations from the U.S. ports, there was still an enormous challenge to deal with the ongoing outbreaks that were at sea that neither the COVID threat itself, the virus specifically, had been mitigated sufficiently to remove that threat, nor had the challenges of the ongoing outbreaks been sufficiently met to have a sort of a pause and a reset. And so the order needed to be extended.

In addition, it was clear that the industry would need -- or it was our opinion that the industry may be engaging in expanding its own public health advice and authorities from an independent -- separate from the -- from CDC and that that work would be ongoing and that work would involve public health consultants, former CDC people and other public health consultants, to address a whole series of issues. And that would be an ongoing process through the summer.

So I think that was some of the genesis. One, the threat hadn't mitigated sufficiently; two, we weren't in a position to resume normal sailing; three, there were

inadequate, you know, controls still being put in place to mitigate the outbreaks that were already out there, that were still challenges of folks with COVID at sea, and there needed to be much more engagement in the planning process, you know, that would happen somewhat independently to the other mechanisms that we became aware of.

So those were -- I think I'm just trying to remember this point in time and what was going on and why another extension was needed and that we couldn't go back to this idea of the industry alone can handle it on its own through voluntary processes and would have ample -- both experience, guidance, and paths to follow.

Q And I wanted to ask you about the third paragraph and the information included there.

A Yes. I think that's basically the very crisp summary of some of the data that supports what I just shared with you verbally.

Q So this was --

A This was an ongoing issue, and, quite honestly, those were just the ones we knew about where people were within a sufficient U.S. jurisdiction to have -- to actually be reporting, as was required in the no-sail order, to have a regular reporting frequency, but it would not necessarily account for all of the outbreaks that didn't involve vessels with a U.S.-based itinerary for port calls.

So, you know, at the least, this is the kind of tip of the iceberg issue that we were seeing for what eventually got reported to the CDC maritime unit, but not necessarily the totality of the experience, which was likely larger.

And I believe we have -- further, after this July date, I think we have a further series of summary publications that included, you know, broader assessments of the various magnitudes. We can make those available through Kevin at another time.

Q Sure. And let's just talk about the scope of the problem at this point. It's at 38,000 hours managing outbreaks, almost 3,000 cases, 34 deaths.

Can you tell us about how these things were happening? And we had basically the stop at embarkations and then the April order. What were you seeing at this point in July in terms of --

A I think this is mostly focusing on that -- on that time period where even with the orders in place, without adding new people to the journeys, to the cruising journeys, the residual effect between March and July was that these outbreaks were continuing and amplifying and extending and it was, you know -- it was not under control.

And it was not a time to lower the guard and roll back and resume normal cruising at this point in the pandemic, but rather, really significant processes need to be in place

at -- quite honestly, a lot of this because of so many other things that were accelerating in the pandemic in its early time frame and well before the availability of vaccines, for example, and other medical countermeasures, CDC wasn't going to be in the capacity to provide all the consultative support alone that the industry would need to be able to handle these decisions in an unregulated environment.

And I was encouraged by the fact that the recommendations that I was making is that they were going to need some independent public health experts that would be actively commissioned to get engaged. And such a panel, the healthy sail panel, was actually not just contemplated but created and led by a former HHS secretary, Levitt, with a number of former CDC publication health folks and other non-CDC public health folks that were really tasked or requested by the industry or at least two of the lines with some representation from other parts of the industry to help engage in some really deep and difficult and technical conversations about how to move into a potentially safe sailing space, what would be some of the requirements to do that before there could be resumption.

And so that panel started, and that was important. I think part of this paragraph was intended to reflect that the problem was still very much ongoing and part of it was to reflect that the enormous challenge that was posed by the

problem for CDC that was also dealing with a huge number of domestic outbreaks around the country at that scale.

It was going to require that this other process that they really wanted to move into a "what's the future look like for safe and healthy sailing" was going to require a very deep engagement process with public health.

Q And moving forward to the -- what we'll call the third extension. That's Exhibit 9. That's the September 20, 2020, order.

Obviously this one is different. Can you tell us about the process that led up to this order?

[Exhibit 9 was marked for identification.]

A Some of the things that were different were that summer healthy sail panel that was commissioned did intensive work. I think -- don't hold me to the dates, but roughly over that summer, a three-month period, you know, July, August, and moving into September, and they were coming up with a series of a more concrete, very specific set of plans and recommendations.

CDC had two liaisons that were requested and cleared by our general counsel to sit as liaison members on the healthy sail panel that participated and listened in on some of the conversations and were available as a resource to answer questions in that regard to provide technical input or answer specific questions about the surveillance data or

things that were being learned about the virus.

And that process had been ongoing over that summer period. And it was chaired by, I believe, former Secretary Levitt.

You're muted.

Q In terms of the legal authorities, this was a conditional order as opposed to the prior orders. Do you recall why that was?

A You're referring now to the --

Q September 20, Exhibit 9.

A Okay. So the discussion was, you know, you take one perspective and what sort of -- when are we going to be in a better place. The recommendations and the other kinds of inputs that were coming, and then the desire from the industry is what is it going to take in the future in order for us to resume the business and have safer sailing; right?

And so the flavor here was, you know, whether we extended the no-sail order through the winter, it was a big winter sailing season that was upcoming and that how long it might take to get to a better place both in the perspective of the virus, the perspective of the planning, and the perspective of proof -- going beyond plans but proof of concept in a safe, iterative way. And that's how this piece evolved.

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

see here is a conditional sail order that laid out a series of phases and that by achieving each phase successfully -- so it's not just having the plan for a phase but getting through it, having some oversight and documenting the ability to execute in that phase, take lessons learned from phase one, phase two, and phase three and incorporate them and incrementally scale up before full resumption of commercial passenger services could be done safely. That's where the framing of the conditional sail order came from.

And the concept of what would it take, what conditions would need to be met, you know, from CDC in order to plan toward a future resumption of commercial sailing.

Q Did you think the industry was going to comply and get to a position where people could sail again?

A You know, I have not prognosticated with any certainty what this virus will do, what the curveball is going to look like. I know when we weren't there. I knew how hard it would be to get to that place.

And I knew there would be a number of contingencies and uncertainties that, if fulfilled, might bring us closer. For example, there was beginning to be a lot of discussion about the eventual availability of an effective vaccine. That would be a potential game changer in the way we looked at the pandemic.

I knew that there were evolutions in the types of

testing that were available that we would gain that capacity and some of the other nonpharmaceutical and mitigation measures. The surveillance components, the portable -- you know, the rapid test would play into this picture.

And the understanding would be not to pretend we knew the outcome with some certainty, but to have both a set of incremental measures in the phases and then documentation that those would actually work.

