COMMITTEE ON OVERSIGHT AND ACCOUNTABILITY,

SELECT SUBCOMMITTEE ON THE CORONAVIRUS PANDEMIC,

U.S. HOUSE OF REPRESENTATIVES,

WASHINGTON, D.C.

INTERVIEW OF: ANTHONY S. FAUCI (DAY 2)

Tuesday, January 9, 2024

Washington, D.C.

The interview in the above matter was held in room CVC-268, Capitol Visitor Center, commencing at 10:00 a.m.

Present: Representatives Wenstrup, Griffith, Malliotakis, Jackson of Texas, Cloud, McCormick, Ruiz, Ross, Dingell, and Castor.

Appearances:

For the SELECT SUBCOMMITTEE ON THE CORONAVIRUS PANDEMIC:

MITCH BENZINE, STAFF DIRECTOR.
MADELINE BREWER, COUNSEL
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For the U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES:

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For the WHITE HOUSE:

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ALSO PRESENT:

[redacted]

[redacted]
GRACE MCMAHON (PARALEGAL)
MATT LAGANZA (PARALEGAL)

[redacted] We can go on the record.

Good morning, Dr. Fauci.

Dr. Fauci. Good morning.

[redacted] Thank you for coming back.

Just a couple of housekeeping items. One is that all the same rules from yesterday's conversation will also apply to today's conversation. Another is that the exhibit labels, both majority and minority, will be continuous. We'll just pick up where we left off yesterday.

And with that, I think we'll have folks in the room identify themselves. It might be logical just to start here. [redacted] chief minority counsel, select subcommittee.

[redacted] [redacted] chief counsel for the minority, Energy and Commerce Committee, Oversight and Investigations Subcommittee.

[redacted] [redacted] senior counsel, Democratic staff, select subcommittee.

[redacted] [redacted], minority counsel, select subcommittee.

[redacted] [redacted] Democratic staff director of the select subcommittee.

Mrs. Dingell. Debbie Dingell, select committee member, Energy and Commerce Committee member, and the Representative for the University of Michigan. Go Blue.

Dr. Wenstrup. Brad Wenstrup, Ohio Second District.

Mr. Benzine. Mitch Benzine, staff director for the majority of the select subcommittee.

Mr. Strom. John Strom, senior counsel, House Energy and Commerce Committee majority, Subcommittee on Oversight and Investigations.

Ms. Brewer. Madeline Brewer, majority counsel, select subcommittee.

Mr. Spectre. Peter Spectre, professional staff member, select subcommittee

majority.

Ms. Langley. Anna-Blake Langley, professional staff member, majority, select subcommittee.

Mr. Osterhues. Eric Osterhues, chief counsel, majority, select subcommittee.

[redacted]

Mr. LaGanza. Matt LaGanza, paralegal.

Ms. McMahon. Grace McMahon, paralegal.

[redacted]

Mr. Barstow. Kevin Barstow, White House Counsel's Office.

Mr. Cooke. Perrin Cooke, senior counsel at HHS.

Mr. Onorato. Danny Onorato, counsel for Dr. Fauci.

Mr. Schertler. David Schertler, counsel for Dr. Fauci.

Dr. Fauci. Anthony Fauci, former director of NIAID; currently, professor at Georgetown.

[redacted] Great. Thank you, all. We'll start our timer.

EXAMINATION

BY [redacted]

Q Dr. Fauci, I will just start with a few pretty discrete, narrow questions about a few things that were discussed in the last hour of yesterday's conversation.

And the first one of those is just, there was a conversation about Dr. Ping Chen at NIAID and her trip to the Wuhan Institute of Virology BSL-4 lab, and her observations as it related to the training levels of the folks working at that lab. You provided a little bit of context about how the French helped the Chinese build that lab.

I just want to ask, our understanding is it's not at all clear to us that that is the lab where the EcoHealth work occurred.

We understand that it seems much more likely to be the case that that work, the year 5 report, all those experiments that we keep talking about, occurred in a BSL-2 or 2+ or 3, whatever environment on a completely different campus that's like 45 minutes away by car from the BSL-4 lab.

I don't know if you have a similar understanding.

A I have an understanding of the relationship between a BSL-4 lab and the experiments that were conducted under the NIH subaward through Eco to the Wuhan Institute of Virology, and those experiments would not have all been done or required to be done in BSL-4.

So I think the confusion, if I might say, that occurs when people bring up reference to a BSL-4 and/or the training that might be required of or requested for individuals who will be working in BSL-4 is unrelated to the experiments that were done, which would be either BSL-2 or BSL-3.

I'm not sure of the physical location of the two. But the one thing that's clear is that what we're all talking about here are not BSL-4 experiments.

Q I appreciate it. Thank you.

My next question relates to majority exhibit 13, and that's an email starting with Dr. David Morens. It does not have a Bates number, but I'll give counsel a moment to find it and I'll give you a moment to flip back through it.

[Pause.]

A Okay. Yes.

Q My only item of interest is on the third page of the physical document. Down at the bottom there's an email from Dr. Morens to Dr. Daszak that starts with, "Great info, thanks." I don't know if you see that.

A I see it.

Q I'm going to read the sort of pertinent part out loud.

"Great info, thanks. Tony doesn't maintain awareness of these things and doesn't know unless program officers tell him, which they rarely do, since they are across town and may not see him more than once a year, or less..."

So just setting a little bit of context, it's a little bit of what we talked about yesterday. It sounds like this is sort of contemporaneous, late January even, Dr. Morens is saying, hey, in general, Dr. Fauci doesn't know anything about a particular grant at any given moment, and in this particular conversation about EcoHealth Alliance, he does not have awareness of what we're talking about.

Is that what you read here, and is that what you recall?

A It's what I read, and it's what I recall.

As I mentioned yesterday, we have thousands of grants. We have very highly trained subject matter experts at the program level that look at the grants and monitor the grants. It would be physically impossible for me to get into and look at every grant.

And that's the reason why you have trained personnel at the program level, one of which, for example, is Cristina Cassetti, who's the deputy director of the Division of Microbiology and Infectious Diseases. She is Emily Erbelding's deputy.

And then, as we spoke yesterday, you have the people down the line in the program, Erik Stemmy, Diane Post, and et cetera, et cetera.

Q I understand. Thank you. Great.

I also have a question or clarification about majority exhibit 17, and I'll give folks a minute to flip to it. That's an October 20th, 2021, letter from Dr. Tabak to Representative Comer.

Mr. Schertler. What exhibit number is that?

[redacted] Seventeen is what I have.

Mr. Schertler. Got it. Thanks.

BY [redacted]

Q So I'll give you a moment just to glance back over that, if you'd like to.

A Is that the one dated October 20th?

Q It is.

A Okay.

[Pause.]

A Yes.

Q Great.

So my question is, on the second page of the letter, there's a little bit of discussion. I might just read a few excerpts, starting with above those bullet points.

There's a sentence that reads, "The second document," which is not seen here but was attached to the letter, "is a genetic analysis demonstrating that the naturally occurring bat coronaviruses used in experiments under the NIH grant from 2014 to 2018 are decades removed from SARS-CoV-2 evolutionarily."

And then subsequent to that are a series of five bullet points describing five different viruses. The fourth bullet point there is RaTG13. I'm just going to read that one.

"RaTG13, one of the closest bat coronavirus relatives to SARS-CoV-2 collected by the Wuhan Institute of Virology."

In the paragraph following that, there's a discussion of how a 96 or a 97 percent match actually represents decades of evolutionary distance; therefore, the conclusion is the bat coronaviruses studied under the EcoHealth Alliance grant could not have been the source of SARS-CoV-2 and the COVID-19 pandemic.

There was some discussion yesterday about this general part of the letter. I

don't know to the extent to which you're familiar or not, but I just wanted to ask, we're not sure, and, in fact, I think we think that RaTG13, although it has gotten lots of interest because it's sitting at that 96 percent match, it's not clear to us that that had anything to do with the NIH grant or the EcoHealth work. It seems that that was collected in --

A Right.

Q -- field work done by the Wuhan Institute on its own time, on its own dime. Do you have any sense of that?

A That is my understanding. The virus that was part of the experiments that were funded through that subaward is WIV-1. That's different than RaTG13.

Q Precisely. And so I only clarify it because the phrasing of the letter could lead a reader to think that every virus named here was part of the NIH work. I don't think that that is actually the case.

A That is not the case, yeah.

Q All right. Great.

The last question or clarification from me is that -- there's no exhibit for this. I'm just going to read something to you.

There was some discussion towards the end of the day yesterday about the previous exchanges that you have had with Senator Rand Paul on the general topic of gain-of-function, the extent to which those exchanges were either clear or not so clear.

I'm just not sure that they are as unclear as maybe it seems like, listening to our conversation yesterday. So I just want to read a few excerpts from those conversations, if it's okay with you.

In the May 2021 Senate HELP hearing, which I think is the same hearing that has the initial quote that we discussed yesterday that we did not ever fund gain-of-function, Senator Marshall asked you, "My point is, is there national security implications with

something as theoretically lethal as viral gain-of-function?'"

You answered, "Sure, there is. That is why we have committees. We have a P3CO committee, which is the Potential Pathogen" -- "Pandemic Pathogen Care and Observation" -- "and Oversight," excuse me.

So my point is just to note that it does seem as if within the context of that hearing you pointed folks to the P3CO framework.

A Yes. I did.

Q Great.

In a separate hearing, in November 2021, where yourself and Senator Paul again discussed this same topic, you said the following to Senator Paul.

Quote, "Senator, with all due respect, I disagree with so many of the things that you have said. First of all, gain-of-function is a very nebulous term. We have spent -- not us but outside bodies -- a considerable amount of effort to give a more precise definition to the type of research that is of concern that might lead to a dangerous situation. You are aware of that. That is called P3CO."

That's the end of the quote.

So I just wanted to highlight that to emphasize it. It seems to us that for a listener --

A Right.

Q -- of those exchanges --

A Right.

Q -- there would have been some degree of clarity --

A Right.

Q -- about what you were talking about.

A Yeah. I'm glad you brought that up. It didn't come into the conversation

yesterday. But it isn't as if P3CO was never brought up in the discussions that I had. As you said there, it was brought up twice, at least, maybe more.

Q And there are others that --

A Yeah.

Q -- I won't bother to sit here and read them.

A Maybe more, at least once to Senator Paul and clearly once to Senator Marshall.

Q It looks like you may have read him out loud the whole definition about highly transmissible and uncontrollable, et cetera.

A Yeah.

Q Great. That was all, I think, I had. And with that I'll turn it over to my colleague Will.

[redacted] Great. Thank you.

Before I start on questions, I know that a couple members joined immediately after introductions. Now is a good point of --

Ms. Castor. Congresswoman Kathy Castor.

Ms. Malliotakis. Congresswoman Nicole Malliotakis.

[redacted] Great. I think that's everybody.

BY [redacted]

Q Good morning, Dr. Fauci.

A Good morning.

Q I recall at the end of yesterday's long 7 hours of questions there was an exchange that my colleague [redacted] was just going through some of the clarification on testimony, and something that you said I wanted to revisit.

You know, you mentioned that you've endured roughly 3 years now of people

taking things that you had said, taking them out of context, mischaracterizing them, using them in ways that are political, nefarious, disingenuous, et cetera.

So, candidly, I actually thought that many of yesterday's questions from both sides were helpful and I thought illuminated a lot of what your role was at NIAID, the crucial lifesaving work you and your colleagues did in the middle of the pandemic, and a lot of what the lessons were that we learned and should apply going forward to prevent illness, save lives, prevent or address the inevitable next emerging threat.

So that's why -- last night, the select subcommittee on their Twitter account -- this is the Republicans, they're in the majority, so they control the committee Twitter account -- they sent out their version of how they saw the day's testimony.

Let me first ask, I know you're not a social media guy. I think everybody who's read a lot of stuff here knows that you're not on social media platforms.

A Right.

Q You didn't see the tweets --

A I didn't.

Q -- last night? Okay.

A I didn't see the tweets, no.

Q Okay. So I thought -- and you didn't tweet out your own recap of yesterday's --

A I don't know how to tweet.

Q Okay. Great. I didn't think so.

Ms. Malliotakis. I wish I didn't either.

[redacted] Okay.

Mrs. Dingell. My staff won't let me.

[redacted] So I just thought you should see them as we enter a second day

of questioning, in case you wanted to react to them or clarify anything for any confusion.

So there is a thread of tweets, a series of tweets, and we'll just take them one at a time.

So I'm introducing first as exhibit J. This is the first tweet in the -- K? Oh, we're on K. I'm sorry. We ended on J. We are on K.

So this is exhibit K.

[Fauci Minority Exhibit K
was marked for identification.]

BY [redacted]:

Q And this is the first tweet in the series from the Select Subcommittee on the Coronavirus Pandemic Twitter account @COVIDSelect. I know it's X now, but I just can't stop calling it Twitter, so I'll just keep calling it Twitter.

So this tweet reads -- and I'll just read it for the record. It's short. There's some red sirens around the first part.

"DR. FAUCI DAY 1 TAKEAWAYS: Today, @COVIDSelect questioned Dr. Anthony Fauci for seven hours about his role during the COVID-19 pandemic. Dr. Fauci's testimony uncovered drastic and systemic failures in America's public health systems." And then, "Key highlights below."

So I wanted to, you know, ask your impression of this statement that your testimony, quote, "uncovered drastic and systemic failures in America's public health systems."

Now, I know that, you know, we talked about lessons learned, we talked about things we can improve. I think there was some great exchanges particularly on public health data, you know --

A Right.

Q -- therapeutics --

A Right.

Q -- countermeasures, all of that.

But do you think it's a fair characterization of your testimony yesterday that we uncovered drastic and systemic failures in America's public health systems?

A No. I mean, it was discussed under lessons learned. And one of the things that I said yesterday is that the CDC, for example, and the public -- local public health infrastructure, we don't have that kind of realtime communication that goes back and forth, and that needs to be corrected so that we can get realtime data in our decision making. But I wouldn't characterize it as a drastic and systemic failure.

Q Okay. Thank you.

So I'll introduce now the next tweet in that thread, exhibit L. I'll read it for you as well.

[Fauci Minority Exhibit L
was marked for identification.]

BY [redacted]

Q So the next tweet in the thread read, "Dr. Fauci claimed that he 'did not recall' pertinent COVID-19 information or conversations more than 100 times."

So as anybody who was sitting here yesterday, particularly during the first hour, I think this is a pretty distorted characterization of what actually happened. So I want to unpack this a little bit with you and see if your recollection squares with mine.

So do you recall in the first hour of your testimony yesterday being asked whether you had conversations with a long list of individuals about three particular topics? I think it was COVID origins, the Wuhan Institute of Virology, or EcoHealth Alliance. Is that your recollection as well?

A Correct.

Q Okay. And there was a long list, I think, you know, off the top of my head maybe 50, 60 different individuals, at least. Is that about right?

A It was a large number. I don't remember.

Q Okay. A large number.

So you were asked essentially if over a 3-year period during which you were playing a key role in our country's response to a novel coronavirus pandemic whether you recalled specific conversations with specific individuals on three specific topics, right?

A Correct.

Q Okay. And I imagine that during that period you likely had thousands of conversations easily with different individuals around the world, scientists, public officials, about the coronavirus in some fashion. Is that fair?

A Correct.

Q Okay. So when you were answering in those instances that you did not recall whether you had conversations with specific individuals, that may well be because you either didn't have a conversation with them about something or you may have, but the conversation about a specific grant, for example, among the thousands and thousands of conversations you were having about COVID generally wasn't memorable in the context of a pandemic that at its peak was killing thousands of Americans every day.

Is that fair?

A That is correct.

Q Okay. So in a few instances, if I recall correctly, you even volunteered that someone may have been part of a conference call or a broader group, and that even if that didn't fit in the literal definition of having a specific conversation with them, that you wanted to be clear and transparent, they may have been part of a conversation, they may

have been included in a conversation even if you didn't speak with them directly about a topic.

Is that right?

A That's correct.

Q Okay. And I'm assuming that the reason you did that is because you take this seriously, you want to be as transparent as possible, and you don't want to be accused improperly of hiding anything or not being forthcoming. Is that right?

A That's correct.

Q Okay. Thank you. And we appreciate that.

Let's move to the next tweet in the thread. This will be exhibit M.

[Fauci Minority Exhibit M
was marked for identification.]

BY [redacted]

Q Okay. I'll read this into the record as well. These are all short.

"Dr. Fauci profusely defended his previous testimony where he stated NIH does not fund gain-of-function research in Wuhan. Today, he repeatedly played semantics with the definition of gain-of-function in an attempt to avoid conceding that NIH funded this dangerous research."

So, now, I think the first part of this tweet we probably generally agree on. You did defend your prior testimony because, as my colleague just walked you through again, for the sake of being clear for the record, your previous testimony was accurate.

Is that right?

A It was accurate, correct.

Q So, now, the second part says that you, quote, "played semantics with the definition of gain-of-function," end quote.

Do you think that's a fair characterization of your testimony yesterday?

A No, that was unfair --

Q Okay.

A -- because that's not what I was doing.

Q And if I remember correctly, you were being precise about using a term with a specific regulatory meaning.

Is that right?

A Correct.

Q Okay. And so as we've discussed, and I imagine it will come up again today, if I had to guess, that the use of gain-of-function broadly is meaningless in one sense, and then for you, in the context in which you were evaluating whether something was gain-of-function and in congressional testimony when you were being asked if something was gain-of-function, that hit a specific meaning due to a regulatory framework that determined if something was gain-of-function.

Is that right?

A Correct.

Q Okay. Do you consider that to be semantic or precise?

A Precise.

Q Okay. I do, too.

So, in fact, not only did you state that the research funded through a subaward at the Wuhan Institute did not meet the gain-of-function -- the definition of gain-of-function under the P3CO framework, but I actually recall majority staff agreeing with you several times toward the end that research conducted at the Wuhan Institute of Virology through the subaward was not subject to the P3CO framework and its definition of gain-of-function.

So I think people seem to understand in the room, despite the tweet suggesting otherwise.

So we can move on to the next one in the thread, which we'll mark as exhibit N.

[Fauci Minority Exhibit N
was marked for identification.]

BY [redacted]

Q Okay. And I'll read this one as well.

"Dr. Fauci testified that he signed off on every foreign and domestic NIAID grant without reviewing the proposals."

Now, we talked about this just a second ago, but I think, again, just to clear up any confusion, do you think that's a fair and accurate characterization of your testimony?

A That is quite unfair.

Q Okay. In fact, you testified yesterday and then just before, you know, I started questions that there are multiple layers of review by numerous experts before grant approvals came to your desk for your signature.

Is that right?

A That is correct.

Q Okay. And do you think that's important context that should have been included here?

A I do think that this is very misleading.

Q Okay. And you testified yesterday and then this morning as well that, you know, in any given year there could be a thousand, thousands, I'm sure it fluctuates, of -- or so grants each year, just under NIAID, right?

A Correct.

Q Okay. And do you think it would have made sense -- you already touched

on this, so you know where I'm going -- do you think it would have made sense for you to personally review the entire proposal of each submitted grant proposal that had already been scrutinized and reviewed and approved by numerous subject matter experts within and outside NIAID?

A It would not have been appropriate and necessary and would've been physically impossible, literally. I mean, to do my job and review every grant, it would have been essentially temporally physically impossible to do that.

Q And that's why you and many in government and elsewhere, many people in this room, rely on the expertise and the hard work of other people to make sound recommendations, right?

A Correct.

Q Okay. I'll move on to the next one. We're marking this as exhibit O.

[Fauci Minority Exhibit O
was marked for identification.]

BY [redacted]:

Q So I'll read this aloud while it's going around the room.

"A 2020 email, previously released by the Select Subcommittee, proved Dr. Fauci was aware of dangerous gain-of-function research occurring in Wuhan, China. Today, he backtracked by arguing he should not have stated that as 'fact.'"

Okay. Do you think that's a fair and accurate characterization of your testimony yesterday?

A Definitely not.

Q Okay. And, in fact, if I recall correctly, you provided context yesterday that explained why you thought that the single word picked out of one email was imprecise.

Is that right?

A Correct.

Q Okay. And could you just, to the extent that you recall what that email was --

A Yeah.

Q -- and what they're discussing here, provide that again?

A It was an email in which I gave the summary of the February 1st conference call among the evolutionary virologists in which I attended on a listen mode. And I was reporting to my superiors at HHS what the content of that discussion by others were.

And the phrase of talking about gain-of-function research in Wuhan was said at the conference by one of the people who were on the call, not me. I was reporting what other people were saying.

Q Okay. So this was -- again, just to reiterate, because there seems to be some confusion -- this was not about something you had personal knowledge of. This was you relaying something that you had heard but not yet personally pressure tested or substantiated.

A Yeah. Everything that was in that email, it was sort of, you know, like an after-activity report. This was an after-telephone-call report to my superiors.

Q So, again, just to sort of put in context, you know, here we are, we have -- we're in our second day of talking about this. You've been subjected to numerous congressional hearings, some productive, some not as productive perhaps, and you've spoken about this a lot.

You were working pretty hard during the pandemic, to be -- is that fair?

A Yeah, like about 16 to 18 hours a day, yes.

Q Okay. That's what I figured.

A Right.

Q So you were on a lot of phone calls, read a lot of emails, wrote a lot of emails, had lots of meetings, basically all day. That was probably your day most days, right?

A Correct.

Q Okay. So do you think it's -- do you think it's accurate to say that your choice of a single word in a single email in which you are describing what you heard on a call, absent any other evidence, proves that you were aware of certain research as this tweet indicates?

A Absolutely not.

Q Okay. And do you think it is fair for somebody to look at a single email among hundreds, thousands, and many of the other things that you have repeatedly said in public forums, including congressional hearings and to the press, and use that to somehow suggest that you had knowledge that you never talked about anywhere else? Do you think that that's fair?

A No, it's not fair.

Q Okay. We'll move on to the next exhibit, marking this as exhibit P.

[Fauci Minority Exhibit P
was marked for identification.]

BY [redacted]

Q This is the next tweet in the thread. It was a long thread, but we're almost there.

So exhibit P. "Dr. Fauci was unable to confirm if NIAID has ANY mechanisms to conduct oversight of the foreign laboratories they fund."

Okay. Do you think this is a fair and accurate characterization of your testimony yesterday?

A No.

Q Okay. In fact, what's missing in part from this tweet is you explained that the State Department has an important role in which it conducts some sort of review. You don't work for the State Department so you don't know the mechanics of it, but you know that either making them aware or getting some sort of signoff from the State Department is integral to approval of international research.

Is that right?

A Correct.

Q Okay. Any -- anything else that -- any other context you think with you was missed from this that you would want to add?

A Well, I think, it was that "any mechanisms to conduct oversight" I think was an exaggeration. I was saying that when you talk about the oversight, one, you mentioned the State Department thing, but also the determination of what oversight goes down at what you called compliance and other elements of the grant, which is the people that I spoke about at various levels in my own staff.

And I could not pinpoint precisely what they did in oversight, but there was foreign oversight, and one of them was the State Department.

But to say that I couldn't confirm any mechanisms because I wanted to be precise and careful, because I didn't know exactly what that individual mechanism was, but to say -- to assume that there's no mechanism of oversight I think was a bit unfair.

Q Well, it also seems a little strange, because I feel like we spent a lot of time yesterday going through exhibits that actually demonstrated --

A Right.

Q -- oversight --

A Right.

Q -- over research.

A Right.

Q We talked about a suspension --

A Right.

Q -- of a subaward. We talked about cancellation of a grant. We talked about all the terms and conditions that were put in place upon the resumption of that.

A Right.

Q So it strikes me as a little odd --

A Sure. Yeah.

Q -- that that was the takeaway. Is that fair?

A I mean, the practicality of what happened was proof that this is unfair.

Q Okay. Thank you.

And we're now at the end of the thread. This is exhibit Q.

[Fauci Minority Exhibit Q
was marked for identification.]

BY [redacted]:

Q This tweet reads, "Clearly, the American people and the United States Government are operating with completely different expectations about the responsibilities of our public health leaders and the accountability of our public health agencies. More accountability coming soon!"

So, again, I thought this characterization was a little interesting. I actually recall you having what at least appeared to me at the end of the table to be a very productive exchange with one of the members about ways to possibly increase or at least evaluate the adequacy of current oversight measures over potentially risky research, including over international research, research that's not funded through Federal grants, and other

domestic, non-federally funded research.

Do you recall that exchange?

A I do.

Q Okay. Did you think that was productive to talk through at the time?

A I thought it was a good conversation.

Q Okay. I did, too.

So do you think that -- you know, I wanted to give you the opportunity here again to just provide any context and clarity to your testimony.

Do you think that the government and the American people are totally different about expectations for public health agencies?

A What I gathered from this, from reading this for the first time here, showing it to me, is that it's implying seemingly strongly that the American people really care about responsibilities and the United States Government doesn't. And that's not so, because we do care very much about our responsibilities.

Q Did you take your role seriously during the pandemic when you held it?

A I took my role very seriously.

Q Okay. And is that why you worked 16-, 18-hour days?

A Yes.

Q Okay. Thank you. That's the end of my questions. I just wanted to make sure that you understood how your testimony was being interpreted, give you the opportunity to provide any context and clarity to those that we all have the same understanding going forward into our second day. So thank you.

A Thank you.

BY [redacted]:

Q Good morning, Dr. Fauci.

A Good morning.

Q I want to apologize from the start, because my question line here is probably not going to be the most pleasant for you, but I do think it is important for the record.

During the course of the COVID-19 pandemic, did you receive threats to your life and safety in your role as a leading voice on the pandemic response?

A Yes.

Q When did those threats begin to occur?

A You know, I don't recall exactly when they began to occur, but they certainly reached a point when I began pushing back a bit on some of the statements that were coming out from the Trump White House, for example, about hydroxychloroquine and the virus is going to disappear and go away. And I was saying, no, that's not the case. Then I started getting threats and they accelerated and accelerated.

Q And what was the nature of those threats, if you recall?

A Well, some of them were outright death threats. Some were documented. And a couple of individuals were arrested, one who had an AR-15 in their car with multiple magazines of ammunition and a bulletproof vest with a GPS going to Washington. And he was stopped in a traffic stop and asked where he was going, and he was going to go to kill me and a couple of other people.

Others were harassing phone calls. They made it very clear, whoever they were, that they knew --

Q I -- this is -- it's hard.

A Time out for a second.

Q Yeah, take your time.

Mr. Schertler. Yeah. Take a break.

[redacted] If you need a moment to leave the room --

Mr. Schertler. Yeah. Would it be all right if we go off the record?

[redacted]. Yes. We can go off the record.

[Discussion off the record.]

BY [redacted]

Q Back on the record.

A Yeah, I'm sorry about that, but it just --

Q No.

A I don't want to talk too much about it because I don't want to get it.

But it was constant threats to me, my wife, and my children, calling up -- I have three daughters, and they're, you know, at the time 28, 31, and 33, calling them up and saying -- I don't know how they got their phone number -- but calling them up and telling them, "We know where you live, we know where you work," and very, very aggressive, violent, sexually explicit threats against them and against my wife, so -- not to mention the threats against me, which, you know, I get used to, which triggered the need for security, which I still have to this day.

And every time somebody gets up, and every time Senator Rand Paul gets up and says I'm responsible for the death of 4 million people, the death threats go up off the wall, the threats against me and my wife and my children go off of the wall.

Q Thank you for sharing. I can personally not even imagine what you and your family went through. And it sounds like, just to reiterate, that it started because you used your scientific data and knowledge to disagree with misinformation from President Trump.

Is that correct?

A That's correct.

Q And you mentioned your security detail. Public reporting states that that

began in early April --

Mr. Barstow. I'm going to stop you here. I don't think we should. I think he acknowledges that he's being provided security. I don't think we should have further conversation about that detail or why those decisions were made.

[redacted]. All right. I was just going to ask and confirm when it started, if that's okay? If not, we can move on.

Mr. Barstow. I think we have established that he was provided a security detail. It started in 2020, and it continues.

BY [redacted]

Q We can move on.

Did any threats that you received impact the staff at NIAID who worked closely with you?

A I'm not sure what they -- but they were very, very shook up that their leader was being threatened and his family was being threatened.

So I don't know what kind of threats they got, but they certainly were shaken up by the fact that it was clear that I was -- I was being threatened. I guess they were worried about me but also worried about themselves being associated with me.

Q And I want to get into a little bit about threats to other scientists, because you were not the only one who experienced threats during the pandemic.

Is that correct?

A That is correct.

Q And, in general, does this treatment of scientists discourage them from speaking publicly about their work?

A Yes, very profoundly. In fact, when scientists would sometimes want to push back at the misinformation and disinformation that's out there, as soon as they do,

almost immediately they wind up getting threats. I don't know how that happens, but it happens quickly. Like, it's clear that when somebody gets up and defends Tony Fauci on social media or what have you, within an hour they get threats themselves.

So that's the reason why many of the scientists who want to come out and say, "Hey, what are you doing, this is not what happened," et cetera, et cetera, they're afraid to come out and publicly defend. And they've told me so, that they're afraid. "I'm sorry I'm not defending you, but if I do, I'm going to start getting threatened."

Q And there's the concerns obviously for those scientists in the moment; but in a future-looking way, are there concerns about how this might impact bright young scholars going into science and public service and sharing that information with the world?

A It is in my opinion, but it's well documented by people who have done surveys that people are very reluctant now to get into public health. People have left public health and people don't want to get into it because of what's going on, of the threats on individuals in public health.

Q You're right, there have been studies that have actually proven this. In particular, a GAO report titled, "Pandemic Origins: Technologies and Challenges for Biological Investigations," which was issued in January of 2023, said, "Researchers may experience unwanted attention or pressure because of their involvement in pandemic origin investigations and leave the field or refuse to participate."

What kind of impact on science might that have if people are refusing to take part in investigations or leaving the field because of fear?

A That's going to have an obvious negative impact, because if the best and the brightest don't want to go into a field that right now is really very, very important, maybe even more important than it has been, given the history over the last couple of -- few

decades of emerging infectious diseases, you know, that we spoke about yesterday, from HIV to Ebola to Zika to pandemic flu to COVID, et cetera, we need good people in public health, and if they're intimidated about going into public health then we have a problem in this country.

Q Similarly, Nature published an article in October 2021 titled, "I Hope You Die: How the COVID Pandemic Unleashed Attacks on Scientists." This article included dozens of researchers who shared their stories about death threats or threats of physical or sexual violence.

There was an associated editorial, also in Nature, that said, "Institutions at all levels must do more to protect and defend scientists and to condemn intimidation."

They further said, "Taking steps to support scientists who face harassment does not mean silencing robust open criticism and discussion. The coronavirus pandemic has seen plenty of disagreement and changing views as new data has come in, as well as differing stances on which policies to adopt. Scientists and health officials should expect their research to be questioned and challenged and should welcome critical feedback that is given in good faith. But threats of violence and extreme online abuse do nothing to encourage debate and risk undermining science communication at a time when it has never mattered more."

Do you agree with those statements?

A Absolutely.

Q And is that in line with your experience?

A Very much in line with my experience.

Q And what can the United States do to ensure we have a properly staffed and qualified workforce for scientific research and, specifically, pandemic preparedness?

A Well, I think there are a lot of things. One of the things is to show obvious

support for public health officials.

You had mentioned, there certainly are disagreements that are valid disagreements for discussion. But when public health officials and individuals are demonized, I think there needs to be a lot of support for those people publicly by everyone, including at all branches of government.

Q I agree with that.

I'm going to go back to the threats specifically to you. I'm not going to go into a lot of detail, but I do want to get this on the record. So I am going to introduce this as minority exhibit R.

[Fauci Minority Exhibit R
was marked for identification.]

BY [redacted]:

Q This exhibit is an affidavit filed in Federal Court in Maryland on July 26th, 2021, by Brett Rowland. It was filed in support of criminal charges against someone named Thomas Patrick Connally for threatening to kill you and members of your family.

Are you generally familiar with this case?

A Yes, I am.

Q This affidavit is full of tremendously violent and awful language, and we do not need to get into that. Obviously, it's very emotional for everybody.

So on page 3 of the affidavit -- and you don't need to look at it if you don't want to because I'm going to read some of this -- there's an email that was sent to you with the subject, "Hope you get a bullet in your compromised satanic elf skull today."

The email goes through various other threats to you that are horrific. It has been passed around. It is now in the record. So I will allow others to read those for themselves.

But do you recall these threats being made to you?

A Yes.

Q And, clearly, they had a profound impact on you?

A [Nonverbal response.]

Q The reference to you -- or some of these references to you clearly came from media coverage of public officials who were making similar statements, maybe not as extreme. But the language of calling you an elf seems to clearly have come from Florida Governor Ron DeSantis.

Do you recall him using that language?

A Yes. I believe he said he wants to throw that elf over the Potomac River.

Q And so it's clear that statements from public officials, you mentioned President Trump, now Florida Governor Ron DeSantis, their statements had an effect on the threats that were made towards you?

A I believe they had a strong effect.

Q And I think with that, we can end the questions on this tough subject and move onto something a little more palatable.

BY [redacted]

Q Yeah, I actually did have just one discrete follow-up on that.

You know, I think it's very clear from what we just heard how much you and public health officials and scientists did take on during the pandemic, how much of this vitriol was present.

I think there are thousands of young people at this point in time who are contemplating careers in science, careers in public health, careers in medicine, and probably feel apprehensive based on how people in these professions have been treated in the past 3 or 4 years.

I'd be curious, as a leading public health official, what you would tell people who are considering those careers but feeling fearful as a result.

A You know, I would encourage them to get into public health because the positive impact you can have on your country, the citizens of your country, is worth it. I wish there were not these kind of threats, but I would encourage them to not be put aback, and hopefully something will be done to diminish that.

And by diminishing it, I mean what you were referring to, stop having the -- well, you can't stop people from doing things because they can say whatever they want to say. But when public officials and media demonize health officials that is a real strong disincentive.

And I would encourage them to try to look past that at the rewards of what public health does, is namely taking care of people, which is what I and many of my colleagues have done for a very long period of time.

Again, it's a tough situation because you can't, because of freedom of speech, you can't prevent someone from saying what it is that they want to say.

One of the things that we could do is to encourage public officials, who supposedly have the good of the country involved, not to be part of the problem of demonizing. And I have been demonized by a lot of public officials. I mean, I have become a campaign slogan throughout some of the election cycles, which is very, very clear.

And that's no secret. I can say that definitively as opposed to "I can't recall." I do recall definitively what that is. I have been completely demonized in various elections, you know. "Fire Fauci. Throw him in jail. Vote for me."

Q Thank you.

I'd like to move again back to this idea we were discussing yesterday, the

importance of looking at the hours we have with you today and learning from you and your perspective on how we can approach our perspective on the COVID-19 pandemic, apply lessons learned for future pandemic preparedness and response.

I'd actually like to look at the discrete issue of long COVID for a few minutes.

During the course of the pandemic, I think it became clear rather quickly that the process of recovering from COVID-19 was not the same for everyone.

In particular, it appeared that some patients were carrying forward residual symptoms for months, potentially years following their infection in a phenomenon that eventually became known as long COVID.

So, Dr. Fauci, could you explain for us in just a bit more detail what we know about long COVID so far?

A Yeah. We know it's real. Long COVID is a syndrome, and it varies in what the percentage is, in some studies as little as 5 percent, some as high as 20. The real number may be probably somewhere around 7 percent.

But we're still trying to figure out because of the, I would say, the looseness first early on of the definition of it. But it really is the persistence of symptomatology long after the acute phase of COVID infections subsides and by normal testing the person is no longer infected.

And yet, anywhere from weeks to months and in some cases to years, they have a constellation of signs and symptoms that are very puzzling, because there is, at this point, with some recent data showing some hints as to what the potential underlying mechanism might be. But they have everything from sleep disturbances to very severe post-exercise fatigue, particularly seen in young people, athletes, who were very well trained, who get tired walking up a flight of stairs.

