NATIONAL CITIZENS INQUIRY

Winnipeg, MB **Day 1**

April 13, 2023

EVIDENCE

Witness 2: Dr. Jayanta Bhattacharya
Full Day 1 Timestamp: 03:43:12–05:07:15
Source URL: https://rumble.com/v2hz2rc-national-citizens-inquiry-winnipeg-day-1.html

[00:00:00]

Shawn Buckley
We have joining us now virtually Dr. Jay Bhattacharya. Jay, can you hear us?

Dr. Jayanta Bhattacharya
Yes. I can hear you. Can you hear me?

Shawn Buckley
I can. I'd like to just start by asking you to state your full name for the record, spelling your first and last name.

Dr. Jayanta Bhattacharya
My name is Jayanta Bhattacharya, J-A-Y-A-N-T-A. Bhattacharya, B-H-A-T-T-A-C-H-A-R-Y-A.

Shawn Buckley
And Dr. Bhattacharya, do you promise to tell the truth, the whole truth, and nothing but the truth, so help you God?

Dr. Jayanta Bhattacharya
I do.

Shawn Buckley
Now my understanding— And I think a lot of people are familiar with you. And I'll tell you, you sent us a rather impressive CV that we've entered as Exhibit WI-8b. But my understanding is that you are currently a professor at Stanford University Medical School.

Dr. Jayanta Bhattacharya
I am.

Shawn Buckley
You're also a physician.

Dr. Jayanta Bhattacharya
Yes, I have an MD.

Shawn Buckley
Yeah. And you're an epidemiologist?

Dr. Jayanta Bhattacharya
I publish and teach epidemiology, through for decades.

Shawn Buckley
And then you're a health economist?

Dr. Jayanta Bhattacharya
Yes, my PhD is in economics.

Shawn Buckley
And you are a public health policy expert focusing on infectious diseases and vulnerable populations.

Dr. Jayanta Bhattacharya
Yes.

Shawn Buckley
And you are one of the three authors of the Great Barrington Declaration.

Dr. Jayanta Bhattacharya
Yes.

Shawn Buckley
Now, we've invited you here today to speak about several issues. One of them is that you have participated in doing an expert report concerning a lawsuit in the province of Alberta. Can you share with us why you did that and a little bit about that?

Dr. Jayanta Bhattacharya
Yes. Well, it stems from the ideas in the Great Barrington Declaration. The primary goal that I had in participating in that lawsuit, which was a lawsuit aimed at changing the Alberta policy of lockdowns away from lockdowns toward a more focused protection policy, exactly was what we wrote in the Great Barrington Declaration.

The ideas of the Great Barrington Declaration are based on two incontrovertible scientific facts. The first is that there's a very steep age gradient in the mortality risk from COVID infection. It's older people who die at a thousand times or more higher rates of infection than young people. For children, especially healthy children, the risk of dying from COVID is vanishingly small. Whereas for older people, it's much, much higher. That's incontrovertible, I think, universally acknowledged.

The second fact—again incontrovertible, and I think universally acknowledged—is that the lockdown policies that we have followed, and Canada has followed, has caused tremendous harm especially to the lives of young people. I don't just mean economic harm. I mean health harms, psychological harms, a whole host of harms that will play themselves out over a long period of time and have already caused major health problems for the Canadian people.

So the right strategy, the Great Barrington Declaration, what it says is: let's use our resources to protect vulnerable older people from the disease while at the same time lifting lockdowns, which have caused so much harm to the lives of young people. It's the standard pandemic strategy that we followed for a century of respiratory virus pandemics before this one. And it worked.

So that was my main motivation for participating as an expert in that Alberta case, was to provide the scientific documentation for that strategy.

Shawn Buckley
I'll just ask, being that you started talking about those two things. You're saying the lockdowns, especially for the younger, were very detrimental on several levels, physical, psychological, social isolation. Can you just elaborate a little more on that so that the commissioners and the people listening understand exactly what you're referring to?

Dr. Jayanta Bhattacharya
Yeah, so I brought some statistics just to give some sense of it. But it's not possible to do it full justice because the extent of the harms caused by lockdowns on population health are so extensive. Just to give a smattering of the flavour of this. During 2020 and 2021 when the lockdowns were primarily in force, a lot of the emphasis was on making sure hospital systems and healthcare systems were not overwhelmed.

One way that this happened was by,

[00:05:00]

essentially, causing people to fear to come into hospital systems or being told explicitly not to come into healthcare systems for the conduct of basic preventive care.

So for instance, many people skipped cancer screening that's recommended: colon cancer screening, cervical cancer screening, a whole host of other recommended cancer

screenings, breast cancer screenings. As a result, many men and women will show up now with later stage breast cancer or prostate cancer, or whatnot, that should have been caught at an earlier stage. And they will die from it when they would have survived it had it been detected earlier.

Another major health harm from the lockdown policies has to do with mental health. There are reports from Canada from 2021, even as early as 2020, suggesting that the psychological distress caused by lockdown policies—the isolation from others, the disruption of normal rhythms of daily life—led a tremendous number of Canadians, especially young Canadians, to overdose with drugs. The rate of excess death among the young from drug overdoses in Canada increased sharply even as early as 2020, according to a Statistics Canada report that was issued in 2021.

The [CBC] reported that one in five Canadians need mental health services. The demand for mental health services in Canada climbed substantially even as wait times for specialists got longer and longer. So at the moment when Canadians needed the most help from medical health professionals, it was the least available because of the lockdowns.

The consequences are hard to summarize in a very, very simple way because the health effects of investments in health by healthcare systems is so important and so pervasive in life. And ending those or stopping those or pausing those even for short periods of time can have long term consequences on the health of populations. One measure of this— If it's possible for me to share the screen, I'd like to share one slide.

Shawn Buckley
Absolutely, you can share the screen. It should be set up for you to be able to do that.

Dr. Jayanta Bhattacharya
Perfect. So I'm just going to share one slide. One sort of summary measure of this is the cumulative age-adjusted, all-cause mortality rate in Canada. And I wanted to do a comparison country, Sweden, which followed much closer to a focused protection approach than Canada did. Much more aligned with the Great Barrington Declaration we discussed earlier.

The way that cumulative all-cause, age-adjusted excess mortality is calculated is you look at baseline mortality rates. In this case, I think from 2015 to 2019, in each country, adjusted for age so that you're comparing like with like. So older populations, of course, are likely to die at higher rates. And then, track over time from the beginning of the pandemic—here on the left side of the graph is February 2020, all the way to now—how much above that baseline expected mortality rate you actually see. The red line here is Canada and the blue line here is Sweden: all-cause excess deaths, age-adjusted mortality rates. The Canadian all-cause excess deaths, sometime around May 2021, crossed the blue line, Sweden's all-cause excess mortality rate. And what you see is that the rate of death, the cumulative all-cause excess death in Canada as of the late 2022 was actually about 50 per cent higher than that experienced by Sweden, which did not impose the kind of draconian lockdown policies that Canada followed during the pandemic. It's almost a 50 per cent higher all-cause excess death rates.