And so that was the thinking behind it. I thought it was a very good sign that at least some of the lines had commissioned the healthy sail panel and they were beginning to develop a more earnest and realistic sense of the magnitude of the challenges that the virus was posing and imposing on their industry.

I thought that there were people really coming to grips to how hard this problem was. I also thought that we were making potential progress on the pharmaceutical and nonpharmaceutical front.

And this seemed to be a way to provide both what the government thought would be necessary to assure a safer pathway, a healthier pathway, in addition to providing some future clear direction to an industry.

And so that's how this ended. And the recommendations coming out of the healthy sail panel were validating and aligning very well with CDC's perspective, so that that gap

that I talked about earlier, the disconnect between an industry that was largely not getting independent public health input and not just saying "we got this, we can do it all on our own," which I felt was really unrealistic.

And the kinds of input that they were getting from experts that were not regulators from the CDC side was a very encouraging process. That's how we ended up here in this new space.

Q The public reporting has been that Director Redfield wanted to extend the order into the winter, as you discussed, but there was an intervention from the White House.

Did you work with Director Redfield on this particular conditional order?

A Yes.

Q And he --

A We basically -- the statement is true. Our initial draft was another extension. We didn't see the vaccine really for the other things we're discussing were going to happen. They wanted to be able to clearly forecast what to do, what to tell about passengers who were booking in the winter sailing season.

It seemed unrealistically that full commercial sailing would be doable in a safe and healthy way until several more months, and progress on the vaccinations, progress on all

the other fronts were needed. The healthy sail recommendations were a report, but not necessarily with demonstrable impact.

So there were many ways to go, and this idea of creating a conditional sail with spelling out criteria on steps along the way was another way to get there.

Q And can you describe what that intervention was sort of around the time that this order was expiring?

A Which intervention are you talking about?

Q From the White House that's been reported.

A I don't know what specific reporting source you're using in that regard, but they were very engaged, as they had been in this topic all along since the beginning, as you're aware.

And so I'm not sure. I'm not exactly sure what you're asking.

Q Sure. And there's an exhibit, if you want to refer back to the reporting. I will just get the exhibit number. It is Exhibit 15.

[Exhibit 15 was marked for identification.]

A So I wasn't in the meetings that were being discussed in this New York Times piece by Sheila Kaplan. And, like I said, I don't talk to reporters on these kinds of topics, and this seems like a more appropriate question for Dr. Redfield, who is obviously here and quoted. I don't

know what to say about that.

Q We spoke to Dr. Redfield, and here's what he said about that. He said -- and I'm going to quote him from our interview:

"In October they gave me an extension to October 31, and I wanted an extension to like March. And, to be honest, I was prepared to step down as CDC director if that issue got prevented, because I felt so strongly about the no-sail order. And I came through with the idea of a conditional sail order and we wrote that guidance, and that guidance -- actually, the rigor of the debate against me subsided after that."

And he made the point that this conditional order was a compromise position that the industry wouldn't actually meet and it effectively served as a no-sail order.

Is that accurate?

A Well, all I can say is when Dr. Redfield came back from these meetings, what he said to me was "let's work on a conditional sail order that provided an incremental pathway." I didn't -- he didn't give me all the things he just said to you, and I wasn't privy to this interview with the New York Times.

But he said that's where we landed, and can you do everything possible to rewrite everything and make it work this way, and we set about doing that.

Q And effectively, is that what happened? Did this, essentially, in effect, act as a de facto no-sail order?

A Well, if you're asking the question did commercial sailing resume with full complement of passengers on board in October, November, or December or even January, you know, of 2020 and '21, the answer is no, it did not -- there were -- it did not resume. The answer is no, it didn't resume.

And because the steps that were required to go through the phases of conditional sailing to demonstrate that there was the ability to effectively sail with this pandemic with the tools that were on hand had not been met, but it did provide a pathway toward what needed to be done.

And then as we moved into '21 and vaccines started to become available, in addition to the stipulations that we had in our three phases of the conditional sail order. We then began to incorporate by amendment and modification criteria on the proportion of passengers and crew that would have to be fully vaccinated in addition to being tested to embark and tested at disembarking.

So we had another tool in the tool kit which essentially made the difference. And it wasn't really until that vaccine tool was added to the tool kit did the contemplation of resuming commercial sailing take place. And that actually -- I don't remember exactly when that happened, but

it was into -- closer to the summer sailing season of '21.

I don't know exactly what you mean by -- it was basically trying to stipulate what would be required not only in the phases, but oversight and proof of concept. In sailing, for example, there were phases where you had to have a plan, where you had to certify the capacity, the number of tests, the various port agreements. Those were all built into the conditional phasing.

And then there would be periods of essentially test sails that did not involve any commercial passengers. First crew would come back and resume without passengers at all. There would be simulated voyages in which they would be able to detect early and contain any COVID outbreaks, and these simulated voyages did not involve paying commercial passengers. And then there would be a scale-up in volume and so on.

So that halfway process of getting there and then, in effect, really scaling up a safe and healthy sailing process also really became very contingent upon having a highly vaccinated cohort of passengers and crew, like over 95 percent.

Ultimately, it was all of those things in the evolution really in the months of '21 that led to the resumption of commercial sailing voyages. And so I think we ended up with a very deliberative, calculated, measured, safer process.

But in terms of -- if there would have been a no-sail order through the winter -- and the winter season always proves to be a little bit more challenging with COVID -- versus this approach, essentially commercial sailing would not have been resumed. So there you have it.

Q Okay.

A That's how it evolved.

Q I wanted to move on from cruise ships and ask you generally and briefly about CDC's quarantine powers and in an emergency response, how they can be exercised. So maybe you can give us just a brief overview of how that works.

A Yeah, that's a tall order. I'll just say in general the federal quarantine authorities come in with regard to preventing importation and spread of -- a series of communicable disease come into areas of scope and conditionality.

So in terms of scope, the federal jurisdiction is international arrival, interstate movement. It includes the territories, for example, and whether that movement poses a risk, you know, air, land, and sea kind of thing, and whether it's the movement of people, animal, or inanimate things.

So that's the general scope that derives from the Public Health Service Act of 1944. The authorities are then -- that statute has been clarified in regulations. Part 70 is

usually what we call the domestic component, 71 the international component, and it specifies the circumstances under which the federal government would be able to -- the legal language in there is "detain, apprehend, and conditionally release" in that framing.

And for human movement, the criteria is specified around a set of specific disease conditions that are enumerated, and the list of those unique conditions has been augmented and added over time as we face different epidemic and pandemic threats, whether it be SARS, Severe Acute Respiratory Disease, MERS, Middle East Respiratory Syndrome, and those kinds of conditions covered under SARS rubric, and so on and so on. Diseases have been added to the list of which human movement can be added to the apprehension, detention, and conditional release.