They have what's called unexplained tachycardia, autonomic disturbances,

temperature dysregulation, sweating, hair loss, a whole variety, which is really very confusing.

Some of the -- in fact, there was an article that came out yesterday or the day before, while we were here, that there were even a considerable number of deaths associated with long COVID, people who had cardiovascular and neurovascular and neurological symptomatology that ultimately led to their death.

Usually it is not a lethal syndrome, but it has disrupted the lives. And if the percentage of people who actually have long COVID is even as low as a very, very small percent on the spectrum of the different reports, then we have a significant problem because of the fact that so many millions and hundreds of millions of people throughout the world have gotten infected.

So we really need to know a precise handle on what the actual occurrence of it is, because it's a heterogeneous syndrome. It isn't -- if it's a one, unidimensional syndrome, it's easy to follow and easy to do studies. But because it's so heterogeneous, we really need to get a better feel on the epidemiology of it and then look at what the pathogenic mechanisms are to be able to intervene.

A recent study showed that even in people who, long after you think the acute phase is over, they still have recognizable, subtle immune abnormalities and some subtle persistence of nucleotides of the virus that you can identify. So maybe there's not active infection but residual of infection.

That's a little bit of a long-winded answer to your question, but that's, you know, that usually happens when you don't know a lot about something. The more concise the answer, the more precisely you know about things.

Q And so just for the record and for sort of lay folks, when you are saying that long COVID is heterogeneous in nature, what you're saying is that long COVID is not

necessarily manifesting the same way in every patient.

A Oh, absolutely. Wide variety of manifestations, wide variety.

I mean, some people, for example, have just chronic fatigue, and other people might have dysesthesias, which are neurological tingling in their feet or in their hands. In fact, that's what Senator Tom (sic) Kaine has.

Q And then just taking a step backwards, looking at the larger picture of communicable diseases, I'm curious, are there other communicable diseases that similarly result in these longer-term residual symptoms for patients, or is this a phenomenon that is pretty unique to COVID-19?

A Well, it in some respects is unique, but it's not unprecedented to get post-viral syndromes.

For example, the classic one that probably all of us recognize was mononucleosis. I mean, when you know the stories of kids who are in school, they get mononucleosis, they seem to recover, and they're out of school for weeks and weeks and weeks. That is a post-viral asthenia or a post-viral washout or weakness.

Influenza occasionally does that in some people. They get influenza and they don't bounce back for a considerable period of time. And there have been some studies showing that post-influenza there are an increased incidence of heart attack 6 months after a bad influenza season.

So there are situations of post-viral persistent symptomatology, but nothing as obvious and as high percentage as this.

This is unique in that respect, but the concept of a post-viral syndrome is not unique. And there's the whole issue of myalgic encephalomyelitis/chronic fatigue syndrome, which very likely is related to a prior unrecognized infection.

Q And so you obviously mentioned earlier in this discussion that there is a

great deal that remains unknown about long COVID.

Are you able to offer perspective on the current steps our scientific community, our medical community is taking to better understand long COVID? Are we doing enough there? Should we be doing more?

A Yeah.

Q What more could we be doing?

A Yeah. We should be doing more, no doubt, because we don't have the answers.

Initially, the President's budget and the Congress agreed to give to the NIH $1.15 billion to do a very large cohort study to try and determine.

We need more studies. A study came out in, I believe, Cell, the journal Cell, yesterday from a large group of people who did a systems biology approach and broke it down into four types of what they call phenotypes of COVID. One is minimal, one is physical, one is mental and cognitive, and one is mixed.

And they showed that there were various immunological abnormalities associated with each, like activated B cells or various cytokine expressions, et cetera.

That's a big -- that's a good start, but it's only the tip of the iceberg of what we need to learn. So the answer to your question is, we absolutely need to do more.

Q Before we conclude on long COVID, is there anything more you'd like to offer perspective-wise on the topic?

A Yeah. There are a lot of things that we need to learn. I mean, there are many, many lessons that we can learn from this.

One of them is that we never realized -- and you brought it up -- long COVID. I mean, there's a lot that these viruses have effect on us, and we really need to learn a lot more about it.

[redacted] Before we conclude the round, I just want to make sure, Congresswoman Castor, Congresswoman Dingell, anything you'd like to add on any of the topics we covered in this hour?

Ms. Castor. I think I'll wait till the next hour.

[redacted] Okay. In which case, I think we can go off the record.

[Recess.]

[11:14 a.m.]

Mr. Benzine. We can go on the record.

Dr. Fauci, last hour, there was a significant amount of time devoted to threats and what public health officials and you in particular have experienced.

I want to reiterate what the chairman said at the beginning of this interview, that we, of course, unequivocally denounce all threats against you, anybody, for doing anything, and say for the record I've received death threats. I've received emails awfully similar to "I want to put a bullet in your head and see blood spill down the steps in Washington." Some of them parrot talking points from my minority colleagues.

So we're all kind of in the same boat here. This morning, the chairman got a call saying that it would be better if he was just dead.

Like, I think we spent an awful lot of time on it, and it is terrible, and I wanted to say that we unequivocally condemn anything against you.

Moving on, you went through a lot of ours, the committee's social media in the last hour as well. I want to introduce majority exhibit 19.

[Fauci Exhibit No. 19
was marked for identification.]

BY MR. BENZINE:

Q This is the press release issued by the minority of the committee last night. I don't want to talk about the content of the release, but, just for the record, the ranking member of the committee is Raul Ruiz. Do you remember seeing Dr. Ruiz in this room yesterday?

A No, I didn't see him in the room.

Q All right. Thank you.

All right. Shifting gears to talk about the conference call, the February 1, 2020,

conference call.

A Yes.

Q I'm sure there are 10,000 conference calls that you've been a part of, but when I say "conference call" in the spirit of this interview, this is the one I mean.

And I want to introduce majority exhibit 20.

[Fauci Exhibit No. 20
was marked for identification.]

BY MR. BENZINE:

Q So this is an email chain that you were also presented with yesterday. As I just said, it's from a different custodian, though, and Bates numbered REV 750 through 753.

And since you had time to review it yesterday, I just want to go ahead and flip to the last page, so the first email in the chain. And it's a January 31st email from Dr. Farrar to you, saying, "Really would like to speak with you this evening. ... 10pm now UK. Can you phone me on" -- whichever phone number that is.

Prior to this call -- at least, we haven't seen it; maybe it's outside of, kind of, the origin space -- had you had communications with Dr. Farrar about the pandemic?

A Not to my recollection, no, I don't think so. No.

Q In this --

A You know, I don't think so. I'm trying to remem- -- no, I really can't recall if I had anything prior to this about the pandemic.

Q No, that's -- thank you. I appreciate it.

Before I mis-title her, is Patricia Conrad a doctor?

A No.

Q Okay. Ms. Conrad then --

A Yes.

Q -- responds on your behalf and says, "Will call shortly."

And then the next email up from Dr. Farrar -- I'm assuming you spoke to Dr. Farrar that morning --

A Yes.

Q -- on January 31st?

A I did.

Q Do you remember any of the content of that conversation?

A He said that he and Kristian Andersen and -- I believe it was also Eddie Holmes -- but he and maybe one or two other people, one of which certainly was Kristian and very likely Eddie Holmes, but I'm not 100 percent sure about Eddie; maybe Bob Garry --

Q Uh-huh.

A -- I'm not sure -- have looked at the virus and they had some concerns regarding the molecular configuration of it, that it could possibly be something that was manufactured. He said, why don't you call Kristian and get more information from him --

Q All right.

A -- which I did.

Q I don't know how Dr. Farrar relayed it. Obviously, in this email, he mentions the people involved are Dr. Andersen, Dr. Garry, and Dr. Holmes.

A Uh-huh.

Q Prior to this point in time, to the best of your recollection, had you had any interactions with Dr. Andersen, Dr. Garry, or Dr. Holmes just in, kind of, your normal role as Director of NIAID?

Mr. Schertler. You just mean in the past?

Mr. Benzine. In the past, yeah.

BY MR. BENZINE:

Q I'm just trying to figure out if this is the first time that those names hit your radar screen or --

A I mean, I obviously know who Kristian Andersen is. He's a very well-respected molecular virologist.

Bob Garry is somebody that I may have had communication with years and years ago, back in the influenza days. So I can't say that I've never had any interaction with Bob. It's possible that I did.

Q Uh-huh.

A Eddie Holmes, I doubt. I mean, Eddie's Australian, and it would -- not that that means I wouldn't have contact with him. But I would say that this was the first time that I had any meaningful contact with these people.

Q All right.

Mr. Strom. Dr. Fauci, is Dr. Andersen a coronavirus virologist, I guess, prior to COVID-19?

Dr. Fauci. I don't know. I don't know. I'd have to guess. I'm not sure if he was a corona- -- but he is clearly a well-recognized evolutionary virologist.

Mr. Strom. Thank you.

BY MR. BENZINE:

Q And then the next-to-the bottom email on the first page, the first one from you, that we went through briefly yesterday, you relay to Dr. Farrar, "I just got off the phone with Kristian Andersen and he related to me his concern about the furin site mutation in the spike protein of the currently circulating 2019 novel coronavirus. I told

him that as soon as possible he and Eddie Holmes should get a group of evolutionary biologists together to examine carefully the data to determine if his concerns are valid."

And then you say, "He should do this very quickly and if everyone agrees with this concern, they should report it to the appropriate authorities. ... in the USA this would be the FBI and in the UK it would be MI5."

And then, "In the meantime, I will alert my US Government colleagues of my conversation with you and Kristian and determine what further investigation they recommend."

I'm going to kind of parse this out a little bit and start with the FBI and MI5 reference. Prior to this, had you worked with the FBI before?

A Worked with them, no --

Q No.

A -- but, you know, given them -- years ago, they wanted me to give a lecture to their people about -- I don't even remember what it was. But I haven't interacted with them in a -- what's the right word? -- in a criminal justice way.

Q Okay. So, when you wrote "I would imagine," you literally meant "I would imagine." There wasn't a, kind of, experience saying the FBI are the people to call?

A I don't have experience about who to call, but they were the first ones that came to my mind.

Q No, that's totally fair.

And, then, moving down in the email, you wrote, "In the meantime, I will alert my US Government official colleagues of my conversation...."

And we discussed it a little bit yesterday, the, kind of, email after the February 1st conference call. You said that that satisfied this sentence, that that was you alerting --

A Yes.

Q -- Mr. Harrison and Dr. Kadlec --

A Yeah. And I believe -- I believe -- then I gave a quick call to Alex Azar and the Department, saying, "I'm going to be getting on a call with the group of these people. I'll get back to you after." And the getting back was the email we discussed yesterday.

Q All right.

So that was the nature of my next question. Because the way you wrote this -- and, again, excuse me if I'm, like, taking it out of context -- "I will alert my US Government colleagues of my conversation with you and Kristian," that sounds like alerting of the January 31st phone call, not the February 1st phone call. So --

A Yeah. In other words, what I believe I did -- and I think there are emails that would verify that -- I believe I got on the phone with Alex Azar and probably Garrett Grigsby, but certainly Alex, and said, "I'm going to have a phone call tomorrow with a group of evolutionary virologists. I'll give you a followup about that call." And that followup was my email to -- to -- I forgot who it was.

Q Brian Harrison and Dr. Kadlec.

A Brian Harrison and -- yeah, yeah.

Q We'll talk about that in a minute too.

A Yeah. Right.

Mr. Strom. Can I ask one quick question?

When you mentioned the FBI, did you have in mind because they were sort of the lead agency for past -- I'm thinking, like, the anthrax mailings and stuff like that?

Dr. Fauci. Yep. Yep.

Mr. Strom. Was that the basis for thinking --

Dr. Fauci. Exactly.

Mr. Strom. -- of them instead of DHS --

Dr. Fauci. Exactly.

Mr. Strom. -- or somebody?

Dr. Fauci. Exactly. You know, I had a lot of experience with the anthrax from a medical standpoint --

Mr. Strom. Sure.

Dr. Fauci. -- so I kind of knew what they were doing.

Mr. Strom. Okay.

BY MR. BENZINE:

Q And, then, at this point, I guess, to the best of your recollection -- we'll get to an email, but -- do you recall if the February 1st call had been set at this point, or was it still in motion?

Mr. Schertler. And this is, like, that Friday evening --

Mr. Benzine. The Friday --

Mr. Schertler. -- the Friday of this email. Is that correct?

Mr. Benzine. Yes. Yes, sir.

Mr. Schertler. Thanks.

Dr. Fauci. I recall that there were -- in fact, you may have shown -- I may have been shown it yesterday. I believe that there were a bunch of emails back and forth about logistics. Here's a number; you know, these are the --

Mr. Benzine. Uh-huh.

Dr. Fauci. -- kind of people on the call, et cetera, et cetera. That was essentially orchestrated by Jeremy.

Q Okay. Let me -- okay, I'll keep going on this one.

"Orchestrated by Jeremy," so meaning setting up the logistics, maybe who was on the call, was Jeremy?

A Yes.

Q You wrote in here, "I told him," meaning Dr. Andersen, "that as soon as possible he and Eddie Holmes should get a group of evolutionary biologists together to examine carefully the data to determine if his concerns are validated."

Do you think it was that push from you that got the call going, or do you think the call was already going?

A I think it was a combination. I think Kristian already in his mind felt that he wanted to make sure that he had other input from other people. And somehow that merged into my saying, you know, we really should do that.

Q Uh-huh.

A Yeah, it was a combination. I don't think it was Kristian alone or me alone.

I just felt that it was important to be as transparent as possible. It was all part of the theme of the email. You know, get virologists together, get the FBI, get MI5, get the Department, just -- let's open this up.

Q Uh-huh.

A There's no -- you know, there's no -- we really need to make this, you know, transparent.

Q I appreciate that and agree. I'm trying to kind of, I guess, bifurcate the setting-up-the-logistics version verse, like, setting up the call itself.

A Right.

Q And I think the minority has introduced exhibits of Dr. Farrar sending around call-in numbers, sending around --

A Right.

Q -- you know, all those kinds of things. So I think it's pretty well-established that Dr. Farrar set up the logistics of the call.

A Right.

Q But trying to get a better understanding if the decision to actually need to have a call --

A Yeah.

Q -- was originated with you or a combination.

A No, I think it was a combination. I have to say -- I mean, it was years ago, so I don't remember exactly what it was --

Q Uh-huh.

A -- but I think it was very likely it was a combination of Kristian saying, "We really need to discuss this with other people," with my saying, "Yeah, why don't we get together a call and do it," you know?

Q So you would say -- and this will be my last question on it -- that the logistics side, clearly Dr. Farrar. The phone number we've --

A Right.

Q -- seen, who's on it.

A Right.

Q But the idea to discuss the topic would've been you, Dr. Farrar, and Dr. Andersen --

A Yes.

Q -- kind of coalesced together?

A Right. I think so.

Q Thank you.

I want to introduce majority exhibit 21.

[Fauci Majority Exhibit No. 21
was marked for identification.]

BY MR. BENZINE:

Q This is an email we haven't seen yet, but the vast majority of the email is an article by Jon Cohen that came out on January 31st regarding "Mining Coronavirus Genomes for Clues to the Outbreak's Origins."

I don't necessarily have any questions about that article, more about the email, so --

A Yeah. Sure.

Q -- I won't go through it. But, for the record, it's an email -- emails between Mr. Folkers, yourself, Dr. Andersen, Dr. Farrar, and is from a FOIA production but Bates marked NIH 2396 through 2402.

And you forward that Science article, which I think everyone will stipulate is about the origins of COVID and what we need to find in order to determine it, to Dr. Farrar and Dr. Andersen and say, "You may have seen it. If not, it is of interest to the current discussion."

And this is when -- and I'm sure you've seen -- if you don't recall this email from sending it, you certainly recall it from the news reports since --

A Yes.

Q -- Dr. Andersen's email back, where he said, "The" -- he said a number of things, but -- "The unusual features of the virus make up a really small part of the genome so one has to look really closely at all the sequences to see that some of the features (potentially) look engineered."

I'll get to, kind of, the next line, but do you recall, was the feature he was discussing there the furin cleavage site?

A I'm not sure.

Q Okay.

A Yeah.

Q He then --

A Yeah, I'm not sure, because I -- I'm not sure if the idea of the furin cleavage site was specifically brought up in my telephone call with Kristian prior to set up the email or whether it was after.

Q If you want to just briefly look back at 20.

Mr. Schertler. Give us a second.

Mr. Benzine. Yeah.

Mr. Schertler. Any particular place?

Mr. Benzine. Just the top line of Dr. Fauci's email to Dr. Farrar: "I just got the phone with Dr. Andersen and he related to me his concern about the furin site mutation in the spike protein."

Dr. Fauci. Right. Okay. Sure. Refreshed my memory, yeah.

BY MR. BENZINE:

Q So, fair enough to say the unusual feature that he was worried about is the furin site?

A Right.

Q Dr. Andersen continues in the second paragraph, "I should mention that after discussions earlier today, Eddie, Bob, Mike, and myself all find the genome inconsistent with expectations from evolutionary theory. But we have to look at this much more closely and there are still further analyses to be done, so those opinions could still change."

Is your -- again, we've asked Dr. Andersen, but just your understanding when you got this email, that "Eddie" was Dr. Holmes, "Bob" was Bob Garry, and "Mike" was Dr. Farzan?

A Certain that "Bob" was Garry. "Mike" probably was Farzan.

Q Okay.

Again -- I've said it probably 15 times at this point over day one and will say it 15 times today -- not a scientist, and understand that there are some terms of art that maybe look one way on paper but not -- not what they meant.

What does "inconsistent with expectations from evolutionary theory" mean?

A I believe what he was referring to -- again, I can't say what's in somebody's mind, but I would believe what he's saying is: inconsistent with the natural evolution of a virus.

Q So, at this point -- and, granted, Andersen hedged a little bit --

A But his next sentence --

Q Yes.

A -- is very critical.

Q That more work needs --

A He says, "We have to look at this much more closely and there are still further analyses needed to be done, so these opinions could still change."

Q And I was going to ask about that, too. Dr. Andersen's at least first blush was that it looks --

A His first blush was that it was inconsistent with natural evolution.

Q But hedged and said, we need to do a little bit --

A And said, this could change when you do further analysis.

Q I want to introduce majority exhibit 22.

[Fauci Majority Exhibit No. 22
was marked for identification.]

Mr. Benzine. And it's just one email. And, for my own clarity, the sent time is

Saturday, February 1, 2020. It says 12:29, but the 0000 after that is Greenwich Mean Time?

Mr. Schertler. I think that's right.

Dr. Fauci. Right.

Mr. Benzine. So --

Dr. Fauci. Just add -- just go back 5 hours. This was --

Mr. Benzine. Like, 7:30 in the morning?

Dr. Fauci. 7:30, yeah.

Mr. Benzine. Is that consistent across your emails, that they're in -- did you set it that way, I guess?

Dr. Fauci. I didn't.

Mr. Schertler. I think it's the way --

Dr. Fauci. I don't know where they got this from.

Mr. Schertler. We've had this happen before.

Dr. Fauci. I think you got this from the Brits.

Mr. Benzine. Maybe. I don't know.

Mr. Schertler. I think sometimes it's just the way it's printed out when it's produced.

Mr. Benzine. Okay. Yeah. I just wanted to make sure that we're talking 7:30 in the morning.

Dr. Fauci. We're talking 7:30 in the morning.

BY MR. BENZINE:

Q All right. Perfect.

And, again, I'm sure you're familiar with this email by this point --

A Yes.

Q -- but you write to Dr. Auchincloss, "It is essential that we speak this AM. Keep your cell phone on. I have a conference call at 7:45 AM with Azar," so 15 minutes later. "It will likely be over at 8:45 AM. Read this paper as well as the e-mail that I will forward to you now. You will have tasks today that must be done."

So, in conjunction with this one, I want to introduce majority exhibit 23.

[Fauci Majority Exhibit No. 23
was marked for identification.]

BY MR. BENZINE:

Q And, in this one, you're forwarding to Dr. Auchincloss and Dr. Lane, now, the same Science article that you had forwarded to Dr. Andersen and Dr. Farrar.

And I just want to ask, is this the email that "I will forward to you now" that is being referenced in exhibit 22?

A I'm sorry. Now I'm confused about exhibits.

Q So, in 22, you say, "Read this paper" -- there's a paper attached; I'm assuming that's what you're referencing -- "as well as the email that I will forward to you now." And then 9 seconds later you're forwarding an email to Dr. Auchincloss with an article.

Is it safe to assume that 22 is referencing 23?

A Yeah. Again, I don't recall that, but the circumstances --

Q Yes.

A -- of the emails strongly suggest that.

Q All right. I want to talk briefly about exhibit 22.

So you'd kind of just had your first call with Dr. Andersen and Dr. Farrar the day before, had been told about potential irregularities, at least unexpected irregularities, particularly with the furin site, and the next morning emailed your deputy,

Dr. Auchincloss.

And, taking the first line, "It is essential that we speak this AM. Keep your cell phone on."

Why? I guess, why? Why was it essential? What information did you need to relay to Dr. Auchincloss?

A I wanted him to "keep your cell phone on" because I wanted to find out a little bit more about what was going on. Because we went from -- there's information that I was getting, emails way back from Greg Folkers about "these are the kinds of things that are going on, these are the experts" that was, sort of, information gathering.

Q Uh-huh.

A Then I'm told by someone that he has concern about a possibility of an engineered virus.

So then I said to myself -- I put two and two together. It was natural for me to say, okay, now I really need to know some details about what we are doing in our grants so that I will know what we're doing. And I need to know.

So it says, "Keep your cell phone on. I may need to get back to you. I have a conference call. Read this paper as well as the email that I will forward to you. You have tasks." And the task was: find out and get back to me about what we're doing.

Q So you were -- and correct me if this is a mischaracterization, but -- you had been told that there was NIAID work in Wuhan January 27th --

A The original -- yeah. I didn't get any information about what it was and what they were doing.

Q Yeah.

A But I knew that we were doing -- well, you saw the email. It was, you know, Baric's doing this, and these are the experts, and the other person's doing that, and

we're doing this, et cetera, et cetera.

So that was fine. That's information preparing me for the press conference.

Q Uh-huh.

A Like, what are we doing, as well as who are the experts that we can tap to learn a little bit more about coronaviruses and what might potentially be going on, just as information.

Then, when I had the telephone call with Kristian and with Jeremy that there is now suspicion that there may have been an engineered virus, then it turned from not only information but, really, what, specifically, are we doing.

Q So -- and apologies if this is, like, way dumbing it down -- but, at this point, it was an attempt to determine if your broad understanding of NIAID work in Wuhan could have facilitated what Dr. Andersen --

A Right.

Q -- just warned you of.

A Yes. Yes.

Q Okay.

A It was a natural -- I believe I would've been irresponsible not to do that.

Q Yes. I just wanted to -- there's a lot of email traffic --

A Yes.

Q -- and I'm trying to figure it out.

In this email in exhibit 22, you forward a paper called "Baric, Shi," "SARS Gain of function."

Do you recall who --

Mr. Schertler. I think you said -- is that in --

Mr. Benzine. Twenty-two.

Mr. Schertler. Okay. I'm sorry. I see.

Mr. Benzine. It's under the "Attachments."

Mr. Schertler. Yep. Got it.

BY MR. BENZINE:

Q I have it if you need it, but I'm just going to ask if you recall, why -- why that paper?

A What we were trying to do is -- I believe that was sent to me by Greg Folkers as -- you know, he's an information fount, in fact, in a very good way. He just keeps sending things. Like, you know, "Give us all the information we have." He's the person that briefs me for the -- any variety of things I might do.

So I just -- I believe -- I don't recall why I did this, to be quite honest. I don't know why I sent this. But it is entirely compatible with, "Greg sent me this. Here, take a look at this. This is another paper of the things we're funding." But this is the North Carolina --

Q Uh-huh.

A -- work. This isn't Wuhan work.

Q No. And we don't need to get into the whole paper, but the paper describes an experiment that resulted in an underlying virus gaining pathogenicity. And Baric actually warns that these kinds of experiments could be dangerous.

So I was just wondering, why -- like, why that paper? Was it specific to that, or just in general that it was Wuhan-affiliated?

A Well, it wasn't Wuhan-affiliated. It was --

Q No, the work was done in UNC --

A Yeah.

Q -- but had Wuhan as a collaborator.

A We had, I think -- at least, what I found out subsequent to this, way subsequent, is that a collaboration gave Shi the sequence of a virus. That's the extent of the collaboration. There were no experiments done in Wuhan. They gave him a sequence. So that was the collaboration.

I'm not sure why I sent it to him, but I think it was just the flow of things that Greg was sending me that I was sending to our people, "Hey, heads-up, take a look at this."

Q Yeah.

A It was the same thing, I think -- well, I don't know. I may have sent something to -- in fact, you just showed it to me. I sent something to Kristian, then said, "Take a look." He said, "I know. I'm actually" --

Q Quoted in it, yeah.

A Yeah.

Q Do you recall if you ended up speaking with Dr. Auchincloss after your conference call with the Secretary?

A I know there was an email. Yeah, I believe I did, but I don't know exactly when.

I recall an email where he said, yeah, the work that Baric -- yeah, show it to me --

Q Yeah.

A -- and we'll go over --

Q We'll introduce that as majority exhibit 24.

[Fauci Majority Exhibit No. 24
was marked for identification.]

BY MR. BENZINE:

Q Is this the email that you were just thinking about?

A "The paper you sent says the experiments were performed before the gain

of function pause but have since been reviewed and approved by NIH."

So that's good. Thank you.

"Not sure what that means since Emily is sure that no Coronavirus work has gone through the P3 framework. She will try to determine if we have any distant ties to this...."

And --

Mr. Schertler. "... to this work abroad."

Dr. Fauci. Yeah. And "work abroad," I believe he was referring to China.

Mr. Benzine. Uh-huh.

Dr. Fauci. I cannot imagine -- I'm not sure what else we were doing.

Yeah, I recall this email.

Mr. Benzine. So Dr. Auchincloss would be referencing the Baric-Shi paper, not necessarily the -- we've talked to him, and he was referencing the Baric-Shi paper, not necessarily the article that you had also forwarded.

Mr. Schertler. And the article is just a --

Mr. Benzine. It's just an article.

Mr. Schertler. That's an article from Cohen --

Dr. Fauci. Right, right.

Mr. Schertler. -- on January 30th or 31st --

Mr. Benzine. Correct.

Mr. Schertler. -- which was also forwarded to Dr. Auchincloss.

Mr. Benzine. Yes.

Dr. Fauci. So there were two that were forwarded to him.

BY MR. BENZINE:

Q And, in this email, he's referencing the paper, the Baric-Shi paper.

A Right.

Q "... experiments were performed before the gain of function pause" -- so that would've been pre-2014-ish?

A Right. Right.

Q "... but have since been reviewed and approved by NIH."

What is that process?

A Again -- we went over it yesterday -- it depends on the years. If the years were '14 to '17, it would have been the pause. If it's '17 on, it would've been the P3CO.

Q I guess what is confusing is they were conducted before the pause; therefore, like, they were all good. They didn't violate anything that was in place. Why would they be reviewed afterwards if the experiment was already concluded?

A I'm not sure what he meant by that.

Q Okay.

A I'd have to ask him. You could ask Hugh, or you might've already asked him.

Q He didn't really know either, so --

A So, if he didn't know, for sure I don't know.

Q Yeah.

And, as you read, Dr. Auchincloss continues, "Not sure what that means since Emily is sure that no Coronavirus work has gone through the P3 framework."

I guess this is what we're trying to understand, is, in kind of, like, the process within NIAID of reviewing these things, the research was done before there was any programmatic pause --

A Right.

Q -- or definition. The pause went into effect. It looks like, from how they

treated the EcoHealth grant --

Mr. Schertler. And, Mitch, if I could just -- I'm not sure it's clear that, you know, whether experiments were done before the pause and then after the pause and then after the pause may be reviewed. I know the article --

Mr. Benzine. Yeah, I don't know.

Mr. Schertler. -- is a 2015 article, I believe, so --

Dr. Fauci. I'm not sure what he's referring to. But what is in this email is that Emily is sure that no coronavirus work, in general -- I don't think she was referring -- has gone through the P3C framework.

Mr. Benzine. Uh-huh.

Dr. Fauci. Which means that no coronavirus work that we are funding has been of the kind that would go through the definition we went over multiple times yesterday. Which means that we're good with regard to coronavirus work. It's all gone through the appropriate --

Mr. Benzine. Okay.

Dr. Fauci. -- evaluation, and it was determined that it did not need to go up to a higher level.

So it's pretty clear. I mean, it says it very explicitly: is sure that no coronavirus work has gone through the P3CO.

BY MR. BENZINE:

Q And then you respond, "OK. Stay tuned."

Do you recall if you talked to Dr. Auchincloss after this email?

A I don't recall, but I might have. I mean, likely that I did. And he confirmed that, in fact, nothing went through. But I don't recall if I specifically spoke to him. I likely did.

Q Moving on further through the February 1st chronology and introducing majority exhibit 25.

[Fauci Majority Exhibit No. 25
was marked for identification.]

BY MR. BENZINE:

Q This is an email chain. At the very bottom is the logistics email from Dr. Farrar to you from 6:00 in the morning someone's time; I'm not sure whose. And this email is Bates marked SSCP_NIH 1902 to 1903 and has the call-in details for the February 1st conference call that we've talked about.

You then forwarded the information to Dr. Collins. Dr. Collins says he'd join.

At some point, Dr. Tabak gets included, says, "Would you like me to join?" Collins says, "Fine with me, but I note Jeremy says he wants to keep this a 'really tight group.' Tony, what do you think?"

And then Dr. Tabak, after the call, introduces a publication.

I think it's pretty clear for the record, but just one more time: You were on the February 1st call?

A I was on the February 1st call.

Q Okay. And Dr. Collins was also on?

A Dr. Collins was on the February 1st call.

Q And was Dr. Tabak also on the call?

A Well, Tabak was not officially on the call. You know, I don't know who was on a speakerphone, but he was not on the call.

Mr. Schertler. So, if you could just give us your recollection of --

Dr. Fauci. My recollection is that Dr. Tabak was not on the call.

BY MR. BENZINE:

Q Not?

A Yeah. I don't recall him being on the call.

Q Were there any other -- do you recall any other government employees being on the call?

A To my knowledge, it was just Francis and I. I don't recall Larry being on the call.

Q We --

A He could have been, but I don't recall him being on the call.

Q Okay. That's fair. We talked to Dr. Tabak. He was on the call, and he talked about O-linked glycans on the call. But --

A Well, he was silent, at least.

Q So I want to talk about the first forward of yours to Dr. Collins. Did Dr. Collins request to be on the call? Like, how did the process -- you obviously forwarded the call-in details to Dr. Collins. How did that process play out?

A Well, Dr. Collins is my boss. So this seemed like a pretty important call for NIH, so I thought it would be a good idea to let my boss know.

Q So you got invited -- or you had the January 31st call, got invited to the conference call after Farrar set it all up, and then went and was like, "Dr. Collins, there's this call happening. Would you like to take part?" Is that fair?

A I believe that's the way it went, because -- yeah, I believe that's the way it went.

Q Okay.

It's been in the news for a while and Dr. Redfield has talked about this a lot and testified in front of us in March that he was not included in the call. He was very clear to say he was not -- he's not testifying that he was intentionally excluded, just that he was

not included.

At any point, did --

A Actually, he said that I kept him out of the call because he had a different viewpoint.

Q He did say that --

A He said that clearly.

Q Do you recall having any conversations with --

A Sorry.

Q No. No problem. Do you recall having any conversations with Dr. Redfield about the call?

A No. No.

Q Why not?

A Because why would I do that? This was a call that was organized by Jeremy Farrar, who was the organizer of the call, and it wasn't my call who was in and on. But it was perfectly appropriate for me to notify my boss.

Q This is the beginning of a pandemic, discussing how to respond to the pandemic.

A Yeah. Yeah.

Q Dr. Redfield is the head of the CDC --

A No, I'm sorry, I disagree with you.

Q Okay.

A I disagree with you completely. It is my responsibility to notify my boss. The next morning, I notified the chief of staff of the Department of Health and Human Services, who is the chief of staff to the Secretary, who is Bob Redfield's boss.

Q Did you have any conversations with Dr. Redfield after the fact regarding the

call?

A I don't recall.

BY MR. STROM:

Q And just for completeness, would the same chain-of-command concern also apply to Dr. Kadlec? So you said --

Mr. Schertler. I'm sorry. Could you just clarify that, Jon?

BY MR. STROM:

Q You said that it was appropriate for you to go to Dr. Collins and then email Harrison a summary of the chat, of the call, but that reaching out directly to Bob Redfield, because he's the head of the CDC, would've been -- and I'm not trying to put words in your mouth; I'm just trying to understand -- would've been inappropriate.

Does that same concern apply to Dr. Kadlec, as the Assistant Secretary?

A Does what same concern? I'm sorry. I'm a little confused.

Q I'm trying to understand why, without the distorting light of hindsight, why Dr. Redfield wouldn't be invited just as, like, a courtesy or as, like, you know, someone who's also working the response issue.

A You'd have to ask Dr. Farrar. He was the one --

Q Okay.

A -- that organized the call. He invited me on the call --

Q Uh-huh.

A -- and I felt it was my responsibility to let my boss know that I was going to be on that call.

Q Okay. Thank you.

A Yeah.

Q I'm just trying to understand.

A Yeah.

BY MR. BENZINE:

Q Prior to notifying Dr. Collins, did you ask Dr. Farrar if you could invite Dr. Collins?

A Dr. Collins and Dr. Farrar are pretty good friends. So I didn't think that that was going to be an issue.

Q Okay.

This was introduced yesterday, but I'm going to introduce it again, but you've already looked at this email, majority exhibit 26.

[Fauci Majority Exhibit No. 26
was marked for identification.]

BY MR. BENZINE:

Q And as we went through yesterday, we're going to -- this is Bates marked SSCP_NIH 1796 through 1798.

And the email on 1797, like we talked about yesterday, is, kind of, your summary of the conference call and, as you said earlier this hour, your, I guess, notification that the call happened --

A Right.

Q -- to the chief of staff and a few others, Dr. Kadlec being one of them.

And we talked about this email quite a bit yesterday, so I'm not going to harp too much on it. We focused a lot on the line about "the fact that scientists in Wuhan University are known to have been working on gain-of-function experiments to determine the molecular mechanisms associated with bat viruses adapting to human infection, and the outbreak originated in Wuhan."

And the, kind of, context of that statement is that, now that we've walked through

all this, from Dr. -- I believe it was Dr. Andersen that told you that particular line.

Mr. Schertler. So I'm not sure that that -- I'm not sure that Dr. Fauci had a clear recollection of who told him that.

Dr. Fauci. Yeah. I said I wasn't sure who said that.

Mr. Benzine. Okay.

Dr. Fauci. That was my statement.

BY MR. BENZINE:

Q No, no, I'm saying I believe from our investigation it was Dr. Andersen.

A You believe from your investigation --

Q Yes.

A -- it was Dr. Andersen?

Q Not your recollection.

A Okay.

Q So I'm walking back through the timeline a little bit.

January 31st, Farrar asked you to call Dr. Andersen. On the call with Dr. Andersen, he expresses some concern about this being inconsistent with evolutionary theory and the furin cleavage site looking possibly like an intentional mutation.

And then it's that concern coupled with the outbreak originating in Wuhan that kind of pieces together what is happening -- what research is happening in Wuhan, that now we're concerned about the research happening in Wuhan.

And you said yesterday that -- and apologies again if I mischaracterize it, but -- that you maybe shouldn't have said "by the fact" that scientists in Wuhan University have been known to do gain-of-function research, that it was something that was relayed to you, not --

A Right.

Q -- something that you knew as fact.

A I didn't know, myself, as a fact.