Now, most of that, I think, or much of that, is not actually due to COVID because the COVID rates in Canada were actually relatively well controlled. Most of that is due to lockdown harms, I think. Whereas Sweden—which didn't impose lockdowns,

[00:10:00]

had much more voluntary policies and a greater emphasis on focused protection of vulnerable older people, rather than trying to protect hospital systems—had much lower all-cause excess deaths because they invested in the health of the population, the normal investments in the health of preventive care, and so on, and didn't panic the population. And as you can see, the results over time: it's gotten worse and worse for Canada and better and better for Sweden.

Shawn Buckley
Now, I think in Canada we all recall actually the mainstream media criticizing Sweden at the time for the role that they were taking. I imagine that you saw similar reports in the United States media.

Dr. Jayanta Bhattacharya
I did. I saw in the United States media that the Swedish strategy was characterized as reckless, as just letting the virus rip.

Shawn Buckley
Right. But now with hindsight we can see that it wasn't reckless in any way.

Dr. Jayanta Bhattacharya
No. It was not.

Shawn Buckley
As I understand this focused protection: basically, this premise of the Great Barrington Declaration is once we knew that it was affecting the older populations, so we'd focus the resources there but not do things like lockdown younger people. Now in Canada, our media— And definitely children were being taught that they basically should be doing their part to protect old people. And I'm wondering if you can comment on the risk of children spreading the disease and whether or not it was proper to be locking down children.

Dr. Jayanta Bhattacharya
Absolutely. So first, from very early in the pandemic, it was clear from the scientific evidence that children were not super-spreaders. Children, of course, can get the disease and, of course, can spread the disease. They're not like perfect sinks in that sense. However, the risk of children spreading the disease is, in some ways, measured rates are lower than adults.

Let me give you two pieces of scientific evidence that were available from very early on in the pandemic. In Iceland, there was a study done in March 2020 where the scientific group sampled, I think, 12 per cent of the Icelandic population and did a test to see if the patients that they sampled had active cases of COVID, including sampling the standard PCR test to measure whether the virus is present. And then a nonstandard sequencing test to look at the virus and see what mutations the virus had.

They paired this with a very, very detailed contact tracing approach to see who the people that were positive had come in contact with. And from this kind of approach, you can distinguish whether somebody— Like if two people come into contact with each other, contact tracing normally can't tell who passed the virus to whom because you just know that these two people were near each other. And they may have been, of course, near other people. But with a sequencing analysis, you can say, okay, the two people that are in contact with each other, the viruses share the mutation patterns. So they may have passed the virus to each other. Whereas people who have very, very different, disparate mutation patterns of the virus that they have are unlikely to have passed the virus to each other.

The striking finding from this Icelandic study was that while there were many, many instances of parents passing the virus on to children, there was not a single instance in the study of a child passing the disease on to their parents. The children were not super-spreaders. Now, as I said, kids can spread the disease, especially older kids. Younger kids, I think, are less likely.

So let me talk about a second study, this time out of Sweden. Sweden even in spring of 2020 did not close its primary and early secondary schools. Every child under the age of 16, I think, experienced no disruption in their schooling at all because those schools were not closed in Sweden.

A study was conducted by Swedish researchers looking at the mortality rate of teachers in those schools relative to COVID mortality rates of other workers in the population. And what it found was that teachers actually had a lower risk of COVID mortality than the average risk faced by other workers in the Swedish population during that period. In a sense, working in schools protected teachers against COVID relative to the rest of the population, at least empirically based on that.

Based on these findings, it was really clear early on

[00:15:00]

that closing schools was a tremendous mistake, that it was unnecessary to protect older people in this way. Alternate policies would have been better to protect older people and would not have caused the harm to children. If I may, may I talk a little bit about what the harms to children actually are?

Shawn Buckley
Actually, please do.

Dr. Jayanta Bhattacharya
If you go back in the social science literature decades, what you find is a very common theme about how important investments in children are in terms of schooling. And it's not just that our schools provide education, which is important for future job prospects and so on. That's true, they do. But, in fact, they are absolutely crucial to the health of children.

In an immediate sense, schools are where many children receive much of the nutrition for the day. If you close schools, you reduce the amount of nutrition available to children. Of course, Ontario, I know, closed schools for a time.

The other thing is that, again, schools are places where social services are provided. Child abuse is often picked up at schools because it's teachers who see the results of child abuse and then report it to authorities. When you close schools, child abuse continues to happen. But you won't pick it up because the outside people who care about children aren't there to look.

So both of those things happened during the pandemic in places that closed schools. Worse nutrition for children, children skipping meals as a result, and also child abuse not being picked up and reported.

The long-run effects are even worse of closing schools. The key thing is that when you have children miss school for even relatively short periods of time in their lives, according to the social science literature, it has long-term negative health consequences. Children who miss school for even, again, in the social science literature, for short periods of time end up having shorter, less healthy lives because they lead poorer lives.

One estimate, published in the pediatrics literature early in the pandemic in the United States, found that just the American school closures in spring 2020, cost American school kids nearly five and a half million life-years in expectation over their lifetimes. So the consequences are not trivial. You're essentially taking life-years away from children and exposing them to abuse that needed to get corrected. Schools are absolutely vital and closing them was a tremendous mistake that harmed children.

Now, if I may, can I talk a little bit about the failure of focused protection in Canada? And I just wanted to bring up a couple of data points.

Shawn Buckley
Yes, please do.

Dr. Jayanta Bhattacharya
One from very early in the pandemic. A public health policy that's focused, that recognized the unique risk that the COVID posed to older people, would have moved heaven and earth to protect the lives of older people. Especially early in the pandemic when we didn't have very good treatments or vaccines, and whatnot.

The key idea was to find where the vulnerable older people live and devote resources to protecting them. Instead, what happened in Canada—not just unique to Canada but happened elsewhere as well—is that places like care homes and nursing homes where the most vulnerable older people lived became places where, essentially, of neglect and abuse. And in fact, became places where COVID was spread.

So in Montreal, for instance, the earliest days of the pandemic, there are reports—again, in the Canadian press—that the staff of nursing homes in Montreal abandoned their posts in part because they were so afraid of getting COVID. And left older patients with dementia to die from dehydration and neglect. You have, in many places in the United States—for instance, in New York, in Michigan, in Pennsylvania—you had governors sending COVID-infected patients out of hospitals early into nursing homes where, then, the disease spread rapidly, infecting the most vulnerable people.