With regard to inanimate products or animate or animals --

Q Just --

A -- it's more broad.

Q -- for brevity, let's stick with human beings.

A Okay. So that's the setting on the human aspects of it under the quarantine authorities. By statute, they go to the secretary, and I believe maybe in the older statutes the surgeon general before, the CDC, and then the HHS secretary, the secretary -- the director of the CDC and, by

further delegation, to the director of global migration and quarantine. That's the general sense of where those sit.

It is notable that there are a number of these jurisdictions which -- that is interstate movement transportation corridors, you know, surface transport as well as air and even sea transport have some specific mentions.

And some of those jurisdictional authorities are overlapping. Particularly complicated are sort of airports and train and bus stations, which have interstate or international touch point as well as a local touch point.

So there are places in which that happens in coordination with the state and local. That's basically the broad sense of that. And there are some specific measures that are mentioned and a general reference to other measures that are appropriate to control introductions.

Q I'm going to look back to the interstate authorities later.

But I would say that the exercise of these authorities has been a big part of your life's work; safe to say?

A Yes. Both when I first came into the division in '96 and we looked at the existing authorities and determined an overhaul, what needed a modernization and regulatory change, as well as in pandemic planning process.

And then particularly in the COVID response where we had

a whole different scale in terms of the level of need, as I mentioned, a threat that we haven't seen in quite this magnitude in over 100 years.

So yeah, that has been a huge part of my life's work.

Q And you have probably -- and this is probably hard to agree with, but one of the foremost experts in the exercise of these authorities in the federal government?

A I've spent a lot of time in deep assessment of these authorities, but historically in mathematical modeling and actual practice in over dozens of epidemics, local and global, over my 30-year career. So I'm heavily invested. I'm sure there are other very smart people as well.

Q I wanted to ask you about the principles that should guide your use when it comes to human beings.

A Well, I think my staff has heard me say and one of the things that I have tried to study and learn along the way is the importance of asking some really key questions in these kinds of settings and also learning from historical mistakes when some of the questions weren't asked.

Frequently it's asked may we do it, can we do it, should we do it. And sometimes there's a short circuit between what we may do and what we can do, and sometimes that's a disconnect. Sometimes there's a disconnect between the most important question is what should we do, what's the right thing to do in terms of reducing morbidity and mortality and

saving lives.

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

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

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

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

considerations, and frankly, the opportunity for appeal in terms of the process and opportunity to be heard and to limit the time.

If we're in an assessment phase and we don't know or we have reason to believe that there's an infectious threat being represented that we have a conditional approach for a short period of time and reassess the evidence as more is needed and confirm whether that person is infected or not or there's a true exposure or not and then take kind of a stepwise approach.

So those have been the framing principles in which I've tried to both respect and understand the magnitude of having these types of authorities where we balance the interests of the public good. And sometimes doing what we need to do, that if it meets all those criteria can be resource intensive and requires investing in order to meet the bar on all those things.

That's kind of how I've approached my responsibilities with this job since being in this role since 1996.

Q Thank you for that context.

One thing that you said -- and I'm now referring to the March 20 order commonly referred to as the Title 42 order that my colleagues in the minority asked you about.

You called this order unprecedented, and I wanted to give you an opportunity to elaborate why.

A That kind of wholesale border closure restriction and not only closure against admission, but also active deportation and the suspension of other types of rights that come -- that are protected under -- not under the public health side, I don't think, to my knowledge, have -- we have seen going back a very, very long way under our public health rationale.

I'm not speaking to immigration authorities, Title 8 and all other kinds of authorities that exist in the front war on terrorism, whatever. I'm talking specifically about the responsibilities derived under the Public Health Service Act and the orders that would be -- the regulation and orders that would be generated under a specific public health threat.

So it's unprecedented. It would require jumping directly to the most restrictive approach rather than looking at lesser restrictive approaches to whether they could achieve the same goals.

And I think it also bypassed some very fundamental public health principles in terms of going to root cause of the public health concerns. I think I mentioned this in the beginning when we talked about this topic -- cohorting, testing, assessment, use of nonpharmaceutical interventions, masks, et cetera.

Understanding that the threat that was being addressed

was a real and present danger, so what is the risk of importation into a setting where the reported burden of the virus was very low in the groups that were being targeted but the amount of virus that was already present in the United States was substantial and the tools that would be in place to mitigate the threat, you know, domestically were available to be used.

And so on balance, in looking at all of those things, I didn't feel that this approach met the responsibilities that we had taken on for using public health authorities appropriately, judiciously, most widely, and with the least public health collateral damage. I thought some of these kinds of consequences that were not being realized would end up having greater both COVID consequences and other public health damaging consequences.

Leaving unaccompanied minor children in camps at the mercy of many other both diseases and other consequential health risks.

So on balance, it didn't meet, you know, the thresholds for -- that we have -- you know, I've expressed and held in high regard, particularly at that March 2020 moment when this was being contemplated.

You're muted.

Q I want to follow up on a number of things you just articulated. Before I do that, I want to ask you about

process in terms of how this particular order fit into the process, as you understood it, of exercising this kind of authority.

A I'm not sure I really follow your question. Sorry.

Q The idea for this order, where did it originate from? I'll start with that question.

A It did not originate from CDC.

Q Where did it originate? How did you first learn about it?

A I was informed by the director that this was something that was being discussed. I had also been on a few conversations with the director in which this -- you know, interagency conversations in which this was actively being discussed. And as I told the director, he sought my advice and that I would offer him my advice as a career public health official. But ultimately this was a decision that was his to make, not mine to make.

But I offered him my risk assessment, the factors that are aligned with the principles that I just described.

Q Those interagency discussions have been reported on publicly. I wanted to ask you about the involvement of the president's senior advisor, Stephen Miller. Specifically, it's been reported that on March 17 there was a group call where Mr. Miller reportedly urged CDC to use its authorities to close the border immediately.

Is that true?

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

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

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

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

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

consistent with taking these kinds of unprecedented actions.

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

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

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

Q Not asking you about anything that was said.

A Just representation?

Q Exactly.

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

Q And so who was represented there?

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

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

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

originating at the White House at some times or whether NSC separately or some of the departments and agencies -- there were, you know, a number of ways in which they could be initiated and CDC would be asked to participate.

Q And who from CDC was on the call?

A To my knowledge, it was Dr. Redfield and I. I don't know that there was anyone else. I can't be a hundred percent sure of that.

Q Aside from Mr. Miller, was anyone else on the call representing the White House?