This entire email is a report of the phone call, of which I was in listening mode. And I was reporting, as you say, all of the scientists on the call felt that this was not -- blah, blah, blah. They were concerned about the fact that, upon reviewing the sequences -- yada ya.

"The suspicion was heightened" -- their suspicion was heightened by their statement --

Q Uh-huh.

A -- that they had heard that there was gain-of-function or whatever it is that was going on at Wuhan.

Q And just if you do recall, you wrote "Wuhan University." Did you mean Wuhan Institute of Virology, or do you not --

A I can tell you that my knowledge of Wuhan, the Wuhan Institute of Virology, Wuhan University, was so vague that I don't believe at the time that -- even though there was an email from Greg that said these are the things we're doing, I didn't make that connection. So I didn't even know there was a Wuhan Institute of Virology, and I called it Wuhan University.

He may have said "Wuhan Institute of Virology" during that call, but I believe that just goes to show you how little I knew about what was going on in Wuhan.

Q So it'd be more fair -- obviously, you're relaying what someone told you on a conference call, but it would be more fair to read this sentence as: "... the fact that" -- well -- "scientists in Wuhan," maybe cutting out the "University" -- that you didn't know -- that you knew the suspicion was in Wuhan, but not necessarily which institution in Wuhan.

A I said "Wuhan University" -- I didn't say it. I thought that that's --

Q Okay.

A -- what he said. Therefore, I misinterpreted what he said.

Q Outside of this email, do you recall anything else that was discussed on the conference call?

A Well, I believe we said it yesterday, but I'll re-say it again if you'd like. There was different discussions -- it was different opinions of different people. Some people said that they didn't think that this was an issue at all. Other people said, you know, I think that this is something that we really need to look at carefully. And then a few people said, yeah, I'm not sure either, let's look at it.

The final takeaway was, I believe, articulated by me in the last paragraph: "They pass no judgment at all at this point," and they feel we need to look at it a little more carefully. "No assumption." "Scientific look" at the evolutionary virology. What that leads to "remains to be seen."

So the tenor of the conversation, which I summarized in this email, was that we need to find out more.

Q A few lines down from the Wuhan line, there's a sentence that starts with "Bottom line." Let me know when you find it.

A "Bottom line."

Q Yeah. "Bottom line is that they all agreed with my strong suggestion to gather an even larger group under the auspices of an internationally credible organization."

On the call, did you make that suggestion?

A I must have. I wrote it down, so --

Q And the next sentence: "After some discussion they all felt that the WHO

would be the most appropriate convener of such a group."

I guess I'm just trying to understand the flow. WHO didn't investigate the origins for, like, another year after this.

A Right.

Q And trying to understand what the, kind of, direction after the call was supposed to be.

A Yeah.

Q So there are some communications with you, Dr. Collins, and Dr. Farrar after this about this convening a WHO group.

A Right.

Q Is that what you meant?

A Yeah. The responsibility to nudge the WHO to put a group together was Jeremy's, predominantly, perhaps a bit of Francis. You can ask Francis.

Q Uh-huh.

A Or you maybe already asked Francis; I don't know. But it was predominantly Jeremy. But Jeremy and Francis, I believe, went back and forth about the WHO.

My responsibility, which is what I did, was to let the people on the Department know, particularly Garrett Grigsby, who's the international affairs guy, as well as Bob Kadlec, as well as Brian Harrison, to let the Secretary know.

And I believe that the Department -- it was a multifaceted approach. I believe that the Department was going to take the lead in getting the National Academy of Sciences to take a look at it.

Q I want to introduce majority exhibit 27.

[Fauci Majority Exhibit No. 27

was marked for identification.]

Mr. Benzine. And it's very tiny font, and I apologize for that, but that's how it was printed.

Mr. Schertler. Get your glasses out.

Mr. Benzine. Yeah, get the glasses out.

Dr. Fauci. Even with glasses, it's --

Mr. Benzine. It's small. Hopefully Dave can read it and can assure him that what I'm reading is --

Mr. Schertler. So, listen, I've got an app --

Mr. Benzine. Oh, we don't need to do all that. I'll just read it.

BY MR. BENZINE:

Q So this is a Slack conversation that is Bates marked REV 2902 that was provided to us by Dr. Andersen. In the conversation is Dr. Andersen, Dr. Holmes, Dr. Rambaut, and eventually Dr. Garry.

The very top message -- these messages are from February 1, 2020 -- Andersen says, "Yes, call. Cheers."

Andrew Rambaut says, "Stay on here in case we need to message."

Andersen agrees.

It goes down a little bit further. The first message from Eddie Holmes, who's the square avatar, says, "Big ask!"

Do you think he's referring to your ask of a WHO-convened group?

A You know, I can't speculate what he meant by -- I can't even see it, but I can't speculate what Eddie meant by "Big ask!"

But let me ask you, it says here --

Mr. Schertler. The time sequence would be top to bottom?

Mr. Benzine. Top to bottom, yes, sir.

Mr. Schertler. Okay.

Dr. Fauci. -- "Yes, call. Cheers."

"Stay on here in case we need to message."

"Yup."

"Just FYI - o-linked glycan also present in bat."

"Crap, don't know the context around 5 that make them glycan sites. I might be wrong. The series are there in the bat."

I don't know what "Big ask!" means. I don't -- I'm not sure what he means.

BY MR. BENZINE:

Q The next message, which is the last one that I want to ask about, Andersen says, "Destroy the world based on sequence data. Yay or nay?"

Any recollection of something like that happening on the conference call?

A No.

Q No? Okay.

After the conference call broke, besides the, kind of, summary email that you sent up your chain, did you have any other conversations with anyone in the government regarding the call?

A You know, I don't recall that I did. I just don't. I've been thinking about it and thinking about it. I don't recall anything after that, except that I -- you know, I felt I fulfilled my responsibility.

Q Yeah.

A You know, I told my boss, I told this, I told this, I told that, I told the chief of staff to the Secretary. I kind of covered the bases.

BY MR. STROM:

Q There's a letter from OSTP to the National Academies.

A Yeah.

Q Do you recall talking to OSTP about this? Or was that --

Mr. Schertler. I'm sorry. Could you --

Mr. Strom. There's a letter from OSTP to the National Academies asking them to convene.

Mr. Schertler. When would that -- could you give us a little date?

Mr. Strom. It would be after February 4th, so after this initial call.

BY MR. STROM:

Q Do you recall having any discussions with OSTP about the issue?

A You know, I don't. I don't.

Q Okay.

And then you mentioned thinking about the FBI being the appropriate agency. You don't recall talking to them about it?

A No, I don't.

Q Okay. Thanks.

BY MR. BENZINE:

Q At any point on either of the calls, January 31st or February 1st, do you recall suggesting drafting a paper or a manuscript or any kind of publication about what they were doing?

A You know, there was some back-and-forth about a report or what have you, vaguely, back and forth. Yeah.

Q Do you recall whose suggestion it was to draft --

A No, I don't know what it was, but I remember when the report -- when the discussion came up about what to do with it, I said, if you do anything with it, you've got

to do it in a peer-reviewed way so that it can get evaluated outside of this group.

I think if you can look at the emails that I have been shown since, which I forgot -- and I don't have access to them, because I don't have access to the NIH anymore --

Q Yeah.

A -- is that my whole tenor throughout the entire thing was transparency, not only transparency in letting everybody know but also, if you're going to do it, make sure you do it in a way that gets peer-reviewed, not just coming out with your opinion. Get your opinion peer-reviewed.

Q Eventually -- and we talked about it yesterday a little bit, but I want to ask a few final, kind of, clarifying questions on the "Proximal Origin" paper that came out first as a blog post on Virological in the middle of February and then in Nature, Nature Medicine, in March.

Did you ever edit or suggest any edits to that paper?

A No.

Q To your knowledge, did Dr. Collins ever edit or suggest any edits to that paper?

A To my knowledge, he did not, but you'll have to ask him.

Q And, to your knowledge, did Dr. Farrar ever edit or suggest any edits to that paper?

A I cannot speak for Dr. Farrar. I don't know.

Q As the minority said, we've talked to all the U.S.-based authors or those who are acknowledged on that paper, so I won't go through all of the science in it, except for I want -- you were sent drafts periodically?

A Right.

Q A couple. I think it was less than 10, more than 5, drafts --

A Right.

Q -- periodically. Do you recall ever reviewing the drafts as they were coming in?

A It depends on what you mean by "review." I took a look at them. I didn't make any editing or modification of it.

As they came in, I remember once saying -- after maybe the final one came in, and said, you know, "Well done, nice job," sort of a courtesy response.

But, again, not being an evolutionary virologist, I didn't quite understand the sequences.

Q Yeah, yeah. No, I understand. They're difficult to follow, that's for sure.

A Yes.

Q It's kind of drinking from a fire hose.

So I want to understand that correctly. The drafts would come in. You maybe, maybe not, would open them, read them --

A Yes.

Q -- and then say, "Thanks," something like that, in response?

A Yeah. It was mostly "Thanks," you know, "Appreciate it."

Q The paper made two primary conclusions by the March publication. It changed a little bit between February and March in the peer-review process.

The first one was, "Our analyses clearly show that COVID-19 is not a laboratory construct or a purposefully manipulated virus."

Do you agree with that statement?

A I'm not sure what you mean, do I "agree." I didn't examine the molecular biology, so I would only say that I have faith in people that I know are very, very

accomplished evolutionary virologists. So, when you say "agree with it," I mean, I haven't examined it myself and said, "Ah, this is my conclusion." There are certain things that, when you're out of your lane of expertise, you have to rely on the consensus of people who make a statement. So, in that respect, I would agree. But it's not my evaluation of it.

Q The second major conclusion was, "However, since we observed all notable COVID-19 features, including the optimized receptor-binding domain and polybasic cleavage site, in related coronaviruses in nature, we do not believe that any type of laboratory-based scenario is plausible."

You've said that you have an open mind about the outcome of the virus, but --

A Right.

Q -- that's a definitive statement: No laboratory-based scenario is plausible.

I'm going to ask you the same question. Do you agree with their outcome in that nature?

A Again, I would have to agree -- let me go step by step so we don't get any misinterpretation.

When I say I have an open mind, I have an open mind of a lab leak or I have an open mind that it is a natural occurrence of a spillover.

I believe specifically what he's saying is something that's manufactured. And as I mentioned to the chairman yesterday, you know, a lab leak could be somebody, you know, gets a virus in the environment, comes to the lab, and then it leaks out of the lab. So that's what I meant by that.

I can't say I agree or disagree, except that I trust the evolutionary virologist who examined it. And I believe when he went over it, over it, and over it again, he looked at what it would require for this to have been manufactured, and he didn't think that that

was a plausible explanation. And several very good evolutionary virologists agree with him.

So when you say do I agree, I agree that, usually, almost always, I take the recommendation of a group of highly respected people. And, in that respect, I would have to say I don't necessarily agree because of me but I take their word.

Q I guess what -- we talked a little bit about yesterday that, like, words on paper matter as, kind of, people are reading this.

A Right.

Q And we talked about this, so this isn't necessarily a question to you. But the intent versus what was written down appears to be different, of -- they wrote down, "We do not believe any type of laboratory-based scenario is plausible." That would eliminate, in my mind, any type of laboratory-based scenario, not just purposeful genetic manipulation.

So I don't have a question for you, because I think you'll just say, we'll go with what they said or --

A Right.

Q -- you're not in Dr. Andersen's head.

A Yeah.

Dr. Wenstrup. Mitch, can I --

Mr. Benzine. Yes.

Dr. Wenstrup. First of all, I appreciate talking about some of the scientific findings. You know, we were talking about long COVID before and medical challenges. And when COVID started and we're in lockdown, I'm on the phone with another doctor in Ohio; we're trying to research anything we can. Our first thought is, how the heck do we treat this thing, you know? But, also, you know, where did this come from?

And so, you know, in that vein, I guess, I'm looking at the Slack message from Dr. Andersen, April 17, 2020. And he says, "We also can't fully rule out engineering. That furin site could have been inserted via Gibson assembly. And, clearly, creating the reverse genetic system isn't hard -- the Germans managed to do exactly that for SARS-CoV-2 in less than a month."

Well, this is the same day, the very same day, that you talked about "Proximal Origins" paper on the White House lawn, and there was no discussion. It was just -- you know, I'm just telling you what people perceive at home, right?

Dr. Fauci. Uh-huh.

Dr. Wenstrup. There was no discussion about what Dr. Andersen said the very same day, and he's the one who was one of the authors of "Proximal Origins."

Other concerns that he had -- you know, we started hearing about lab leaks --

Mr. Schertler. Chairman, I don't mean to interrupt. Is this a document that Dr. Fauci was on? Or is this --

Dr. Wenstrup. I'm just framing my experience here, okay? So nothing -- just for the record, this is what I saw and what I heard.

Mr. Schertler. No, I just wondered if he should've been familiar with this or if he had seen it before.

Dr. Wenstrup. Well, he introduced "Proximal Origins" on the White House --

Mr. Schertler. No, I --

Dr. Wenstrup. -- lawn that same day.

Mr. Schertler. But you're talking about a Slack message. I wasn't sure what that was.

Dr. Wenstrup. Well, they've been public. We've already produced them.

But, anyway, I'm just telling you, this is my experience, okay? Can you accept

that?

Mr. Schertler. Yes, of course.

Dr. Wenstrup. Okay. Okay.

And so, also, Ian Lipkin. "The Wuhan Institute of Virology" -- this is October 30th of '22. "The Wuhan Institute of Virology has worked with bat samples and cultured bat viruses at BSL-2. This is a matter of published record -- materials and methods in two papers. This is unacceptable."

That seemed to be the feeling of most of the authors on "Proximal Origins," from some of the things that have been revealed in their comments.

So this is, like, February of '20 that I start looking for stuff with another friend of mine at home. And I see, in 2012, you wrote a paper asking for Dr. Fouchier -- I might be saying it incorrectly.

Dr. Fauci. Fouchier.

Dr. Wenstrup. Fouchier -- for his research to be banned because it revealed the four mutations needed for H5N1 to go human to human. That sounds pretty dangerous. I think I agree with you on seeking a ban for that.

Then I also found an article with you and Dr. Collins from 2011 where you were talking about potential benefits of gain-of-function research -- I'm not sure which definition, but that doesn't matter -- gain-of-function research and that there are some risks involved. That's in the article.

And then you had an interview in 2012 that I found with Weekend Australias. And one of the questions they posed to you was, are you concerned about the potential of a lab leak and creating a pandemic with this type of research? You responded by saying that you thought that the benefits outweighed the risk.

And so, you know, that gives me a lot of concern, and I do want to note what's

going on. And so, you know, you talk about it coming from nature. That's fine. But, also, we're talking about certain capabilities within a lab.

And, you know, in medicine and a lot of times when people come to me and want to pass a bill, I have kind of a golden rule: Well, okay, but who disagrees with you and why? And I think that's important to hold onto.

And so you're referencing the environmental virologist, which I am not, but, you know, I've read their writings. But I've also read some other writings.

So are you familiar with the published works of Rossana Segreto and Yuri Deigin, D-e-i-g-i-n, regarding their analysis of the SARS-CoV-2 genome?

Dr. Fauci. Not to my recollection, no.

Dr. Wenstrup. Well, their works were published in 2020 and 2021, ultimately from scientists from six different countries not aligned with China or the CCP -- from Austria, Canada, Japan, Spain, the U.S., and Australia.

Just, it might be good to review their work. I think it's very interesting and might calibrate your overall thoughts on the origins of COVID, and, as you said, you're open to other suggestions.

One of the things they wrote in there is, "Considering the devastating impacts of SARS-CoV-2 and the importance of preventing future pandemics, researchers have a responsibility to carry out a thorough analysis of all possible SARS-CoV-2 origins."

Do you agree with that?

Dr. Fauci. The responsibility to look at all -- yeah. That's why I say I have an open mind.

Dr. Wenstrup. They also said, "Both the cleavage site and the specific receptor-binding domain could result from site-directed mutagenesis, a procedure that does not leave a trace."

Are you familiar with the published research on site-directed mutagenesis?

Dr. Fauci. No. No, I'm not.

Dr. Wenstrup. Okay.

Well, this is where I think we need to go, is the point I'm trying to make. We haven't had enough conversation. And you can say "I'm open to everything," but if we don't open a book or open our ears or listen to others, we're never going to get there.

And so, as we're talking about this, lessons learned, things we can do better or things we can do now, we need to do this. And would you agree?

Dr. Fauci. I did. And I've actually publicly said that we need to continue to look --

Dr. Wenstrup. Who is "we"?

Dr. Fauci. Excuse me?

Dr. Wenstrup. Who's "we"?

Dr. Fauci. Me. I said "we," being the scientific community.

Dr. Wenstrup. That's fine.

Dr. Fauci. Yeah.

Dr. Wenstrup. That answers it.

Dr. Fauci. Yeah.

Dr. Wenstrup. Have you ever -- well, obviously never spoke to these two, Segreto and Deigin. Have you ever spoken to or read any of the works of Dr. Steven Quay?

Dr. Fauci. The name is -- I recognize the name, but I don't believe I've -- yeah.

Dr. Wenstrup. Dr. William Muller?

Dr. Fauci. No.

Dr. Wenstrup. Dr. Richard Ebright?

Dr. Fauci. Are they -- is Quay a virologist? What is his area of expertise?

Dr. Wenstrup. I don't know his exact --

Dr. Fauci. Yeah, I think he's --

Dr. Wenstrup. -- expertise.

Dr. Fauci. Yeah, I don't --

Dr. Wenstrup. He might be a physicist with NIH.

Dr. Fauci. Yeah, that --

Dr. Wenstrup. NIH has written about how physicists should be involved with this. That's something else I found, because I thought that was kind of odd, when I saw that.

Dr. Fauci. Yeah. I would --

Dr. Wenstrup. I think Muller's a physicist, anyway.

Dr. Fauci. Yeah, but they're not virologists, so --

Dr. Wenstrup. No, but I'm just wondering -- you know, let's talk to everybody, right? NIH has said it's important that we talk to physicists. They wrote that.

Dr. Fauci. Well, I didn't write it.

Dr. Wenstrup. You can find it.

Dr. Fauci. Yeah. So I didn't write it.

Dr. Wenstrup. I'm just, again, giving you my view.

Dr. Fauci. I hear you, Mr. Chairman. I hear you.

Dr. Wenstrup. And how about Dr. Richard Ebright?

Dr. Fauci. I've heard of Dr. Ebright, yeah.

Dr. Wenstrup. All right.

With that, that's all I have.

Mr. Benzine. All right.

Dr. Fauci. Okay. Thank you.

Mr. Benzine. We can go off the record.

[Recess.]

[12:50 p.m.]

[redacted] We can go back on the record.

First, just some housekeeping. In the previous hour, Congress Members Cloud and Joyce joined, are not currently with us, and if other Members who have since joined could identify themselves as well, please.

Dr. McCormick. Dr. Rich McCormick.

Mr. Griffith. And Morgan Griffith, chairman of the Oversight and Investigations Subcommittee on Energy and Commerce.

[redacted] Great. Thank you.

BY [redacted]

Q So, Dr. Fauci, if I could ask a few questions about some of the emails and documents that we walked through in the previous hour. And so you or your counsel may need access to those, starting with what I have marked as majority exhibit No. 20, and that's Bates number REV750.

You have seen this email more than once and more than twice, but you're welcome to flip through it if you would like to.

A Just one second.

Q Sure, of course.

A Got it.

Q Great. So in your email to Jeremy at the bottom of the first page, I just wanted to focus on a small excerpt, which is, you say, "He," being Dr. Andersen, "should do this very quickly," meaning get a group of evolutionary biologists together to examine the concerns. And you say that, "If everyone agrees with this concern, they should report it to the appropriate authorities." You go on to talk about the FBI and MI5.

It's just a point of clarification, but I think one worth making, that your own memo

describing what you heard on the February 1st conference call -- which is a different email, but we've looked at that several times. I won't make you look at it again. But it is crystal clear, I think, that the participants on that call, the virologists -- evolutionary virologists -- were disagreeing amongst themselves from the get-go. In other words, not everyone did agree with this concern.

A Right.

Q Isn't that right?

A Yes.

Q Okay. Great. And when you talk in this email about, hey, Dr. Andersen, as soon as possible, you and Dr. Holmes should get a group together to examine it -- I'm repeating myself from yesterday, but I'll do it anyway.

The point of this at this point was, people were saying that they thought it may have come from a lab.

A Right.

Q And your point is, if you think it came from a lab, you need to examine that urgently.

A Yes. Correct.

Q In other words, that is sort of the opposite of what we would expect to see if one were trying to suppress a lab leak theory. Is that right?

A That is correct.

Q All right. Great.

In exhibit -- majority exhibit 21 -- I'll give you a moment to glance at that. That seems to have a Bates number at the bottom of NIH-2396. I'll give you a moment to glance at it if you'd like.

A Yes.

Q So Dr. Andersen's email in the middle of the first page, he talks in his first paragraph about unusual features of the virus are a really small part of the genome. You have spoken with ourselves as well as the majority at length about how that is likely referring to the furin cleavage site.

I just want to emphasize that we spoke to Dr. Andersen, who was very clear with us that, at this point in the chronology, he was not yet aware of the extent to which furin cleavage sites existed in beta coronaviruses, the genus above whatever subgenus we're dealing with here.

A Right.

Q And so I don't know the extent to which you -- because you're one degree removed from him -- would even have been aware of any of that, but I suspect if I ask you, you would say you likely don't recall that type of detail. Is that right?

A That is correct.

Q All right. Well, then I'm simply letting you know that Dr. Andersen did not know that at the time he wrote this, and that he learned it, and he learned all sorts of other things, ultimately resulting in a shift in that paper from probably where they started when you first talked to them.

A Yeah.

Q Great.

A Correct.

Q Okay. A minor point on majority exhibit 22. So that's a Bates number NIH-2432. It's an email from yourself to Dr. Auchincloss.

So just a point on that particular paper, the Baric-Shi paper, which we do not have in front of us. I'm not going to make us have it in front of us, but there was a mention about certain chimeric viruses in that paper resulting in increased pathogenicity. I don't

expect that you would have memorized that paper sitting here, but --

A No.

Q -- I think our understanding is that when we talk about the backbone of the chimeric virus performing on its own at the full genome length --

A Right.

Q -- that, as compared to the chimera, there was, in fact, a loss of function.

A Right.

Q So not a gain-of-function, a loss of function.

A Correct.

Q Decreased pathogenicity.

Where the complexity sometimes comes into play is Dr. Baric included sort of a side discussion of the extent to which the chimera compared to wild-type --

A Right.

Q -- SARS. The backbone is mouse-adapted. That's a loss of function.

A Right.

Q Wild-type, maybe a gain-of-function. I don't know if you recall that nuance, but I did just want to note that.

A Right. I recall this being explained to me long after the fact in my preparations for hearings. It's exactly like you said. When you're talking about any gain-of-function at all, that you have to make sure you have the correct comparator. And what you stated was correct. If you do the appropriate comparator, it was actually loss of its function and not gain.

Q Great. That was the sole point I wanted to make there.

With respect to majority exhibit 24, if you could pull that up. That's got an NIH-2415 number at the bottom. I'll give you just a moment to glance back over that

one.

A Got it.

Q Just two discrete points from Dr. Auchincloss' email. He ends by saying that, "Emily is going to try to determine if we have any distant ties to this work abroad."

I think we've deduced from context that we are likely here still talking about that Baric-Shi paper.

A Yes.

Q I just want to note that that work -- it was noted in a previous round, but I'm going to note it again -- was not abroad, right?

A The Baric work was done in North Carolina.

Q That is my only question for you.

And then, in addition, I just wanted to ask, the way that Dr. Auchincloss sort of thinks about this type of a question in this email, we can see that he immediately refers to the gain-of-function pause --

A Right.

Q -- to the P3 framework.

Would you say that that is consistent with what we talked about at length yesterday? In other words, you and your folks think in terms of what are the regulations that govern us and what are the right decisions inside of that box?

A Correct. What I believe that Dr. Auchincloss was referring to was exactly what you said, that no work has gone through the P3 framework, which means none of that work elevated to the need for further scrutiny according to the framework that we discussed in detail yesterday about P3C0.

Q And Dr. Auchincloss' analysis does not include a reference to whatever that other website -- layman's concept?

A No. No.

Q Great. This is more a point about I think what you might not know, which is this factual question of, Dr. Baric's experiments for this paper, were they before the gain-of-function pause? Were they during? Were they after? How did that approval work?

I just want to ask, consistent with the idea that you would not typically be involved in the minutiae of particular grants, you would not have been involved with any of those questions. Is that right?

A I was not involved in any of those questions.

Q And I'll just say that there are plenty of folks who probably were or at the very least would know a little bit more about it that we have either spoken to or are going to speak to, and so I think we should just ask them.

A I think that's a good idea.

Q Great. On majority exhibit 25, it has a Bates number NIH-1902. I'll give you a moment to glance over that one.

A Got it.

Q All right. So towards the top of that first page, we have this exchange where there's a question of whether Dr. Tabak is going to join the February 1st call or not join that call, and Dr. Collins says it's fine with him, but he knows that Jeremy says that he -- being Jeremy -- wants to keep this call a really tight group.

I think we're getting into almost, like, philosophical questions about who felt connected to this call, but just from your point of view, it would seem that the very most influence a person can have over a call is a decision about who's going to be on it and is it going to be big or small.

Is your recollection essentially that Dr. Farrar was making the substantive

decisions as it related to this February 1st phone call?

A That is correct.

Q Great. And I will not read it to you because I don't have it handy, but I will note for you that we have sat and read in detail Dr. Farrar's book "Spike" in which he talks at length about how he set up this call not as an administrator who had particularly convenient dial-in lines, but because he was substantively concerned about the possibility of genetic manipulation and the implications of that possibility. So I just wanted to note that context for you as well.

I'm going to go, if I could, to majority exhibit 26, and this is your sort of lengthy email summarizing what happened on the February 1st call.

A Yes.

Q I've got a very, very small point of detail, but there's some discussion about the words "Wuhan University" here and whether that possibly could have been Wuhan Institute of Virology that you heard. Who knows?

I just want to know, are we sure that it wasn't Wuhan University? Because Wuhan University had a subaward under this EcoHealth Alliance grant, had some other separate grant from NIH, and I think had a funding stream through USAID and the PREDICT program.

So I just want to ask you whether we are sure whether or not what you heard somebody else say was, in fact, Wuhan University or WIV or we don't know.

A We don't know. I'm not sure what that was. I put down "university," and I'm not sure whether that is exactly what I heard or something else.

Q Great. And then some discussion about the aspect of this that talks about convening a group under the auspices of an internationally credible organization like the WHO.

It's sort of a comment followed by a question. We, again, spoke at length with Dr. Andersen, Dr. Garry, and I as a reader read this and said, okay, this WHO idea is what turned into "Proximal Origin." The two of them say to me, no, it's not. There were two different conversations going on. There was a conversation about convening the WHO to look at this question, and then we got into a separate conversation with Dr. Farrar about the importance of looking at the same question but maybe a little bit faster in a peer-reviewed context starting with a report, then a peer-reviewed article.

So I assume, is it right, that you personally don't remember anything about those distinctions because, again, you're just repeating what other people have said?

A Correct.

Q Great. For your information, it sounds like the people who said it say that this is a different conversation from what turned into "Proximal Origin."

A Right.

Q And my only last thing -- we don't have "Proximal Origin" in front of us, but you were asked about some specific excerpts from the paper, some of the paper's conclusions.

A Right.

Q I would just -- having, again, sat in excruciating detail with the folks who wrote it -- urge caution when it comes to trying to interpret exactly what they meant without the benefit of talking to them about it for 8 hours because they say that when they use the phrase "laboratory construct" -- which, to me, as a total layperson, I read as anything that was in a lab. They say, well, no, we meant that as a term of art. That was referring more to the idea of deliberate --

A Creating.

Q -- deliberately created, right?

And so that, in and of itself, to them, it sounds like, was not really commenting on something lab-like, but not fitting that, such as serial passage.

A Right.

Q And I'll just read an excerpt elsewhere in that paper, which can be read to conflict a little bit with some of their other conclusions.

They say elsewhere in the paper that, "Although the evidence shows that SARS-CoV-2 is not a purposefully manipulated virus, it is currently impossible to prove or disprove the other theories of its origin described here."

And one of those other theories was serial passage in a lab. So although that does not fit neatly with “no lab-based scenario is plausible,” I just -- is it right for you as a reader that the paper did seem to leave itself some wiggle room with respect to lab versus animal?

A Yes, it did. It explicitly said that.

[redacted] Great.

That is all I had. And with that, I'm going to turn it over.

[redacted] Great.

BY [redacted]

Q Good afternoon, Dr. Fauci.

A Good afternoon.

Q Yesterday, throughout the various questions – at several points, actually -- you spoke about how impressive the COVID-19 vaccine development process was compared to the typical vaccine development process that you've been aware of.

So to help us fully understand that and how impressive the COVID-19 vaccine development was, I think it would help to start with, what is the typical process for vaccine development?

A The typical process, if it's a brand-new pathogen, is to identify the pathogen and then develop the appropriate platform and immunogen to become your ultimate vaccine, to test it in an animal model to determine if there's anything grossly adverse-event-associated, but more importantly, to determine if it has an effect in an animal model.

Then you go into a phase 1 study, which is usually measured in tens to a hundred individuals -- not very many more than that -- primarily to safety, but then to determine the hint of any degree of efficacy.

But the numbers in a phase 1 trial, you're not going to get clinical efficacy. You'll likely get to get a laboratory indication that might project that you might be efficacious.

Then when that's finished, you go into a phase 2 trial, which is measured in several hundreds and sometimes up to a thousand or so to determine further information about safety, but more information about the level of the immune response, and then is there an even stronger hint of efficacy.

When that's finished, you then go into a phase 3 trial, which is generally measured sometime depending upon the incidence of infection, that could be measured in several years. For example, HIV trials have gone on for 8 or 9 years before it was shown they didn't work. The Zika trial, even though we didn't need the Zika vaccine, took a few years to do.

That whole process, from the time you know what the pathogen is to the time you get a vaccine made, tested in the multiple phases, really is measured generally in 7 to 10 years, when you're successful. Sometimes it's 20 years, but 7 to 10 years is a reasonable time for that.

And what was happened, as you know -- as I outlined yesterday -- the amount of investment that was made in basic and clinical research and platform technology,

together with immunogen design, allowed us to start a process of vaccine development within about 5 days from the awareness of the genomic sequence. That is amazingly beyond precedent. That usually takes years before you do that -- a few years.

And then we went into high-risk clinical trial. High risk means, instead of waiting for the end of one phase, you start preparing and going into another phase. If you were just a pharmaceutical company, you wouldn't take the risk of the investment in developing a phase 2 until you knew the phase 1 was done, and you certainly would not prepare for a 30,000-person clinical trial in a phase 3 unless you knew what the phase 2 showed.

So there was a big risk that was taken, not to mention the purchase of vaccines, even though we didn't know what the exact efficacy was. So a multi-, multiyear process was truncated into 11 months. So that was, you know, by anybody's imagination, an unbelievably unprecedented feat.

Q Absolutely. And when you mention the normal timeline being 7 to 10 years, is that just the development, or is that development and approval?

A The approval sometimes adds a couple of years to that, yes.

Q So when you think about that, you know, that 10 could become 12, 13?

A Right. Yeah. I mean, I have a slide that I show when I talk about vaccines, that if you look at -- on the one scale is the time that the vaccine -- that the virus was identified, and on the other scale, how long it took to get a vaccine.

And it's kind of, in many respects, almost a tongue-in-cheek. You know, typhoid, it took 102 years. You know, the other ones, 50, 20, 30, 10. And then when you get down to SARS, you saw it was 11 months -- SARS-CoV-2.

Q And that 11 months for SARS also includes sort of releasing it to the public. It included the manufacture --

A Right.

Q -- as well, which also can sometimes take time.

A Right.

Q With that sped-up timeline, how was safety still ensured with the vaccine?

A Well, it went through the classic safety hurdles, as it were, with the phase 1 and then the phase 2. They were following it very, very carefully.

To have a 30,000-person phase 3 trial with no safety concerns of -- you know, I mean, nothing is 100 percent safe. Like, sitting here, I could fall off the chair and break my neck. But it's a very, very rare adverse event, if any.

But then after that 20,000, 30,000 phase trial, when the vaccine is finally approved or at least given an emergency use authorization and administered to literally hundreds of millions if not billions of people, that's an after-approval safety observation. And the safety profile of the vaccine is now in billions of people, which is also unprecedented in the number of people who've received it. It has a very, very strong safety profile. Of course, there are rare adverse events associated with any intervention, but the adverse events were extraordinarily rare.

Q And I assume, in order to ensure safety and ensure approval, NIH worked with FDA and potentially other Federal agencies on this vaccine development process. Is that correct?

A That's correct.

Q How did that interagency relationship work in relation to the vaccine?

A Well, we provide data from the clinical trials. So the NIH was in collaboration with several of the pharmaceutical companies that utilized our clinical trial infrastructure that we built up actually dating back to the AIDS years. That was built to do testing of drugs, vaccines, prevention. We mobilized our team and collaborated with

the pharmaceutical companies, and that data we made available to the FDA to analyze it both for its efficacy and its safety.

Q Generally, how does research on what makes a virus more or less transmissible contribute to the development of vaccinations?

A How does a vaccine that determines more or less -- well, to understand if you're dealing with a very transmissible virus -- and one of the parameters that you're going to use is, does it protect against infection? If you do experiments understanding the virus and all aspects of the virus, it will give you an idea of the level of immune response that will be required to ultimately protect either against initial infection and/or disease following initial infection.

Q And I just want to follow up with a point you made that there was already research that had been done prior to the COVID-19 outbreak that really helped speed this process along.

So there is a value in doing research without sort of the pressure of having an outbreak or the pressure of having a known infection?

A Yeah. Well, it's essential. It's not just okay. It's essential. I mean, the paper that we funded together with a variety of other funders that led to the initial observation that you can modify a molecule of RNA to make it appropriate for a vaccine was in 2005. So, you know, we started on the vaccine in 2020. So you're talking 15 years of research. The work that led to the optimal immunogen design is work that goes back at least two to three decades on structural biological development of confirmation that's the proper design of an immunogen.

So all that work that had gone on for a few decades was just perched to then just jump into when we had the outbreak. So the work before an outbreak is absolutely essential. That's part of prepared.

And, by the way, as I think it was implied in your question, when Drew Weissman and Katy Kariko were doing the RNA -- mRNA work, they didn't have any pathogen on their mind, much less COVID. And when Barney Graham and Jason McLellan and Kizzy Corbett were doing work on the immunogen design, they started that work way before COVID. They were doing it with regard to respiratory syncytial virus.

Q And so these researchers did not have COVID in mind, but without the work they had done, that 11-month timeline would have been impossible?

A It would have been totally impossible. Right.

Q And I assume that that work that's been done, the work that's been done on COVID-19, will also potentially give a benefit to future viruses that we don't yet know about?

A Oh, absolutely. COVID-19, it turns out, as we've discussed before, to be a very, very unusual virus in its ability to continue to have new variants. And even today, you know, if you look at the statistics, we have now the variant that's a subvariant of XBB, that's it's a JN.1 that is a subvariant of Omicron. So they keep having subvariants.

Q You mentioned the mRNA technology. I think we all heard a lot about that when the vaccine was in development and how it was new but not really new because it had been worked on for 15 years.

Is there anything else you want to tell us about that technology and that research and what potential it holds for future vaccine development?

A Well, the proof of the pudding is what's going on. So, right now, the extraordinary success of the mRNA vaccine with COVID has triggered a real wave of very eloquent research that is being -- using the mRNA technology for any of a number of pathogens, including for some cancers. Vaccines against cancer. So the mRNA technology, because of its great success, has been adopted by the scientific community to

use broadly.