The reason why this happened— It wasn't, I don't think, a criminal act. I think it was actually an act

[00:20:00]

as a result of ignorance about what to do about the most vulnerable people. Instead of making protection of vulnerable people the central goal—focused protection, the central goal of pandemic policy—instead, the goal was to empty hospital systems to keep hospital systems not overwhelmed. In a sense, we inverted the normal relationship between the public and medicine. Normally, you would think about people in medicine, public health, serving the public. But the rhetoric and the reality flipped, where the idea was that the public would serve healthcare systems. We recruited the public as a way to protect hospital systems, healthcare systems, rather than hospital systems and healthcare systems serving the public. And one consequence of that was that we forgot about focused protection and sent COVID-infected patients back to nursing homes, killing many people who would otherwise have potentially survived much longer as a result if that had not happened.

Let me give you one last data point from the Canadian experience that I know of. In Ontario, in the district of Haldimand-Norfolk Health, there was a health minister named Dr. Matthew Strauss who explicitly adopted the idea of focused protection: did not impose mask mandates; when the vaccine became available, prioritized high-risk individuals for the vaccines; put out centres for the infusion of monoclonal antibodies, an effective treatment for much of the pandemic; and made available antivirals rapidly as soon as they became available. As a result of his approach, which eschewed mandates—did not adopt any of the sort of restrictions that were imposed by much of the rest of Ontario—as a result, the age-adjusted mortality from COVID in Haldimand-Norfolk was actually 30 per cent lower than the rest of the province.

Focused protection works. Focused protection would have worked better in Canada than the lockdown-focused policy. And it would not have harmed the children in the way that they were harmed as a result of the lockdown policies that were followed.

Shawn Buckley
Now, you've spoken about restrictions on children, can you also comment on young adults?

Dr. Jayanta Bhattacharya
Yes, so there hasn't been as much attention paid to this, but I think it's quite important. The experience of young adults in society is tremendously important for the rest of their lives. In the 2008 recession, for instance, the joblessness among young adults resulted in long-term decreases in life opportunities for those same young adults, including worsening health. The kind of unemployment induced by lockdowns, which happened in Canada for years, has especially bad long-term consequences for young adults.

The importance of young adults to socialize with one another is critically important for their mental health. And there's evidence that as a consequence of lockdowns and the isolation of lockdowns, those kinds of mental health problems that I mentioned earlier—one in five Canadians needing professional help—those were exacerbated by the lockdowns, particularly among young adults.

The same thing, I think, is true to explain the rise in overdoses of illicit drugs in Canada. It's primarily young adults that face that. And again, it's not a surprise given the mental health consequences of isolation and anxiety caused by the lockdown policies that Canada followed.

Shawn Buckley
Another thing I wanted to ask you, before we move on to the topic, because I want to cover the topic of censorship with you and some of your experiences there. But in Canada, basically the federal government and every single province was very aggressive on taking measures to, I'll use the word, encourage, but really it was coercion to be vaccinated. And there was basically zero allowance for natural immunity.

[00:25:00]

And I'm wondering if you can comment on the policy of basically mandating vaccines and ignoring natural immunity and your thoughts on that.

Dr. Jayanta Bhattacharya
Yeah. So I think a couple of things about the science of the vaccines is really important to understand. To understand why those vaccine mandates were both unnecessary and a bad idea.

So first of all, as I've already mentioned, there is a very sharp gradient in the mortality risk of COVID. Now the vaccines, when the randomized trials of vaccines were conducted in 2020, what those randomized trials showed was that against a placebo group—a group that received a placebo rather than the vaccine—the vaccines protected people against symptomatic infection for about two months after the vaccination. That was how long the trials lasted before they ended. The median person was followed for about two months. So you have 95 per cent protection for two months against symptomatic infection. That sounds impressive and is impressive. But it's actually not the key epidemiological endpoint that you care about for a policy perspective.

From a policy perspective, there's two potential epidemiological endpoints you might care about separate from prevention of symptomatic infection. First is protection against severe disease: Does the vaccine stop you from dying if you get infected? The trial did not answer that question because it didn't have that as a primary endpoint. And it didn't have sufficient numbers of people enrolled to be able to answer that question with any statistical confidence.

Shawn Buckley
I just want to make sure that we understand what you're saying. So let's use the Pfizer trial as an example. You're basically saying they weren't actually measuring as an endpoint whether or not it would reduce serious illness.

Dr. Jayanta Bhattacharya
Yes. They didn't have that as a primary statistical endpoint. And they would have needed to design the trial differently to have that as a primary statistical endpoint. They would have needed either many, many, many more people than the 40-some thousand, whatever they enrolled, or they would have needed to primarily have conducted the trial in a high-risk population like the elderly. Both would have been defensible. Of course, the first would have been much harder. Instead, they had prevention of symptomatic infection.

Shawn Buckley
I think this is important to Canadians because we endured some pretty draconian lockdowns, some very significant messaging that, to this day, we are totally divided. And basically, it was to prevent us from getting seriously ill, including dying. That really would have been why people were participating in this. And you're telling us they weren't even measuring for those things as an outcome?

Dr. Jayanta Bhattacharya
Yeah, they didn't have that. They didn't power the trial to measure that as a primary outcome.

Shawn Buckley
And can I also just ask you. You use this 95 per cent figure. But my understanding is, is that that wouldn't be an absolute risk figure, that would be just a relative risk figure that was used?

Dr. Jayanta Bhattacharya
Yeah, so 95 per cent relative risk reduction. You know, that's actually pretty standard in vaccine trials, so I'm not terribly exercised by that. But the absolute risk reduction has to do with more than just the trial itself. So for instance, if the virus is not spreading in a population, a very highly efficacious vaccine will produce zero absolute risk reduction because there's, you know, just no risk in the population getting the virus. So the absolute risk reduction is both a function of the vaccine itself and also whether the virus is spreading when the measurement takes place.

Shawn Buckley
Right, okay. And then you were going to talk about natural immunity, but I didn't want to cut you short on the vaccine.

Dr. Jayanta Bhattacharya
Yeah. I wanted to get to natural immunity. I just wanted to tell the story about the vaccines because it's related. It's very closely related to the vaccine mandates and the lack of necessity for them.

I mentioned that it's symptomatic infection prevention. It didn't check for whether it prevented— The trial was not statistically powered to test prevention of death from COVID. On the other hand, you also could have used the trial to check whether the vaccine prevents you from getting any infection. Any infection, of course, is distinct from symptomatic infection

[00:30:00]

because you can get a non-symptomatic infection, asymptomatic infection.

You could also have checked to see if the vaccine protects against transmission of the disease. If I have the vaccine, although I may get sick, it might reduce the risk of my spreading the disease to others.

The trials did not check for either of those endpoints. So what we knew was two months of prevention of symptomatic disease. And that's it.

Now, the other thing about the trial that's important is that the trial explicitly excluded from its efficacy calculations patients who had already previously had COVID and recovered. That subgroup of the trial actually turned out to have almost no cases of COVID at all after they'd recovered. And so, they wouldn't have been able to find much effect of the vaccine in that group. And if you read the supplementary appendices in the vaccine trials, what you'll see is that those groups, while they were recruited in order to check the safety of the vaccine, were actually excluded from the efficacy calculations in the randomized trials that were published in 2020.