A I don't know for sure, but my best recollection is probably so. But I really can't remember. These were -- one, it's a long time ago, and, two, you know, there were people that were on -- that might have been on or weren't announced or whatever. I don't really know all the participants.

Q Was this a one-off call or a series of calls?

A There were a number of deliberations about this topic, and to my knowledge, it was not a one-off call. Dr. Redfield was the normal -- would be the normal invitee from CDC. He had asked me to join him on occasion with some of these conversations, whether it was with the White House directly or folks from Homeland Security or a call with the CBP commissioner.

Q And because you've -- your team looked into the

rationale -- let me ask you: Do you recall any other specific names of people who were working on these issues?

A I don't know, but if I did, that would be information -- sort of privileged information that I wouldn't be comfortable talking about.

Q So what was discussed is -- may be privileged, but who participated is not privileged. We can check with Kevin, but that's our position.

[Majority Counsel]. Kevin, if you'd like to put an objection on the record, please feel --

Mr. Barstow. I think if Dr. Cetron remembers who was on the calls or some of these deliberations, he's allowed to say so. I think he's saying that he doesn't remember.

The Witness. I don't remember specifically enough to call in or out specific individuals named by omission or commission. I just remember there were commissions around this that involved sort of the normal folks who have equities in these kind of policy deliberations. That's where I'm uncomfortable in terms of my memory of these topics.

[Majority Counsel]. Just to be clear, have you limited any of your answers based on instruction from Kevin?

The Witness. You mean just now?

[Majority Counsel]. Yes.

The Witness. No.

[Majority Counsel]. Thank you.

Q So following this discussion, the interagency discussion, your teams looked at this risk; is that right?

A Yes. We made some assessment trying to gather data to look at the strength of -- argument about the risk of importing this from -- from some folks, migration, and didn't -- it did not jibe.

And like I said, there were hot spots in the pandemic that were clearly very apparent, and there were hot spots in the U.S. that were much more powerfully overwhelming at the moment and some, as I also mentioned in terms of at sea, with repatriating, you know, American citizens.

This was a -- this was out of proportion to the risk, and there were many sanitary measures and nonpharmaceutical interventions that needed to be done to improve those settings, you know, very much as a first step, and there were some significant collateral damages and consequences from a public health perspective.

The problem doesn't go away simply because those people, you know, that have a legitimate fear of persecution from where they are or where they're staying and so on, COVID concerns wouldn't be addressed by these other settings on top of other public health risks that might be encountered. So that was our assessment.

Q I want to ask you about the piece of paper itself,

the order. It's been reported that a Department of Health and Human Services attorney sent your team the proposed order following a call with Mr. Miller; is that accurate?

A The order -- the proposed order was not drafted by me or my team. And there was one handed to us. As I said, you know, my job was to advise Dr. Redfield. That's been my experience as a career public health official, and I offered that advice when that order came.

I asked him if I could be excused from that process in that this was going to be a decision for the director and it should be handled by folks in the office of the director. And he respected that -- my position on that.

And I don't know specifically who had first pen or edit or who was all involved in crafting it, but to the best of my knowledge and understanding right now, certainly it wasn't members of my team, and it came from outside the CDC subject matter experts.

Where the inputs came and how it derived and all of those things, we were excused from that process, and it was managed between the CDC office of the director and other officials in the administration, the HHS or beyond.

Q I'll get into some of the reactions of your team. They've been published in the press. And specifically I'm referring to the ProPublica article. According to that article, a team member working under you said that the

proposed order included a "misrepresented and incomplete piece of data" to overstate the public health risk at the border. Is that accurate?

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

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

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

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

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

So, yeah.

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

check in with you, Kevin and colleagues in the minority, if you have any questions. But we're getting closer to wrapping up.

[Minority Counsel]. We'll have a few questions. Are you done with your hour?

[Majority Counsel]. Yes. This makes sense in terms of the time to stop.

[Minority Counsel]. If the witness is okay, the minority would like to request a five-minute break. Or four minutes, like 3:00.

[Recess].

BY Mr. Barstow.

Q You said that the risk COVID 19 at the border was overstated. If you explained it, pardon my reiteration of the question, but can you explain that again, why it was overstated?

A I think a lot of the argument was the -- made that there was a lot of COVID coming in and crossing the border and represented a risk for introduction and -- and spread. And based on all the data that we were sort of able to gather, that was the part that was overstated.

And the other aspect of it was that COVID was well established in the United States, and there were a number of hot spots, and we were also learning about the types of tools that were available in terms of nonpharmaceutical

interventions and hygiene.

And, quite honestly, those were things that had been recommended before with regard to other lesser threats, and those were the kinds of things that we thought were appropriate for the context at the time and that there was not a commensurate rationale and that there were significant harms that would come of the proposed actions that were taken.

So there was a lack of proportionality, there was a lack of legitimate threat coming in, and that there were other potential consequential harms in terms of both COVID and other public health consequences that would come with the manner in which was proposed to resolve the problem that was already well established in the United States.

Q And I'm not a medical doctor, but with an exponential disease like COVID, does stopping even one case pose its benefits?

A The benefits of stopping one case when you're already in exponential spread in widespread communities, you know, in different places across the U.S. has a differential impact, marginal impact relative to the risk of essentially repeated consequential exposures in that regard.

So yeah, I don't think stopping one case is the same when your day one January 1, 2020, as it is when you're in March.

Q Would that same logic apply to a testing requirement for Americans coming back from abroad that stopping one case isn't necessarily the end-all deal?

A So the testing requirement for -- the predeparture testing requirement had -- it's not about -- it's not about one case. We're talking about sort of the millions in terms of volume. An idea of the predeparture testing requirement is to prevent its introduction in the travel corridor and not so it's creating a safe and healthy travel corridor so that the movements and the benefits of engaging in international travel, as stipulated in the international health recommendations, can be maintained, because there's a lot of important activity that occurs with regard to maintaining the international exchange of goods and services in the case of travel, for example, and not having, you know, airlines take down the conduit that can move reagents, supply chain items for vaccine development, medical ingredients for pharmaceutical production, all of those things. So the calculus is different in that regard; right?

So I think that it's not about stopping every case or only one case. We know that there's a certain amount of leakiness being tolerated. We had a testing requirement for -- first none, then 72 hours in advance. Then it was, with Omicron it was moved closer to the time.

So these are all tailored to the circumstances and the

goals, and they're not amenable to -- by analogy, to simple, you know, generalizations, because the context matters in terms of the issues and the consequences.

Q So the testing requirement to reenter the country, that same fear doesn't apply at ports of entry? I mean, I was at the border a month ago and saw miles long of people trying to walk across that, to me, poses a congregate setting similar to --

A Right, but it is not quite the same. It's a different kind of engagement. So, for example, we don't have a testing requirement at the land crossing. We do have one in the international airspace. And it's for the very -- you know, some of that very reason, right, is that it's a different setting and so on.