So I think as the years go by, you're going to see a lot of other successes. We're doing it with HIV. We're doing it with malaria. We're doing it with some cancers. There's an awful lot of work going on using the initial success with COVID for that.

Q Good. Something for us all to look forward to.

We talked about ensuring safety in a general way, but there are specific populations that need to be examined for safety due to differing circumstances, specifically children, pregnant people, and the elderly.

How specifically was the COVID vaccine ensured to be safe for those populations?

A Of course, trials were done specifically. And, I mean -- so that's what we did. Whenever you do clinical trials, you always start with healthy adults, and then you go and -- if it's okay in healthy adults, then children that are more vulnerable, pregnant women who are more vulnerable -- then you do the study and then -- to try and make sure that when you give the vaccine to those subgroups, that it is equally as safe and equally as effective.

Q And I think that also played out in the rollout of the vaccine. I think we saw adults were given access to the vaccine before children were recommended to take the vaccine.

A Right. That's correct.

Q And speaking about the rollout of the vaccine, what role, if any, did you have in the strategy of how to distribute the vaccine?

A Of how to distribute it? I really didn't have any major role in how to distribute it. It was -- my role was major into development of the vaccine.

Q Do you have any thoughts on how effective the government's vaccination campaign was when the vaccine was first released?

A Well, it was -- you know, it was released in the end of November, the beginning of December, and then there was a month and a half to 2 months of one administration, and then you had another administration. What administration are you referring to?

Q The initial rollout, which I believe was -- it crossed over the lines. It was December of 2020 going into January of 2021 when the vaccine was first released to the public.

A In the beginning, the mechanism of the distribution -- though what was put into place was a mechanism of doing that through General Perna and others -- it didn't get off the ground quickly. And I wouldn't say quickly. It had some growing pains in the beginning.

Q And I believe at the very beginning when the vaccine was first released, there was quite a demand. I remember, you know, lines. You could look up online who had a vaccine available. There were wait lists to get it, that sort of thing. So there was clearly demand for the vaccine.

What was done to speed up production or help with production to meet the demand?

A You know, I'm not really sure, because that was -- you know, that was in a totally different lane than my lane. That had to do with FEMA and General Perna and that whole group, which I didn't get deeply involved in that at all. So, I mean, I was probably in on some discussions about that at the Coronavirus Task Force, but I don't recall what specific mechanisms were used.

[redacted] I understand. Thank you.

I'm going to turn things over to my colleague.

[redacted] Great.

So picking up where [redacted] left off, Dr. Fauci, I'd like to discuss with you the role that COVID-19 vaccines played in turning the tide on the pandemic. And I'd like to focus our initial phase of this discussion on a December 2022 Commonwealth Fund study that I'd like to enter into the record. This will be exhibit S.

[Fauci Minority exhibit No. S
was marked for identification.]

BY [redacted]

Q I'll give you a moment to take a look at that, Dr. Fauci.

A Okay.

Q So this Commonwealth Fund study has a number of different findings. I'd like to walk through a few of them.

First, the study finds that the first 2 years of administering the COVID-19 vaccine was responsible for or contributed to 3 million prevented deaths and the prevention of 18 million hospitalizations.

Does this finding surprise you?

A It didn't surprise me because we knew from the degree of efficacy from the clinical trials and the large number of infections that were occurring at the time that a vaccine with a good degree of efficacy to the tune, at least initially, of 93, 94, 95 percent, would have a very, very profound effect on preventing hospitalizations and deaths and saving, you know, $1.1 trillion in healthcare costs.

It wasn't surprising. I was very pleased to see it, but it didn't surprise me. It's what the power of vaccines are when you're in the middle of a pandemic.

Q And in your conversation with [redacted] a few minutes ago, you discussed some details about the way that the vaccine works to protect people to build immunity and save lives.

Is there anything you'd like to add detail wise about the sort of underlying science or way in which the vaccine works to achieve the results found here with respect to lives saved and hospitalizations prevented?

A Well, there's even a multiplier effect because, obviously, the vaccine turned out, but in the beginning, it did prevent some infections, not as much as it prevented hospitalizations. But a multiplier effect would be that, for those infections which you prevented, you then would multiply another certain amount of people who would be saved from getting to the hospital and dying because they never would have been infected.

Later on, as we all know, as the virus evolved, the ability to prevent infection was less, but the ability to prevent hospitalizations and deaths sustained itself, particularly with boosters later on.

Q You bring up a very interesting point, which was, at the beginning of the rollout of the vaccine, we observed, I think, greater strength or effectiveness with respect to preventing infection.

A Right.

Q At the current state of the pandemic, we understand the vaccine remains incredibly effective with respect to preventing severe symptoms and death. But some have suggested that because the vaccine does not prevent every instance of infection, it does not work.

Is there anything you would say to correct the record on that?

A Yeah. Well, that's just not the case. I mean, the primary goal is to prevent people from getting sick. And in this case, since it's a virus with such a high degree of pathogenic potential, a lot of people, particularly vulnerables, have gotten seriously ill. So a vaccine that prevents hospitalizations and deaths is a very, very

successful vaccine.

There are charts that I know -- because I've lectured on it and I have slides on it -- where if you show the hospitalizations and deaths of unvaccinated individuals and the hospitalizations and deaths of vaccinated individuals, the difference is profound. There's a multifold advantage in the sense of death and hospitalization for the vaccinated versus the unvaccinated.

Q So moving from deaths and hospitalizations, this report also found that, during the first 2 years that the COVID-19 vaccine was available, it contributed to the savior of more than $1 trillion in medical costs.

You touched on this a little bit in the previous questions, but just to put a finer point on it, could you explain how COVID-19 vaccines serve a role in reducing medical expenditures in the American healthcare system?

A Yeah, I will. It's pretty obvious. When you keep people out of the hospital -- particularly when you look at the hospital costs of people with COVID, their hospital cost is often prolonged. I mean, there are examples of people in the hospital and in ICUs that's measured in weeks and weeks, and those who are more vulnerable very often succumb, leading to the 1.16 million lives that have been lost thus far in this country.

So the healthcare costs of not only hospitalizations but that hospitalizations that often require intensive care, the healthcare cost of that is phenomenal, leading to the estimate that $1.19 trillion was saved during that 2-year period. We're now in year 5 as of a few weeks ago -- about a week ago -- so that's probably a lot more than just that 3 million.

Q Right. And stemming from that, probably fair to say as well, not just lives saved, but hospitalizations prevented, medical expenditures reduced, all of that likely

greater now 5 years in than this 2-year period estimate?

A Yeah, obviously. And just another thing to mention that it doesn't relate necessarily to the United States, but this is 3 million deaths and 18 million hospitalizations in the United States. If you look at the fact that a few billion people have been vaccinated worldwide, there are probably tens and tens and tens of millions of lives saved.

Q Important.

Another point in this study. So the study also points to the role of the vaccine in, I think, two very important things for American society coming out of the most acute phase of the COVID-19 pandemic: the resumption of safe, in-person learning in schools, and the reopening of businesses in our economy.

Can you provide your perspective or your assessment of the role of the COVID-19 vaccine in achieving those two aims?

A Oh, yes. I mean, obviously, if you prevent people -- to some extent, again -- to get infected -- but now, as we know, that's not as effective as it was -- but the degree to which you prevent infection, you're going to prevent children from getting infected and workers from getting infected -- not only infected, from being in the hospital -- that has an important impact on the economy, of keeping businesses open.

I mean, back in the height of the outbreak, we saw that there were many people in different industries who were infected and couldn't go to work, and many died.

Q And so since the rollout of the initial COVID-19 vaccine -- and you mentioned this at a few points in the past day and a half -- we have seen the deployment of boosters and updated vaccines.

Could you explain the need for boosters and updated vaccines and the role that these serve in continuing to control and have a handle on COVID-19?

A Well, there are two aspects of a booster that I think are important: the duration of the protection of a given vaccine against a given strain, and the fact that we're living in a very unusual situation where we have the evolution of different strains that -- when Alpha evolves to Beta, to Delta, to Omicron, to B45, to XBB.1, to all of the others that we're dealing with -- that it escapes the protection not only from protection to the extent that there is protection against infection, but to the protection against severe disease.

And, again, the data validates that, because when you look at those same charts, that if you have unvaccinated deaths here, vaccinated deaths here, vaccinated with boosters deaths here, which means for -- I know you can't see that on the recording, but it means that there are more deaths in the unvaccinated than there are in the vaccinated, and there are more deaths in people who are vaccinated but not boosted than there are in people who are vaccinated and boosted.

Q And so in the previous exchange you had with [redacted], she mentioned the enthusiasm that existed for the primary series of the COVID-19 vaccine. Lines out the door, very difficult to get appointments initially through online platforms and the like.

I think it's fair to say we haven't seen that same level of enthusiasm for boosters or updated vaccines, and I'm curious why you think that might be.

A It's complicated. I think there are multiple conflating reasons. One of them is that there is a disturbing anti-vax trend in this country where vaccines are, for reasons that don't make any sense to me, essentially have a negative connotation to a number of people.

And we know that. I mean, there are studies that you're all perfectly aware of, that the vaccination rate in some States is significantly different than others, and in the States in which the vaccination rate is low compared to a State in which it's high, there

are more deaths in the State in which the vaccination rate is low than there are in that. That's one thing that gets people.

Also, I believe that there's misinformation and disinformation out there about vaccines, such as -- you know, whenever somebody dies who's a young person, they always say, well, that person got vaccinated within the last few months. It must have been the vaccination. We've seen that particularly with certain athletes. So that's another reason why.

And I think a third reason of conflating is that people are tired of COVID. They want to put COVID behind them. And they have the misperception that, you know, my goodness, I've already been vaccinated, or I've gotten infected, so I just don't want to be bothered with anything that has to do with COVID. And that's really unfortunate because I believe less than 20 percent of the people who are eligible to get the latest XBB.1 vaccine have gotten the vaccine, and yet we now have something like 1,400 deaths last week with COVID, and the hospitalizations are going up again.

So, right now, to think that COVID is behind us and gone is a misperception. And you add that misperception to the misinformation about vaccines, you know, to all of the other things that are going on about people who are anti-vax, I just think that's an unfortunate situation we have in this country.

[redacted] I think that segues very well to a few questions Congresswoman Castor has.

Ms. Castor. Yes.

Thank you, Dr. Fauci.

If we go back to the early days of vaccinations and the initial rollout at the end of 2020, but it really didn't take off until passage of the American Rescue Plan in March of 2021, where the Congress provided billions of dollars to get widespread vaccination plans

underway. Do you agree with that?

Dr. Fauci. Well, certainly, I'm not sure of cause and effect, but I can say that what you're saying is correct. That the vaccine took off pretty -- I would say the sharp incline in vaccines took place according to the timeline you mentioned associated with what you mentioned.

Ms. Castor. The American Rescue Plan was passed in March -- early March of 2021 and provided billions of dollars for COVID-19 vaccine distribution and administration. It provided funds to our local communities, to our States, to bolster their public health systems, to hire people.

I remember very well, in Tampa, with the help of FEMA and the National Guard, we set up a mass vaccination site at an old dog track that had a huge parking lot and people could just drive through. I remember very well setting up the same kind of system at our big VA hospital. And people were so relieved at that time that a safe and effective vaccine was available.

You know, Florida is an interesting case study, and one of the tragic consequences of the pandemic across the board is that many people died who should not have died because they were not vaccinated for whatever reason. In the early days, we didn't have the vaccine.

And then just what you were talking about, this anti-vax thread that has kind of taken hold. There was one study by Brown University Public Health, Brigham and Women's Hospital, MicroAI, that said that death -- about 318,000 deaths could have been prevented if they had gotten the vaccine. And that was a study that -- they just looked at January 2021 through April 2022.

What I saw in Florida, early on, people were hungry for that vaccine. They wanted to get back to normal. And early on, our State did pretty well. We have -- our

population skews older, so it's very important to get our older neighbors and in nursing homes and those over 65 to get vaccinated.

But something changed due to politics with our governor. At a September 2021 press conference, he was asked whether people should get vaccinated. He said, at the end of the day, though, it's about your health and whether you want protection or not. It really doesn't impact me or anyone else.

Was Governor DeSantis correct when he said that someone choosing not to get vaccinated doesn't impact anyone else?

Dr. Fauci. I think that what he was referring to was the notion that -- I don't know what he was actually referring to. But let me have you ask the question again, because I don't want to be saying something that is not --

Ms. Castor. Well, I'll ask a different question.

Dr. Fauci. Yeah.

Ms. Castor. How do vaccination rates impact the course of an infectious disease?

Dr. Fauci. Yeah. Well, in two major ways. Number one, it protects people from getting sick and overwhelming the hospital system. You might recall that during the peak of -- and, in fact, we're even getting close to it now. When you overwhelm a hospital system with a disease that's vaccine-preventable, that there are many people who have other diseases who don't have access in the hospital. So it does impact society. Things like elective operations, things like preventive medicine gets impacted.

The other is, to the extent that vaccines prevent infection, that you can interfere to a certain extent with the spread of infection from one person to another. As the vaccines -- as the virus evolved and became more and more variant-prone, the ability to protect against infection actually went down. Not completely, but it went down.

Ms. Castor. So the decision not to get vaccinated can have broad repercussions?

Dr. Fauci. Yeah. Broad repercussions on the hospital system, broad repercussions on individuals, and broad repercussions about the spread to a certain extent.

Ms. Castor. Had anything changed by summer of 2021 as we were going into the Delta surge? Did anything change with the efficacy of the vaccine -- the COVID-19 vaccine? Were we learning that it was safe and effective, or were we learning that, boy, there are some issues with it?

Dr. Fauci. No. What we learned was that the durability of protection -- more so against infection but less so against severe disease -- diminished over time. It was not a highly durable protection, which led to the need for booster shots.

I mean, if you compare a vaccine like measles or a polio vaccine, where the durability of protection is measured minimally in decades and maximally for lifetime, that was not the situation with COVID. The durability was limited to several months, and you saw a diminution more so in protection against infection and less so against protection against disease.

That was the reason why we were recommending appropriately that people who are vaccinated over a period of time get boosted to bring back up. The safety issues remained essentially the same. The more you learned about vaccines with the few rare adverse events that were noticed, the more we realized that the vaccines were actually quite safe.

Ms. Castor. Yeah. You know, as a policymaker -- I was on the Health Subcommittee. I'm very attune to what was happening with the population across my community and just was taken aback by some of the politicization of the vaccine.

Governor DeSantis hired someone to come in and replace our former surgeon

general who was sidelined in October 2022. The new Florida surgeon general, Joseph Ladapo, said that some COVID response mitigation measures were manipulative, destructive, and divisive policy. He said -- he started talking about the -- how vaccines -- you could not rely on the COVID vaccine. In fact, we have -- he wrote to the Federal Government to say we disagree here in the State of Florida that vaccines are the way to go.

Will, do you happen to have the early response from --

This has been ongoing now for over -- well over a year. This is -- and I want to check on time. We may need to --

[redacted] We have 5 minutes.

Ms. Castor. Five minutes. I think we can pass it around.

[redacted] Okay. This is exhibit T.

Thank you.

[Fauci Minority exhibit No. T
was marked for identification.]

Ms. Castor. And do you also have The New York Times article?

Because I know we can talk a little bit more about the politicization of the vaccines and public health and how that has cost lives, because what I witnessed in Florida, as the politics changed, a new surgeon general who discounted public health protocols that were widely accepted, as we were trying to communicate as policymakers to our neighbors what they could do to save their lives and be healthy and then get back to work, get back to school as soon as possible, we were running into this misinformation campaign that really took a toll coming into the summer of 2021 with the Delta surge, where studies subsequent looking at that says, in the State of Florida, more people died after the COVID-19 vaccine became available than beforehand.

This just seemed like a complete abdication of the governor's and the surgeon general's role to protect the people of my State. And I think, as you said, there are severe repercussions when you do not -- if you are not following public health protocols and your advice to get the vaccine, to the point where Dr. Ladapo was -- has been taken to task by the FDA and the CDC. Here, they write that -- let me pick a good part here.

"Focusing on adverse events in the absence of causal association and without the perspective of countervailing benefits is a great disservice to both individuals and public health. Like every other medical intervention, there are adverse effects from vaccination. Serious adverse events from COVID-19 vaccines are rare and are far outweighed by the benefits of these vaccines for every age group."

Just recently, Dr. Ladapo called into question -- again, wrote to the FDA and the CDC alleging that DNA fragments from the Pfizer and Moderna mRNA vaccines could integrate with the DNA of the person they're injected into, causing a host of harmful side effects. And just weeks ago, he called for the halt for the use of the mRNA vaccines.

Do you have any idea what he is talking about when he says that mRNA vaccines could integrate into a person's DNA that they're injected into?

Dr. Fauci. I have an idea of what he's talking about, but it doesn't make any sense.

Ms. Castor. Have you heard of DNA fragments from the Pfizer and Moderna mRNA vaccines integrating with a person's DNA that they're injected into?

Dr. Fauci. There's no evidence whatsoever that that happens, and the mechanisms that would be required for an integration are not present in the cell. So that is sort of physiologically very difficult to comport that with the statement that is made by Dr. Ladapo.

Ms. Castor. So you previously reviewed for us the kinds of studies and controls

that went into the research and approval of the mRNA COVID vaccine for it being safe and effective.

What does this kind of anti-vax propaganda from a health official that leads the State, what does that do, in your opinion? Does it risk lives?

Dr. Fauci. Well, it certainly confuses people and would lead to people not getting vaccinated. And as we've said multiple times, vaccines save lives, and when you compare the death and hospitalization of vaccinated versus unvaccinated people, you can make a reasonable conclusion that if people don't get vaccinated, they have a greater risk of being hospitalized or dying. I think that's a scientific medical public health fact that's not disputed.

Ms. Castor. Well, just to close out, the FDA agreed with you and had to write back to Dr. Ladapo that, "The challenge we continue to face is the ongoing proliferation of misinformation and disinformation about these vaccines, which results in vaccine hesitancy that lowers vaccine uptake. Given the dramatic reduction in the risk of death, hospitalization, and serious illness afforded by the vaccines, lower vaccine uptake is contributing to the continued death and serious illness toll of COVID-19."

I'll close there.

[redacted] And we can go off the record.

[2:06 p.m.]

Mr. Benzine. All right. We can go back on the record.

Mr. Strom. Dr. Fauci, I want to, I guess, circle back on a couple things that were mentioned both earlier today and in our discussions yesterday.

You talked a lot about the scope of NIAID's research that was -- excuse me, NIAID-funded research at the WIV versus the broader scope of general coronavirus research at the WIV, and how delineating sort of that small portion of NIAID funding versus the overall institute activities was -- I think you get lost in the discussion, for lack of a better way to phrase it.

So just for the benefit of the record, even though the NIAID-funded work was determined not to qualify under the P3CO framework for further review, that's a separate question from whether or not Wuhan was doing gain-of-function research of concern on coronaviruses.

Dr. Fauci. Right.

Mr. Strom. Is that -- were you able to get that?

The Reporter. Can you repeat that?

BY MR. STROM:

Q Just a little bit louder, sir, for the microphone.

A No, I'm sorry.

I don't have eyes onto or knowledge of the scope of what's going on in Wuhan, in China, or in any other place. The only thing that I had eyes on through my staff was what was done according to the subaward that was granted to the Wuhan.

So I have no way of knowing, nor does anyone, I think, what's going on in other laboratories in China.

Q And then, the other issue I wanted to talk on and has come up more today is

that you mentioned several times that when you're -- where you're trying to sort through, I mean, the various iterations as to the origins of the virus, all the way from sort of the HI -- the real out there stuff of the HIV insert to the more maybe rational discussion about the two -- the two accepted hypotheses.

A Right.

Q That you had to defer to subject matter experts.

And so one of the things I think our committee is interested on trying to delineate is how do you deal with a circumstance where a lot of the experts, coronavirus virologists, the people that you would need to consult with, because it's a relatively small specialized research field, have research ties or have interests that may not be immediately apparent to the public with respect to the debate about origins.

And so to be just a little more specific, if we're talking about somebody like, I think Peter Daszak is probably the most prominent example, he has what appears to me to sort of meet the definition of a conflict of interest or a competing interest that should be disclosed, particularly when you have sort of public-facing or widely disseminated articles to the public, that he has collaborated extensively with the WIV, that he is reliant on the WIV for viral samples and things like that.

And so I was wondering if -- and this isn't necessarily a financial conflict of interest; it's a non-financial conflict of interest or the appearance of a conflict of interest.

And so I was wondering if you had thoughts on whether Dr. Daszak should have filed competing interest statements when he was weighing in on these issues, whether through the National Academies or other venues.

A You know, I hesitate to speculate about what someone else should do. The only people that I am involved with is my own staff, who we've mentioned many times in this discussion, who don't have a conflict of interest.

Q Sure.

A I mean, they are there working for the Federal Government, the NIH, HHS.

So, I mean, I would hesitate to comment on what he should and should not have done. I guess, that's somebody's own individual decision.

Q If I can do one more potential example, and I'll read this to you. This is from Taylor & Francis, which I believe is an academic publishing house.

So Dr. Holmes is another one that I've had -- I think a layman would consider having potential conflicts of interest or competing interests. He does a lot of collaborations with researchers in China. He's obviously, as with Dr. Daszak, you're dependent on where the viruses are. I mean, if they're in southern China, you've got to work with --

A Right.

Q -- those individuals, including their government.

And so one of the non-financial conflict of interest examples that Taylor & Francis mentions is access to data repositories, archival resources, museum collections by an entity that might benefit or be at a disadvantage financially or reputationally from the published findings.

And so, again, would we have been better served during the debate if these sort of competing interests had been more forthrightly -- I can understand how a scientist reading a Nature article would understand that by virtue of Dr. Holmes' specialty and focus that he likely has a lot of ties to the Chinese researchers, because that's who he's got to collaborate with.

But when you start talking about the general public being interested in a topic of this magnitude, I mean, would a competing interest note -- should that have been filed in some of these papers?

A You know, I don't think I could give an opinion on that, because if you look at the larger scope of the discussions, I mean, in the discussions that I've been in with scientists in which someone might have a conflict of interest that has not been publicly disclosed, the culture of science is that you don't get away with that when you're dealing with 12, 13, 14, 15 scientists. I mean, it's almost a self-corrective process as opposed to an official filing of something when you're dealing with the scientific community.

Q And I guess, again, what I'm struck by, and I think this could apply to some of the more direct and forceful proponents of a lab leak, is that these are very strongly held views that these individuals have, that many of the people that are so adamant, I think perhaps beyond what the evidence would suggest that it's a zoonotic origin, are also the individuals that have professionally benefited and continue to perform gain-of-function research of concern.

And so obviously you do have sort of a -- at least the appearance of competing interests here, where if it is in some fashion conclusively established or determined that it's a lab leak, these people would -- the work that they do would be directly impacted from a regulatory standpoint, things like that.

A From my knowledge and decades of experience with scientists, I think -- I mean, that is possible. But the culture of the scientists that I've been associated with, that would be something that would be very unusual, that they would have that kind of a conflict interfere with their honest appraisal of what was going on.

Q Would you be, just as a general matter, in favor of additional disclosures when you have a potential high-impact, prominent paper that laymen are going to read?

A Well, my mantra has always been, and I've mentioned that multiple times in this discussion, one of transparency. I've always been that way myself, and I would hope that other people would be.

Q Great. Thank you.

A Yes.

Mr. Benzine. Thanks, John.

I want to close out the conversation on proximal origins and introduce majority exhibit 28.

[Fauci Majority Exhibit No. 28
was marked for identification.]

Mr. Benzine. This is a letter from Mr. Comer and Mr. Jordan to Secretary Becerra from January 11th, 2022. It's like a 30-page letter, so I'm just going to flip to the page that I want you to look at. We don't need to look at the whole thing. There is no context you are missing. It is a copy of an email.

Mr. Schertler. It could take up a good 30 minutes.

Mr. Benzine. I know it could.

BY MR. BENZINE:

Q So this is, you can see, the top portion is the email that has been redacted. The bottom portion is a transcription from staff that we're allowed to view this email in camera.

I want to state for the record that despite this email being responsive to select subcommittee requests for now 11 months, it has not yet been produced to the select subcommittee, so all we can go off of is this transcription.

A What do you mean by a transcription? In other words --

Q I went to the HHS headquarters. They showed me the email. I wrote it all down and then typed it out.

A And unredacted?

Q Correct.

A Oh, good. Good. Good for you.

[Laughter.]

Q And in the minority that's about the best you can get. In the majority, it's supposed to --

A Things work in the world, right.

Q Sometimes.

A Yes.

Q So the -- it doesn't match up precisely with what the gray boxes look like, but the bottom is what Dr. Collins wrote in this email. And I want to read it out loud.

"Wondering if there is something NIH can do to help put down this very destructive conspiracy with what seems to be growing momentum." It's then a link to a Bret Baier article regarding the outbreak starting in a Wuhan lab.

"I hoped the Nature Medicine article on the genomic sequence of SARS-CoV-2 would settle this. But probably didn't get much visibility. Anything more we can do?"

Your response is on the next page. But it's, to your credit, it's pretty bland.

"I would not do anything about this right now. It's a shiny object that'll go away in time."

A Right.

Q Do you recall having any conversations with Dr. Collins regarding this email?

A I don't think we had a conversation, but I think the conversation was an email conversation as opposed to a verbal. We could've, but I don't recall it. But I recall my saying, "Calm down, Francis." Yeah.

Q And we'll have an opportunity to ask Dr. Collins these questions.

A Yes.

Q But you're sitting in front of us. And if you would rather us ask Dr. Collins,

just let me know.

A Yeah.

Q He seems to -- well, he doesn't seem to. He writes down that, at least based off the headline of this article, that the outbreak starting in a Wuhan lab is a very destructive conspiracy.

I take it by your own public statements that you have an open mind, that you disagree with that statement?

A Well, first of all, A, for the record, you have to ask Dr. Collins what he meant by that.

I've not used that language. I still have an open mind. But I think it would be important in the context of really wanting to get down to what's going on.

And I'm looking at the date, April 16th, which is sort of months into that. And Francis will tell you, I think, that there was a lot of strange things going on in social media.

I think I alluded to that on our first marathon day, that there were really an amazing number of things going on. And I think that probably was frustrating Francis about the things that just didn't make much sense. But I believe Francis could clarify that for you.

Q Just you sitting here today, do you think the possibility or the hypothesis that the coronavirus emerged from a laboratory accident is a conspiracy theory?

A Well, it's a possibility. I think people have made conspiracy aspects from it. And I think you have to separate the two when you keep an open mind, that it could be a lab leak or it could be a natural occurrence.

I've mentioned in this committee that I believe the evidence that I've seen weighs my opinion towards one, which is a natural occurrence, but I still leave an open mind.

So I think that in and of itself isn't inherently a conspiracy theory, but some people

spin off things from that that are kind of crazy.

Q No, that's fair.

A Okay.

Q Dr. Collins continues, "I hoped the Nature Medicine article --" I'm going to presume you -- don't have to presume -- that he's referencing the proximal origin of SARS-CoV-2.

A Yes, I would imagine that's the case.

Q "-- would settle this." And then he said, "Anything more we can do?"

And again, I'm nitpicking words here, and you said that, and I believe that you were testifying truthfully, that no edits, no revisions, nothing to Proximal Origin.

"Anything more we can do?" "More" kind of signifies that you've already done something.

A No. I think what he was -- my impression -- and, again, ask him, I'm pretty sure he'll verify what I'm saying.

I believe -- I know Francis -- I believe what he was saying, is there anything more we can do to make this particular paper and what's in the paper more widely known, because his next sentence is, "Ask the National Academy to weigh in."

You should ask -- I know you're going to ask him that. But if you ask him that, he may verify what my opinion is, is what he meant by doing anything more is let's get the Academy involved in this.

Q The chairman alluded to this, but the next day, on April 17th, you were asked a question at a White House briefing --

A Right.

Q -- regarding the origins of the coronavirus.

A Right.

Q And you said at the time -- I don't -- I'm not going to quote it -- but that you didn't remember the authors' names, but that they -- evolutionary biologists or virologists just came out with a new paper.

A Right.

Q And then, after the fact, a reporter followed up and you sent him Proximal Origin.

A Right.

Q Did -- first, did you know that that question was going to get posed at that press conference?

A No.

Q No?

A No.

Q Had you told anyone at the White House about Proximal Origin by that point?

A I don't recall that I did.

Q Did -- so you just kind of said, and I don't want to mischaracterize it, but was that in response -- was citing Proximal Origin in response to this email? You just said Dr. Collins seemed to want --

A No.

Q -- more visibility.

A No.

Q No?

A No. I mean, I just -- I was asked a question, and I responded with that.

Q Okay. I'm going to shift gears a little bit and very, very briefly talk about the WHO investigation into the origins.

The WHO, from January 14th, '21, to February 10th, 2021, sent a team to China to investigate the origins of COVID-19.

What we've heard is that the United States submitted three names to be on that trip. We have yet to hear who those three names were.

Do you have any knowledge as to who the United States submitted?

A This is the original WHO trip to China?

Q No, no, no. The origins investigation in 2021, not the Cliff Lane trip in 2020.

A No, I don't, I don't know about that one.

Q Did you have any conversations with Dr. Lipkin about that trip?

A You know, Mitch, I might have. I just don't recall.

I know there was a trip. I mean, I get called a fair amount, "Hey, you got any names for us?" So it is quite conceivable that Ian might have called me and says, "Tony, what do you think about this person?"

But I really, honestly, don't recall that.

Q Do -- the WHO produced a report from that trip. Do you recall reading it?

A No, I did not read it.

Q At the time it came out --

A I mean, I skimmed through it, I believe --

Q Yeah.

A But I -- I mean, the easiest way to get me not to read something is to make it multiple, multiple, multiple pages.

Q And this was like 350, so it was --

A Yeah, so forget it. I didn't read it.

Q It was quite the read.

A Okay.

Q Dr. Daszak, who we've talked about an awful lot over the last 10 hours, was the only American on that trip. Before, by John, you were asked whether or not you thought he should submit competing interests.

A Right.

Q I'm going to ask your opinion now. He has obviously been intertwined with the Wuhan Institute for a long time, has made numerous public statements, has now -- over the past 3 years, we've seen numerous compliance issues with his grants.

Do you think that he has a conflict of interest in investigating the origins question?

A I believe that he could've saved himself a lot of trouble if he did.

Q If he did disclose a conflict of interest?

A Yeah, yeah, because he's obviously received a lot of flak about that and had doubts about his credibility on that. I think, retrospectively, thinking about it, he probably would've said it would have been a better idea to do.

Q That's fair.

Do you recall, when Dr. Daszak returned from that trip, whether or not he briefed you regarding it?

A I guess this is going to go into the thing of Fauci said so many times he can't recall, but I can't recall.

Q I won't do it on this one. He did brief you after the trip.

A Okay.

Q He briefed you and Dr. Lane.

A Okay.

Q I won't ask you about the contents of the briefing because --

A Mitch, do you have any clue about how many times I get briefed over -- I mean, like hundreds of times. Okay.

Q I'm not going to say I get as many as you, but I --

A Yeah.

Q There's an awful lot. Just trying to figure -- you know, understand what -- what's stood out.

I'm going to stay on the same big topic but switch a little bit of topics.

Since early 2020, the intelligence community at large has been investigating the origins of COVID-19. At any point during their review, were you contacted by anyone in that community to assist in that investigation?

A It depends on what you mean by assisting in the investigation. I do -- again, I brief a lot.

One briefing I do recall was the National Security Council people with Beth Cameron asked me to come to the Executive Office Building and was just asking me scientific questions, and I remember that.

There may have been other times when I was asked by people in the White House framework of security.

But the one -- the thing that I do remember is the briefing of Beth Cameron and her team in the Security Council.

Q A whistleblower came forward to this committee, and according to him, you visited CIA headquarters and assisted the CIA in their investigation.

A Right.

Q Have you ever been to the CIA headquarters?

A I have been to the CIA headquarters several years ago, I believe during either the anthrax attacks or something. And I went there, I believe, with one of the other scientists. I forgot who it was. Joshua Lederberg, I think, and I went, I'm pretty sure. But it was decades ago, decades ago.

Q But not since 2020?

A No. No.

Q Okay. Thank you.

My final -- maybe final origins question and then a couple other questions.

You said numerous times here, numerous times publicly you keep an open mind, to mean -- and you've also said that the evidence that you've seen pushes you towards natural evolution.

Open mind, at least in my mind, and you can correct me if I'm wrong, means there's a part of you that thinks a lab leak is possible, which I guess you kind of touched on. It's not a conspiracy theory.

A Right.

Q It's definitely a possibility.

So I'm interested in -- I think I know what papers you're referring to in Nature. You've talked about Dr. Worobey, Dr. Pekar, obviously proximal origins.

A Right.

Q But why the open mind about the possibility of a lab leak?

A Because the authors themselves said that we have not had definitive proof. They said that in both of those papers. They said they believe the heavy weight of evidence points towards a natural occurrence.

And the way I think about things scientifically, unless you have a definitive proof scientifically of something, you can have a strong opinion that it is a natural origin, but if you really want to keep an open mind, we may find out that some lab that we don't even hear of, we don't even know about, somewhere in Wuhan or in a place close to Wuhan, actually was playing with a virus and it leaked.

So in my mind, I keep that open. That often gets conflated with a specific grant

that we're funding, et cetera.

So those things -- I mean, my open mind is that it certainly could've been something else. I don't know what it is. And I've said that if evidence accumulates that definitively proves it's something else, then I will, you know, accept that definitive evidence.

Q What would be -- we know the kind of stereotypical zoonotic evidence, finding an intermediary host, finding a virus in the wild.

A Right.

Q What would be evidence, in your mind, to kind of move the needle towards a lab origin?

A I think we would need much, much cooperation from the Chinese to be able to do that, yeah.

Q Do you think -- we're 4 years and 9 days post pandemic beginning, post virus coming out. Do you think we'll ever know?

A Given the relationship and the tension and the back-and-forth-type accusations that have gone on, I think that makes it less and less likely that we'll ever know.

Q I'm going to shift gears and talk about --

Q Fauci: Mitch, before -- I just -- I apologize, because it's going back to the WHO 2021 trip.

So understanding, you know, if you have the choice, if they came to you and said, "Dr. Fauci, whoever you name, pick two or three names, U.S. scientists to be on that trip," who would you have picked?

A Fauci: You know, I know a lot of very, very brilliant people, several of whom are Nobel laureates. I probably would've picked one of those.

Q Fauci: Just, I mean, one or two off the top of your head, I mean, specifically given the particular issues, you know, in your consideration.

A Fauci: You know why I hesitate, because I could see those guys standing out there saying, "Well, Dr. Fauci, said such and such." So I'm not going to go there with you.

Q Mitch: You don't want any hurt feelings among your colleagues.

A Fauci: No. I don't want to go there.

Q Mitch: I understand. Okay.

A Fauci: Yeah.

Q Mitch: Fair enough.

Mr. Slobodin. Do you recall --

Mr. Benzine. Could you identify yourself first?

BY MR. SLOBODIN:

Q Oh, I'm sorry. Alan Slobodin with the House Energy and Commerce Committee.

Dr. Fauci, do you recall attending a National Security Council meeting -- this would have been during the Trump administration, maybe September 2020, might have been a meeting convened by Matt Pottinger -- do you have any recollection?

A No, I don't recall. I mean, I've spoken to Matt a bunch of times. He hangs around the White House. He was part of the group. But I don't recall specifically a National Security Council meeting with Matt. It could've happened, Alan, but I don't recall it.

Q Is it possible -- just trying to see if this might help refresh any kind of recollection -- at such a meeting you remember Secretary of Energy Dan Brouillette being in attendance?

A No, don't recall.

Q Okay. Thank you.

A No, I don't recall.