The reason is simple. There's a tremendous amount of evidence, again from 2020 on, that the patients who get COVID and recover have very substantial protection against both subsequent infection and also severe disease on reinfection. Now, what we've learned is that a new variant can escape that immunity. So that if you'd had COVID in the first wave in 2020, you may have gotten it again in 2021 during the time of a new variant, but the protection against severe disease is long-lasting. If you got COVID and recovered the first time, it's very likely that the second time you get it, maybe with a new variant, will be milder, at least less likely to produce severe disease and death than the first time you got it.

Shawn Buckley
So you're referring to what we would call natural immunity?

Dr. Jayanta Bhattacharya
Yeah. So I like to say recovered immunity just to distinguish— Sometimes people say natural immunity, and what they mean is that even before you're exposed, you have some substantial protection. And you do, but it's not the same kind of protection as you get after you've had COVID and recovered. That immunity is durable. And it's very effective against reducing the risk of severe disease and death upon reinfection.

Shawn Buckley
So using your term recovered immunity, you're saying that that's robust vis-a-vis significant disease coming forward. How would that compare with the protection offered by the COVID-19 vaccines? So going forward, are they providing a similar robust protection?

Dr. Jayanta Bhattacharya
Yeah, I think there's some scientific discussion and debate about exactly it. But I think the general consensus is that the amount of immunity provided in terms of reinfection risk is better if you've had recovered immunity than an immune naive person who just has the vaccine. And the protection against severe disease and death, I think, is at least as good as someone who's immune naive and has the vaccine.

Just to give one data point again on this. There was a study out of Bergamo, Italy, in 2021 that was published that looked at patients who'd had COVID in the first wave, during that big wave in Italy in 2020, and tracked them for a year. And only 0.3 per cent of that group was reinfected during that whole entire year after that initial infection.

That's better protection against infection than the vaccines, which in careful epidemiological studies done in places like Qatar and Sweden and elsewhere found that after two or three months, the efficacy against infection, even symptomatic infection, drops pretty substantially down to 20 per cent, sometimes near 0 per cent, maybe just three, four, five, or six months after you've had the vaccine. It's very, very common, then, to have had the vaccine and then gotten infected just a few months after you had it. That actually happened to me. I was vaccinated in April of 2021 using the Pfizer vaccine. And then four months later in August of 2021, I got COVID.

Shawn Buckley
So now, from a public policy perspective for trying to get the best health outcomes,

[00:35:00]

would you agree then that it would have been prudent to take into account recovered immunity and permit people to opt out of a vaccine mandate?

Dr. Jayanta Bhattacharya
Yes. And that's for a number of reasons. So first of all, before I answer that directly, if you don't mind, let me talk a little bit about why these scientific facts we just talked about means that the necessary conditions that you would want for a vaccine mandate are not actually there.

Now, I believe that the vaccine does reduce the risk of all-cause mortality. It wasn't in the trial. But there are a number of high-quality epidemiological studies done by people who are not affiliated with any of the drug companies. Very skilled epidemiologists, using careful cohort approaches, that demonstrate that the vaccine does reduce mortality risk from COVID, I think, for up to six or seven months after you've had it. So let's take that as given.

The right use then for the vaccine is to recommend it very strongly in the population that faces the highest risk from COVID, the elderly. The vaccine should have been used for focused protection of the elderly. That's essentially what Dr. Strauss did, for instance, in Haldimand-Norfolk. It's very important, then, from a personal health point of view that high-risk individuals get vaccinated. On the other hand, for low-risk individuals, from a personal health point of view, it's much less important that they get vaccinated because the absolute risk reduction for them—for instance, for younger people—is small. That means the expected benefit from the vaccine for a low-risk person is low just by the basic math of it, right? If you face a zero risk of dying from COVID, the vaccine produces zero benefit because you can't go below zero.

And on the other hand, the vaccine is not without side effects. We've learned, for instance, that the vaccine, especially in young men, produces myocarditis, which is the inflammation of the heart muscle. It can be a very serious condition resulting in death at, I think, at unacceptably high rates given the small benefit of the vaccine in young men, especially from the second dose or the boosters.

So from a private health perspective—private meaning from an individual patient's perspective—whether the vaccine is a wise thing will depend on how old you are, your health condition, a whole host of other things. Things that you normally would expect to be

able to talk to your doctor about and decide for yourself whether the vaccine is right for you.

On the other hand, from a public health perspective, if a vaccine does not stop transmission of the disease or only has a very limited effect on the transmission disease for a short period of time, well, the idea that you need to vaccinate other people so that I'm protected is just false. Now, normally with other vaccines, like the measles vaccine that does stop transmission, that idea isn't false. The protection provided by the measles vaccine against transmission means that when I'm around patients or people who've had the measles vaccine, I'm very unlikely to get measles because those people are not susceptible to getting measles. That's essentially a kind of herd immunity provided by vaccines. By the way, recovered immunity can provide the very similar kind of effect. But this vaccine, this COVID vaccine, does not stop transmission.

And in fact, in those same careful epidemiological studies that I just mentioned where they found reductions in the risk of mortality after the vaccine, they find that the protection against infection is very short-lived. And what that means, then, is that the public benefit—"public" meaning my vaccination protects you—is very, very limited from this vaccine. But that public benefit is a necessary condition, I think, for imposing a mandate. Because the idea of the mandate is that well, there are people that are not getting the vaccine endangering the public by not doing so. Well, that's just not true for this vaccine.

So if you are lacking in that necessary condition for the vaccine mandate, it's not wise public policy to impose it.

[00:40:00]

It's because it doesn't actually end up protecting the public, and the public thinks they are protected. But I think there are even broader, even deeper reasons why I think the vaccine mandates were such an unwise idea.

First, I think it created this idea that there was an unclean group of people walking around. It demonized people who, for whatever reason, chose against getting the vaccine. It essentially gave open season to discriminate against them: People lost their jobs. In Canada, unlike most Western countries, I think even in most of the rest of the world, unvaccinated individuals were not allowed to travel internally for years. That's a gross violation of human rights. And it essentially demonized people who, again, for whatever medical reason or whatever reason, chose not to get the vaccine. For those who chose not to get the vaccine, it should always have remained a private medical decision, given the epidemiological facts I've said. It should never have become an issue of public health in the sense of forcing them to get the vaccine. So it essentially created social divisions that were absolutely unnecessary for public health to induce.

And actually, the second knock-on effect of that is, I think, it undermined trust in public health and in vaccines more generally among a substantial fraction of the population. The vaccine skeptics movement that I've seen throughout my career has always been a relatively small group of people. What I've seen now in Canada and in the United States and elsewhere is that that group has grown very, very sharply. And they question not simply the COVID vaccine but other vaccines as well and public health more generally.