So we do have adapted COVID measures that are contingent on the specific context and looking at the collateral damages versus those kinds of things.

So in order to maintain the movement of trucks that are bringing required goods for infrastructure, for medicines and all of those things and that kind of exchange, the testing requirement is not done in that setting.

So all of these different settings are a little bit different in trying to balance those kinds of benefits, and that's why they aren't the same in that regard.

Our requirements at sea are based on the unique

environment of a cruise ship and what's available, and even with the vaccination requirement, when we had the vaccines that aren't necessarily working as well in that setting, we might have, you know, a testing requirement in that space when there's a structure to do that.

So it's very, very much, you know, contextually derived.

Q The assertions that you said that the COVID-19 threat at the border, was that overstated, is that based on your team's visits and, I imagine, briefings back to you?

A There are a number of factors that came into place, including some of the team's visits, including some of the team's work with other organizations that had the ability to test and report on the incidence of infection that they were discovering and testing.

BY [MINORITY COUNSEL].

Q Did you have any data on this? Did you guys conduct any studies at the border? Were you testing -- like, you know, sampling and doing -- did you have any studies or data to back up all these assertions you're making?

A Actually, let me just reframe. Partner organizations that have been involved in some of these locations did have data, as did community organizations that were involved in testing migrants in different settings.

So yeah, there were data on this in regard to -- that

informed that the COVID infection rates were not justified to try to, you know, stop an entire set of movements based on the COVID risk in that setting.

And then there were other things that could be done that might be able to mitigate that or when the situation was more manageable, that illness could be assessed and cohorting could occur. There were different rates of COVID that were occurring in different -- it was a lot of different --

Q Could you provide those studies to us? Of the third-party partners.

A I don't know about how quickly or whether we can get that information to you.

Q You're sort of comparing flights and people crossing at land ports of entry, and you're making judgments based on, you know, the values of burdening and not burdening travel through those two means.

And I'm just wondering is that -- whose job is it to -- is it your job -- you know, is there some sort of HHS directive that says it's your job to make those value judgments, that it makes sense to test air -- people repatriating via air, but not people repatriating and sometimes migrating across land borders?

A It's our job to bring the public health data that are available and the perspectives into these discussions

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

Q Is that Dr. Redfield at the time?

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

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

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

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

Q Over the course of, you know -- I mean, the Select Subcommittee is conducting this investigation based on lots of media reports, and I think you've discussed some of those media reports with [Redacted]. There's a reporter named Dan Diamond who has written a series of articles on political interference at CDC.

Are you familiar with Dan Diamond's work?

A Not off the top of my head based on your question right now. But in general my policy is not to talk to reporters about these kind of things or do background or off the record or anything else. Everything -- every engagement with reporters that I would do is cleared through the channels with the director and HHS and others.

Q Is there an HHS or CDC policy on engaging with reporters?

A I don't know what the CDC policy is, but in general the practice of people like me when there's an outreach for any of that stuff is to tell the folks to talk to the people in public affairs and public relations, and they will scope it out and they will get the clearance that's necessary. I don't do that.

Q There was a letter that one of the prior directors wrote to Dr. Redfield about -- criticizing some of his decisions, and I think that letter got leaked.

Are you familiar with that letter?

A Are you talking about the letter that Dr. Foege --

Q Yes.

A I was familiar with it after the fact. I was unfamiliar with it at the time.

Q Are you concerned that there's lots of folks at CDC that talked to the media on or off the record, but anonymously? Does that concern you?

A In general, I think what we do as career folks is dependent on having the integrity of a deliberative process and providing our best advice and respecting the privacy of those deliberative processes so people who are in charge of decision-making make the best informed decisions.

And I wouldn't want to see anything that chilled that process. I don't think leaks or all these other things are healthy for the way we need to operate. And it's been my practice to avoid that at every setting unless I was asked and cleared to speak.

Q Do you have any recommendations for going forward what the agency should do to sort of stop what some may view as insubordination through leaks to the press? Do you have any recommendation? Should there be a policy?

I'm just asking based on your experience, your 20-plus years of experience.

A No. I'm trying to understand exactly what you're asking me. I think you're asking whether I thought it was a

good idea that people speak off the record or anonymously. I don't think it's a good idea and I don't do it. Are you asking me whether --

Q I'm asking going forward like what could CDC do differently to prevent, you know, these leaks that I think chip away at the American public's trust in our public health officials. But that's my personal opinion. You may not believe that, and I wouldn't want -- I'm not putting words in your mouth. I'm just asking for recommendations for going forward.

A I didn't actually -- I wasn't prepared to come here with a thoughtful answer to that question. I certainly can provide some thinking about that. It's probably not a straightforward question.

I think there's all sorts of things that need to happen to improve the quality of communication, the integrity of communication, the protecting the deliberative process. You know, I don't think leaks serve our public health purposes in that regard.

I'm -- you know, there may be people who have a different point of view on that, but you won't find me participating in that process, I can assure you of that.

[Minority Counsel]. Okay. [Redacted], do you want to take over? I might have a few more, but go ahead.

By [MINORITY COUNSEL].

Q So you talked a little bit about -- and I agree with you it should be the goal to use the least restrictive means possible to achieve the desired end of -- in this case, as few deaths and hospitalizations in cases as possible.

Were you involved in -- I'm asking you a question about deliberations after you just said you don't want to talk about deliberations, but were you involved in any other decisions to close businesses or close schools?

A Yeah, that has generally not been the purview of my scope in this response. I had mentioned that, you know, in the development of planning, going back to the early aughts, we looked at what was in the purview of when and if border measures were appropriate and how and what would be the benefits and consequences and what point of time it would work and how much could they achieve, and then what were the benefits of looking at 1918 in models and contemporary experiences around the globe in flattening the curve.

It turns -- as it's unfolded in the scale of this pandemic outside of the preparedness realm, the actual guidance and responsibilities about the areas you're asking were taking place in another set of the response, another task force in the response on the timing of those decisions on schools and businesses and so on.

I believe that some of the decision or the preparedness

work that we did informed that, but as was quite clear, multiple layers had different types of contribution. If you think of them as Swiss cheese, some have bigger holes than others. Some have more collateral consequences than others and have to be carefully selected and evaluated and looked at in that regard.

So the simple answer was I wasn't involved.

Q Considering your history in infectious disease, I'm going to ask you your opinion on it. Do you think there were less restrictive means to achieving the end than closing businesses?