Mr. Benzine. I want to shift gears and talk about some of the policies and mitigation measures and various aspects that went into those dynamics. And as we're going through this, we are trying to figure out kind of what worked, what went wrong, what went well, and how we may apply those aspects in the future.

At a task force briefing on April 13th, 2020, you said that you recommended travel restrictions be instituted at -- I believe, at that point, they had been instituted to China, Europe, and the U.K. Did you recommend instituting travel restrictions in response to the pandemic?

Mr. Barstow. I'm going to step in here.

Mr. Benzine. On what grounds?

Mr. Barstow. On you're asking about recommendations as part of the White House task force. We have executive branch confidentiality interests in that -- in that discussion.

BY MR. BENZINE:

Q Dr. Fauci, in your opinion, are travel restrictions a good public health tool?

A It's context and circumstance dependent, and it depends on what's -- in general. I'm talking generically. I'm not talking about your question.

It depends on at what stage of the outbreak you do it. It depends on the level of the particular infection in question that is already in your country. It depends on the efficiency of the transmissibility of a particular infection, because if you have people in your country that are already infected and it's highly transmissible, it doesn't make a lot of sense to restrict.

But in a very, very precise period of time when you have virtually nothing in there, you may want to have a temporary restriction to give you time to prepare. That's one of the things that we did.

Q Did you agree with the President's decision to restrict travel from China?

A I did, and I said there were caveats to restrictions. I agreed with it, but I said that we've got to be careful because sometimes when you do restrictions they have negative consequences in that you don't have open access to help or even information.

But fundamentally I agreed at that time, since we had almost no infections that we knew of in our country, that at least a temporary restriction would be important.

Q Did you also agree with the EU travel restriction?

A I agreed with the suggestion that that be done, yes.

Q Did you agree with the U.K. travel restriction?

A Yes, I did.

Q Does immigration, legal or illegal, influence America's public health during an outbreak of a respiratory virus?

A Again, it goes right back to what I said, Mitch. It's really very much context dependent, like what is the level of infection elsewhere, what is the level of infection in the country, what is the degree of transmissibility.

Q Since -- well, for a while now, but particularly since 2021, we've seen an influx of immigration at the southern border, both legal and illegal. Did you have any conversations with anyone in the White House regarding the conditions at the southern border?

Mr. Barstow. I'm going to step in here again.

Mr. Benzine. On what grounds?

Mr. Barstow. Executive branch confidentiality interests in potential White House

discussions.

Mr. Benzine. I didn't ask if he was recommending -- like what specific grounds?

Mr. Barstow. Can you ask your question again?

Mr. Benzine. Did you have any conversations with anyone in the White House regarding the conditions at the southern border?

Mr. Barstow. He can ask -- or answer whether he had discussions but not reveal the substance of those.

Mr. Benzine. All right.

Dr. Fauci. I don't really recall having discussions about the southern border that -- I might have. But, you know, I generally tend to stay away from those kinds of discussions.

But it's possible that when we were in the task force meeting that somebody brought it up and I made a comment about that, but I don't recall the content of it.

Dr. Wenstrup. Can I jump on that for just a second?

Were you concerned at all, like I was, that people were coming across the border by the thousands, for one thing, but they weren't getting tested or vaccinated?

Dr. Fauci. Well, it depends, Mr. Chairman, at what points they were coming over. I mean, if you have --

Dr. Wenstrup. Well, they've been coming over for 3 years.

Dr. Fauci. No, no, no, no. I mean, if you're talking about people coming over from the border when we already are having thousands and thousands and thousands of infections of a highly transmissible agent in our own country, to think that someone coming into the country is going to make it any worse is probably not the case.

What I would think would be important, it would be great if we could, when people come in, provide them with care and vaccination and treatment if necessary.

Dr. Wenstrup. Yeah, but we weren't doing that.

Dr. Fauci. Yeah, but that would be nice if we did. Yeah.

Dr. Wenstrup. Thank you.

Dr. Fauci. You're welcome.

BY MR. BENZINE:

Q Thank you, sir.

I'm going to shift again, and you've talked about masks a little bit, but talk about masks a little bit more.

At the beginning of the pandemic, did you support universal masking?

A In the beginning of the pandemic, no, I did not.

Q Why not?

A Well, there were three reasons, and I've said that many times, but let me repeat it for the record, and I'll do it as succinctly as possible.

Q Thank you.

A All right. The three reasons were, A, it was clear to us at the time, and it was made clear to us in the task force, that there was already or would be a shortage of masks since PPE for our healthcare providers was in scarcity. And there was a concern that if you told everybody to get a mask that the masks would be completely and very quickly used up in a non-medical setting that would therefore endanger our healthcare workers, point number one.

Point number two, it was -- first of all, also this is point 1A, this is 1B -- is that that was also recommended by the Surgeon General under the Trump administration and the CDC under the Trump administration, that we don't wear masks early on.

So point number two, there was not any good evidence that outside of the hospital setting that a mask is effective in preventing the acquisition or transmissibility.

And number three, we did not fully appreciate at the time that a substantial proportion, 50 to 60 percent of the people in the country who were transmitting, were asymptomatic.

So those three things we didn't know. I know you didn't ask it, but I hope you do, that that changed as the months went by. We learned the answers to those three questions, which had me change my position about the importance of masks, otherwise referred to some as flip-flopping. But I didn't flip-flop.

Q So before I introduce exhibits and ask specific things, you reviewed data throughout the pandemic that then changed your perspective on things.

A Right.

Q Is that fair?

A Yeah.

Q Okay.

A Yeah.

Q I want to introduce majority exhibit 29.

[Fauci Majority Exhibit No. 29
was marked for identification.]

BY MR. BENZINE:

Q And I'm sure you're aware of this email as it caught a lot of news when it came out.

A Yes. It's my -- I don't even have to read it.

Q Oh, okay. Perfect. Even better.

A This is my email to Sylvia.

Q We don't need to -- he said we didn't need to read it.

A So, no, but let's read it so that everybody can hear it.

Q Well, I just want to ask about -- you pretty much just walked through -- you walked through this in your original.

A Right.

Q One of the questions I have though, the typical mask you buy in the drugstore is not really effective in keeping out virus, which is small enough to pass through the material. That didn't change throughout the pandemic, though, the size of the fabric --

A Right.

Q -- the weave in the mask --

A Right.

Q -- nor the size of the virus changed. How did --

A No, no. What it is that most people, if you look at it, who wear the masks that you buy, they don't fit well, they're open on the side, and they often have tatters on them that -- so clearly you're not going to effectively keep virus out. That's what I was referring to, to Sylvia.

Q But that was the primary mask worn throughout the pandemic, was we could just go to CVS and get surgical masks and they didn't fit and they had gaps.

A Right.

Q So I'm just trying to understand kind of like, we're going to get to it, but the validity of, you know, mandating someone wear something that is not -- does not work --

A Yeah.

Q -- as well as maybe it could.

A But studies did come out -- you might have them -- that if you look at the gradation of protection, that there's some protection with a cloth mask or a surgical mask, there's better protection with a KN-95, and there's much better protection with an

N-95.

So it isn't a question of all or none; it's the gradation of the degree of protection.

Q Were those studies double blind?

A I don't recall. I'd have to -- well, it's kind of tough to do a double-blind study of something you're putting on your face.

Q You'd have to infect people, right?

A Yeah.

Q Like that'd be kind of hard.

A Yeah, let me try that one, double blind.

Q On April 3rd, 2020, the CDC recommended masks for people who were confirmed or suspected to have COVID-19.

Were you involved in that recommendation?

A Say that again, Mitch, please.

Q It was April 3rd, 2020. It was the first time the CDC recommended wearing masks. And it was -- the recommendation was specific to those who were confirmed or suspected to have COVID-19.

A I don't -- I don't recall being involved in that recommendation. I probably heard about it. Probably it was brought to the attention of the task force. But I was not involved in that decision or discussion to my recollection.

Q Do you recall any disagreements among the task force regarding masking?

Mr. Barstow. I'm going to step in here.

Mr. Benzine. On what grounds?

Mr. Barstow. Again, you're talking about discussions at the task force level. The executive branch has confidentiality interests in those conversations.

BY MR. BENZINE:

Q Were you ever part of a discussion with anyone where they -- anyone in the Federal Government where they expressed disagreements or differing opinions on masking?

A I don't recall those discussions, but I would be surprised. I don't think anybody fully has a hundred percent agreement on anything. So I would imagine that in some discussions somewhere there were people who said that they didn't agree that masks should be worn.

Q You talked briefly kind of the levels of protection, homemade probably being the lowest, cloth and homemade, surgical, K-95, N-95. Is that fair?

A Right.

Q You had said at one point that it became clear that we had enough protective equipment and that cloth masks and homemade masks were as good as masks that you would buy from surgical supply stores.

What did you mean?

A I'm sorry, are you quoting? Can I see what you're saying?

Q Yes, I'm quoting you.

A Yeah.

Mr. Cooke. And for the record, can you tell us where this quote comes from?

Mr. Benzine. It was an interview that he did with InStyle magazine.

Mr. Cooke. Is there a date?

Mr. Benzine. I can tell you the date when I get it back.

Mr. Schertler. July 15th, 2020.

Dr. Fauci. It's July 15th, 2020.

Mr. Cooke. Okay. I just want to make sure the record is clear.

Dr. Fauci. Yeah, I'm not sure why -- what made me say that at that time. I must

have been referring to something, but I'm not sure.

Mr. Benzine. Okay.

Dr. Fauci. That was 4 years ago or 3 and a half years ago.

Mr. Benzine. No, I understand.

When -- on the first day of the Biden administration he signed two executive orders, one mandating masks in commercial travel, planes and trains, and one for Federal employees.

Do you recall those orders?

Dr. Fauci. Yeah. I mean, I don't recall discussion about it, but I recall the orders.

Mr. Benzine. Were you involved at all in crafting those orders?

Dr. Fauci. I wasn't involved in crafting them.

Mrs. Dingell. Can you speak louder? We can't hear down here.

Dr. Fauci. I said, I wasn't involved in crafting the orders.

Mrs. Dingell. Thank you.

BY MR. BENZINE:

Q The commercial mask mandate was struck down by a judge in Florida. And in response you said, "We are concerned about that, about courts getting involved in things that are unequivocally a public health decision. This is a CDC issue. It should not have been a court issue."

You also said, "I think it is unfortunate that a court order came in and I believe superseded the authority of the CDC."

What were you basing those statements off of?

A I believe the CDC knows more about public health than most courts.

Q Do you believe that courts do not have jurisdiction over public health?

A I believe that courts have jurisdiction over whatever it is they're supposed to have jurisdiction of, and when a court makes an order then you obey the order of the court.

But I was a little bit concerned that we were getting a judge who may or may not have had any experience in health or public health overriding the order of the Centers for Disease Control and Prevention.

Q You've been asked this before more combatively than I'm going to ask it now. I believe the exact quote before is -- like is around the lines of, do you believe the Constitution can be suspended in times of public health emergency? I'm going to ask more --

A I've never -- other people have said the Constitution could be suspended. I haven't said that.

Q No, and I agree. I'm saying you've been asked that before.

A Yeah. Okay.

Q But I'm going to ask for the record today, do you believe that Americans retain constitutional rights during public health emergencies?

A I believe strongly in the Constitution of the United States.

Q All right. Thank you.

Another question that we get a lot in the masking space is the masking of children, particularly kids down to 2 years old.

A Right.

Q The WHO recommended against masking children less than 5 because masks are, and I'm quoting them, not in the overall interest of the child, and then against children 6 to 11 from wearing masks because, and, again, quoting, of the potential impact of wearing a mask on learning and psychological development.

Was there ever a cost-benefit analysis done on the unintended consequences of masking kids versus the protection that it would give them?

A Not to my knowledge.

Q Do you believe that masking children as young as 2 was necessary?

A I think it's context dependent. It really depends on where you are. I think you were having a time like when you're having a tsunami of infections and you're desperately trying to protect people from getting infected and dying to the point where every one of our healthcare facilities are in danger of overrunning, you might want to do something that might seem -- what's the right word? -- excessive, whereas under most other circumstances you won't.

And I believe the CDC felt at that time that that's what was needed given the dire -- I would say the dire situation that we were in.

Q This was kind of, I won't say -- it was definitely a novel virus, but new also in kind of the way that it didn't affect children very much. Like there were obviously kids that caught it, there were obviously kids that transmitted it, and there was obviously, sadly, kids that passed away.

A Well, I would just correct it a little bit, Mitch.

Q Okay.

A I don't think there is really strong evidence that it doesn't infect children as well.

Q Affect.

A Yeah, affect in the sense of serious illnesses.

Children, compared to adults, which was a public health crisis of adults with all the deaths we've had, didn't have as much likelihood of developing severe consequence leading to hospitals and death.

But there was, you know, a considerable number of children who have died compared to something like influenza, multifold, right.

Q Do you recall reviewing any studies or data supporting masking for children?

A You know, I might have, Mitch, but I don't recall specifically that I did. I might have.

Q Since the -- there's been a lot of studies that have come out since the pandemic started, but specifically on this there have been significant on kind of like the learning loss and speech and development issues that have been associated with particularly young children wearing masks while they're growing up. They can't see their teacher talk and can't learn how to form words.

Have you followed any of those studies?

A No. But I believe that there are a lot of conflicting studies too, that there are those that say, yes, there is an impact, and there are those that say there's not. I still think that's up in the air.

I mean, I'm very sensitive to children. I have children and I have grandchildren. So I don't want to have anything that would do to harm them.

But I think that there was a conflicting discussion about the negative impact on speech and formation of the bones of the face, and that I think was debunked pretty easily.

Q Okay. I appreciate that.

Do you think this -- going forward that -- I mean, obviously this hit our shores quickly. We had to react quickly. The first little while you're just kind of like reading and reacting, right?

A Right.

Q You're not -- you don't have time to go read 15 studies and then make a

decision.

A Correct.

Q Do you think going forward -- like do you think it's important that public health officials, as science and data come out, that they change their mind?

A Absolutely, that you go with the data. And if the data essentially negates your first decision -- and getting back to the question you asked me about 8 minutes ago when I made my discussions about the use of masks, the three hypotheses that I put forth were all disproven, and I changed my mind about masks, and I said we should be wearing masks.

So I definitely agree that as data come out, that you should adjust your decisions, your guidelines, your recommendations according to the data that comes out.

Q You also -- and it was recently, I believe, this year made a statement that kind of universal or mass masking works on the margins, is I believe your exact quote, 10 percent or something on the margins.

Do you recall that statement?

A No. What was --

Q I don't have it.

A Yeah. Some -- I don't --

Q I don't have it in front of me.

A Okay.

Q But I was just wondering.

I'm going to shift gears and stick kind of in the children aspect of the pandemic.

Schools K through college closed pretty quickly. And I think, and I have heard numerous times, that it was probably the right thing to do the spring semester, like we just talked about. No one knew what was going on.

A Right thing to do.

Q Right thing to do is to learn and come back.

Did you have any role in -- obviously the administration was helping those situations. Did you have any role in that?

A I didn't make a decision to close the schools.

Q No, I'm not asking that. I'm --

Mr. Schertler. Could you just be clear, role in --

Mr. Benzine. Did you -- were you a part of conversations where the topic of initially closing schools came up?

Dr. Fauci. Not specifically closing schools. I was involved -- and, again, I think I'll have to turn to Kevin because of the decisions of when we were doing the 15-day pause and then the 30-day pause, which, in fact, included schools, I believe.

Mr. Barstow. He just answered that he was involved in conversations.

BY MR. BENZINE:

Q Okay. And you just answered this, that at the beginning, because of all the unknowns, supportive of closing schools in the beginning?

A Right.

Q In -- we then saw through the summer there was obviously some like summer camp things and some infections at camps. And then a lot of schools began reopening going into the fall semester of 2021.

Do you recall any conversations regarding advocating for school reopening --

A Yeah. I --

Q -- in the fall of 2020?

A Yeah. I think if you -- I'm surprised you haven't shown me something that I said. I have often said we need to open up the schools as quickly and as safely as

possible, and I must have said that 500 times on TV.

Q I have it a couple times --

A Yeah.

Q -- but I figured I'd just ask you.

A Yes. Yes. That was my sound bite to the world, we need to reopen the schools as quickly and as safely as possible.

Q So that's been pretty consistent across the board, and we get different from like -- we've talked to CDC folks, obviously you, other public health professionals, but also the unions and teachers and parents and kids, and everyone has a different definition of what "safely" meant.

A Right.

Q What was yours?

A My -- it depends on where you were. For example, if you had vaccines available, you really want to make sure that you surround the children with people who are vaccinated. That you use the money that has been set aside to increase the ventilation in schools. You have some distancing. You make sure that the people who are driving the children to school. You surround the children with a cocoon of safety. That's one of the things that you could do.

Q You mentioned ventilation. Was upgrading ventilation, in your mind, a prerequisite for opening --

A I thought it was very important. I thought that -- I know that there was a considerable amount of money that was allocated to the CDC to enhance safety.

And I know it's difficult sometimes, particularly in some of the older schools, to increase the ventilation. But I felt ventilation was absolutely critical, particularly as we got more information that the virus could be spread by an asymptomatic person.

So a child could come to school feeling perfectly well, and then somebody sitting right next to them is going to get possibly infected, whereas we know getting infected out of doors is much, much less likely than indoors, and the more you ventilate the more you approximate an outdoor situation.

Q Part of that answer was going to be my next question, and Dr. Collins has touched on this recently in an interview that he just did of public health determinations, kind of not taking necessarily into account the practicality of those recommendations. Like you mentioned difficult to increase ventilation in older schools.

A Right.

Q Our understanding is it would also be difficult in poorer schools, inner-city schools, those kinds of areas.

If school districts went strictly based off -- if CDC recommended you can't reopen until your ventilation is increased, I mean, I don't know a school district that would've reopened regardless of how much money Congress passed.

A Right.

Q Do you think it's important --

A Well, that would've been almost an inherently impossible recommendation, and I would doubt -- I would think that would be foolish to make a recommendation like that.

Q Do you think public health officials should take into account the practicality of the recommendations that they're making?

A No. I think public health officials should be sensitive to the negative consequences, but public health officials should give information to the deciders as to what the public health implications are, and the deciders should balance the other factors that go with it.

I don't think that a public health official should say, "Well, we think you should do this and this, but, by the way, the economy will do this and the stock market would drop that."

That's not what a public health official should do. But that doesn't mean that a public health official should be insensitive to the secondary effects of what they're talking about, but they should give the information to the people who make the decision about whether you're going to close this or whether you're going to recommend that.

Q And along those lines, and this is just me from my outside perspective, that you would see -- you would see that on the task force there was a makeup around the board, like you had FEMA, you had you, you had domestic policy, you had national security policy, you had economic policy all on the task force, and I think that continued through to the response team, is the Biden administration one. Is that right?

A Right.

Q But then --

A Wait a minute, it wasn't as much. I mean, the response team was mostly medical people.

Q Okay.

A Yeah. It was not multiple different agencies. It was --

Q So the task force had the multiple.

A The task force had more non-public health people than public health people.

Q Okay.

A Whereas the response team under the Biden administration was almost exclusively public health people, except for Jeff and then -- Jeff Zients and Ashish Jha.

Q So I guess my --

A And Ashish Jha, by the way, was a public health person.

Q Yes, he was.

I guess, my long-winded point is that you see kind of the flows of advice going to the decisionmakers. The decisionmakers go and then say what the decision was. But then some of the advisers would go and undermine the decision.

And I'm not blaming you, but various press conferences where the President would say we're going to do this, excluding some of the more outlandish comments, and then a reporter would ask you a question and you'd be like, well, that's not what I advise for public health.

A Right.

Q Like, do you have concerns with that? Do you think it should, like, for a future pandemic should be --

A Can you -- I'm sorry, Mitch, I don't mean -- I don't suggest that you're tricking me.

Q No, no, no. I --

A But give me chapter and verse of what I said.

Q It was more hypothetical. So I'll frame it not in people that we know.

A Okay.

Q If you have a decisionmaker, the President of the United States, takes all the advice into account and makes a decision, goes out into a press conference, has all his advisers behind him, says the decision.

A reporter asks one aspect of it, so asks the economic person, you know, "What did you advise?" and the economic person has said, "Well, I advised something different than what the President just told you."

Do you think it's important in future responses to have kind of one voice leading the public-facing response to a pandemic?

A I think there should be one decisionmaker and that decisionmaker should take in information from a number of sources and make their decision.

Q Okay. In the time I have remaining, moving through schools still a little bit.

In December 2020, President-elect Biden announced that he wanted the majority of schools to reopen within a hundred days of his new administration. Do you recall that?

A I recall them saying that, yes.

Q At the time, what did you think about that promise?

A I thought it was a good idea if we could do it, and that's when I kept on saying let's open the schools as safely as we possibly can.

Q At the -- close to what you said at the time of that may not happen because there may be mitigating circumstances, new variants --

A Right.

Q -- various things like that. Obviously, we were pretty early in the vaccine rollout as well.

A Right.

Q A few days into office, President Biden walked it back in saying he didn't mean all schools, he meant kindergarten through eighth grade, not high school.

Do you recall that?

A I didn't have any input into that delineation between one group or another. That was mostly a CDC type of advice.

Q Did -- you've said here your kind of public advice, and I assume private advice, has always been reopen the schools as quickly and safely as possible.

A Yes.

Q Did you advise the incoming transition team on COVID-19?

A I was on -- oh, the transition team?

Q Yes, sir.

A No, I spoke with the transition team, but I didn't advise them much on anything.

Q Did you have any conversations with President Biden while he was President-elect?

A I had --

Mr. Barstow. Dr. Fauci.

Dr. Fauci. Yeah. Sorry.

Mr. Barstow. You're allowed to say whether you had conversations --

Dr. Fauci. I'm sorry.

Mr. Barstow. -- but you shouldn't talk about the substance of those conversations.

Mr. Schertler. You can say you had conversations, but don't discuss the substance.

Dr. Fauci. Yeah.

I don't recall conversations with the President. I had conversations with Ron Klain.

BY MR. BENZINE:

Q Okay. Do you generally, without --

A And, now, let me just back off and say, I don't recall whether I had conversation like a day before he was inaugurated or a day after he was inaugurated.

Q Okay.

A Okay?

Q No, that's fair.

A But I didn't have a lot of conversations with the President. I won't say what I said. But I didn't have multiple conversations with the President-elect. I had a few conversations with Ron Klain.

Q Generally, without getting into kind of any advice that you gave during those conversations, do you recall the topics with either the President or Mr. Klain?

A I think the topic might have been vaccination.

Q Did you have any -- she was not CDC Director yet -- but did you have any conversations with CDC Director Walensky during the kind of post-election, pre-inauguration timeframe?

A Yes.

Q Regarding what?

A That I was recommending her to be the Director of CDC.

Q Did you have any conversations with her regarding school reopenings?

A No.

Q And in the scope of this question, I understand that you have done events with the American Federation of Teachers, so I'm not asking about conversations regarding those events. But have you had any conversations with Randi Weingarten regarding school reopenings?

A I don't know whether it was regarding school reopenings. I think I was on a Zoom or podcast or something with her, but I didn't make any recommendations, in my mind, that I can recall. I don't recall recommendations of saying you should or should not reopen schools.

Q Going -- as we got further into 2021 and vaccines became more available, was it ever your opinion that vaccination for students and teachers was a prerequisite of reopening schools?

A I don't recall that I would say it was a prerequisite. I was very much in favor of vaccinating the children who were eligible for vaccination and vaccinating the teachers.

I don't recall whether I said anything about a prerequisite.

Q Same question. But was it ever your opinion that mask mandates were necessary or a prerequisite for reopening schools?

A Again, I think the operative word here, Mitch, is "prerequisite." I don't recall that I said "prerequisite." I may have said, we really should get people wearing masks in schools by both the teachers and certain children of a certain age.

Q But they didn't -- like, it wasn't necessary to reopen the school?

A I don't recall that I said prerequisite. I just don't recall.

Q No, that's --

A I mean, you have a lot of discussions. I just don't recall.

Q That's all I was asking.

Finishing out our hour really quickly, I think everyone in here will agree COVID-19 hit the elderly and nursing home population quite hard, both early on and throughout the pandemic.

One of the decisions that we've been investigating was by, at that point, New York Governor Andrew Cuomo and the March 25th, 2020, order that directed nursing homes to accept potentially or COVID-positive patients without testing them.

Do you recall any conversations regarding that order amongst the task force or in your job?

A Not to my recollection, no.

Q Did you ever speak to Governor Cuomo during the pandemic?

A I spoke -- I did, a few times.

Q On what topics?

A A variety of topics, you know, vaccination, how were things going, you know, what do you think about where we're going, what's -- you know, just medical questions.

Q Did you ever have any discussions with him regarding nursing homes or that order?

A No. No.

Q Did you ever speak with New York Health Commissioner Zucker?

A I know Howard. I'm trying to remember if I spoke to him. I don't recall, but it would not be surprising to me if I did. Yeah.

Q But just -- so just for the record, you don't recall conversations, so therefore, probably don't recall if the conversations were about the nursing home -- the nursing home order?

A Right. I don't recall any conversations about nursing homes with him.

Q Okay. Do you recall -- this came in the news pretty -- around the summer of 2020, and CMS Administrator Verma said some things. We've talked to Dr. Birx, and she told us that she thought the Cuomo guidance violated CMS guidance at the time.

Do you recall any conversations about that?

A I didn't have conversations with that, no.

Q All right. I have about 60 seconds left in my hour, so I'm going to try to tick off two more questions.

One of the kind of interesting things that we heard is the different -- and please correct me if I'm like way off base on this -- but the difference of dying from COVID or with COVID and how that would affect the death statistics.

Do you have any knowledge or anything to share on that?

A I know that that was a topic of heated discussion and disagreement.

Q When?

A Just pervasive.

Q Beginning in 2020?

A I don't know when it began, but I remember that topic came up. If somebody -- you know, it -- I'm going to dribble around here and run the clock out, but I'm not going to --

[Laughter.]

A I'm not trying to run the clock out. I'll even give you an extra minute or so.

But the fact is that it's a complicated issue, because if someone comes in who is -- has COVID and nothing else wrong with them and they die from COVID, that's a clear COVID death.

If someone comes in who got hit by a car and had his head crashed in but happens to test positive, that's not a COVID death.

But if someone comes in with significant aortic valve dysfunction and bad flow congestive heart failure and they get COVID and get febrile and get a pneumonia, yeah, that's a COVID death even though they died of congestive heart failure.

Q So there's kind of --

A You agree?

Dr. Wenstrup. Yeah.

BY MR. BENZINE:

Q Kind of three buckets there. A very, very clear nothing wrong with you, which I'm sure maybe zero percent of the population --

A Right.

Q -- has nothing wrong with them, got COVID, died.

A very, very clear had COVID, didn't, like, maybe knew, maybe didn't, got in a car

accident and died.

A Right.

Q And then the underlying condition COVID exacerbated and then died.

A And the person would not have died if they didn't get COVID.

Q Okay.

A I mean, that's the way I would say it.

Dr. Wenstrup. But both conditions should be listed as to why.

Dr. Fauci. Well, I think if someone --

Dr. Wenstrup. So it wasn't just respiratory.

Dr. Fauci. Yeah. I mean, yeah, if somebody has congestive heart failure that's barely compensated and they get COVID and get a COVID respiratory infection and die, that's a COVID death. I think you should list that as a COVID death.

Dr. Wenstrup. Well, they both contributed.

Dr. Fauci. Yes. Yeah.

BY MR. BENZINE:

Q My last question, and I appreciate not entirely dribbling out the clock on that one.

The same kind of thing happened with case counts. So if I -- everybody going to the hospital was tested for COVID. If they tested positive they were listed as a COVID hospitalization.

And very much agree with testing everybody that goes into the hospital for COVID so you get a good idea of case counts.

But do you think there should've been a better -- like, if I broke my leg and went into the hospital and got tested, should I have been --

A That should not be considered a hospitalized COVID case, in my opinion as a

physician.

Q Okay.

A I mean, if a person is -- you know, breaks their leg and goes in, and is a 19-year-old person who broke their leg in a football game, and they put a cast on and they walked out, and that person happened to test positive for COVID, that's not a COVID hospitalization.

Q Perfect.

A That's a COVID case but not a COVID hospitalization.

Mr. Benzine. Perfect. Thank you very much.

We can go off the record.

[Recess.]

[3:23 p.m.]

[redacted] We can go on the record.

I just want to start off this next hour with a few housekeeping items. I first want to revisit quickly two items that Congresswoman Castor introduced for the record last round and register them into the record.

The first is the letter from Dr. Marks to Florida Surgeon General Dr. Ladapo. This is going to be exhibit U.

[Fauci Minority Exhibit U
was marked for identification.]

[redacted] And then the second exhibit is going to be the L.A. Times article that the Congresswoman referenced. This is going to be exhibit V.

[Fauci Minority Exhibit V
was marked for identification.]

[redacted] And then while we're passing those around, we have a new member who's joined us.

Congresswoman Ross, could you introduce yourself for the record? And if there's anything you'd like to say at the start of the round, please do.

Ms. Ross. Thank you.

Dr. Fauci, thank you so much for your patience, but, most importantly, thank you for your service --

Dr. Fauci. Thank you.

Ms. Ross. -- to our country and to public health. My father is a physician, and I know it's not easy providing all the answers under uncertain circumstances.

Dr. Fauci. Thank you.

Ms. Ross. I represent the Research Triangle area of North Carolina. In fact,

Dr. Mandy Cohen is my constituent.

And I just want to share -- I know I'm coming late to this party, but I do want to share how important it has been to my area of the country to really follow the science and take care of the most vulnerable. We have a very science/technology/medical-oriented district. We were one of the only places in the country that provided free testing from the very beginning of the pandemic. We had a lab, which is in my district, that had come up with early testing.

Every time I drove -- and I drive from North Carolina here, and, of course, I had to do it during the pandemic -- I would stop at the hospital, in the most compromised area of my district, in the parking lot and get my test.

And I want to applaud you for following the science as you found it; for making sure that we always focused on the most vulnerable populations. Because, of course, when vaccines were available, people who had access to physicians and means and could get different places, they could get what they needed, but you always paid attention to the most vulnerable.

My district, the State of North Carolina, we followed your advice, and North Carolina had better outcomes because of it. And I know that the most vulnerable people in my district had better outcomes because of your advice and your service.

So I know it's been a, you know, kind of interesting couple days for you, but I want you to know toward the end of the process how much the people of this country and my district appreciate your service.

Dr. Fauci. Thank you. Thank you.

[redacted] With that, I will turn it over to Congresswoman Dingell.

Mrs. Dingell. So I want to return to the subject of the masks, which we can all agree is a point of contention, but I think that there are some facts that we need to make

sure we really are getting on the record. I want to discuss both the efficacy and the effectiveness of masking.

First, Dr. Fauci, could you please explain for us the different kinds of masks or face coverings that were used during the pandemic? Were some better at protecting people from COVID-19 than others, and why? You got into it a little, but can we expand on that?

Dr. Fauci. Yeah. There are, as I mentioned, let's say, four separate classes.

There's a cloth mask. And that really, really varies, because people make their own cloth masks -- different people, different companies. So that's one level. That's probably the most inconsistent in its protection, and it's probably relatively less than the others.

The next is the surgical mask you buy in the store. That is the next level, a bit more, but not as good as the next two, which is a KN95, which is quite good, but the one that's the state of the art is the N95, which is very good at protecting both the person who might be acquiring it as well as the transmission to someone else.

Mrs. Dingell. How did our understanding of the importance of masks and mask-wearing evolve over the course of the COVID-19 pandemic?

Dr. Fauci. Well, it evolved because of what we realized. As I mentioned in answer to a prior question, that in the beginning there was not a lot of enthusiasm or recommendation for wearing masks for I said three reasons but there's probably a fourth reason, because at the time when we had few cases in this country, when, retrospectively thinking, would've been a time when people should've been wearing masks, because it was sort of the silent virus underneath the surface spreading throughout the country.

But the other three reasons were this understanding, which turned out to be a misunderstanding, that there was such a shortage of masks that if you wore masks in the

general public you could take away from the masks that were available for the people who really needed it, who were the healthcare providers taking care of people in the healthcare setting.

Next, the data which accumulated over a period of months to years about the effectiveness or not of masks in preventing acquisition versus transmission. We didn't have any information that outside of the hospital setting masks were pretty protective. We knew that in the hospital setting, that when you're dealing with a tuberculosis patient in the tuberculosis ward, they clearly were good. We didn't know that, whether that applied to the general population.

And, thirdly, we didn't realize -- even though there was hints of it, we didn't realize the rather substantial proportion of people who were transmitting in an asymptomatic way.

So the reason that's important is that it would be, well, I'm in a room here and there's nobody that's coughing or sneezing, and, by the syndromic approach to viral transmission, you'd say, why should you really wear a mask? There's nobody sick here.

But then when we realized that, in fact, 50 to 60 percent of the people who are transmitting are asymptomatic, that negated the first -- the third hypothesis.

The second hypothesis was negated by the fact that, when studies were done sequentially, finally, over time, it became clear that masks had a significant degree -- they weren't 100-percent protective, but they had a significant degree of protection outside of the setting of a hospital, namely people in the community.

And then, third, it became -- third or fourth, it became clear that there wasn't a PPE shortage among healthcare providers with regard to masks, that if you went out and got a K95 or an N95, you were not preventing a nurse somewhere from getting it.

When those three things coalesced, then it became clear that masks really needed

to be used, because they were effective.

Mrs. Dingell. I'm going to argue that point with you in a minute --

Dr. Fauci. Okay.

Mrs. Dingell. -- because I remember the supply chain.

Dr. Fauci. Right.

Mrs. Dingell. But I want to stay on this right now, just because I can remember being on the phone with people in China having to check the quality of masks, and nurses that were microwaving masks or rewearing. And I want to ask if we're ready for the next time.

But the consensus of the medical and scientific community is that wearing a well-fitting mask reduces the threat. That has been. I think there are multiple studies that I could quote now.

But could you explain a few examples of the scientific studies that demonstrate why masks are effective at preventing COVID-19 and how they did evolve?

Dr. Fauci. Well, they evolved, for example, when you had one particular cohort that's maybe a school or a workplace where they were able to demonstrate that, when you compare a place that regularly used masks or required masks versus a place that didn't have mask use at all, there was clearly a difference in the infection. That was the standard type of study that was used.

Other studies were more specific, where you would actually in a controlled situation show that a mask protected against a particular infection.

So there were controlled studies and there were cohort studies.

Mrs. Dingell. So, in epidemiology and public health, there is a distinction between the concepts of efficacy and effectiveness. Could you explain this distinction?

Dr. Fauci. Yes.

Mrs. Dingell. Would you?

Dr. Fauci. I will.

So efficacy is the capability of a particular intervention to prevent and/or treat a particular disease, let's say.

And let's talk about health, because there's efficacy and effectiveness of things that have nothing to do with health. But in the arena of health, efficacy means that you have shown, usually in a clinical trial, that if you have a well-controlled experiment that this is better than nothing or this is better than that. That is the efficacy of that in intervention.

The effectiveness is, in the real world, what does that particular intervention, which may have been shown to be quite efficacious -- is it effective? A typical simple-to-understand explanation of that is that, if you have an intervention that in a controlled clinical trial is very efficacious but nobody uses it, nor do they use it properly, then it is not an effective intervention, even though in a clinical trial it's efficacious.

Mrs. Dingell. So, in your assessment, is this distinction relevant for mask-wearing to reduce the threat of COVID-19?

Dr. Fauci. It is absolutely relevant. For example, if you have a mask that is properly worn and properly fitted and used all the time when you're in a risk situation, that mask could be very efficacious.

If that same mask is worn intermittently, not properly fitted, and loosely used, then that mask that is efficacious in a trial can be completely ineffective.

And I think what you're getting to is the importance that sometimes studies say, "Well, masks didn't work," and they didn't work because they were not properly used or they weren't fitted well or people used them 30 percent of the time or people say, "Well, I wore a mask all the time except when I went into a crowded restaurant and had a meal,

and I got infected; therefore, masks don't work." No.