A lot of the protests, for instance, the truckers movement was induced by the civil rights violations on the back of these vaccine mandates that were put in place in Canada and the vaccine-related movement restrictions put in place in Canada. The same thing, by the way,

has happened in the United States. Although it didn't have movement restrictions of the same kind. We had vaccine passports, vaccine mandates, that have induced a very similar kind of entirely predictable reaction by people who were upset by this policy, an absolutely unnecessary policy from an epidemiological point of view. And we're going to be facing those problems for years and years.

Shawn Buckley
Now, I'd asked you generally about public health policy with the vaccines and taking into account recovered immunity. And I'm just wondering if I could focus you a little more then specifically with children. Because you were suggesting, I think you were suggesting, that the risk that children would face for serious illness or death from COVID is zero or for all intents and purposes non-existent. So from the individual perspective, the parents making a decision— Should I be vaccinating, not vaccinating? Clearly, you'd say, "Well, why would I do this?"

But you had spoken earlier, and I think this goes to the public health thing about protecting others, that children were also such a low risk for spreading the virus. So can you comment on those two things and then your thoughts from a public health policy. Because we're still pushing to vaccinate children quite aggressively in Canada. And so, we'd appreciate your comments today on our current policy.

Dr. Jayanta Bhattacharya
So I tend to have a philosophy that you should make those kinds of decisions in careful consultation with a physician to decide whether your child should or should not have any particular medical treatment. Parents should be involved. Physicians should be involved in that.

I think that the risk of mortality for a healthy child, while not zero from COVID, is very, very, very, very low. And so that means the benefit from the vaccine in terms of preventing those severe outcomes, again, is also very, very, very, very low for the vast majority of children. That is not to say that there may be some small numbers of children who have particular medical conditions that make the risk of dying from COVID or other respiratory infections higher. And maybe they might benefit from the vaccine relative to the risk they face from taking the vaccine.

So I think this should be a decision that should be made without pressure

[00:45:00]

by parents consulting about their children with their physicians. The role of public health, then, is to reassure parents that, while most of their children face a very low risk from COVID, it's important for the lives and the health of children to have their regular lives go again. That, maybe, if their child is immunocompromised or has some other particular medical conditions, to go seek advice from their doctor. I mean, that's the kind of reassuring advice I would have expected professional public health people to make regarding children.

The idea that there should be universal vaccination of COVID for children I don't think is aligned with basic evidence-based medicine practices. In evidence-based medicine, when you have an uncertainty, for instance, we don't know the full extent of the side effects of the vaccine when given to children—we do know, for instance, young men have higher rates of

myocarditis—and the benefit is low. Generally, the advice is that you would err on the side of caution and not give that therapy. I think that's likely the case for the vast majority of children, that it's not actually wise to get it. But there may be children for whom it is wise. And I think that the key thing there is you need to have those decisions made in careful consultation between parents and doctors.

Shawn Buckley
Now Dr. Bhattacharya, I want to switch gears just briefly, and then I want to allow time for the commissioners to ask you questions.

I want to switch to the area of censorship because for one reason or another, you have been kind of placed in the forefront. And I want you to, first of all, speak about what happened with Canadian media when you came out as one of the three founding authors of the Great Barrington Declaration.

Dr. Jayanta Bhattacharya
So almost immediately after we published the Great Barrington Declaration, I think less than a week or so after, the CBC held a roundtable with two or three scientists who really didn't like the Declaration. But I don't think they understood the Declaration. The CBC essentially allowed them to say on the air, paid for by the Canadian taxpayers, that the Great Barrington Declaration was calling for "letting the virus rip," essentially letting everyone get infected. And in fact, the Great Barrington Declaration, as I've said, was the opposite of that. It was a strategy of focused protection of vulnerable older people. The idea wasn't to let the virus rip. The idea was to let young people live their normal lives. It's very clear that when there was a threat to older people—when the disease is spreading rapidly or at high rates in the population—people would take voluntary action to try to reduce the risk faced by older people. And the Great Barrington Declaration is entirely consistent with that.

It was also consistent with devoting resources and ingenuity to protecting older people who faced a high risk. So for instance, deploying monoclonal antibodies in October 2020. those had just become available. Rapidly deploying them at scale, so that older people if they got sick would have access to them. That would have been a very wise thing to do. Again, entirely consistent with the Great Barrington Declaration. The idea wasn't to let the virus rip. The idea was focused protection of vulnerable older people.

In a sense, the CBC impanelled a group of scientists who slandered us, accused us, essentially, of wanting to kill people. And then, when a Canadian lawyer that we were in contact with complained, the ombudsman, the CBC, said, "No, it was a fair report" and didn't allow us to have any response. So the Canadian people were robbed of the opportunity to understand what exactly we were proposing. And just to be clear, it wasn't just me. I teach at Stanford University. But, also, there was Martin Kulldorff of Harvard University, an epidemiologist and fantastic biostatistician. And then Sunetra Gupta of Oxford University. She's the professor of theoretical epidemiology at Oxford. And tens of thousands of other scientists and doctors, including a Nobel Prize winner here at Stanford, signed on to this. This was a major scientific proposal put out by credentialed scientists. It deserved a fair hearing, not a slandering.

[00:50:00]

And the Canadian people were robbed of that opportunity by the CBC, which essentially impanelled slander against it.

You asked about censorship. You know, I think it's important for the Canadian people to know that this was a systematic effort, not just by the media but by government actors. There was a report in 2020, for instance, that the Canadian military used propaganda techniques on Canadian citizens to combat disobedience against lockdowns in 2020. The physicians' organizations, which license physicians and oversee the conduct of physicians in Canada, used its power to silence dissent by doctors. For instance, in Ontario, there's a doctor named Kulvinder Gill who posted on Twitter messages essentially saying that lockdowns were a very bad idea, that focused protection was a good idea. Entirely consistent with the science. And as a result, the CPSO, the College of Physicians and Surgeons of Ontario, has threatened her licence.

It was a systematic campaign by Canadian government and quasi-governmental organizations to silence dissent so that Canadians got the impression that there was no alternative to lockdown. When, in fact, the scientific community had proposed a very effective alternative to lockdowns that would have worked if it had been adopted in Canada.

Shawn Buckley
Now, my understanding is that you're involved in a lawsuit in the United States. So the State of Louisiana and the State of Missouri and other parties are suing the Biden administration over censorship issues. Can you briefly share with us some of the things that you've discovered about censorship and this COVID experience?

Dr. Jayanta Bhattacharya
Yeah, so the United States has done no better than Canada on this, in many ways worse. The lawsuit that I'm involved with is a federal lawsuit. It's still advancing through the courts. But what the judges allowed us to do is to depose a number of prominent individuals inside the Biden administration and the Health and Human Services bureaucracy of the United States, including Dr. Tony Fauci.