A Do you mean in January of 2020 to January of '21? Is that what you're saying? Or are you talking about a particular point in time? Are you talking about the March --

Q I think the mid one was March 2020 until -- and I think some were still at least operating at marginal capacities until recently.

A It would be hard for me to give you a really specific opinion. What I can say is while we're awaiting for the vaccine development and medical countermeasures, et cetera, a wholesale unmitigated pandemic would have really, really grave consequences.

And I do not espouse to that philosophy of what some would call the sort of "let her rip." And I don't think

that if you take the kind of zero COVID policies that we've seen in certain Asian countries and you keep things, you know, down and suppressed for a very long time that you maintain a totally susceptible population.

But you're buying time with those types of policies, and you aren't prepared to come back with a very robust use of effective medical countermeasures when they're available. You're setting up a vulnerability.

So the answer about where is the sweet spot in trying to attenuate the more severe impacts, once the healthcare system becomes overwhelmed, the collateral damage across broadly beyond COVID is enormous.

And I think that that -- you know, attenuating those kind of severe spikes that you saw with Omicron in late fall and Thanksgiving through something like January, those can be devastating when the entire healthcare systems are brought to the brink and surgeries that are needed can't be performed and response, ICU for a car accident isn't available.

Now you're really talking about serious consequences. You've got to find a sweet spot, and in some ways that depends on what's working in different settings. And it's not an easy thing to answer.

This is why we spend so much time studying it in history, studying it in models and theories, studying it in

practice, looking at the impacts of other countries as they took on different policies, and constantly trying to navigate and find effective approach.

And that approach also changes over the course of the pandemic when the virus issues a curveball and mutates or when population immunity does build up in a less vulnerable group, so they constantly have to be looked at and reflected on.

And I don't think there's a simple answer of all on or all off. I think it's actually neither of those two. It's much more delicate to figure out the right balance.

Q Do you recall who ran -- or, first of all, what was the name of the task force within CDC that was in charge of that kind of stuff and who ran it?

A I don't recall. It was a big issue, and it was broken up into a lot of different settings. There were some that focused a lot on schools and were gathering data on schools. There were some that were collecting data on the use of masks and what impact masks would use. We have modeling and forecasting group that's assessing these kinds of things theoretically and doing projections.

So it's a pretty widespread set of responsibilities.

Q You brought up how mitigation measures evolve and medical countermeasures evolve.

As more vaccines have been brought to market, more

antivirals have been brought to market, we've learned the efficacy or non-efficacy of various nonpharmaceutical interventions, has CDC altered public health policy to kind of flow with it?

A If you're asking my opinion as not the person that's responsible --

Q Yes.

A -- I think there's been an evolution of CDC guidance and recommendations that are adapting to the stages of the pandemic and the availability of interventions. I think it would be pretty apparent if you looked at the course of our guidance over time and from that opening act to -- in early January to where we are now.

Examples include the length of time for isolation and quarantine, availability of tests, types of use, availability of using masking both as personal protection and importantly, very importantly, source of control and the different settings of risk, yes, I think CDC has attempted to be adaptive.

Q In your opinion -- so we've seen how effective vaccines can be and how effective the antivirals can be, how much we've learned from like early processes in hospital care, in at-home care, but unfortunately more likely to continue to see significant deaths, more people dying in 2021 when we have all these things in 2020.

Why do you think that is?

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

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

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

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

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

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

host, the type of host, and the milieu or the environment or the social context to structure the engagement, the policies, the behavior aspects, whether it's, you know -- and one setting differs so much from another, as we've seen sort of zero COVID policies in China with the Omicron.

The high -- the complex circumstances of pathogen hosts and the environment can have the perception of one pathogen, similar pathogen having either low severity overall impact or having a high-severity impact, depending on that interaction.

The truth is this is what keeps people who do this for a living constantly engaged because we're always trying to figure out what's the balance of that interaction between the pathogen we see as it evolves, host of the populations that are at risk and the policies, behaviors, and the milieu and the context and the population and the setting where it occurs. That is a pretty holy trinity principle in infectious disease, public health.

Q Knowing a significant portion of the population is fully vaccinated and another significant portion is not and there's at least another portion that has some level of natural immunity, Dr. Fauci said on TV last week that we're nearing the end of the pandemic phase of the virus. He said it's pretty much moving to endemic. Do you agree?

A Yeah, I think that's a little bit out of scope

here. But the other, you know -- you know, thing about this is, I think there's a lot of misunderstanding about the various terminologies and so on.

Q It's just --

A I'm not going to -- I'm not going to share here and I think it's a much more complicated question than perhaps even you realize.

[Minority Counsel]. [Redacted], do you have anything more?

[Minority Counsel]. No. I just hope that we can get some of that data from the third parties that were testing people at the border in those land crossing areas that helped you solidify your opinion on, you know, the land crossings versus flights coming into America and, you know, those opinions.

Mr. Barstow. As always, we're happy to consider any request that is made by the Committee.

[Minority Counsel]. Thank you, Kevin.

[Minority Counsel]. I think we're good for our hour, then.

[Majority Counsel]. Dr. Cetron, do you want to take five minutes or do you want to keep going? I anticipate having less than an hour left.

The Witness. Let's keep going. It's a long day. So --

[Majority Counsel]. I appreciate that, and I appreciate

your patience.

By [MAJORITY COUNSEL].

Q I wanted to circle back to our discussion and clarify a few things for the record.

Where did this proposed order come from?

A Which proposed order? Which order are you talking about?

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

A I don't know, to be honest with you. I can't say definitively one place. You're talking about the written order, the draft?

Q The draft, yes.

A I can't say with any certainty. I can just say that neither I nor my team were involved in drafting it.

Q Was CDC considering anything like that in terms of restrictions at the land border?

A Do you mean the wholesale closure of the land border to a certain population? Is that what you're talking about?

Q Right.

A As opposed to the other kinds of things that I mentioned?

Q Right.

A I think that we -- you know, I think we've looked at the people that have talked about it. We've discussed

how those types of border closures have worked or not worked or failed in the past and what were the goals and what would be the effective means of trying to address it.

And if the circumstances changed, it's a different situation, but that was not -- it was not deemed to be the appropriate tool or the appropriate use of that authority for that purpose, given all of the totality of circumstances.

Q I want to ask you about another quote that's in the ProPublica piece. And it comes from -- it's attributed to someone reporting to you, and it is an email where this person wrote, "I'm also not a fan of trying to make the case that Canada and Mexico represent a big risk on the land border based on what we believe" -- and "believe" is in quotes -- "is occurring versus what we know about the number of cases, which are far fewer than the number of cases in the U.S. now due to community spread."

Is that an accurate assessment of the data as it was known at that time?