Mrs. Dingell. So you got ahead of me --

Dr. Fauci. I'm sorry.

Mrs. Dingell. No, no, but that's exactly where I was going to go. And in some of the instances, a lot of the critics of mask-wearing pointed to studies that suggested that the mask-wearing initiatives were ineffective. But, as you just said, your assessment is that that's wrong.

So is there anything you want to say to elaborate that for the record so that we really do get the difference between the two?

Dr. Fauci. Yeah. You know, my comment would be that, when you're evaluating a study, you've got to make sure if there are any confounding variables in the study. And if a confounding variable is that a person uses the mask 50 percent of the time, that, to me, negates a conclusion on whether something does or does not work, that you have to have the conditions that adequately evaluate the effectiveness of the mask, not the efficacy of the mask.

Mrs. Dingell. And I have one -- this was not your area of responsibility per se, but the supply chain did have issues at the beginning. I remember going and getting garbage bags from neighbors to take to nursing homes and the nurses that would cry in tears. It was bad in some of the hospitals. And, as you say, we were -- I became a supply-chain expert, with our Governor, trying to get stuff at the beginning.

Are we doing what we need to do if there's another pandemic, in your opinion? Not that it was your responsibility, but I'm just curious.

Dr. Fauci. I would have to say that I have been out of government and off the coronavirus response team for now a year and 4 days --

Mrs. Dingell. How many minutes?

Dr. Fauci. -- and I can't answer that question adequately. But the one thing I do know, we really need to be doing more.

Mrs. Dingell. Is there anything else that you want to elaborate on in this area?

Dr. Fauci. No, I think it's really important, and I think that I'm glad you brought up that particular issue, which is rarely brought up in discussions, of the disparity that people have in their appreciation of whether something works or does not work.

And I think that really leads to a lot of confusion, because every time you have a study that shows one thing, somebody will read a study that shows another thing, and it's not really a valid study. That doesn't mean the investigators are bad investigators, but it's not a valid study.

Mrs. Dingell. Thank you.

I'll turn this back over to [redacted]

BY [redacted]

Q So, Dr. Fauci, I would like to just briefly revisit a topic that my majority colleagues discussed in the last hour. That was the process of resuming in-person learning safely here in the United States.

And so, when COVID-19 took hold in March of 2020, a number of in-person activities that were a routine part of our everyday lives were suspended in an effort to slow the spread of the virus, and one of these activities was in-person learning in classrooms across America.

So, Dr. Fauci, just for the record, can you remind us, at that period in time in March 2020, what we knew and what we didn't know about the virus and how it spread at the time when in-person learning was suspended in communities?

A At that time, when the 15-day "flatten the curve" followed by the 30-day extension was put into effect, it was crisis in the United States. It was at a time where

New York was just on the cusp of getting overwhelmed, when there were freezer trucks outside of Elmhurst Hospital and New York Hospital and the hospitals in Boston, that something needed to be done very, very quickly.

There were things we didn't know about the virus except that it was spreading widely in the population. And it was at that point that the decision was made that we needed to do something to flatten that curve, because if the curve continued to do that, we would run out of hospital beds.

Q And we've discussed this at a few points over the past day and a half; Congresswoman Dingell brought it up just now. But, at that point in time, what challenges were we experiencing with critical supplies of PPE, with testing, with other necessary resources, that further impeded the ability to learn safely in person?

A It was really a crisis, because we didn't have enough masks, we didn't have a vaccine, and the virus was spreading rapidly throughout our society, which was the fundamental reason why it was important, even though it was aware that there were going to be consequences of it, to just do something quickly to stop this exponential increase.

Q And so, digging a little bit more into the decision-making process that communities undertook with respect to in-person learning, just to be clear, you, Dr. Fauci, were not a single person who enacted policies that suspended in-person learning across the United States.

A The answer to that is, absolutely true. And I know I should just answer "yes" or "no," but that is the big misperception, when people are out there saying, "Fauci closed the schools." Fauci did not close the schools.

Q Is there anything more you would like to say, just while we're on the topic, about how Fauci did not close --

A No.

Q -- the schools?

A I did not close the schools. And it became the widespread situation where I became a political target.

In fact, I just -- yesterday, the New York Post had one of their usual misleading stories and had as one of the hyperlinks "How Fauci Shut Down the Schools and Hurt Our Children," something along the line of that. It was yesterday, after this hearing.

Q And this may sound redundant, but you, yourself, Dr. Fauci, were not a person with the authority to decide if and when schools across the country resumed in-person learning. Is that correct?

A That is correct.

Q In fact, that process, the process by which communities suspended and resumed in-person learning, was largely decided at the State and local levels of government. Is that correct?

A That is correct.

Q And so the Federal Government's role in the resumption of safe in-person learning was largely an advisory and support function for State and local governments -- for example, things like ensuring adequate supplies of mitigation measures, like we just discussed, tests and PPE, as well as developing roadmaps and guidance documents for schools to reopen safely.

Does that sound right?

A That is correct.

Q And did the Federal Government experience issues with fulfilling these responsibilities throughout 2020?

A The States sometimes did not respond, right.

Q But the Federal Government with respect to the discrete issues of, let's say, ensuring that there's an adequate supply of mitigation measures, like tests and PPE, getting those to States and communities --

A Oh, I misunderstood your question. Yeah, I mean, as I told you, one of the things that I did to try and get a good feel for what was happening in the trenches, I had -- maybe every couple of weeks, I would get on a phone with local health officials in L.A., Chicago, New Orleans, Washington, New York City, and I would say, what's going on? Do you have enough tests? Are you being able to adequately identify, test, contact trace, et cetera? What about PPE? Do you have enough PPE?

And the universal response was, "No, we don't." And yet there would seem to be a discussion that there was enough, and there wasn't enough.

Q Right.

And on the, sort of, second tranche of Federal responsibilities as it relates to in-person learning and a resumption of in-person learning, do you have a view on whether or not, in calendar year 2020, the Federal Government was doing a sufficient job in putting together guidance documents, roadmaps, equipping community policymakers with the resources that were necessary in order to successfully implement safe in-person learning?

A What I was hearing -- I mean, I didn't evaluate it myself, but what I was hearing at the local level, that they were not.

Q In July 2020, former President Trump tweeted that he was considering cutting off Federal funding if schools were not, quote, "open."

About a week later, then-Education Secretary Betsy DeVos echoed these sentiments during a "Fox News Sunday" interview, stating, and I quote, "If schools aren't going to reopen and not fulfill that promise, they shouldn't get the funds."

In your view, Dr. Fauci, would cutting off Federal funding from public schools during the summer of 2020 have undermined or helped efforts to safely resume in-person learning in the United States?

A Well, I think you'd have to say, if you cut off funding to the schools, it's going to certainly impede their ability to open up safely.

Q And so, shortly after the Biden administration began its work in 2021, the Centers for Disease Control and Prevention issued an operational strategy that offered comprehensive guidance for schools to safely resume in-person learning. This document was complemented by additional roadmaps that were put out by the Department of Education.

Did Federal guidance documents of this nature play a role in facilitating the process of resuming safe in-person learning in communities across the country? And, if so, how?

A Well, I don't know if I can comment about the details of that. But certainly it was generally felt that if you had Federal guidelines and resources to allow you to fulfill those guidelines that that would be a big step in the right direction of getting schools open.

But I wasn't involved in that much of the detail. That was much more of a CDC issue than my issue.

Q And, then, on the flip side to a question I had asked just a bit earlier, shortly into 2021, Democrats in Congress and President Biden passed and signed into law the American Rescue Plan, which included comprehensive investments across the board in public health and in our education infrastructure, in part to ensure the resumption of safe in-person learning.

For example, the American Rescue Plan allocated $122 billion in Federal funding

to the ESSER program that's operated out of the Department of Education.

Is it your view that this influx of Federal funding would've supported the goal of getting kids back in classrooms for safe in-person learning?

A Yes.

Q Great.

And, to your recollection -- and this is a discrete statistic, but we have seen and we have heard from our witnesses here in the select subcommittee that when President Biden took office the number of students who were learning safely in classrooms in person was about 46 percent, kindergarten through middle school. A year into the Biden administration, that number hit 95 percent.

Does that sound familiar --

A Yes.

Q -- or roughly correct to you?

A Yes.

Q Great.

With that, I will turn it over to my colleague, [redacted].

BY [redacted]:

Q Thank you, Dr. Fauci.

During the last hour, you were asked whether you recall visiting the CIA headquarters during the pandemic. And just to make sure I had it correct, your answer was no. You recall during a prior time, perhaps during the anthrax scare, but not during the COVID-19 pandemic.

Is that correct?

A That's correct.

Q Okay.

So the select subcommittee had sent a letter on September 26, 2023, to the Inspector General of HHS. Are you generally aware of that, of what I'm talking about?

A No.

Q Okay. I can give you some context.

So there was a letter sent to the Inspector General from the select subcommittee. This was a public letter. And I'm just going to read to you from a key paragraph here.

"According to information gathered by the select subcommittee, Dr. Anthony Fauci, then-Director of the National Institute of Allergy and Infectious Diseases, played a role in the Central Intelligence Agency's review of the origins of COVID-19. The information provided suggests that Dr. Fauci was escorted into Central Intelligence Agency, CIA, headquarters without a record of entry and participated in the analysis to 'influence' the Agency's review."

So that is part of -- that is an allegation in a letter that was sent on September 26, 2023.

So you were not aware of that letter?

A I had heard that there was an accusation that somehow I got into the CIA without anybody knowing about it, a.k.a. Jason Bourne.

Q So that is -- that's the origin of, I think, that allegation, is --

A I didn't know what the origin of it was, but I had heard the fantastical accusation that somehow I got into the CIA without there being a record. And having gone into the CIA when the anthrax situation was, anybody who knows anything about the CIA knows that that's about as impossible as you can get, is to sneak into the CIA.

Q Well, we've put one origin to rest here today, which is good.

So, just so you know, I mean, that letter was public, and it accompanied a press release that sort of recapped the allegations in here.

And, I guess, given some of the things that we talked about, particularly earlier this morning, does it concern you that, you know, this allegation is made publicly, that you somehow surreptitiously or with the cooperation of the CIA entered without a record and, you know, intended to influence improperly the intelligence community's analysis on the origins of COVID? Do you find that concerning?

A Well, it's really concerning, because it made me go home and say, maybe I somehow went into a fugue state and went into -- but then I realized that you can't get into the CIA without the CIA knowing about it.

So it did concern me. I mean, any real falsification of reality regarding me gets back to what we said before. It has been an extraordinary couple of years of complete fabrications about me. This is just one of a large number of fabrications, all of which have been debunked. And, you know, you may have heard about them. And I don't even want to bring them up, but they're really bizarre.

Q So that actually brings me to a good question. Do you think it's fair to you that allegations -- we'll just take this one -- that this allegation was made in a letter that was made public, along with a press release, and that your answer, your response, to both majority staff's one or two questions on this and then my questions here, that those answers might remain behind closed doors if the transcript of this interview is not released? Is that concerning to you?

A Yes.

Q Do you think that's fair?

A It's unfair, and it's concerning.

Q Okay. Thank you.

Mrs. Dingell. Back to me? Okay.

We've discussed quite a bit yesterday and today the importance of scientific

processes and how data and robust studies are essential to making informed decisions about public health, including treatments.

I'd like to talk with you about the risk to the public when treatments are promoted that have not received rigorous analysis.

In the spring of 2020, President Trump began promoting hydroxychloroquine as a treatment for COVID. I'd like to walk through the timeline and your reaction to the events that happened.

First, at a Coronavirus Task Force press briefing on March 18, 2020, Dr. Birx received a question about some work that French researchers had done with hydroxychloroquine and whether that might be a therapeutic in the U.S.

Dr. Birx responded, in part, that the President asked for a critical briefing on that today and also that there's always anecdotal reports and we're trying to figure out how many anecdotal reports equal real scientific breakthroughs.

Do you generally agree with what Dr. Birx appeared to be saying here, that it's important to not take anecdotal evidence as dispositive and, instead, take the step, where warranted, and subject a potential treatment to solid, methodological, scientific scrutiny to test if it really works as a reliable process?

Dr. Fauci. Yes. And I've said that myself many, many times.

Mrs. Dingell. The next day, again, at a COVID Task Force press briefing that was on March 19, 2020, President Trump said the following: "Now, a drug, chloroquine -- and some people would add to it hydroxy, hydroxychloroquine. So chloroquine or hydroxychloroquine. Now, this is a common" -- this is President Trump saying this.

"This is a common malaria drug. It is also a drug used for strong arthritis, if somebody has pretty serious arthritis. Also use this in a somewhat different -- they also

use it in a somewhat different form. But it is known as a malaria drug, and it's been around for a long time, and it's very powerful.

"But the nice part is, it's been around for a long time, so we know that if things don't go as planned it's not going to kill anybody. When you go with a brand-new drug, you don't know what's going to happen. You have to see and you have to go long test. But this has been used in different forms, very powerful drug in different forms. And it's shown very encouraging -- very, very encouraging early results.

"And we're going to be able to make this drug available almost immediately. And that's where the FDA has been so great. They've gone through the approval process. It's been approved, and they did it. They took it down from many, many months to immediate. So we're going to be able to make the drug available by prescription for States."

So, first, just so we are clear on this, chloroquine -- for you, Dr. Fauci -- chloroquine and hydroxychloro --

Dr. Fauci. Hydroxychloroquine.

Mrs. Dingell. -- thank you -- are two different, distinct drugs, right?

Dr. Fauci. They are. The chloroquine and hydroxychloroquine are used for malaria. For the people who have rheumatoid arthritis, you would prescribe hydroxychloroquine 200 milligrams twice a day at first and then bring it down to 200 milligrams a day.

Mrs. Dingell. So it's actually two distinctive drugs.

Dr. Fauci. Yeah. Yeah. But they're related. They're related.

Mrs. Dingell. So -- but we've gone in one day from Dr. Birx saying that there are some anecdotes that may lead to more rigorous examination of this drug as a treatment to President Trump saying that the FDA has approved that treatment. Is that correct?

Dr. Fauci. Yeah. But I think -- can I --

Mrs. Dingell. You might as well tell me your reaction.

Dr. Fauci. Okay. So there's a couple of things there.

Just because a drug has been used for one disease in a population at a certain dose does not mean that it's effective -- that doesn't mean it's effective for another disease in which there's only anecdotal information that it works.

And as you probably know, you may get to, I was asked a similar question by a reporter at a press conference, in which President Trump said that, hydroxychloroquine, I don't know, I have a good feeling about it, I think it works, you know, why not this, et cetera, et cetera. I got up and said, "No, it's anecdotal, and I would only use a clinical trial to make a decision about that."

And I think the problem here is that there was a confu- -- not a confusion, but there was a statement that, yes, it's been approved by the FDA for rheumatoid arthritis, malaria, and other autoimmune diseases, but it was not approved for COVID. And what we needed was randomized, controlled clinical trials to show that it was safe and effective, and they were not done.

And people were individually giving the President anecdotes that it worked, and I was saying that anecdotes are not the final say when you make a decision about a drug for someone.

And, as it turned out when the studies finally came in, it showed to be not only ineffective but actually not particularly safe.

Mrs. Dingell. So -- I was going to paraphrase you, so you did a great job of paraphrasing yourself.

Dr. Fauci. Right.

Mrs. Dingell. But it seems to me that what you're saying here is pretty

compatible with what Dr. Birx was saying in the first press briefing. You received anecdotal evidence, and maybe, as a result of that, something is put into the pipeline for rigorous study. Do you agree with that?

Dr. Fauci. Yes. Anecdotes should suggest doing a clinical study. But continued anecdotes are not the definitive answer.

Mrs. Dingell. And if --

Dr. Fauci. So you could have a friend tell you it worked in them and another friend said it worked in them and another friend said it worked in them. That's not a clinical study.

Mrs. Dingell. And if you'll recall, the President at the time said it's giving people hope.

Dr. Fauci. Right.

Mrs. Dingell. But hope can have consequences if it's not -- can have consequences. And I know that because my stepson took it and doctors told me he may not live. He was in the hospital for weeks.

But can you talk about the potential harm about just hoping that a treatment will work and giving it to patients without that clinical assessment, without the --

Dr. Fauci. Yeah, I think that's quite risky. And, in fact, a study came out yesterday or the day before from multiple different countries which showed that if you do look at people who have received hydroxychloroquine, that a modeling study showed that that likely led to up to 16- to 17,000 deaths.

Mrs. Dingell. On March --

Dr. Fauci. These are COVID patients.

Mrs. Dingell. Yeah, no, I know that. That's what my stepson took for COVID.

Dr. Fauci. Right.

Mrs. Dingell. On March 28th, the FDA issued -- of that year -- issued an Emergency Use Authorization for hydroxychloroquine and chloroquine to be used in hospitals under certain conditions, including that they be placed on careful heart monitoring.

What was your reaction to that decision? And were you involved in it at all?

Dr. Fauci. I was not involved in the decision. And I was a bit perplexed that it was -- because I still felt you needed more information before you gave it an Emergency Use Authorization.

Mrs. Dingell. So I'm going to ask you, do you think that the narrow circumstances for this were properly communicated, for the Emergency Use, by the FDA?

Dr. Fauci. Well, the FDA's -- what am I trying to say? The FDA's criteria for an Emergency Use Authorization is that there's at least a hint of efficacy and very unlikely to be any toxicity associated with it.

So, again, I wasn't particularly happy that it would be widely used without a study.

Mrs. Dingell. And knowing that the President communicating that would probably have other people -- my stepson is a very strong supporter of the former President and, because he said it, took it.

So I don't want to get you too political here today, but how do we make -- do you have any comments about how we keep things scientific and don't --

Dr. Fauci. It's easy. Just keep things scientific.

Mrs. Dingell. There you go.

And as an apparent consequence of this treatment, there were several unintended but foreseeable events. There were instances of individuals becoming poisoned with non-medicinal chloroquine. One man died in Arizona, you may remember, for example, due to the ingestion of non-pharmaceutical chloroquine, which

is used to clean fish tanks, and others who took this drug off-label experienced heart problems, as we discussed.

As a result, FDA issued a warning on April 24, 2020, less than a month after the EUA, that concluded the following: "The FDA is aware of reports of serious heart rhythm problems in patients with COVID-19 treated with hydrochloric" -- I don't know why I'm having such a problem today -- "hydroxychloroquine or" --

Dr. Fauci. Just say "HC."

Mrs. Dingell. -- "HC or C, often in combination with erythromycin or other QT-prolonging medicines. We are also aware of increased use of these medicines throughout patient prescriptions. Therefore, we would like to remind healthcare professionals and patients of the known risks associated with both HC and chloroquine. We will continue to investigate risks associated with the use of HC and chloroquine for COVID-19 and communicate publicly when we have more information."

They have not been shown to -- and they said then that it had not been shown to be safe and effective for treating or preventing COVID-19.

On June 15, 2020, FDA revoked the EUA altogether. FDA stated that, "We made this determination based on recent results from a large, randomized clinical trial in hospitalized patients that found these medicines showed no benefit for decreasing the likelihood of death or speeding recovery. This outcome was consistent with other new data, including those showing the suggested dosing for these medicines are unlikely to kill or inhibit the virus that causes COVID-19."

So, when we went from one anecdotal study being discussed on March 18th to an FDA EUA on March 28th, an FDA warning on April 24th, and a revocation on June 15th, does that seem like a rather rapid rise and fall for the use of a drug?

Dr. Fauci. Yes.

Mrs. Dingell. And then you are aware, because you brought it up. Are you aware of a recently published study that estimates the number of deaths that appear to be caused by off-label --

Dr. Fauci. Right.

Mrs. Dingell. -- which is a different study? "This meta-analysis examined numerous reports across 6 countries and estimates that over 12,000 individuals in the U.S. may have died as a result."

But since we're trying to learn from the pandemic, what are the lessons you think we should take away from this particular episode? Do you think that it's dangerous for political pressure to dictate scientific decisions?

Dr. Fauci. Yes.

Mrs. Dingell. Do you think it is dangerous to rely on anecdotal evidence to make large-scale health policy decisions?

Dr. Fauci. I think that anecdotal data should trigger a clinical trial and should not be used to make broadly applicable health decisions.

Mrs. Dingell. And do you think it's especially important for political and public health leaders to ensure that their guidance is sound and evidence-based when people are particularly scared and need help?

Dr. Fauci. Yes.

Mrs. Dingell. And, with that, I turn it back to [redacted]

Ms. Castor. Can I ask one thing?

I just want to make sure, this is the February 2024 Biomedicine and Pharmacotherapy article. Just for the transcript purposes, that we ought to put in there that the use of hydroxychloroquine during COVID led to an estimate of 17,000 unnecessary deaths in the 6 countries analyzed. Is that the --

Dr. Fauci. Yes, that's the paper.

Ms. Castor. Thank you.

Mrs. Dingell. Do you have anything else?

BY [redacted]

Q So, Dr. Fauci, I just wanted to quickly touch on a topic that my majority colleagues covered briefly at the tail end of the last hour, and that is COVID-19 in nursing homes and congregate care facilities.

I think a key takeaway from the COVID-19 pandemic is the importance of bolstering infrastructure that's in place to protect medically vulnerable populations, particularly people who are elderly, particularly people with disabilities. And this is particularly important for nursing homes, it's important for assisted living facilities, and it's important for other congregate care facilities.

Dr. Fauci, just briefly, why are residents of congregate care facilities at particular risk when it comes to respiratory infections like COVID-19?

A Well, when you go into a facility like that, you have people who mostly are compromised, either because of a medical condition or age or a medical condition plus age. So, inherently, they're already susceptible to any infection that they might get.

When you're in a closed situation where there's not the ability to move around and are congregated together in rooms like this or in rooms that are adjacent to each other, a respiratory illness in that circumstance can spread rapidly.

And that's historically very, very clear when you see influenza outbreaks in nursing homes or intermediate care homes. And the typical prototype of that is influenza, but we saw that very clearly with COVID when it happened.

Q And so my next question was going to be, are there specific or unique features of COVID-19 compared to other respiratory diseases that made it particularly dangerous for residents in congregate care facilities?

A Yeah. It was -- it's much -- particularly the most recent variants like Omicron is highly, highly transmissible even when people don't have symptoms. So you could have a situation where a person seems reasonably well, goes to the common game room of an intermediate facility, and could spread it very easily to the rest of the folks in there.

But the critical issue of those types of facilities is the overwhelming proportion of vulnerable people in those facilities.

Q And, then, looking back to March 2020, when COVID-19 first really struck across the country, in your view, did nursing homes and other congregate care facilities across the country have adequate infection-control measures in place to sufficiently protect their residents and staff?

A You know, I believe it was even the opinion of Seema Verma at the time that it wasn't; we didn't have enough, and we needed to do better. And she was one that was pushing that we needed better infection control in places.

Q And so, to the idea or the mission of doing better on infection control, what lessons should we be taking away? What policies, as a government, can we be pushing or pursuing to better insulate congregate care facilities from the threat?

A Well, I think you should have better training, better ventilation, all the things that we spoke about. That might even be applicable to schools.

But one of the things that we spoke about that's important is that you should do it before the fact, not chasing an outbreak.

So, right now, we should be -- lessons learned for the future -- and that's what I believe this whole thing should be about, is lessons learned -- is that we should be now preparing those facilities for the possibility of yet again another outbreak. Speaking of which, we are not finished with COVID yet.

Q Right.

So, with the 10 or so minutes that remain in this round, I wanted to revisit a topic and pick up where Congresswoman Castor left off in a previous round, that topic being vaccine hesitancy.

Now, during the course of the COVID-19 pandemic, I think we saw a number of different misrepresentations about the safety and efficacy of the COVID-19 vaccine.

Dr. Fauci, is it your view during the COVID-19 vaccine that vaccine hesitancy grew or increased?

A It grew, yes.

Q And so Ms. Castor, in her round, mentioned a few striking examples of these misrepresentations. Are there any others that you'd quickly like to address or add for the record?

A Well, nothing specific, except that there clearly is a disparity of acceptance of vaccines depending upon what State you're in, which I have found, as a nonpolitical person who's been a nonpolitical person all my career, that it just is so painful to see that people are not getting vaccinated on the basis of the political ideology of a State.

I mean, why should red States have more suffering and deaths than blue States because of a lower level of vaccination? I just think that's unfair to the citizens in those States, to not get vaccinated by a vaccine that is safe and effective and life-saving.

Q And so, looking at vaccine hesitancy, I, personally -- I believe you'll agree, but for the record -- believe that vaccine hesitancy has the potential to be one of the most significant public health threats of our time, to undermine confidence in one of the most integral tools we have to protect public health here in the United States and across the world.

Do you agree with that?

A I definitely agree with that. And my concern is that vaccine hesitancy will spill over from COVID to other vaccines, which would really be a problem.

I mean, for example, we know that whenever there's a diminution in the critical level of people, children, who are vaccinated for measles, that you get measles outbreaks. That's happened time and again. Whenever you fall below the critical level in the community of vaccinations with measles, children get vaccinated (sic). And measles is a very serious disease.

So vaccine hesitancy not only has a negative impact on health for COVID, but if it spills over into other vaccines that have been proven to be life-saving for children and preventing children from getting severe disease, then vaccine hesitancy is going to spread to any of a number of other areas.

Q And so you mentioned measles. Over the course of the past 2, 3, 4 years, we, I think as a society, have seen an uptick in outbreaks of diseases, diseases that we had previously thought eliminated.

Aside from measles, are there other diseases or outbreaks that have been --

A Mumps, pertussis. I think those are the two most important in addition to measles.

Q And you mentioned that we are seeing a decline in vaccination rates for routine vaccinations, such as vaccines for measles, mumps, and rubella, as collateral to some of what we've observed with respect to misrepresentations regarding the COVID-19 vaccine.

I want your perspective here. Because sometimes these declines or these drops in vaccination rates may be a tenth of a percent, 1 percent. But what does that mean, practically, for the number of children in this country or the number of people who are getting vaccinated for diseases like measles, mumps, and rubella?

A Well, it puts them at risk, I mean, because now you're talking about vaccines that prevent the spread of infection. So, when you wind up having people who go below the critical level of protection -- we've seen examples. This is not surmising between you and I.

I mean, when there was the big outbreak at Disney World in California, it was from a group of people, you know, who had -- measles, you should have 90-plus percent of the population vaccinated. When it goes down to in the low-80s, you wind up with an outbreak.

They had a population in the Rockland section, a community just north of New York City, where there was a major measles outbreak because one child came in from Israel who had been infected with measles and mingled with the children in the community, in which measles was under vaccinated, and there was a significant number of cases in that community.

So it isn't hypothetical. It's happened, and it will happen again.

Q And so, as we look to address the rise of vaccine hesitancy in the United States and internationally as well, there is, as I believe it and understand it, a population of people who are apprehensive about vaccines but could be convinced or could be, sort of, persuaded otherwise to obtain the vaccine.

How should public health professionals approach --

A Yeah.

Q -- this community of people and the goal of combating vaccine hesitancy?

A Yeah. Yeah, that's a great question. I'll try to be as succinct as possible.

Of the people who are not getting vaccinated, there are some people who are hardcore anti-vax. No matter what you do, they're not going to get vaccinated. But there are other people that are influenced by the anti-vax and say, "Well, if these people

don't want to get vaccinated, there must be a reason." So they're less anti-vax than hesitant to get vaccinated.

And I think that what we need to do is not treat them all as the same and attack people who are hesitant about vaccination because they need more information or that they have a cultural reason to be concerned about something that's offered from the government.

You've got to be reaching out to them and not condemn them for being hesitant to be vaccinated. Because, again, you've got to separate somebody who's propagating "don't get vaccinated, don't get vaccinated" versus the people who are innocently hesitant because they want more information.

You can convince a lot of those people to get vaccinated if you provide them with the proper information and get them to understand that the misinformation that's being propagated about vaccines -- like, we've heard the example with the Surgeon General in Florida -- I mean, we've got to convince people that that's not true.

Q And you mentioned in our discussion over these past few questions the notion that vaccines have become politicized. In your view, how has the vaccine become politicized, or vaccines writ large? And what have the ramifications of that been?

A Well, you know, it's a pretty complicated situation about how it's become politicized, is because political leaders in general either don't promote vaccines or are outright against vaccines. And that's, I think, detrimental to the health of their constituencies, as we've seen, under certain circumstances. So, to me, that is something that is really unfortunate.

[redacted] We have a few minutes left. I want to make sure -- Congresswoman Castor, Congresswoman Dingell, do you have any questions on

either of these topics?

Ms. Castor. Well, another vaccine comes to mind; that's HPV. Because we were kind of on an upswing before the pandemic, but I've noted that the vaccine uptake for HPV has gone down. And that's a cancer prevention --

Dr. Fauci. Right.

Ms. Castor. -- vaccine. And coming at it from a parent's point of view, if there's a vaccine that would prevent my daughters from contracting certain cancers, I rushed to make sure that they were vaccinated at the appropriate time.

So what does that mean -- with vaccine hesitancy growing and now we have a drop-off of parents getting their children vaccinated for human papillomavirus, what does that mean in the outer years for cancer in families?

Dr. Fauci. No, I think it's pretty obvious what it'll mean. The effect of the HPV vaccine on HPV infection and subsequent cancers is pretty clear. If you have people who pull back and don't get vaccinated, you're going to wind up X number of years from now seeing an increase in that condition.

Ms. Castor. It'll cost lives.

Dr. Fauci. Yeah.

[redacted]. So, Dr. Fauci, we do have -- just for the record, we have the study we were talking about in terms of excess mortality that appears to be caused by hydroxychloroquine worldwide.

Candidly, I was not necessarily going to introduce it as an exhibit, because I figured you were too busy this past week, I think, when this came out to have read it. And then you spontaneously brought it up. So, because you did and because you've obviously read it, I'll just circulate it so everybody has a copy.

This is exhibit W, I think we're up to on the minority side. This is exhibit W.

[Fauci Minority Exhibit W
was marked for identification.]

BY [redacted]

Q So this is a paper -- I think this was just the online publication -- that was going to appear in Biomedicine & Pharmacotherapy entitled "Deaths induced by compassionate use of hydroxychloroquine during the first COVID-19 wave: an estimate."

And, as we discussed, it's a review of 44 different cohort studies across, I think, 6 different countries estimating the number of excess mortality caused by hydroxychloroquine, including I think it's over 12,000 deaths in the United States.

So, if you have any additional comments on it, that's fine. But, again, I didn't want to put this in front of you and make you read it. But you'd already read it.

A No, I have not read the complete paper.

Q Okay.

A I wanted to make sure for the record.

Q Okay.

A I heard about it, I pulled it up, and I looked at the abstract and just quickly skimmed through it, and I just looked at what the results are. I'm going to have to read the paper carefully, but I have not read the paper carefully.

Q You got a copy now.

A But I was aware of it, and I read the abstract.

Q Okay.

Ms. Castor. You know what struck me too? Because I did read it, and I started going into a couple of the footnotes, actually. And one area ripe for, I would hope, a select subcommittee like this or Energy and Commerce O&I is the fly-by-night online

pharmacies that help push a lot of this misinformation that likely made off with millions of dollars at the expense of the health of so many Americans, whether it's hydroxychloroquine or ivermectin or some other.

I don't know if that's something you ever dove into as --

Dr. Fauci. No, I have not. No, I have not.

Ms. Castor. Thank you.

[redacted] And, with that, I think we can go --

[redacted] Off the record, yeah.

[redacted] -- off the record.

[Recess.]

[4:34 p.m.]

Mr. Benzine. We can go back on the record.

BY MR. BENZINE:

Q I want to talk about a couple of other mitigation policies specific to COVID, but then how we can apply them going forward.

There was a, obviously, big to-do about lockdowns and social distancing and all that that kind of caused. And you mentioned previously the 15 days to slow the spread, 30 days to slow the spread that we had seen at least in New York, like, on the tipping point --

A Right.

Q -- of being overwhelmed.

Our -- I'm going to use "lockdowns" colloquially -- but, obviously, we did not see what we did -- what happened in Wuhan did not happen in the United States. And I think you've gone on record saying it probably wouldn't have worked very well in the United States.

A Right.

Q It's just a different --

A We had significant social distancing as opposed to lockdown --

Q Yes.

A -- in a lockdown sense.

Q Do you recall when discussions regarding, kind of, the at-least-a-6-foot threshold began?

A The 6-foot in the school?

Q Six-foot overall. I mean, 6-foot was applied at businesses --

A Yeah.

Q -- it was applied in schools, it was applied here. At least how the messaging was applied was that 6-foot distancing was the distance that needed to be --

A You know, I don't recall. It sort of just appeared. I don't recall, like, a discussion of whether it should be 5 or 6 or whatever. It was just that 6-foot is --

Q Did you see any studies that supported 6 feet?

A I was not aware of studies that -- in fact, that would be a very difficult study to do.

Q I know. I'm just trying to figure out why 6 versus 3 or 4 or 5.

A Yeah. Yeah.

Q Like, 6 is a significant distance. I mean, you've testified here. I think you testified in front of Mr. Scalise a couple times when I was working for him. And recalling the hearing rooms, instead of, like, seven members on the top of the dais, there's two, and --

A Right.

Q -- it was just two staffers behind.

A Yeah. Yeah. I think it would fall under the category of empiric. Just an empiric decision that wasn't based on data or even data that could be accomplished.

But I'm thinking hard as I'm talking to you.

Q Uh-huh.

A I don't recall, like, a discussion of, "Now it's going to be" -- it sort of just appeared, that 6 feet is going to be the distance.

Q We, some members of the staff, took visits to Los Alamos and Livermore National Laboratories --

A Yeah.

Q -- and met with some of their, like, high-throughput computing people and

their epidemiologists. And they said -- and I just want to get your opinion on this, and I trust that what they're saying is a capability that they are able to do -- but that they could, in essence, high-throughput compute and map a sneeze and determine the distance of the germ spread to then kind of figure out what the distance needs to be.

Do you recall anything like that?

A I've seen in literature that I've read and passed through recently and even some time ago, you know, the picture of somebody sneezing, and they show --

Q Uh-huh.

A -- the spray and what the distance of the spray is. But that doesn't take into account aerosol.

Q Like, wind?

A Yeah. Or particles that, even without wind, just hang around for a while.

Q Okay. I didn't think that through, I guess.

But do you think that there are aspects to the government that could be better leveraged in a future pandemic?

A That's a pretty broad question. Like, what do you mean?

Q I guess, like, when we visited -- I'm going to use the labs specifically, but I think there's, like, lots of aspects in the government beyond NIH and CDC that have expertise that could try to attack a pandemic, this being one example.

A Yeah.

Q Do you think, kind of, going beyond just the public health aspect would be better in attacking a pandemic?

A You know, I think the public health element should drive it, but they should get input.

For example, you know, that "Gesundheit Machine" that is used, I think, at the

University of Maryland or up at Hopkins?

Q Uh-huh.

A I think many of the people who are there are not officially public health people but they have technical expertise.

Q Thank you.

I guess one of the things that we're evaluating is trying to leverage the Department of Energy, the labs in particular, a little bit more. They also -- like, the -- I'm dribbling out the clock now, so -- but they said they could use their, kind of, like, nuclear expertise on the radiation clouds to map how things were going through the air --

A Right.

Q -- and stuff like that. So I think just --

A Yeah.

Q -- for your own -- I don't know -- as we move forward, that that kind of stuff is of interest.

A You know, I think the -- I actually, after a while, had some communications with -- I wanted to learn more about aerosol, and there was a group that was doing an aerosol study. And it was really interesting to see that a lot of things that we thought go quickly to the ground actually stay up much, much longer than they do. And that would be someone who's an aerosol expert.

Q Uh-huh.

A Yeah.

Q All right. I want to talk about some specific things. And, early on, you talked about the 15 days to slow the spread. What was the basis for 15 days at that time?