We've also had access through discovery to a huge trove of email communications between a dozen federal government agencies in the United States and social media companies, including Facebook, Google, Twitter, and so on. The content of these emails and these depositions reveal an enormous effort by the federal government to threaten social media companies from a regulatory perspective if they didn't comply with censorship demands. Often these emails have demands on people to censor, posts to censor, ideas to censor, all in the name of combating disinformation. But the disinformation that they're combating is often true information, including information, for instance, about the efficacy of recovered immunity or the harms of lockdowns and so on.

In the United States, this is, to me, a very clear violation of the American First Amendment right to free speech. And even more importantly than it violates a fundamental civil right, it robbed the American people—it robbed the world, frankly—of access to accurate scientific information that had it been available, we might have adopted very, very different policies. It created this impression, this illusion, that there was a scientific consensus around lockdowns that didn't actually exist. It's one of these things where if you'd asked me before the pandemic, could such a thing exist in the United States? I would have told you there's no possibility. The American First Amendment protects against it. But, in fact, it's true.

It's the American government that acted to make sure social media discussions about the efficacy of lockdowns, the harms from lockdowns, recovered immunity, the proper use of the vaccines, all of those discussions, essentially, were censored in favour of the government's favourite policies. Whereas prominent credentialed individuals who dissented against that government narrative were silenced or censored or smeared in other ways. It's an absolutely shocking kind of intrusion on the rights of the people of the world to have done this.

[00:55:00]

And I hope that when we win this lawsuit, this whole censorship regime can be dismantled.

Shawn Buckley
And I will indicate that you provided us with— I think people want to clap.

You provided us with a document called the "Plaintiffs' Proposed Findings of Fact" in support of their motion for a preliminary injunction. I'll advise the commissioners and those people watching that we've entered that as Exhibit WI-8 [*Bhattacharya-Missouri v. Biden* ECF 212-3 Proposed Finding of Fact]. And my understanding is that the court has accepted the plaintiffs proposed findings of fact as true.

Dr. Jayanta Bhattacharya
So far what we've had is a motion to dismiss by the government that's been rejected by the court in [primary part]. They haven't yet addressed the preliminary injunction. So that's still pending. But if you read the rejection of the government's motion to dismiss, it's a very favourable ruling in our favour, which seems, on its face, to accept much of that document that I shared with you. Those documents are based on true facts. Those are based on actual emails we've had from discovery. And they're submitted under oath by the Missouri and Louisiana Attorney General's office to the federal court.

Shawn Buckley
Okay. And before I turn you over to commission questions, I'll also just let you know that we've entered as Exhibit WI-8a, the Great Barrington Declaration. And we've entered your expert report on COVID-19 response in Alberta, Canada, dated January 20th, 2021, as WI-8c. And you did a supplementary report called *Supplementary Expert Report on the COVID Epidemic Response in Alberta, Canada*. We've entered that as WI-8d.

And I'll just let the commissioners know, although I'm going to turn you over to their questions. You're also part of a group called the Norfolk Group, which has gone through tremendous effort to list questions that should be answered, flowing from the world's experience on COVID-19. I think it's 80 pages long of questions. And we've entered that as [Exhibit] WI-8e. And you've participated in that initiative in helping to formulate those questions. I just wanted you to know that those will be before the commissioners for them to consider.

And so I'll ask the commissioners if they have any questions at this time. And they do.

Commissioner Massie
Well, thank you very much, Dr. Bhattacharya, for your very interesting presentation. I have a few questions, some of which are probably simpler. This whole notion that has been documented in Iceland and Sweden that the transmission from children to adults didn't seem to be that important— Is it something that is unique to this particular virus, or is it something that was known before? My understanding was that with flu, children can actually probably transmit it. So what's your take on that?

Dr. Jayanta Bhattacharya
So I was surprised by the result. I did not expect it. Because the general idea was that children actually do spread respiratory viruses at higher rates than adults spread it. It's not that children can't spread this virus; it's just that they're not unique super-spreaders. I think a lot of the school closures and restrictions on the lives of children was premised on this false notion that, like other respiratory viruses, they're super-spreaders for this one. But it doesn't correspond with the actual reality as measured in the studies that came out in early 2020.

And so, we shouldn't have acted as if that were the case. Restricting the lives of children was not a necessary precondition to protecting older people. Active focused protection measures were possible to protect older people without restricting the lives of children: that's the key thing. Children were essentially demonized, made to be seen as "grandma killers." And that was never the case relative to the scientific evidence.

Commissioner Massie
You've done a very interesting study early on to show that, in fact, the rate of the virus was much more prevalent than we initially thought. So is it possible that because children typically exchange their germs, if you want, more readily than adults— Is it possible that children would have generated a recovered immunity faster than adults because of the way they exchange?

[01:00:00]

Dr. Jayanta Bhattacharya
I mean, I think that's certainly possible. I think the key reason why children respond much less harshly to the infection by this is that children's immune systems essentially are pluripotent. They're designed to respond to new threats because almost every threat when you're a very young child is new. And so, they don't have the disease for as long; they're more likely to be asymptomatic. And it's very likely that they have it for a shorter time, and that's partly why they don't spread the disease.

You know, there's a really interesting study, which I didn't mention, but I think I wrote in one of my reports about the mortality risk faced by parents of young children. If you match them against adults of similar age who aren't exposed to young children all the time, they actually, in 2020, had a lower risk of dying from COVID. It's almost as if the parents are inoculated by the children with other, maybe, other coronaviruses. The mechanism is not clear. But the fact is clear that somehow children serve more of a protective role as opposed to a threat as far as infection from this virus goes.

Commissioner Massie
One of the things that actually triggered the mandate for the vaccine was the hope, I would say, that it would prevent transmission. There was no data to support that initially. And I'm not aware of any data showing that injecting a vaccine in the arm would actually prevent respiratory virus transmission. But then, when the Delta wave became pretty intense in the States, we had this statement by the CDC that the vaccine can no longer prevent transmission.

So is it because the initial strain, for whatever reason, was somewhat different and could actually be somewhat prevented by the vaccine? And the Delta was being more transmissible—then even more so when we saw it with Omicron—that the protection was completely overwhelmed by any possible way.

So do you think that this idea that the transmission was something that was potentially real from the get-go is something that was misleading—based on real-world data that we've got from epidemiology—and made us believe at one point that maybe it was working? What's your take on that?

Dr. Jayanta Bhattacharya
I mean, it's almost impossible to answer that question with any rigour because just as the vaccine was being released in December of 2020, the very first variant of concern was identified. I think it was the alpha variant, was what they called it eventually. The vaccine never was tested against transmission in the trials. That would have answered that question. And so, we don't know for certain if the vaccine would have prevented transmission for a very long time. We just know that it prevented symptomatic infection for two months.

What we do know is that the vaccine when it was used in the real world, within just two or three months after vaccination, the efficacy against infection dropped very sharply, again, in high-quality epidemiological studies. And so, the reality from the moment we started using the vaccine was that it wasn't, given the variant that was actually abroad in the world, it wasn't going to protect against transmission.