A Yes, I can't speak to every single word of a quote that somebody else offered on my behalf. But I think, as you've heard me say, you know, a number of times, that comports with the assessment.

Q Okay. The quote is -- starts with "I'm also not a fan of trying to make the case that Canada and Mexico

represent a big risk on the land border."

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

A I think that's what was -- I think that's what was being asked by this proposal that came to us, you know, to invoke that kind of authority is to, you know, see whether that was a justifiable public health action based on the circumstances at the time. I don't know if you would call that making the case. But, in any event...

Q Sure. And you mentioned that you chose to excuse yourself from the ultimate decision to authorize the order. When did that happen?

A I don't know. I think whenever Dr. Redfield said, you know, said to me, this is the decision that's being taken, and I said to him, I think, that there are potentially significant harms in that decision, and I would appreciate it, if that's your decision, if you guys handled it out of the office of the director, which he accepted.

I'd given him my advice on the issue earlier, and from past experiences in other epidemics in other settings, that I thought it might propose a false sense of security about what really needed to be done and should be done first and foremost, and it could be much more effective in addressing this and that it was not a least restrictive means approach.

It was not generated -- insufficient evidence that the

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

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

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

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

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

Can you explain what you meant by that.

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

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

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

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

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

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

Those were some of the things I was very concerned about in addition to the negative public health conditions of misidentifying the source of the problem and not addressing things that were more important and more impactful.

Q And I know you've studied this and the exercise of these authorities throughout history.

What sort of impact has that stigma had in the past in American history?

A I think we've seen a number of examples where, you know, individuals or groups of individuals were blamed for a problem as if that allowed for an explanation that marginalized the problem and kept it at bay or contributed to either a sense of denial -- as long as I listen to that individual or that person, the problem didn't -- wouldn't and didn't impact me, so on, that kind of thing.

That creation of a concept of "other," and "other" is where the risk is and "other" is where the consequences would be. I think that not only has harms in terms of creating the stigma, but it allows for a false sense of security about what an individual may or may not be part of that group need to be doing in order to play a role both in protecting myself and in my responsibilities toward handling the problem.

And there are many examples in history, you know, that would comport with that, whether it's HIV stigmatizations

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

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

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

Did you say that?

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

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

Q Sure. Did you believe that the authority was being

used to keep Hispanics out of the country?

A I can't -- I can't specifically say why all the decisions that have been made around these kinds of things are being done. That's not for me to say what the intentions always were.

What I can say is that the evidence to use the authority did not seem to be sufficient or justifiable, that there were less restrictive means. There was a potential that misrepresenting the situation would create stigma and would create a distraction from doing some of the things that were more important and absolutely necessary and that might create additional public health harms and consequences.

I can't make judgment on, you know, what's in the minds and hearts of other people who are promoting those priorities.

Q Were you concerned that keeping Hispanics out of the country might be the rationale?

A Was I concerned that there might be more than a public health agenda involved and I don't know all the aspects of it? Yes, I was concerned that there may be a motivation that was beyond the specific public health agenda.

But, again, that is for other people who are proponents of the policy to, you know, articulate, not for me.

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

the period that we're talking about.

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

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

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

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

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

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

liberties are restricted for the benefit of the whole, we should be thinking and be very grateful for those people who make that effort and we should try to support in all ways possible mitigating the impact, you know, on these folks, because they are making, you know, compromises.

And the best way to instill that collective spirit in this sense is to actually try to always stay a little bit, you know, above the fray and create a sense of balanced decision-making that's grounded in good science and good practice and with a sense of dignity and honesty and so on.

I've tried to adhere to that, you know, my entire career. It can be very challenging in a pandemic. But I think it gets back to what we really understood to do collectively in terms of battling these problems and not just consider what our own individual perspective is, but consider the perspective of all involved.

Q I want to move on and ask you -- you mentioned that the authorities include interstate authorities. I'll first ask you: At any point during this period did CDC consider any other uses of that authority? I'll ask -- in terms of --

A I'm not sure I understand. I'm not sure I understand the question.

Q That's a bad question.

I'll ask you specifically, it was reported that CDC was

considering a mask requirement on public transportation.

Were you involved in that discussion?

A Absolutely, yes.

Q Okay. And tell us a little bit about what the authorities are in this in terms of that requirement.

A Again, there were a lot of conversations happening jointly in the interagency about how do we mitigate the impacts of the pandemic while minimizing the interference with travel and trade. How do we create safe travel and healthier travel experiences?

How do we maintain the ability for international exchange of goods and services to continue in parts of the economy, you know, in that regard that are critical or important and to continue, how do we move supplies of vaccine and antivirals and critical supply chain reagents around.

And there was a joint interagency effort discussing what's in our tool kit. As I indicated to you, there was a time which this concept of geographic 212F proclamations where we tried to, you know, shut the borders or ban movement.

Could be that wasn't actually going to be sufficient and no longer had the same kind of place in the phasing of where the pandemic as it was globalizing would be, but would have a chilling effect on keeping, you know, flights going and

international exchange.

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

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

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

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

markedly improved by having people wear masks. And there were obviously caveats and exceptions and age limits and all of those things.

But the evidence was scientifically there. We modeled the issue in terms of the risk on its potential contribution, which was significant in risk reduction. And these things were -- you know, this idea was generated out of CDC but discussed in interagency deliberations, and I had talked about it with CDC director and so on.

And there was a general support for that, and we began working on that problem beginning in that July time frame of 2020, and these conversations were ongoing over the course of the summer and the summer travel season in 2020.

So -- and we drafted -- we drafted that -- that order.

Yes, I think it was a potentially important tool in the tool kit that could make a big difference. I know Dr. Redfield was very supportive and has given testimony on the record the tremendous power of masks in reducing transmission, especially if worn properly and worn by everyone and that it wasn't just about what you were doing for yourself to protect yourself; it was also a way of controlling the unknown asymptomatic infection and containing it so that you weren't actively spreading that.

So if everybody participated in these various settings of density and mixing and so on, it would have a tremendous

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

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

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

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

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

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

state or a particular jurisdiction or the risk of one airport versus another or one, you know, entity versus another creating a lot of confusion.

And so this was a -- seemed to be a very good space for a coordinated, unified set of efforts that were guided by best practices in some of the scientific evidence and the public health evidence was emerging.

That was our thinking in developing that order was in that spirit of getting a handle on control, especially in the pre-vaccine era, but not exclusively. Even beyond, it's very important.

Q Can you give us the contours of the order? Where would it have applied, what were the enforcement mechanisms, and --

A Interstate and international arrival transport corridors. That would include both the hubs, the airports as well as on the conveyances, for example; also surface transport with interstate linkages and movements.