A It was Debbie Birx who actually was the main driver of that. And I'm not

sure exactly why she picked 15. I imagine she wanted to get a good start on it, I think, knowing deep down that it was going to be more --

Q Uh-huh.

A -- than 15, but let's try to get the President to agree to 15, and if he agreed to 15, then maybe we, as a Coronavirus Task Force, could convince him to extend it to 30. Because no one, I think, really believed that a pause for 15 days with an outbreak that's doing this exponentially is going to be the final solution.

So I think it was an empiric choice on the part of Debbie.

Q The -- and, again, this is kind of for my own edification. The goal of the 15 days wasn't necessarily to kill the outbreak but to get it to a point that we could recuperate some PPE --

A Yeah.

Q -- recuperate some hospital space. Is that right?

A Right. It was to flatten the curve, so that it wasn't necessarily geared at decreasing the ultimate number of cases, but the number of cases that we could actually handle.

It was very much triggered by a real concern that the hospitals were going to get overrun. And one of the things about hospitals getting overrun that was very, very concerning is to put our healthcare providers in the position of having to decide between two essentially equal people who is going to get the ventilator --

Q Uh-huh.

A -- or who is going to get the intensive care unit bed. That would've been really devastating, to -- and, to me, as a physician, that would be a position I would never want to be in.

Q Uh-huh.

And then you said it was subsequently extended to 30 days --

A Thirty days, yeah.

Q -- I think, a little bit before the 15 was over? Or was it on the 15?

A Yeah. No, no, no, no. I mean, it was clear that -- the 30-day proposal was presented to the President while we were in the 15-day period because it was clear that it was not going to last.

Q Yeah. And, again, the goal there wasn't -- it was to flatten the curve --

A Right.

Q -- to get to a point where we could have a manageable response.

A Right. Exactly.

Q And at that point, and I guess probably never, the goal of these was not to shut down the economy or, like, you know, kick people out of their jobs or anything like that?

A That certainly wasn't the goal, to do that. I think there was a realization on the part of -- I don't know. I'm talking about White House discussions, so I'm getting nervous now. So --

Mr. Barstow. You're okay.

Dr. Fauci. Am I okay?

BY MR. BENZINE:

Q Kevin will tell you if you're not doing okay.

A Okay.

So there was a discussion -- and that gets to what we were saying about who's the ultimate decider.

You know, when Debbie presents -- so the way it went is that Debbie came up with this plan. She showed it to me, you know, relatively soon before she presented it,

and then showed it to the Vice President, and it was agreed to go to the President.

And, then, when she made the presentation, there was a discussion by the economy people, saying, you know, whoa, wait a minute, you know, what effect is this going to have?

Q Uh-huh.

A And the ultimate decision was made, let's go with it for now and see what happens.

So it wasn't directed because we wanted to hurt the economy --

Q Yeah, yeah.

A -- but the economic people weighed in and said, you know, we'd better at least consider the economic implications of this.

Q So it's what we were talking about earlier, that --

A Yeah.

Q -- there should be multiple people at the table during --

A And there were --

Q Yes.

A -- multiple people, and the table was the Resolute desk.

Q And I'm agreeing with you that --

A Yeah.

Q -- during a pandemic, that there needs to be multiple voices. While, obviously, their health and keeping people alive needs to be the primary driver --

A Right.

Q -- but taking into consideration other aspects.

I mean, we've touched on this very briefly, but, at that point, you know, relationships with China were starting to be a little fraught, and, obviously, economic

situations, school situations.

So, I guess, while we're preparing for the future, having a response that is well-rounded is better than single-point-driven. Is that correct?

A Yeah.

Q Okay.

We've talked a decent amount about vaccines, and I want to talk a little bit more, particularly just COVID vaccines. I think we can all agree that COVID vaccines saved probably innumerable lives at this point, kept enumerable people out of the hospital, and probably kept innumerable people from getting sick.

In April 2020 was when Operation Warp Speed was announced. Were you involved in, kind of, the planning process for that program, kind of like the brain trust that says, if we put this on paper, we can do this?

A No, but -- and, if so, in a very minor way.

When we were talking about it, the concept that we were going to have to do something that was really unprecedented in getting this vaccine done, my part was the scientific part.

Q Uh-huh.

A You know, how quickly can you get something into clinical trial?

Operation Warp Speed was a bit more of an implementing function, as opposed to getting the research to be translated to a vaccine. So my responsibility, which I discussed in detail before the group here, was to make sure that we got the vaccine work started, we got it into a phase 1 trial, and we quickly did it the other.

Operation Warp Speed was a combination of making sure that companies knew that we were going to pay and take all the risks financially -- because the companies would not -- for two ways: the risks of the clinical trials, which they did not have to pay

for, we paid for, "we" being the Federal Government, and to pre-purchase --

Q Uh-huh.

A -- the vaccine before it was proven to be effective. So the risk was that, if it isn't effective, we, being the Federal Government, lost a lot of money, and the companies wouldn't lose any money.

All of that I was not involved in. What I was involved in was the scientific component of it.

Q And maybe it was delineated more internally, but at least publicly, part of it was kind of -- "loosening" regulations isn't the right word, but figuring out where we can speed up the process --

A Right.

Q -- obviously, knowing a vaccine was important, where we can speed up the trial process, the approval processes, that kind of stuff.

Were you involved in any of those discussions?

A I might've been. And I'm trying to think about to what extent I was involved with it. It could've been something like, we want to make sure we speed it up but we don't speed it up by compromising safety.

Q Uh-huh.

A And that's one of the things that I probably would've gotten in a discussion in, as opposed to the logistics of getting all of these things done would be more -- how many people do we need on a clinical trial? We need 30,000, you know, total, 15,000 prelim. It's likely I got involved in that discussion of it. It was more of something that related very closely to the science and clinical trials.

Q Do you think the process of Operation Warp Speed, the, kind of, medical side that you were talking about, but also when you were -- you probably saw the other

aspects, right? Like, you were --

A No, I was there. I definitely saw it.

Q -- at least in the room to talk about distribution and that kind of stuff?

A Oh, yeah. Yeah. Yes.

Q Do you think that kind of thought process could be scaled to other pharmaceuticals?

A I think it can.

I mean, I don't think anybody would argue that Operation Warp Speed was a great success. No doubt about that. I think that an Operation Warp Speed-like approach could be applied -- and, I guess, when you talk about lessons learned for other diseases, it could be applied to other diseases.

There was a great, I would say, social and almost emotional need to do this because we were in the middle of a crisis. I would like to see an Operation Warp Speed approach of a great collaboration and synergy between industry and the Federal Government and academia, the way it was, be done in situations that were not only crises. In other words, there are other diseases that we could do this on that are not in a crisis mode.

And I think a lesson could be learned, how successful it is when you get good partnership between the Federal Government and the private sector, which is essentially what Operation Warp Speed was.

Q So maybe applying the thought process to target diseases to prevent a future pandemic or at least attempt to prevent a future pandemic?

A Yeah. Right.

Q On December 11, 2020, the FDA authorized a COVID vaccine -- I think it was Pfizer at that point --

A Right.

Q -- for EUA. Were you involved at all in the EUA process?

A You know, I know it sounds strange when I say, I don't recall. But I probably was involved in the discussion of, let's take a look at the data, and do these -- so I would say, I can't say definitively --

Q Uh-huh.

A -- but it is likely that I was involved in an analysis of the data.

Q When we talked to Dr. Birx, now, in 2021 -- October 2021 is when Dr. Birx sat for a 2-day interview, just like you -- she said that, at that point, she was having discussions about compassionate use for the vaccine; that, I guess, the trials had shown that it wasn't dangerous but not yet proven that it was effective, and that, at that point, you know, you could apply for compassionate use.

Do you recall anything about that?

A I don't recall -- I don't recall at the time -- I don't recall that that's what she was saying at the time. But I know, after the fact, that that's what I think she had mentioned. She wrote it in her book or --

Q Yeah.

A Yeah. I think that's where I remember it.

Q I want to -- and you've touched on it a little bit, some of the misinformation and, kind of, things that surrounded the vaccine. As I said in the beginning, like, it has saved millions of lives, kept millions of people out of the hospital.

And a theme of the past 2 days, I think, across the aisle, has been: Words of people that are in at least perceived positions of authority and public faces matter, and how you say things matters, and promises you make matter.

In March of 2021 -- and we asked Director Walensky about this before, too -- but

she was on TV and said, "Our data from the CDC suggests that vaccinated people do not carry the virus and don't get sick."

I think, as I've just admitted and will admit time and time again, the vaccine was wildly important, but there were breakthrough cases.

A Yeah.

Mr. Schertler. I'm sorry. What date was that, Mitch?

Mr. Benzine. March 2021.

Mr. Schertler. Okay. Got it.

BY MR. BENZINE:

Q And saying, if you get vaccinated, the quote is, "You don't get sick." That's just not accurate, right?

A You know, I think she was speaking in generalities, and with every one of those, there's exceptions.

What I believe that Dr. Walensky was referring to is that, at the time when you're protected -- you know, we know that the efficacy, or the effectiveness, as it were, essentially wanes after X number of months. I think what she was saying -- that when you're at a point of maximum protection, it is very unlikely that you're going to get sick.

And I think when public health people speak about "you're not going to get sick," it means there's always an exception to that. And I would imagine that Dr. Walensky had in mind that there would be exceptions to that.

Q You didn't go quite that far in one statement. You said the vaccine made you a dead-end for the virus. Do you recall that statement?

A No, I don't.

Q It was May 2021. "When you get vaccinated, you not only protect your own health and that of the family, but also you contribute to the community health by

preventing the spread of the virus throughout the community. In other words, you become a dead-end to the virus."

A Right. That was at a time when the data had shown, at least with the variance that we were talking about, that there was a significant degree of protection against infection as well as against serious disease.

As I mentioned during one of the previous questions, as we develop different variants, particularly the Omicron variant, the protection against actual infection, which would protect you from getting infected --

Q Uh-huh.

A -- and essentially make it a dead-end for you -- not a dead-end for the community, but a dead-end for you -- that was a correct statement.

But that statement really, as we got more and more information about the waning of protection against infection -- so, right now, I believe if you ask me -- which you will -- or anybody else, that, right now, vaccines do not necessarily protect very well at all against infection, but the ability to protect you from getting into the hospital is still pretty strong.

Q Uh-huh. And, I mean, putting aside, kind of, the long-COVID symptoms, the goal of most vaccines is to keep you from dying. Is that accurate?

A Well, from getting sick. I mean --

Q Yeah.

A -- I don't like to be in the hospital -- I don't know about you --

Q Well, yeah.

A -- and walk out alive; I'd rather not go to the hospital. But --

Q Yeah. That's fair.

A Okay.

Q Along the same lines, in July of 2021, President Biden was giving a townhall, and he said, "If you're vaccinated, you're not going to be hospitalized, you're not going to be in the IC unit, and you're not going to die."

To my knowledge, President Biden is not a public health expert, so I'm not going to -- he's not --

A Yeah.

Q -- he doesn't have the benefit of speaking in generalities like you just said.

A Yeah.

Q That, to me -- I mean, by July 2021, there were vaccinated people in the hospital, correct?

A Right.

Q There were vaccinated people in the IC unit, correct?

A Yeah. Unusual, but there were people, obviously, who -- I mean, much, much, much, much --

Q Yes.

A -- less of a chance than if you were unvaccinated. But, yes, there were vaccinated people who wound up getting sick and dying.

Q And vaccinated people had passed away by this point?

A Right. Right.

Q I think we've talked a lot about misinformation. Misinformation --

A Yeah.

Q -- cuts both ways.

A Yeah. But I believe, I believe sincerely, that the President meant "for the most part," as opposed to "100 percent."

Q And I get that. And I -- it's just, it's a recurring theme, not just with you, not

just with the President, but that we see people -- this implies to the general public that if I get a vaccine I'm good to go, I'm not going to get sick --

A Right.

Q -- I'm not going to die. And while it's very accurate that you're way less likely to die --

A Right.

Q -- it's not accurate to say you are not going to die.

A Yeah.

Q I mean, generally, do you think people need to be more wise with their words when discussing these things?

A Yeah, I mean, I think it would be more accurate to say that if you get vaccinated there's an overwhelmingly less chance that you're going to get sick or die.

But I think the President very likely meant that, but he said it in a way that seemed a little bit more absolute. I don't think he was -- in fact, I'm fairly certain that he wasn't trying to fool anybody.

Q No, no. And I'm not accusing him of trying to fool anybody.

All I'm saying is that we've seen people -- and I'm -- everybody is guilty of it on this side of the table, and some on that side of the table too -- of parsing out statements and nitpicking certain things. And how we say things, especially in a public health crisis, especially when talking about, you know, it's a vaccine, it's a very minor medical procedure, it's still going to the doctor, it's still getting a shot -- that we should be honest with Americans and --

A Yeah.

Q -- that words from the President of the United States matter.

A Yeah.

Q And I can, like, feel my colleagues on the other side wanting to bring up bleach, and I will say that words matter in that situation too.

A Yeah.

Q But -- I think this will be my last question on this -- like, do you think it could've been reframed --

A Yeah.

Q -- to be more accurate?

A But, again, you used a word, Mitch, that I would just push back on. I don't think the President was being dishonest with the American public.

I think, as a layperson, he was talking more in generalities than in, 100 percent, this is sure. He was saying that because, in his mind, vaccines work really, really well in preventing you from getting infected and dying. I don't believe for a second that there was any degree of dishonesty in that.

Q Thank you.

I want to -- maybe not properly serving to the process of approving the vaccine, but -- skip through the full approvals. I imagine that was mostly FDA? Is --

A Right.

Q -- that fair? And move on to some of the policies that were implemented after the vaccines got their full biologics approval.

Did you have any conversations with any schools, universities, or other educational institutions regarding mandating vaccinations?

A I didn't go out to universities and say, "You should be mandating vaccinations." But I would occasionally get a phone call from a university president saying, you know, "We really want to keep these kids safe. We're thinking of making sure that they get vaccinated. Do you think that would be a reasonable idea?" And I

would say, "I think that would be a reasonable idea."

But I wouldn't all of a sudden, you know, go on a speaking tour --

Q Uh-huh.

A -- to colleges, saying, "You should be mandating." But when they suggest, would that be a way to safeguard everybody, I would say yes.

And then, also, there's always an out for people who don't want to get vaccinated, that they should wind up getting tested frequently enough to be safe.

Q The off-ramp?

A The off-ramp, right.

Q Same kind of question, and if it's the same answer, just tell me it's the same answer.

Any conversations with major corporations -- Amazon, Facebook, others -- about mandating vaccinations for employees?

A Well, you just gave two -- social media. I don't talk to social media.

Q No, not in, like, social media ways. I mean, did you have conversations with major corporations about --

A Yeah, I'm trying to think, and I don't -- I do remember conversations with university provosts --

Q Uh-huh.

A -- and presidents, but I don't recall -- it is entirely conceivable that I did, but I don't specifically recall.

Q You were interviewed for a book written by Michael Specter, and it's just entitled "Fauci." I don't know if you remember that interview.

A I do. It wasn't a book; it was an article, wasn't it?

Q I think it was a --

A Yeah.

Q -- book. You were interviewed by Michael Specter.

A Yeah. It was, I think, for The Atlantic or something like that -- or the New York -- New York Magazine.

Q That might be it.

There was a recorded portion of this interview that he released recently, well past the book, or article. And in the recorded portion -- and I'm happy to play it, but I can just read it to you --

A Tell me.

Q -- if that's easier.

You said, "Once people feel empowered and protected legally, you are going to have -- schools, universities, and colleges are going to say, 'You want to come to this college? Buddy, you're going to get vaccinated. Lady, you're going to get vaccinated.' Big corporations like Amazon and Facebook and all of those others are going to say, 'You want to work for us? You get vaccinated.' And it's been proven that when you make it difficult for people in their lives, they lose their ideological bullshit and they get vaccinated."

Do you recall making that statement?

A No. I mean, I'm sure you are going to play it, but I don't recall making that statement.

Q Okay. I don't have to play it --

A Yeah.

Q -- if it's not going to --

A Yeah.

Q But he recently released the recording.

A Right.

Q Since you don't recall, I'll skip over what did you mean by "ideological bullshit"? I presume it's some of the partisan politics surrounding vaccines.

A Yeah, I mean, I think if I used -- which I'm sure I did, if you're going to play it -- if I used the word "ideological bullshit," it refers to my concern that I mentioned an hour or 2 or 3 ago, that it's very painful for me, as a physician, to see somebody who's in a Republican State not get vaccinated and die because they happen to have an ideological reason not to get vaccinated, whereas someone who doesn't have an ideological reason against vaccination gets protected and lives. I think that's unfair.

Q Uh-huh.

A That's what I mean by "ideological bullshit."

Q Putting aside the ideological reasons, are there reasonable objections to receiving a vaccine?

A Yeah. There are medical reasons that people, you know, might have a condition. For example, a live-attenuated vaccine for someone who's immunocompromised --

Q Uh-huh.

A -- that's a very good reason not to get vaccinated.

Q We saw -- and I don't have it in front of me, but -- some mandates that businesses and stuff didn't have religious exemptions or medical exemptions.

Do you think those kinds of objections to receiving the vaccine are valid?

A They're valid if they're not abused. And there have been a lot of abuses of the exemption by people who have no reason at all and say, I have a medical reason or a psychological reason.

Q Uh-huh.

A I think if you have a broad psychological reason, then there's every reason in the world for you not to get vaccinated.

Q That's fair.

On August 24, 2021, Secretary of Defense Austin announced a policy of mandatory vaccination for all servicemembers. Were you involved in that?

A No.

Q On September 9, 2021, the President announced an executive order requiring Federal employees to be vaccinated against COVID-19. Were you involved at all in that?

A I wasn't involved. I mean, he was always talking about getting people vaccinated. I wasn't involved in that decision.

Q And then on November 4, 2021, the President outlined COVID vaccine mandates issued by the Occupational Safety and Health Administration and the Centers for Medicare and Medicaid Services.

Were you involved in either of those?

A Those were decisions that were above me.

Q And then on November 30, 2021, the Office of Head Start at HHS required COVID-19 vaccination for all Head Start staff. Were you involved at all in that?

A No. I didn't even know that happened, actually.

Q We've talked about some of the consequences of vaccine hesitancy. Do you think mandating vaccines can result in some hesitancy?

A You know, I -- if I can switch over to -- and I'm not dribbling around the court --

Q Uh-huh.

A -- just to switch over to lessons learned, I think one of the things that we

really need to do after the fact, now, to -- you know, after-the-game, after-the-event evaluation of things that need to be done, we really need to take a look at the psyche of the country, have maybe some social-type studies to figure out, does the mandating of vaccines in the way the country's mental framework is right now, does that actually cause more people to not want to get vaccinated, or not? I don't know. But I think that's something we need to know.

Because, in general, the mandating of vaccines -- forget all the political stuff, and forget COVID, and go back -- that mandating for things in our country were very well-accepted before the mindset that we have right now. The idea of mandating vaccines for children in school was something that was easily and widely --

Q Uh-huh.

A -- accepted. Now, there's a lot of question about that.

So I think you need to at least raise the question of whether or not mandating -- with all the positive aspects of controlling an outbreak, which it does -- whether or not that's something that you need to relook at. I -- anyway.

Q Yeah. No, I appreciate that. I think that's very important.

I'm going to touch very briefly on the VAERS system, and then I know the chairman has some questions.

A Sure.

Q Generally, VAERS is used to track adverse events --

A Right.

Q -- to vaccines? And I'm not going to ask about -- like, I think there's lots of problems with the VAERS system, that I can go report things.

A It's very misleading.

Q It's very misleading. But, generally -- and we're going to have, I'm sure,

further discussion on reforming VAERS in order to get better for --

A Right.

Q -- tracking this kind of stuff. And with a baseline of it is misleading and I agree with you, is it important to track and monitor adverse effects of vaccines?

A It is important --

Q Okay.

A -- to track and monitor adverse events, for sure.

Mr. Benzine. I know the chairman has some questions.

Dr. Wenstrup. Yeah. Thank you. I have quite a few things.

You know, I look back at the very beginning of this, and I think the trials were done tremendously well. Thirty- to 40,000 people. I mean, I applaud the Americans that volunteered themselves, you know, to get into these trials with so many unknowns. I thought that was a great thing.

In Cincinnati, I tried to get in Moderna. When I got there, I had given blood 2 weeks before, they said, no, you can't get in. And then when we hit 4 weeks, they said, you know, you're not who we're after, actually. We want people from higher-risk categories. And I said, that's fine. Makes sense to me. That makes for a better study.

You know, again, I believe you saved hundreds and hundreds of thousands of lives. But it didn't prevent. And I think that that was one thing -- we knew from the trials that the people that got vaccinated could still get COVID but they were less likely to get sick, less likely to get hospitalized.

I don't think we shared that very well as a country. I don't think our messaging was good enough. I mean, I was trying to tell people this all the time. I was out giving vaccinations, especially during emergency use, and what I saw were the people that I

thought looked like they were the high-risk people based on what we knew.

And I do hear, you know, even within this committee, you know, Members saying, no, these things are safe, they're effective. Well, that's up to interpretation. You even said, you can't ever say something is completely safe.

You know, I'm not violating any HIPAA rules, but Debbie Dingell has told us how, you know, when she got a vaccine when she was younger, she got Guillain-Barre. So she was very nervous about this one or any one she might get. That's fair. She went and talked to her doctor about it, and she ended up getting vaccinated.

And that's the same with effectiveness. It's not 100-percent effective, right, because people still get it. It's not like the polio vaccine, which has a much greater effectiveness of ever getting it with getting vaccinated.

So, when Americans do hear, you know, "Get vaccinated, no ICU, no death," that's dangerous, because people interpret -- just like people thought -- I didn't think President Trump was serious about injecting bleach. I thought he was being sarcastic. But other people interpreted it differently. You've got to be careful with how we do that.

And, you know, I did a thing with some people that were hesitant, and when I talked to them about the vaccine, explained it to them, explained what their risk might be, explained the benefits of this -- these were all hesitant people -- they said, well, we just want to be educated, not indoctrinated, okay? And then they said they were more inclined to maybe get the vaccine.

And so, you know -- and I've said the same thing to Mandy Cohen. When you make CDC recommendations, please explain why you're making this recommendation so people understand.

But you go to the mandates -- and this is the problem I have, as a physician, with medicine in America. That mandate was being heard from a politician. And that, I

think, was the wrong messenger, all the way across. And there's no doctor involved. It's, "Do this, or you're fired." And it's not like, "Go sit down with your doctor." Every other medicine, every drug that runs an ad, they've got to say, "Talk to your doctor, and these are the side effects." We weren't doing that.

Americans don't do well -- to what you were saying, Doctor, the psychology of America -- they don't do well with, "Because I told you so." They want to be educated. They want to know. These are the types of things that I think we can do well.

And I think, you know, it's always stoic with patients. Just say what you don't know. Be honest with patients, you know? I know I remember hearing, "Oh, this may go away in the summer." Well, it didn't. Well, some people thought that because other coronaviruses do. This one didn't.

So that's just my take on that point with vaccines. And I'd love to offline sometime talk to you more --

Dr. Fauci. Sure.

Dr. Wenstrup. -- about it --

Dr. Fauci. I'd be happy to.

Dr. Wenstrup. -- to get a better policy.

But I do have another thing I want to bring up. You pointed out that vaccines usually take about 7 years. And I'm just looking at this -- I was looking back at stuff coming out of China. Yusen Zhou had a patent for a SARS-CoV-2 vaccine in March of 2020. March 19th is the date I have. Zhengli Shi announced the sequence January 20th of 2020.

So we're saying from January 20th to March, 2 months later, he had a vaccine. That struck me as odd.

Dr. Fauci. Hmm.

Dr. Wenstrup. Does that strike you as odd?

Dr. Fauci. Well, I don't know if he had a vaccine. What I'm hearing --

Dr. Wenstrup. He was seeking a patent on the vaccine.

Dr. Fauci. No, he was seeking a patent -- and, again, I --

Dr. Wenstrup. I could be wrong.

Dr. Fauci. You might be, and I might be. But let me --

Dr. Wenstrup. Okay.

Dr. Fauci. But let me tell you, when I heard that, I was trying to figure out what that meant. And you could have a patent for an idea without even having a vaccine in your hand that you've tested.

For example, if there were cases in China at the end of December, which we knew there were, and they isolated the virus -- they may not have sequenced it yet, but they isolated the virus, and they did some simple tests. Like, they took the virus, they inactivated it, they put it in a mouse, and they found out that if you infect the mouse --

Dr. Wenstrup. Yes.

Dr. Fauci. And then they get a pattern, which is really --

Dr. Wenstrup. I understand --

Dr. Fauci. -- a conceptual pattern.

Dr. Wenstrup. I understand the process.

Dr. Fauci. So I think you can get a patent in March --

Dr. Wenstrup. Okay.

Dr. Fauci. -- for something that you had in December and January.

Dr. Wenstrup. Well, I think that's something we should look into, but it --

Dr. Fauci. Yeah.

Dr. Wenstrup. -- might not be this subcommittee. It might be downstairs.

Dr. Fauci. No, actually, it would be a good idea to do that. Because when I heard that and people were saying, understandably, how could you get a pattern so quickly --

Dr. Wenstrup. Yeah.

Dr. Fauci. -- it depends on what kind of patent you need.

Dr. Wenstrup. Okay. That may be something we have to look --

Dr. Fauci. Yeah. It's a good idea.

Dr. Wenstrup. -- into through the Intelligence Committee --

Dr. Fauci. Well --

Dr. Wenstrup. -- because I don't think he's going to answer our calls.

Dr. Fauci. Yeah, no, I don't think so.

Dr. Wenstrup. Thank you.

Dr. Fauci. You're welcome. Thank you.

BY MR. BENZINE:

Q I want to, in the time remaining, try to get through our last few topics. And so, if I cut you off or ask for a brief answer, I apologize.

A I will shoot the jump shot as soon as you give me the ball.

Q Awesome.

A Okay. Right.

Q I want to talk about natural immunity for a minute. In general, is natural immunity a real thing?

A Well, if you mean, "natural immunity," the immunity that you get after you get infected --

Q Yes, sir.

A Let's establish that's what we mean.

Q Yes, sir.

A Because natural immunity could also be innate immunity --

Q Oh, no, no.

A -- that has nothing to do --

Q The infection-acquired immunity.

A Natural immunity post-infection, got it. Okay.

Q Yes.

A It's a real thing.

Q All right.

And my understanding of the way out of a pandemic is through what -- it's now been kind of villainized -- but herd immunity, either via infection-acquired or vaccine-acquired immunity. Is that generally right?

A It is generally right depending on the pathogen. And this is critical, Mitch. It's critical. So -- and I've written about this, okay?

Q Uh-huh.

A If you have a vaccine or an infection in which you're dealing with a pathogen that does not change -- and I'm really not dribbling. I think --

Q No, no.

A -- it is important for the committee to hear this.

For example, I got infected with measles when I was a child because I'm old enough not to have been vaccinated for measles, okay? The post-infection natural immunity from measles -- you're dealing with measles. The same measles that infected me is exactly the same measles that's infecting children in the developing world. The virus has not changed. Point number one.

Point number two, that the immunity that you get from either infection or

vaccination is measured minimally in decades and generally for a lifetime. So, when you have an infection like measles or, in some respects, polio and you get infected, natural immunity is as good as it gets, because you have as good protection as you can get from anything.

Q Uh-huh.

A When you have a pathogen where the infection itself gives you immunity that does not last more than months to a year, and you have a pathogen that starts off as the initial strain and then becomes Alpha, Beta, Gamma, Delta, Omicron, and then subgroups of Omicron, the whole concept of natural immunity is the same problem we have with vaccination. It doesn't last forever.

So that, I think, is the question --

Q Yes.

A -- you're going to get to --

Q Yeah.

A -- is that, when people have been infected, why would you want to vaccinate them? Because a vaccinated infected person is better off than just an infected person.

Q And I agree. And I think studies have come out that hybrid is, like, kind of, the best. But, of course --

A The best.

Q -- you don't want to go out and, like, go out and get sick.

A No, you don't want to get infected just for the sake of getting protected. That's sort of a little backwards.

Q What you just said, kind of -- a little bit of it struck me. So we've seen -- and you've mentioned it today -- kind of, the vaccine-induced immunity waning too, so that's why boosters have come out.

A Right.

Q So that phenomenon, the mutating virus harms vaccine-acquired immunity in the same way that it harms --

A Exactly.

Q -- infection-acquired immunity.

A Exactly.

Q Okay.

I'm not going to introduce it, and I'm going to go through it quickly because I think you've talked about it before. You're generally familiar with the Great Barrington Declaration?

A I am.

Q Dr. Collins sent you an email calling the authors "fringe epidemiologists" and, in essence, requesting, I think he used, "devastating takedown" of the Great Barrington Declaration.

A Yes.

Q To your knowledge, did NIAID publish anything or act on that instruction?

A Act on the instruction to take it down?

Q Uh-huh.

A No. No.

Q Are you aware of the Federal Government publishing any papers that was an intentional takedown of the Great Barrington Declaration?

A You know, they may have, but I don't think so. I mean, I'd be happy to talk to you about the Barrington Declaration if you'd like.

Q If I had some more time, I would, but --

A No, I could even do it with a quick jump shot.

Q No, well, we'll move on. I'm more worried --

A Okay. All right.

Q -- about, kind of, the debate process in this.

A Okay.

Mr. Benzine. I know -- sir, do you want to ask treatment questions, or do you want --

Dr. Wenstrup. Yeah, if we can. Thank you.

I mean, I think we recognize that the golden standard of things is to have a double-blind study to support any treatment or before any approval of treatments.

You know, look, there were no golden standards of treatment when we really had no tests and we had no definitive treatment, we had no vaccines. I mean, I think golden standards are ideal, but when nonexistent, it isn't always real.

And, you know, in war, you don't always have everything you want. You know, I spent a year in Iraq. A lot of times, you don't have everything you want. The equipment may break. You may be out of certain medicines. You try something else. Whatever you do. And I think February 2020 felt like we were at war, that's for sure, at least on the medical front.

So I'm curious, before we had approved COVID tests, what tests did you order to try and diagnose a COVID patient? With COVID, that is.

Dr. Fauci. Before there were any tests?

Dr. Wenstrup. Yeah.

Dr. Fauci. I think the clinical situation would be pretty easily identifiable.

Dr. Wenstrup. Yeah.

Dr. Fauci. And I'm sure you've taken care of and I've taken care of COVID patients. If you have somebody that comes in that doesn't have influenza and doesn't

have everything else and you're in the middle of a COVID outbreak, it's pretty easy to make a diagnosis.

Dr. Wenstrup. Well, yeah, just by the symptoms.

Dr. Fauci. Yeah.

Dr. Wenstrup. There were other things, too, that I thought were interesting.

Dr. Fauci. Yeah.

Dr. Wenstrup. An increase in IL-6. Of course, all the inflammatory markers --

Dr. Fauci. Loss of taste and smell.

Dr. Wenstrup. All those things, yeah.

Dr. Fauci. Okay.

Dr. Wenstrup. So that's where we were at that time. And so, you know, there weren't necessarily double-blind studies, but these were the things we were picking up and employing into our thought process.

So, I mean, when you were bedside-treating COVID patients, especially, you know, ones that were really failing, you know, what did you prescribe?

Dr. Fauci. What did we prescribe?

Dr. Wenstrup. Yeah.

Dr. Fauci. We prescribed just supportive care.

Dr. Wenstrup. Like what?

Dr. Fauci. Supportive care.

Dr. Wenstrup. What?

Dr. Fauci. Maintaining fluids, maintaining blood pressure, maintaining oxygen flow. That's what we did.

Dr. Wenstrup. Yeah. [Inaudible.]

Dr. Fauci. Yeah.

Dr. Wenstrup. And it turned out that wasn't necessarily the best for everybody.

Dr. Fauci. Right.

Dr. Wenstrup. And did your treatments vary depending upon, I guess, the level of symptoms?

Dr. Fauci. Yeah. Yeah. I mean, obviously, you'd be very aggressive if you had somebody with a pulse ox that's in the 70s.

Dr. Wenstrup. I guess what I'm saying is, I'm trying to feel for those that were in that situation --

Dr. Fauci. Yeah. No, I understand what you're saying.

Dr. Wenstrup. -- caring for patients, and, like, holy cow --

Dr. Fauci. Right.

Dr. Wenstrup. -- you know, what else can we do?

And, you know, I think as we move forward, maybe there's other things we can do that maybe could be better next time, especially with a similar type of thing.

Like, you mentioned earlier, we talked about the furin cleavage site and how furin cleaves the site and subsequently makes SARS-CoV-2 more infectious to humans. I think we agree on that, right? And this was the first SARS virus published or known that had a furin cleavage site.

Dr. Fauci. Yeah.

Dr. Wenstrup. So I just wonder, have we scientifically established what patients typically have higher furin levels? Because it seems to me, the more furin you have, the more infectious this can become.

You know, was it diabetics? Is it obesity? Age? COPD? CHF? I mean, have we scientifically looked into this?

Dr. Fauci. I don't know if they've looked in furin levels, but I know there's a lot of

system biology looking at what's going on -- not only with COVID, but with long COVID, as to what's going on.

You mentioned a couple of them. Like, what does the D-dimer do? What does IL-6 do? What does some of the other inflammatory markers do? Yeah. That really does need -- it's being done, but it's still a mystery.

Dr. Wenstrup. Yeah. From the beginning with some of our colleagues, cardiologists were really interested in D-dimers --

Dr. Fauci. Yeah.

Dr. Wenstrup. -- and what's going on there.

So, I mean, what occurs to me -- and I'm just seeking an opinion on this. I know there is some research. Maybe we can accelerate treatment sometime, like Operation Warp Speed.

Dr. Fauci. Right.

Dr. Wenstrup. It was accelerated. We accelerated treatments because people still got COVID and they were going to need treatment.

So what if we were testing furin inhibitors or something along that line?

Dr. Fauci. Yeah.

Dr. Wenstrup. Does that seem a reasonable thing to pursue?

Dr. Fauci. Well, I'm not an expert in what other implications furin has in the system, because you've got to be careful --

Dr. Wenstrup. Yeah.

Dr. Fauci. -- that if furin is involved in an enzymatic involvement of a lot of good body functions, you don't want to get too much or too little furin, so --

Dr. Wenstrup. You don't want to rob Peter to pay Paul, right?

Dr. Fauci. Exactly. Exactly.

Dr. Wenstrup. And there are studies I want to dig into a little bit more because I'm curious.

Dr. Fauci. Yeah.

Dr. Wenstrup. Just trying to think of, you know, what kind of process we can have to enable -- like you were just saying, maybe some things besides just the crisis can we look into, and maybe do the public-private partnerships. You know, you mentioned monoclonal antibodies, antivirals. You know, zinc was being recommended, vitamin D. I got on it.

Dr. Fauci. There's a lot of things that you're alluding to. But one of them I think you'd be interested in, I'm sure, is that one of the really concerning things was that, when you didn't identify after -- remember, when you were taking patients -- when we were, patients would go 6 or 7 days deteriorating slowly, slowly, slowly, and then they would crash and then they would go to the ICU.

Raul, I know you know that. You're an emergency medicine person.

That would happen, and then there would be no identifiable virus. And you would say, why are they having such problems in their lungs and in their kidney and in their brain?

We now know that -- there is a study that just came out that, if you look at autopsies, there's evidence of virus in multiple organ systems, which means it is not just confined to the upper airway.

Dr. Wenstrup. Uh-huh.

Dr. Fauci. Even when you look in the lung and you don't see virus, there's likely remnants of virus there that are triggering an immunologic and inflammatory response that's responsible for the pulmonary failure, which we're just finding out now, like, years after the beginning of the outbreak.

Dr. Wenstrup. Just a couple other thoughts in the line of treatments.