You could see this very early on in 2021. Heavily vaccinated countries and regions were experiencing big cases. I think the very first one I saw was in the Seychelles Islands. I think it was March or April 2021. They used the Chinese vaccine: they were 90 per cent vaccinated, or a very high per cent vaccinated, and they had a huge outbreak of cases.

There was another outbreak of cases in Gibraltar, again, heavily vaccinated; this time, I think, with the AstraZeneca vaccine. And of course, Israel in 2021 very quickly vaccinated a very large fraction of its population and then experienced a very large outbreak of cases. The evidence was there from within months of the vaccination campaign starting that the vaccine was not going to stop transmission, was not going to protect people from getting infected.

Commissioner Massie
In terms of protection against severe outcomes or death, we have indeed the study showing that the vaccine seems to have done a reasonable job. But with the, I would say, less virulent—or we think it's less virulent—Omicron strain, do you think that we have generated, or we can generate data to show that convincingly at this point?

[01:05:00]

Dr. Jayanta Bhattacharya
I think it would be very hard. I think a very large fraction of the Canadian population have been infected with Omicron. And as a result, most of the Canadian population— I mean all of them infected and recovered have recovered immunity. And so, with patients who have recovered immunity, the marginal benefit of the vaccine is going to be lower because the recovered immunity by itself provides a protection against severe disease and death.

There is a literature that suggests something called hybrid immunity: so if you're vaccinated and you have recovered immunity, COVID and recovered, you have a different kind of level of protection than someone who's just simply had recovered immunity or someone who simply had the vaccine. To me, these are like esoteric questions because the actual risk reduction from any of those is very, very high relative to the immune naive person. So that's why we're in such a different place now in April of 2023 than we were in March of 2020. Such a large fraction of the population has recovered immunity. Such a large fraction of the population has had the vaccine. We don't need to worry so much about COVID because of the durable protection against severe disease provided by those two facts. I think especially recovered immunity, it seems to me, is probably more important, but there are scientists that disagree.

Commissioner Massie
Thank you very much.

Commissioner Drysdale
Good morning. I have a couple of questions. And the first one is— You were talking about, I believe you said, that there's been some credible studies that seem to indicate that the vax does reduce mortality due to COVID.

And my question on that is— We've had a significant number of witnesses, prior to yourself, come on and tell us that there were issues with the vaccine from inception to putting it in arms. You know, non-aspiration. It was my understanding from the testimony that manufacturers recommended not to mix different manufacturers and that was done. There were issues with, or at least alleged issues, of quality control in the production.

And I would like you to comment on—in these studies that indicated or seem to indicate that the vaccine reduced the potential for death—were those production vaccines given to those test subjects the same as they were done to the general population? Or were they not necessarily the same production vial that Joe Black got at the pharmacy in Winnipeg?

Dr. Jayanta Bhattacharya
Yeah, so I can't speak to Winnipeg in particular. But I can say that the studies are based on population records. There are observational studies where they're tracking at scale regular people that had got the vaccine, for instance in Qatar or in Sweden or in Denmark or in Northern California where some of these studies were conducted. So it wasn't that they were like special test subjects. They were actually just regular people getting the regular vaccine.

I have seen, by the way, some of that literature, and some of it is actually quite concerning. I'm not surprised in some sense. The vaccine testing and the rollout was done at a very

rapid clip. Normally, something like this would have taken years and years and years of testing. And I can understand why. Like you have a big threat to especially vulnerable older people, you want to rapidly test and roll out a vaccine. That makes a lot of sense to me. And then it also makes sense that given the speed at which it's done, there are mistakes made that can happen and we learn things over time about how to administer, and so on. So none of that is surprising to me.

The key question to me is, given all of those mistakes, what effect did it have at the population level? Ideally, I would have liked to see a long-term randomized study done over, you know, not just where you track patients for two months but for a year or longer to see what the effects of the vaccines were, including the side-effect profiles.

That's not possible after December 2020, when they ceased those big large-scale trials. And we don't have any more of those large-scale randomized trials. The best we have available are these epidemiological studies that I cite in the Alberta report. And those are the kinds of studies that—

[01:10:00]

I work with the US Food and Drug Administration on vaccine safety, for instance. Those are very similar to the kinds of studies that I've done and conducted where the idea is to carefully match patients who've had the vaccine with patients who haven't as best you can, given it's not randomized. And then track them over time using passive data systems, like electronic health records, like medical claims. And then conduct this longitudinal analysis comparing the outcomes of patients who've had and who've not had the vaccine. That's essentially what those studies do. They're not perfect. They're not randomized. They're, unfortunately, the best we have.

Commissioner Drysdale
As a policy analyst—as you being a policy analyst, not me, by the way—my understanding of policy is when you examine issues or problems, you examine suggested solutions and, then, you try to understand how those solutions to that problem will affect the overall tapestry of our culture or our world in this matter. I mean, you know, we seemed to impose things that tugged on every fibre of our society. We locked people down. We isolated old people in old folk homes. We censored people. So we almost tugged on every single fabric of our society.

And my question to you then is, as a policy analyst, are you aware of any detailed cost-benefit studies on these things that were done in Canada or United States?

Dr. Jayanta Bhattacharya
No, none. And I think it was a malpractice, a public policy malpractice not to have done such a thing. Essentially public health acted as if all that mattered was COVID risk—and not just COVID risk but the spread of COVID—and adopted policies, tremendously destructive policies like lockdowns, like school closures without an eye toward any of the other so easily predictable social consequences and health consequences from those policies.

An honest and responsible public health considers both the costs and benefits, the harms and benefits from policies it recommends. It looks at public health holistically, holistically not in the sense that the World Health Organization only means it. Health is a very, very broad multifaceted thing. It's not simply the prevention of a single infectious disease. And

so, when you adopt policies that are aimed at simply the protection against a single infectious disease, you are almost automatically going to harm other aspects of health. And that's exactly what's happened.

Commissioner Drysdale
As a professional myself, I understand the importance of explaining to my client in terms that they can understand what exactly I'm talking about. You know, as a professional, yourself included, we can use all kinds of terminology that is normal to us that our clients can't understand. In this particular instance, and from what I observed, this was probably the most significant time where folks needed to understand what was going on in order to give informed consent. And you spoke a little bit earlier about efficacy and you talked about relative efficacy versus absolute efficacy. And you said, well, that was a reasonable thing to you as a professional. But what I'm asking you is— Do you think that the general public, when they were told that they [the vaccines] had a 97 per cent efficacy, understood the difference between absolute efficacy and relative efficacy?

Dr. Jayanta Bhattacharya
No, I don't. I think that a lot of times people use that 95 per cent number without actually telling people, as they should have, what the caveat is about that number. So for instance, I think the most important caveat is it did not measure 95 per cent efficacy against severe disease and death. It only measured efficacy for the first two months after the vaccination. Those caveats should have been told to the public at large.