So which is the buses, terminals and the buses that moved, you had linkages that would be transporting interstate passengers. You know, that was one of the overall framing of this.

And that there were carve-outs for places on the grounds that were either, you know, outdoors and well ventilated or wholly private nonpublic-facing and so on. They were framed

in those regards.

There were carve-outs for folks with certain disabilities that had medical authorization and inability to use a mask or children under a certain age that couldn't be expected to regularly, you know, use masks in that regard.

But yeah, aside from the sort of carve-out issues, it was meant to be that jurisdictional space within the federal government where the federal government had interstate movement on the international level.

Q You said your team drafted it in July?

A We began the discussions and we began evolution of the drafts and interagency deliberations and building the argument and presenting the data. And then we were moving it up.

We had, as I indicated, support of our director and the secretary, and it was being moved into those kinds of decision-making processes for White House task force and the interagency and so on.

Q So what happened with that order?

A Despite what seemed like a fairly broad consensus, ultimately that decision was made and we were told that there would be no such use of federal authority for masking in a transportation corridor, mask requirements in the transportation corridor, and that that would not happen.

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

A Not specifically. There was all sorts of speculation, but I don't care to speculate. But it wasn't -- it wasn't going to happen, and we needed to look for alternatives to being able to use that tool.

Q It was reported in October of 2020 that the White House blocked that order. We have an article there that covers it. I think it's the last exhibit, but let me check. Hold on one second.

Yes, Exhibit 16.

[Exhibit 16 was marked for identification.]

A Okay. What's your question?

Q It says there that "the White House Coronavirus Task Force, led by Vice President Mike Pence, declined to even discuss it."

Is that accurate?

A I think that that's also a question for Dr. Redfield. It sounds like meetings that he was involved in that I wasn't at.

But I think it sounds like Dr. Redfield, you know, interviewed with Sheila Kaplan on this article, and maybe you asked him the same question. I'm not sure.

Q Do you think that -- and I think you went into this.

Do you think that such an order would have been in the best interest of public health at the time?

A I do.

Q We saw a very deadly surge of the virus in the winter of 2020. Do you think that implementation of this order could have saved lives?

A I think it would have helped. Just like I said, multiple layers implemented early effectively, you know, makes a difference. And I think this would have -- I'm not saying it would have stopped the surge or the waves.

I think it would have affected the shape of the surge, along with many other things that needed to be done, and I think the risk of both importation and spread, I think especially the risks of spread, travel of the many waves that we've now seen over two and a half years has been tightly correlated with resurging waves.

It's been correlated with the introduction of variants, and it's been correlated with the shape of surges. As travel volume has gone up, it has amplified and extended and accelerated the shape of those curves, and I think that, you know, masking in the transportation corridor could have made a significant contribution.

And I was disappointed when we were unable to use that tool. And in my opinion, it was well within the scope of the federal public health authority that the CDC was given.

Q Apart from the episodes that we've discussed, did CDC seek to institute any other orders in this time period

that didn't happen?

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

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

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

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

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

best advice to -- whether it's the director who's asking or anybody else in an agency discussion. I think it's important to understand the larger picture at play.

So I think we're responsible for all of the -- you know, the authorities and the advice that's given to us as leaders and to use it with a strong moral compass.

Q Were there any other times where your moral compass was challenged in that way?

A You know, this has been a difficult pandemic on so many grounds, and it has been challenging to make hard decisions in a lot of places. I think suffice it to say that, you know, I looked and tried to consult the framing of all the decision that I make that is infused by a set of principles.

I've served -- you know, the integrity of the science, communication, honesty of process, the balance of the equities, the least restrictive means, the opportunity to appeal given the decisions, the proportionality.

I don't know if you call that a collection of moral assumptions or just, you know, parts of trying to execute my job faithfully and with responsibility and integrity.

Q There has been a great deal of public reporting about political interference in the CDC scientific work by Trump administration officials. Do you think political pressure was a problem for the CDC in 2020?

A I think that, yes, I think it was a problem in various aspects. I think that's, you know, not much in dispute in that regard.

You know, pandemics are whole of society events. They involve taking into perspectives the political, public health, private sector population. There's lots of perspectives that they should all be as part of what we need to do as whole of society is rather than seeing all these things as a battle and a fight and false dichotomies that it's either public health or, you know, a private interest or a population desire or, you know, a political interest, it's all of those things.

If we constantly are finger-pointing and blaming somebody else for things, we lose the fact that the real enemy here was the virus and its ability to cause just a tremendous amount of suffering, harms, morbidity, mortality, death, mental health consequences, missed opportunity, and collateral damages across multiple sectors.

We are all best served if we're going to battle pandemics if we can find a way for those things to not be in false dichotomy, but to find a win/win where it's not an either/or but it's a both/and. How do we comprehensively work together to battle the threat of this virus, because at stake here is risk to all of us, no matter which lens we're 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?

A Never too late to start. Better communication, better listening, better understanding. You know, truth and honesty, quelling the act of disinformation, fair representation of the circumstances and situation at hand, acknowledging uncertainty, living in difficult spaces but knowing that there are better and less well paths forward and trying to find those solutions jointly.

I think that will help restoring the integrity of our institutions and our leaders, but also having more collective responsibility for one another at the individual local level as well.

Q One final question: Are there any policies or procedures that you wish had been in place and could have protected the CDC or could have protected the public?

A I think that's a really long answer, and I think that we'll -- we'll need to sit back and take time and tease this apart and do, you know, a full dissection and we will come up with recommendations and interim actions.

My only hope is that we can do that with a sense of collective fairness for what's at stake and respect for one another and that we deliberate around that with a sense of integrity rather than a sense of divisiveness, because there's a lot at stake if we don't.

And I would like to see some of the lessons observed really turn into lessons learned in a very honest way,

self-reflection and reflection on others. And too often I think there's lessons that are observed that are never really learned and mistakes that are repeated.

I know that when I look back at the 1918 pandemic in detail, it feels like there were lessons there that were missed and ignored as we came into this pandemic, and I hope we can do a better job in that reflection in the future.

Q Any specific lessons top of mind?

A There are going to be many, and I'd hate to leave some out at the end of a very long day. Probably that will take some time, but I just hope we commit to honestly engaging in that instead of blaming, finger-pointing.

I really hope that we actually can see our way collectively to looking at what worked and what didn't and what we might do differently and have some genuine conversation around that.

Q Is there anything else that you'd like to put on the record before we close?

A No.

[Majority Counsel]. On behalf of the majority staff, I want to thank you for your decades of service to this country and particularly the sacrifices you've made over the last couple of years, and I want to thank you for taking the time to speak with us today.

The Witness. Thank you. Thank you to all the members

here.

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

[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