You know, I know, early on, we were making the call, "If you had COVID and you recovered, donate your plasma." And patients in Cincinnati, I know, were getting convalescent plasma and doing pretty well. I think we could've maybe continued to hype that a little bit, when other things weren't working especially.

And, you know, the natural immunity is interesting to me, because I got Pfizer, both doses, in early -- what was it -- January or February. August, I got COVID. And the only reason I knew? I was cooking and I couldn't smell garlic salt. Okay? And that was the only way that I knew.

Dr. Fauci. That's a tragedy, if you can't smell garlic.

Dr. Wenstrup. I know. I'm Italian, too. Anyway.

So I said to my wife, I said, I had COVID. Remember last week I had a chill, right?

So then I was going to Germany, and they said, well, you've got to get a booster before we go. I said, can we check my antibodies and T cells first? They said, well, we can do antibodies here. So I got my results, and it said a strong number was 40, and my number was 821. So I questioned whether I should be getting a booster.

And what I'm saying is, we need to get back to personalizing medicine so you have a conversation with your doctor. This is a time where who knows who was saying I had to have a booster to do this.

So -- and I think those are the things that are twisting people's minds in America. They want that personal medicine. I think we've got to keep that in mind going forward.

And then just one other thing with the vaccines. I've been doing some reading on mucosal vaccines, and I think, for this, this may be the next step. Would you agree?

Dr. Fauci. Absolutely. I mean, to get the virus blocked at its point of entry, now you're really talking about preventing infection.

Dr. Wenstrup. Yeah.

Well, listen, I thank you. My points I'm trying to make are: a more organized message, a better message, more clarity, we can do better in those regards and pursue every one of those avenues.

Dr. Fauci. Right. I agree.

Dr. Wenstrup. Thank you.

Dr. Fauci. Thank you.

BY MR. BENZINE:

Q We have about 5 minutes left in our hour, I think, and I want to ask one, kind of, very high-level question on royalties before concluding.

I know you have said that you've donated your royalties, and I'm not going to ask about individual royalties.

A Right.

Q But current NIH policy is that royalties are just part of your income and, therefore, it doesn't need to be disclosed?

A Yeah.

Q I think we've heard some concerns that, because of the things NIH employees are working on and then possibly advising on, that not having public disclosure of royalties could hide, for lack of a better word, a conflict of interest.

A Yeah.

Q Do you think that that needs to be changed?

A You know, I don't know if you want to change it, but it just goes -- Mitch, I've said every time and I'll say it again for the record: I'm always in favor of a great deal of transparency, always.

Q Thank you.

A Yeah.

Q My last, kind of, conclusory statement is, like I said, I worked for Mr. Scalise when he was ranking member of this committee. You testified a few times back then. And I actually remember, the first hearing in the Oversight Committee on the pandemic was, like, late February or something. You testified on that too.

And you actually had to -- you and Dr. Redfield and, I think it might've been Admiral Giroir at the time, had to leave halfway through because you got called to the White House, and then you came back the next day. And that's just kind of engrained in my memory.

A Right.

Q But at one of these hearings, you were asked by Mr. Jordan about, kind of, the threshold that would need to be met in order for mitigation measures to be lessened. And I have your answer, but the answer doesn't really matter.

At the time, you were being filmed by PBS in part of the documentary that --

A Yes.

Q -- they released on "American Masters." And I want to read what you said after you got back in your car after that hearing.

"One of the things I've learned from hearings like this, even though in some respects it's a show, the fact is, I found, even when people act like jerks, sometimes there is a kernel of truth in what they say. And it may be advantageous to say, okay, should we be a little bit more flexible in telling people, okay, fine, here's the recommendations that we say, where you can go and what you can do after you've been vaccinated. However, if you want to take the risk, take the risk."

To me, that seems like the path forward here, that in future outbreaks it would be better to inform the American public of what they can do, what their relative risk is, and

then let the public make the decision based on that risk profile.

Do you agree, disagree, or have any comments on that?

A No, I mean, I -- you know, again, just to get back to that, Congressman Jordan was really --

Q Yes.

A -- pestering me about that, you know? And, you know, I felt bad, I said -- in fact, I said, I think you're ranting.

And I felt badly when I got in the car, because I said that, you know, even though he was acting in a very aggressive way to me -- he wasn't giving me the opportunity to say a word. When I got in the car, I said, you know, despite the fact that he was being very, very aggressive --

Q Uh-huh.

A -- that there was a kernel of truth in what he was saying, and I think that we should keep an open mind to, you know, listening to when people have an objection to what you're doing.

I think it just confirms what I told you 4 minutes ago, that I am a transparent type of person. I want to at least honor everybody's opinion enough to at least consider it.

Q No, I appreciate that.

Mr. Benzine. And, with that, I want to thank you again for being here voluntarily for both days, 14 hours, potentially, total.

And we can go off the record.

Dr. Fauci. Thank you.

[Recess.]

[5:48 p.m.]

[redacted] We can go back on the record.

Before we begin this final round of questions, I just want to have Congressman Dr. Ruiz, Ranking Member Ruiz, who just joined us, introduce himself for the record and give any comments he'd like to.

Dr. Ruiz. Congressman Dr. Raul Ruiz, ranking member for the Select Subcommittee on the COVID Pandemic. Nice to meet everybody.

Dr. Fauci. Thank you.

Mr. Schertler. Likewise.

Dr. Fauci. Good to see you.

Dr. Ruiz. It's always wonderful to see you and even more pleasurable to hear you speak in the interplay between the art and science of medicine and of public health. It is poetry to my ears. And I appreciate you, your knowledge, your wisdom, and the enormous amount of contributions that you have given to our Nation.

As I've said before in previous hearings in the Energy and Commerce Committee, you are the doctor's doctor. And many medical students today still aspire to make such an impact not only for our country but for the world as you have done in your career. And we recognize it, we see it, and we wholeheartedly appreciate it.

Dr. Fauci. Thank you.

Dr. Ruiz. I also want to say that I am truly sorry for the incredible negative experience that you have undergone through the intimidation, the threats, the political violence on you and your family.

I think it's important that we share the humanity and the lack thereof of these type of inquiries and agenda-pursuing crusades that really cause distress, not only for the individual that's being targeted but for their entire family.

And so I see it, and I empathize. And I want to make sure that you're okay, your family is okay, and that you continue to be the wonderful Dr. Fauci that you are for humanity. And I appreciate that.

Dr. Fauci. Thank you.

Dr. Ruiz. I have some questions that are in the line of health inequities and some questions on the current uptick of COVID-19 cases that we're currently seeing.

As you know, the Democrats on our committee have been laser focused on putting people over politics and finding real solutions with thoughtful questions that can actually lead to preventing and preparing for the next pandemic, which is inevitably going to happen.

And so we want to be able to really align ourselves with the true intent of our purpose, which is to save lives, and through a lessons learned, and not pursue an extreme partisan crusade vilifying individuals like yourself and other public health officials for partisan political gain.

So looking back on the most severe period of the COVID-19 pandemic, it is abundantly clear that the virus took a heavier toll on different communities across our population. For example, people of color, people with less income, people with disabilities, LGBTQ+ people, and other marginalized populations experienced greater morbidity and mortality from COVID-19.

So I'd like to discuss these health inequities in more detail.

What do we know about the pandemic's disproportionate impact on communities of color in the United States? And how and why was this the case?

Dr. Fauci. There were two reasons for that. One was the initial risk of getting infected. The other -- well, actually, probably three reasons. The initial risk of getting infected. The inequities of access to healthcare. And the underlying conditions that

people of poor economic status and people who are in disenfranchised groups, such as some of the minorities.

If you take point number one, that if you look at the -- you know, it's dangerous to generalize, but this, I think, is a generalization that helps you to understand the situation, that people of color and somewhat more less economically privileged people generally have jobs that necessitate for their economic survival that they are out in the community. They have essential jobs. They can't sit behind a computer and continue to do their job virtually. So they are the ones that are out there getting infected more.

Then, when they do get infected, when you have people of color and other individuals who are less fortunate to have access to healthcare, that when they do get sick they don't have the immediate access of getting the kind of care that you would expect them to get, and often they don't get the care until they have an advanced disease.

Then the third one is that there are underlying conditions that African Americans and some Latinos and certainly some Native Americans and others have a higher incidence of the underlying conditions, that when you do get infected it makes you statistically more likely that you're going to have a poor outcome with hospitalizations and deaths.

To name a few, you have obesity, you have hypertension, you have chronic renal disease, you have chronic lung disease, you have cardiovascular disease, all of which disproportionately, due to the social determinants of health, are in individuals not because of their race or their ethnic origin; it has to do with the social determinants of health that have not allowed them to have proper diet, to have proper healthcare when they were younger, a whole variety of things.

So three compelling and conflating reasons why the results that you talk about are

true.

Dr. Ruiz. And one of those that comes to mind, given that my first home was in a trailer park, is overcrowded housing with multifamilies --

Dr. Fauci. Right.

Dr. Ruiz. -- living due to issues of poverty, et cetera. And so that increased the risk of transmissions within households of people of lower income.

And so how about, do you have other examples of this disparity in people with less income despite race?

Dr. Fauci. Oh, yeah. I mean, of an individual with less incomes, I think you mentioned one of them, housing. And you're not going to have somebody that has their own apartment with two bedrooms; you're going to have somebody that's living with their grandparents, with their parents, and with their children.

And that is one of the reasons why when you have a multigenerational home that that's almost like a perfect storm for getting a lot of different people infected.

Also, they may not be able to afford tests. They may not be able to afford any of the things that are not available to be free. So whenever you get away from government supplying things free, you're going to wind up who's going to suffer the most from them and those who are less economically privileged.

Dr. Ruiz. Another example that comes to mind is people who cannot afford internet.

Dr. Fauci. Right.

Dr. Ruiz. And when you have to register online to get your vaccine dose or for an appointment, they're at a disadvantage to get that, those services.

So how about people with disabilities, can you discuss some of their barriers and risks?

Dr. Fauci. Yeah. I mean, disability is just access. I mean, how do you have somebody to get you to a drugstore, to get you to a clinic. Again, it's all part of the constraints on equal access, and people with disabilities, in many respects, don't have equal access.

Dr. Ruiz. And LGBTQ+ people?

Dr. Fauci. Well, that's stigmatization, and stigmatization is the enemy of public health. So the LGBT community suffers from that.

Dr. Ruiz. By not being -- can you elaborate more on the stigmatization?

Dr. Fauci. Yeah. I mean, there are some physicians, unfortunately, healthcare providers who don't want to treat individuals who are LGBT. So that makes them often not even wanting to come out and open as to who they are because of the stigma associated with it.

Dr. Ruiz. Okay. Are there other marginalized populations who bore the brunt of the pandemic that we haven't addressed?

Dr. Fauci. I think we've covered most of them, yeah.

Dr. Ruiz. Okay. And how have COVID-19's disproportionate impacts on marginalized communities compared to those of other outbreaks and pandemics? So how did this elucidate the disparities in death and morbidity compared to other pandemics? Were they similar in previous pandemics, or was this more pronounced?

Dr. Fauci. You know, I think that this was more pronounced because of the magnitude of it and the issues that are associated with access to healthcare was rather almost a tsunami of that, as opposed to a much less impactful outbreak.

There always was an underlying lack of access. I'll give you an example that I know you're familiar with.

When you were thinking about HIV, where you have, you know, 13 percent of the

population is African American and 45 percent of all the new infections are among African Americans, they don't have access for a number of reasons.

One, LGBTQ status is not as much accepted in the African American community as it is in the general population. There's an incredible amount of discrimination against people that makes them not seek out healthcare. They live in usually an economically less privileged group.

So I think when you look at AIDS disproportionately affects ethnic groups more, it has a lot more to do than differences in sexual behavior for sure.

Dr. Ruiz. And so what kinds -- I know this is a big, big question -- but what kinds of systemic reforms to the U.S. healthcare system are necessary to reduce the threat of future outbreaks and pandemics to historically marginalized communities?

Dr. Fauci. Well, I think it's building up of the health -- the local healthcare system, particularly in those areas that are populated predominantly by people of color.

I mean, we were discussing at yesterday and maybe even part of today the importance of the attenuation of the healthcare infrastructure locally.

And many of the neighborhoods that people of color live in, they don't have good healthcare infrastructure to begin with, and when you have an attenuation of healthcare infrastructure it affects that population even more.

Dr. Ruiz. Can you be a little more specific in terms of healthcare infrastructure just for the record?

Dr. Fauci. I'm talking about health clinics.

Dr. Ruiz. Clinics.

Dr. Fauci. I'm talking about clinics, clinics, pharmacies that are in neighborhoods.

Dr. Ruiz. Okay.

Dr. Fauci. Yeah.

Dr. Ruiz. Infrastructure can also be interpreted as human capital --

Dr. Fauci. Yes.

Dr. Ruiz. -- the providers and nurses and --

Dr. Fauci. When I said infrastructure I mean not only clinics and pharmacies but the people who are out there who go into the community to help.

Dr. Ruiz. So when people that go out there that go into the community to help, you're referring to community health workers?

Dr. Fauci. Yes.

Dr. Ruiz. Okay. And so how can we incorporate, in your thoughts, how can we incorporate community health workers into our healthcare system to prevent the disparities not just in a future pandemic but even now?

Dr. Fauci. To support them. To support them. To give them status that would attract people to that particular avocation as opposed to making it not an attractive occupation.

Dr. Ruiz. Okay. And now to bring a big question even bigger, what about system reforms outside of our healthcare system, such as reforms to our economic systems, transportation systems, and more?

Dr. Fauci. Yeah.

[Laughter.]

Dr. Fauci. Yeah, I mean, transportation is one important one. If you look at the ability of somebody to get to a doctor's office or to get to a clinic, to get to a testing site, it is much less likely that a population that we're referring to now, people of color and others, that they don't have the capability or the resources to get to where they need to get to get the proper healthcare.

Dr. Ruiz. What about the concept of taking the care to the people?

Dr. Fauci. Yeah. That's what I -- one of my favorite topics is to go into the community and to support financially and resource-wise actually getting clinics and physicians at the community level.

And you can incentivize at multiple levels. You know that all, but I'll say it for the record. You could incentivize from the level of medical school and post-medical school training to make it much more attractive for people to go into community work as opposed to, you know, having an office on K Street.

Dr. Ruiz. Yeah.

So now I'll talk about the uptick in COVID-19 cases, the current one. As we have observed in the past year, the U.S. is currently experiencing a seasonal uptick in COVID-19 cases.

Could you explain the reasoning for this trend of higher case numbers during the late fall and winter season?

Dr. Fauci. Any respiratory infection is always much more likely to occur in a situation where you have cold weather that brings people in together in a room where the ventilation is not particularly good.

I think, if you superimposed upon that, is that COVID, even without seasonal blips, is present all the time. It's -- you know, we would've assumed incorrectly that it was a seasonal virus from the beginning, expecting that maybe it would go away. That turned out -- the first glimpse of warm weather in April and May proved to be absolutely not the case.

But when you start off at a higher baseline and then you go into a winter season, it does this [indicating]. And if you look at the end of the summer, the number of cases per day -- the number of deaths. I don't think we can count cases, because the case counts are all off because tests are no longer reported. So you can measure it from

wastewater for cases and hospitalizations and death.

Then we had a low level of less than a hundred deaths per day, it was like 70, 50, something like that. It's now over 200 as of yesterday. So here we are in January and it's gone way up.

Thankfully, it hasn't gone up to what it was at the peak of the outbreak, when it was 4,000 to 5,000 per day.

Dr. Ruiz. So I understand the need to coalesce in warmer venues to be out of the cold, and therefore the proximity of individuals increases the potential for transmission.

Is there anything innate in the virus itself that thrives more in cold and wet weather?

Dr. Fauci. Yeah. Yeah. I mean, viruses generally, in the survival of the aerosol and what have you, do much, much better in cold, dry weather than they do in warm, moist weather. That's just a function of most respiratory viruses.

Dr. Ruiz. Okay. And is this a trend we should continue to expect annually?

Dr. Fauci. Yes, I think that's the case. Again, but just with the caveat, Raul, that, yes, you could expect it, but don't expect that in the summer COVID is going to go away.

Dr. Ruiz. Yes, correct.

Dr. Fauci. Yeah, right.

Dr. Ruiz. And what steps should the Federal Government be taking annually to prepare for the trend of seasonal upticks?

Dr. Fauci. Yeah. I think that one is, you know, continue the supply of testing, making sure that we don't have a diminution in accessibility of testing.

But also, as we mentioned yesterday and today, I think we've got to really take seriously ventilation, so that when people are indoors in the cold weather there's a

degree of ventilation, you know. That's both natural ventilation of getting good air flow as opposed to confined, but also things like HEPA filters in places that are classrooms or assembly halls or what have you.

Dr. Ruiz. And what is your assessment of the risk of this current uptick poses to Americans?

Dr. Fauci. You know, I don't think that you're going to see the kind of Armageddon-type approach that we saw back when we were having 5,000 deaths per day, but I think you're going to see deaths and hospitalizations that should be troublesome to us.

One of the things about COVID or any disease that you have for a long time past the -- we're now in our fifth year of COVID. I mean, we were talking over the last 2 days about the unprecedented nature of certain things, the speed of vaccines, et cetera.

It is unprecedented to have a 5-year season, is what we've had. You know, we have influenza seasons, you know, it starts at the end of November, peaks in January, it goes away in March, and then you're good for the rest. That's not the case.

So what I'm concerned at is that there's a complacency around that we're done with COVID. But when you look at the fact that you have now almost 200 or more deaths per day, and you do the math on that and you compare it, that the mortality is much greater in COVID than it is with influenza.

And influenza itself, as you know as a physician, is a bane in the existence of the elderly, the infirm, et cetera. You multiply that multiple-fold, and we still have to worry that the vulnerables are going to get into trouble.

The other thing is that you always got to factor in long COVID, because people say, well, you know, I'm 30 years old, I'm fine, I can get infected, no problem, I'll get a sore throat, I'll blow my nose, and I'll be okay. You could still wind up getting long COVID.

So the idea that we have this much COVID going on right now is troublesome to me.

Dr. Ruiz. So in addition to that, now that the public health emergency has concluded, what adjustments are necessary for the Federal Government to respond to these seasonal upticks?

Dr. Fauci. Yeah. You know, that's not my lane as a physician. But I think the things that disappear when you have an emergency go away, there are still people who were depending on the things that you got from an emergency who still are dependent on them, drugs, tests, or what have you.

Dr. Ruiz. Right. So one of the more apt metaphors I've heard when it comes to COVID-19 mitigation measures are the comparison between a light switch that just turns on and off and a light switch that brightens and dims, which is to say that there will be times Americans should consider taking greater precautions, such as masking, to reduce the threat of COVID-19.

When we observe upticks in cases due to changing seasons or new variants, what steps should Americans take to protect themselves and their loved ones?

Dr. Fauci. I think we're starting to see it right now, as we were having no masks that are required in medical centers until now, if you look across the country, it's sort of like a domino effect of the facilities. They're requiring, if you're going to come into a healthcare facility with people at risk, you're going to wear a mask.

And I think we need to realize that we're not talking about, you know, draconian measures, but we're talking about just what you said, as you get an uptick in cases, you've got to adjust accordingly.

Dr. Ruiz. Thank you.

Dr. Fauci. Yeah.

[redacted] I believe Congresswoman Dingell had a discrete item.

Mrs. Dingell. I have one question.

One of our colleagues tweeted that you've had the best year of your life this last year, after you left here. And I looked at them and said, "He's been living in hell."

Would you care to comment?

Ms. Castor. It was COVID was the best year of your life.

Mrs. Dingell. Was it COVID? I didn't even see the actual tweet. But they said you've been living the best year.

I think your life has been a living hell. Do you care to comment on that tweet?

Dr. Fauci. Are they talking about this past year, or are they talking about the year -- the COVID year? Why were they saying it was the best year of my life, because I somehow --

Ms. Castor. You got a lot of media attention.

Dr. Fauci. So that's what they're referring to.

Ms. Castor. I'm not sure.

Mrs. Dingell. Is that media attention --

[redacted] There was a tweet suggesting that your salary increased during the year that COVID-19 took hold, 2020, and that it was the highest it was in 2020, and that that was therefore a predicate for it being the best year of your life.

Dr. Fauci, do you believe that 2020 was the best year of your life?

Mr. Schertler. Can you tell us who tweeted?

[redacted] Congressman Michael Cloud.

Mrs. Dingell. And my actual reaction was, "His life has been a living hell."

Dr. Fauci. Well, it was. I mean, 2020 was one of the worst years of my life. I think it was comparable to the first few years of HIV.

Mrs. Dingell. Which I remember.

Dr. Fauci. Yeah.

Mrs. Dingell. Why don't you elaborate on that just so we can have it on the record, so everybody knows what -- yeah.

Dr. Fauci. No, I mean, for months and months I was sleeping 4 hours a day. My wife was on me all the time about making sure you drink water and you go to sleep and you eat.

That was really tough, because of the burden of seeing this emerging outbreak that you were responsible for developing a vaccine and you had to do it and you had to do it right.

And then I was also -- my clinical responsibilities was also -- I didn't see as many patients as I used to see when I was more on the wards than as running an institute. But also, we had patients that were, you know, obviously people who were -- and all healthcare providers were similarly traumatized by that.

But then what really put the cap on it is with the point that you brought up, is that in the middle of all this, all of a sudden I became the villain number one of the extremists in the population.

So to say that it was the best year of my life is completely crazy. And I don't know what they're talking about my salary. My salary is not determined by me.

And that was another thing that was ridiculous, the attacks that I had on me that, you know, I made money out of the -- what are they talking about? Does anybody know anything about the government? How do you make money out of an outbreak?

So, yeah, it was one of the worst years of my life.

Mrs. Dingell. And I do know you. I first met you -- I don't want to say how long ago because it was a long time ago -- when you were working on HIV/AIDS, and I was

working at Children's Inn at NIH, and the young patients. I remember the tears in your eyes as you were worried about children dying.

And there was -- you gave people hope when there was no hope. When I first met you people were dying. It was a death. And I remember your reaction. So I just -- and I remember how bad that was.

So I wanted you to comment on that. Thank you.

Dr. Fauci. A Congressman tweeted that?

Ms. Castor. Yeah.

Dr. Fauci. Jesus.

BY [redacted]

Q Dr. Fauci, if you will bear with me, I just want to quickly revisit the topic of vaccine requirements and the different kinds of immunity just to make sure the record is comprehensive there.

On numerous different occasions the select subcommittee has examined the issue of COVID-19 vaccine requirements.

Briefly, could you just explain for us the premise of COVID-19 vaccine requirements and how they were implemented across the country?

A How they were implemented?

Q Yes.

A I want to make sure I understand your question.

Q Yes.

A Could you just say it again?

Q Yes. So with respect to vaccine requirements, as I understand it, oftentimes people were given an opportunity to either get the vaccine or take other mitigation measures to ensure that they could reenter common spaces --

A Right.

Q -- safely and reduce the risk of transmitting the virus. Is that consistent with your understanding?

A Yes, that was.

Q And across the board, as we look at the different vaccine requirements that were put into place in 2021, could you just briefly describe for us how successful those were in encouraging uptake of the COVID-19 vaccine?

A They were successful. I mean, a lot of people got vaccinated that perhaps would not have gotten vaccinated.

Q We've heard suggestions in the select subcommittee that vaccine requirements were not evidence-based and that they were in defiance of the patient-physician relationship.

Dr. Fauci, you are a trained physician, and you, yourself, have practiced medicine. As a trained physician, what do you make of the criticism that vaccine requirements interfered with the patient-physician relationship?

A Well, first, I believe strongly that a patient-physician relationship is very, very important. But I think that it's not incompatible with a patient-physician relationship under certain circumstances to require vaccinations.

I mean, I think, if you look at the success of protecting our children in school where there's a requirement for vaccination in school, I don't think that every single child who gets vaccinated gets a permission, as it were, from somebody to get vaccinated. The physicians accepted that and accepted it readily, and it led to the saving of a lot of disease in children.

So I don't think they're in -- they're not -- I mean, it isn't all or none. It isn't as if you do that then you're destroying the patient-physician relationship. I don't think that

that's necessarily the case.

Q Great.

In various cases examining different vaccine requirements, major medical societies filed briefs demonstrating their support for vaccine requirements. For example, in BST Holdings v. OSHA, the American Medical Association filed an amicus brief warning that halting enforcement of Federal vaccine requirements would, quote, "severely and irreparably harm the public interest," end quote. And the AMA also filed similar briefis in Kentucky v. Biden and Georgia v. Biden.

Dr. Fauci, does the AMA's support for these policies suggest that the physician community generally supported vaccine requirements?

A I believe that it does indicates that, yes.

Q And would you characterize COVID-19 vaccine requirements as evidence-based policies?

A You know, historically when you require -- I mean, I just gave you an example of it, so that's for the record, was the school. I mean, the children are protected. You don't -- when the vaccines of a certain disease like measles go down, you have outbreaks and children suffer.

Q And just quickly on the --

Dr. Ruiz. Can I follow up on that?

[redacted] Of course, please.

Dr. Ruiz. Are there studies that demonstrate States that had vaccine requirements versus States that don't -- didn't have vaccine requirements and the difference in reducing transmission and reducing mortality from COVID?

Dr. Fauci. Yeah, mostly hospitalization and mortality, yeah. It's a little bit more tough to demonstrate transmission because you have to have everybody tested, and that

was one of the things. But clearly in hospitalizations and death.

Dr. Ruiz. So there was clear evidence --

Dr. Fauci. Yeah.

Dr. Ruiz. -- that vaccination requirements --

Dr. Fauci. Right.

Dr. Ruiz. -- was a protective measure that had population outcomes benefiting saving people's lives?

Dr. Fauci. I don't -- I can't quote the studies, but, you know, my recollection is that that's the case.

Dr. Ruiz. Okay.

BY [redacted]

Q We have also heard suggestions that vaccine requirements were implemented in a manner that did not appropriately take into account people who had acquired immunity via infection.

As I understand it, just succinctly, there are different kinds of immunity, including vaccine-conferred immunity, infection-acquired immunity, and hybrid immunity.

In the last round you discussed this topic, but for the record could you just confirm for us that hybrid immunity, immunity that is conferred both from vaccination and from prior infection, offers greater protection to COVID-19 patients than infection-acquired immunity alone?

A That is true. For the most part, that's true. I mean, as a group. You're going to find individuals where maybe somebody got a response with natural immunity and someone had acquired immunity and they were not as good an immune response.

But when you look at a large group of cohort, that hybrid immunity clearly is better than just immunity from infection, and it's also better than just vaccine.

Q And in your assessment, did COVID-19 vaccine requirements pose any threat to the health of people who had already been infected with COVID-19?

A No. No, no. No evidence at all that vaccinating someone who's been infected and recovered from infection has a negative impact on their health.

Q Okay.

BY [redacted]:

Q Dr. Fauci, I'm not going to belabor the points that I'm going to make, but you've said throughout the 2 days that we've been here that clear and consistent communication by public officials is important in addressing the pandemic, correct?

A Correct.

Q And do you think that it can be harmful for public officials to downplay the risks of the virus?

A Yes. Yes, of course.

Q I'm going to go through a couple of statements that were made, and I just want to get your take on them.

On January 22nd, 2020, President Trump said during a CNBC interview, quote, "We have it totally under control. It's one person coming in from China, and we have it under control. It's going to be just fine," end quote.

Again, this was on January 22nd, 2020.

At that time, did you agree with that statement from President Trump?

A I was concerned about it saying it was under control because of the way outbreaks behave. They start off under the radar screen, and you don't really know if you have it under control. That's something that was an unknowable at the time.

Q Similarly, on February 27th, 2020, President Trump stated, quote, "It's going to disappear. One day -- it's like a miracle -- it will disappear," end quote.

Did you agree with that statement by President Trump?

A No. And I think I -- that was one of the times when I had to publicly disagree with the President, which started the ball rolling.

Q Do you think that this statement harmed America's response to the pandemic by downplaying public concern?

A Yeah. I think that if the President had said that, you know, we really have a problem here and we've really got to address it in a reasonable way, you know, by taking precautions, a lot more people would have done things like wear a mask and take appropriate precautions.

Dr. Ruiz. And, therefore, would you say a lot more people's lives would've been saved?

Dr. Fauci. No, I don't want to quantitate that, Raul, because then that gets taken out of context in a sound bite, and I don't want to do that.

BY [redacted]

Q My colleague on the Republican side forecasted this one to you. But on April 23rd, 2020, President Trump stated, quote, "I see the disinfectant where it knocks it out in a minute, 1 minute. And is there a way we can do something like that by injection or almost a cleaning? Because, you see, it gets in the lungs and it does a tremendous number on the lungs, and so it would be interesting to check that," end quote.

Do you agree with President Trump that injecting disinfectant would've been a legitimate way to treat COVID-19?

A No.

Q And if people were to do that, the result could very likely be death, correct?

A Correct.

Q I want to compare some of these statements to statements that the President made more privately.

On March 19th, 2020, President Trump said to Robert Woodward about the risk of the virus, quote, "I wanted to always play it down," end quote.

Do you think that playing down the risks of a virus is a responsible strategy?

A I've said that publicly, that that's one of the reasons why I spoke out against that.

Q At the time, did you feel like the public officials could've been making statements that were more helpful to the response?

A Well, one of the things I would've hoped was that the President would have,

one, encouraged people to wear a mask and to do more social distancing. I think the idea of not wanting to wear a mask sent a signal out to people that it's not a good idea to wear a mask. And that's one of the ways I think it could've helped, because leadership counts.

[redacted] And with that, I think that's a great place to end. Thank you.

Ms. Castor. So bringing us back to today, in this Congress, thank you very much for, during these long 2 days, going through lessons learned with some recommendations for all of us.

But I don't think we can lose sight of COVID-19, 1.4 million American deaths to date are the estimates. And we just have to do everything we can to prevent that kind of epidemic, pandemic again.

You've said, you advised us, act now, before the fact. Don't chase an outbreak. And even Chairman Wenstrup said, he said that he'd been in a war, and in a war, sometimes you don't have what you need to protect yourself. But that means when our troops come home you surely make sure that they have what's necessary to protect themselves, to protect us for the next war.

So right now, there are some debates in Congress over legislation that could help prepare us. One is, we've been trying to work with our Republican colleagues on the reauthorization of PAHPA.

PAHPA is the Pandemic and All-Hazards Preparedness Act. It's intended to improve the Nation's public health and medical preparedness and response capabilities for emergencies, whether deliberate, accidental, or natural.

One of the critical pieces of PAHPA is the authorization of the Strategic National Stockpile. Right now, it has expired. That stockpile, as you're well aware, is intended to contain lifesaving supplies, resources, and medicines that can be deployed at the

moment a crisis hits.

Do you agree that the Strategic National Stockpile is an important part of our larger public health preparedness?

Dr. Fauci. Yes.

Ms. Castor. And during the COVID-19 pandemic, the resources and supplies within the National Stockpile were critical to responding to COVID-19?

Dr. Fauci. Correct.

Ms. Castor. Do you agree that it is important that the Strategic National Stockpile properly be reauthorized and well resourced so that we can ensure that we are prepared for future pandemics?

Dr. Fauci. Yes.

Ms. Castor. What would the impact of a weakened stockpile, Strategic National Stockpile, be on our ability to address future emergencies?

Dr. Fauci. It would hinder our initial response. If you have to play catchup with a stockpile then you're behind the game to begin with.

One of the most important reasons that the concept of the stockpile was developed years ago was that we could just hit the ground running if you wind up with an emergency. And if you deplete that and the next emergency comes and you don't replete it, then you have a problem.

Ms. Castor. Failure to reauthorize PAHPA has also meant that the public health emergency preparedness grants have also been allowed to expire. Those are the grants that support our local communities back home and States and territorial health departments in preparing for and responding to public health emergencies, be it from infectious diseases or natural disasters or other emerging threats.

Are those kind of resources for States and local communities -- well, let me first

ask, were they vital --

Dr. Fauci. Yes, yeah.

Ms. Castor. -- in the early days of the pandemic?

Dr. Fauci. Yes, they were, of course.

Ms. Castor. And why is it important to have consistent, stable resources in partnership with State and local jurisdictions to ensure that we're able to tackle a public health crisis?

Dr. Fauci. Because, as I mentioned in my previous discussions, that it is very important to have at the local public health level the capability of responding.

Ms. Castor. In real time.

Dr. Fauci. Immediately.

Ms. Castor. Immediately. That saves lives.

Dr. Fauci. Right.

Ms. Castor. Does it save money if we have those things ready to go?

Dr. Fauci. Ultimately, it does. I mean, it's just the same as what we were talking about with the Commonwealth Fund data that showed that if, you know, 3 million infections were prevented -- excuse me, 3 million deaths were prevented, 18 million hospitalizations were prevented, and with that $1.19 trillion was saved.

Ms. Castor. So this Congress has been marked, people will look back on it by shutdowns, threats, and showdowns. September 30th was the end of the last fiscal year, and here we are in early January and there's no -- appropriations bills have not been finalized.

So there are -- you're used to these debates over appropriations in the Congress. It would seem that one thing we should be able to come together and agree on in the wake of the deadliest pandemic we've ever lived through is making sure not just PAHPA is

reauthorized and we incorporate the lessons learned, but that we make sure that we are not cutting our ability to investigate health concerns.

I'm concerned that the majority has forced a lot of these cuts on the American people that are going to ultimately cost us money, cost us lives.

Dr. Fauci's former institute, NIAID, received $836 million from the first COVID-19 supplemental for COVID-19 research, but cuts that Republicans demanded in the Fiscal Responsibility Act rescinded all of those unobligated balances. In total, the FRA will have the effect of cutting $500 million from NIH's budget.

What would the effect be if this is where we end up, with a budget of $500 million of cut to NIH's budget, and specifically NIAID?

Dr. Fauci. That would really be catastrophic to NIAID. I mean, if I were the director now, as I was back, you know, during the pandemic, I would be deeply concerned about a cut at that level.

Because when we responded to COVID, while it was full blown, part of the response was to create the capability -- and I mentioned this in response to the majority's question, to Chairman Wenstrup's question about needing to make more drugs. We need better drugs against these viruses.

And one of the programs was a drug development program that I established right, you know, in the middle of the outbreak not only to give us drugs for the current outbreak but to have better drugs for future outbreaks. I don't see how that program can survive if you cut $500 million.

Ms. Castor. So thank you very much. You've provided us a long list of lessons learned, and I think it would be the most constructive way for the select committee and for the Energy and Commerce Committee, would be for all of us to come together and work in a bipartisan way on these not just commonsense but just critical investments in

the public health for the American people. So thank you for sharing your expertise.

Dr. Fauci. You're welcome.

Ms. Castor. And thank you for your years of service.

Dr. Fauci. Thank you. Appreciate it.

Dr. Ruiz. Thank you. I'd like to close also by thanking you and your family for your incredible sacrifice throughout the years and your support for the population, but also for every patient that you have taken care of, and to the advancements of truth through science that you have proposed and the advancements in public health that you have helped elucidate that has had real impacts in saving lives and improving lives of the American people.

I want to thank you for your time here. I want to thank you for enduring and being resilient during all the attacks and the intimidations and the threats that you and your family have gone through. And I want to really thank you for your expertise and giving us a lot to ponder in the lessons learned in how we move forward to protect more Americans.

Now, I want to wish you luck with the storm out there, both literally and metaphorically, and wish you safe travels back home.

Dr. Fauci. Thank you, Raul.

Dr. Ruiz. Thank you.

Dr. Fauci. Appreciate it.

[redacted] And I think with that, we can go off the record.

[Whereupon, at 6:33 p.m., the interview was concluded.]

Certificate of Deponent/Interviewee

I have read the foregoing ____ pages, which contain the correct transcript of the answers made by me to the questions therein recorded.

_____

Witness Name

_____

Date