You used the words informed consent. I think there was a mass violation of informed consent in the way that the vaccine was rolled out. The force applied to people to take the vaccines through the mandates: the social discrimination, the passports, and movement restrictions—all of that was a mass ethical violation at scale.

Commissioner Drysdale
Once again, as a professional, I'm trained to understand the difference between real risks,

[01:15:00]

weigh them against potential risks, and then decide on what an action is. And I thought what I heard you saying in a number of instances was that there were potential risks.

One of the previous witnesses talked about, and I apologize, I can't remember the name of the doctor who did the studies that said the whole world was going to die. Now, I'm exaggerating that point. And then, there were studies by Pfizer that followed their test subjects for two months and then injected all of the placebo groups. So there was no placebo group past two months. There were doctors coming on TV that were telling us that the vaccines prevented spread when there was no studies on that. So to me, those were all potential risks.

The absolute risks were you locked a child up in their bedroom for two months and they couldn't go to school and what the consequences of that might be. Or you took a dementia patient that we've heard testimony on in a number of instances where they just locked them up and abandoned them to die.

And I guess my question is— Is it not standard practice in public health or in the practice of medicine to understand the difference between absolute and relative risk and weigh those two things together and come up with an appropriate solution given those two different types of risk?

Dr. Jayanta Bhattacharya
In the public health world that I grew up in, I thought that was absolutely bog-standard. You would evaluate the evidence based on the quality of it: you'd prioritize high-quality versus low-quality evidence. You would try to understand the implications, the reasonable implications that could be drawn from evidence and not make inferences outside of what's reasonably inferable. If you had models, you'd check the models against reality to see if the models are actually doing well enough. You would think about a whole wide range of outcomes from a policy, not just simply the putative benefits of a policy but also the potential harms of the policy before you adopt it. All of these I thought were absolutely bog-standard in public health. And I think so many of those principles were thrown aside in the decision-making around COVID and COVID policy. It's been disheartening for me to watch as a public health professional.

Commissioner Drysdale
It almost seems that the fundamentals that we based our society on at almost all levels were ignored or trampled on here. You talked about censorship; you talked about public health, basic science. I'm a scientist, and in basic science, you observe something. You guess what you think it is. You do some testing; you develop a theory. And then you observe some more, and you take another guess. But science is a loop that keeps going round and round and round and round, the basic fundamental of everything in our technological life. And somehow, in this instance, we went around—we seem to have went around in a single loop. And then it became dogma. Is that something that you've observed before in your scientific career?

Dr. Jayanta Bhattacharya
Never. So my colleague, Martin Kulldorff of Harvard University, who co-authored the Great Barrington Declaration, at one point, I think in late 2020, he wrote that this was the end of the Age of the Enlightenment. And you know, at first, I thought he was being hyperbolic. But you know what? He was right.

Essentially, you had a scientific dogma, a relatively small, narrow-minded group of individuals with tremendous power who dominated the scientific life of the world for a time and didn't brook any dissent. When we wrote the Great Barrington Declaration, four days after we wrote it, the head of the National Institute of Health, Francis Collins in the United States, wrote an email to Tony Fauci calling me, Martin Kulldorff, and Sunetra Gupta fringe epidemiologists. And then calling for a devastating takedown of the premises of the Declaration.

I was subject to death threats, propaganda attacks, slander. I mentioned already the CBC slander, saying that I wanted to let the virus rip when, in fact, I wanted focused protection.

It was a systematic attack on the very foundations of science that operate exactly the way you say. You know, you have hypotheses. I would just add one thing to your excellent description of how science works with logic and hypotheses and experiment. It happens in conversation with others who disagree with you. In my experience in my scientific life, I've

learned a tremendous amount from people who disagree with me. It's how science advances. And when the disagreement results in an experiment where one idea is proved right and one idea is wrong, that's exactly how science advances. If you don't brook disagreement in science, you're not doing science.

[01:20:00]

Commissioner Drysdale
Yes, I mean, science is a combination of many minds, not one. And so that's the evolutionary process, if you will. If you're a single monolithic solution to a large problem, everybody's at risk by whether it's correct or not. You have multiple solutions and you have multiple opinions, you're protected. Thank you.

Shawn Buckley
Are there any more questions from the commissioners? There are, okay.

Commissioner Kaikkonen
When I think of the principle of content neutrality in defining the scope of section 2(b) of the *Canadian Charter of Rights and Freedoms*, as I recall, it's no matter how offensive or unpopular or disturbing a comment might be it still needs protection. But here we're speaking about a bias against truth. Can you comment?

Dr. Jayanta Bhattacharya
I have to say, in 2020, it seemed to me like the basic protections for free speech in the United States and Canada were essentially thrown away. The United States, the First Amendment seems to have made some comeback here. And I still have some hope that our lawsuit will succeed. I'm very worried about Canada. My experience in the Canadian lawsuits that I've been involved with—one in Alberta, one in Manitoba against the lockdowns, and then another in Montreal—I have seen very little inclination from the Canadian courts to protect those basic charter rights.

You're absolutely right. This is even more fundamental than somebody just saying bad words on the internet or something. Although I think those are free speech rights that ought to be protected.

What you have here is a fundamental suppression of scientific discussion. And it was a suppression both directly with direct censorship efforts but also by smearing and demonizing people who disagreed with the narrative. Credentialed people, doctors, scientists, where the idea was to—in the minds of Canadians just watching CBC—for them to think that, okay, these are the bad guys; the public health authorities who are making all these lockdown decisions are the good guys. And you should just ignore them because they're fringe, they're outsiders, they're somehow underqualified. Although, I mean, the key thing to me is that kind of idea is dangerous not just from a legal perspective—where you violate fundamental civil rights of peoples, which it absolutely is—but also from a public health perspective.

When public health authorities make mistakes, you have to permit dissent. You have to allow that kind of correction to happen. And if it's going to happen from the outside, where else would it happen if you have a monolithic public health authority that's speaking in one

voice? You can't simultaneously allow that public health authority then to control the organs of the media and allow it to demonize opponents, not with logic but essentially by drowning out or by de-platforming. But that's unfortunately what happened. And I think it harmed the health of Canadians.

Commissioner Kaikkonen
Thank you.

Shawn Buckley
Dr. Bhattacharya, it appears that the commissioners are finished with their questions and I'd like to just on behalf of the National Citizens Inquiry sincerely thank you for taking the time to share with us. Your testimony is greatly appreciated as we jointly just try to find out what happened and figure out how to proceed and heal as a nation. So thank you so much for your contribution.

Dr. Jayanta Bhattacharya
Thank you so much.

[01:24:03]

Final Review and Approval: *Margaret Phillips, August 10, 2023.*

The evidence offered in this transcript is a true and faithful record of witness testimony given during the National Citizens Inquiry (NCI) hearings. The transcript was prepared by members of a team of volunteers using an "intelligent verbatim" transcription method.

For further information on the transcription process, method, and team, see the NCI website: https://nationalcitizensinquiry.ca/about-these-transcripts/