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EXAMINING THE U.S. PUBLIC HEALTH RESPONSE TO THE EBOLA OUTBREAK

THURSDAY, OCTOBER 16, 2014

House of Representatives,

Subcommittee on Oversight and Investigation

Committee on Energy and Commerce

Washington, D.C.

The Subcommittee met, pursuant to call, at 12:02 p.m., in Room 2123 of the Rayburn House Office Building, Hon. Tim Murphy [Chairman of the Subcommittee] presiding.

Present: Representatives Murphy, Burgess, Blackburn, Gingrey, Scalise, Gardner, Griffith, Johnson, Long, Ellmers, Upton (ex officio), DeGette, Braley, Schakowsky, Castor,

Welch, Green, and Waxman (ex officio).

Also present: Representatives Yarmuth, Matheson, Sarbanes, Harris, and Meadows.

Staff present: Gary Andres, Staff Director; Charlotte Baker, Deputy Communications Director; Sean Bonyun, Communications Director; Leighton Brown, Press Assistant; Rebecca Card, Staff Assistant; Karen Christian, Chief Counsel, Oversight; Noelle Clemente, Press Secretary; Mary Dannenfelser, Senior Advisor, Health Policy and Coalitions; Brenda Destro, Professional Staff Member, Health; Andy Duberstein, Deputy Press Secretary; Brad Grantz, Policy Coordinator, Oversight and Investigations; Sydne Harwick, Legislative Clerk; Brittany Havens, Legislative Clerk; Sean Hayes, Deputy Chief Counsel, Oversight and Investigations; Kirby Howard, Legislative Clerk; Charles Ingebretson, Chief Counsel, Oversight and Investigations; Emily Newman, Counsel, Oversight and Investigations; Krista Rosenthall, Counsel to Chairman Emeritus; Macey Sevcik, Press Assistant; Alan Slobodin, Deputy Chief Counsel, Oversight; Sam Spector, Counsel, Oversight; Jean Woodrow, Director, Information Technology; Ziky Ababiya, Democratic Staff Assistant; Peter

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Bodner, Democratic Counsel; Brian Cohen, Democratic Staff Director, Oversight and Investigations, and Senior Policy Advisor; Lisa Goldman, Democratic Counsel; Elizabeth Letter, Democratic Professional Staff Member; Karen Lightfoot, Democratic Communications Director and Senior Policy Advisor, and Nicholas Richter.

Mr. {Murphy.} Good afternoon. I convene this hearing of the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce.

Ms. {DeGette.} Mr. Chairman, I can't see the witnesses.

Mr. {Murphy.} We will need to make sure that the media is--when the witnesses speak and we are clear of the center section.

Today, the world is fighting the worst Ebola epidemic in history. CDC and our public health system are in the middle of a fire. Job one is to put it out completely, and we will not stop until we do. We must be clear-eyed and singular in purpose to protect public health, and to ensure not one additional case is contracted here in the United States. We in Congress stand ready to serve as a strong and solid partner in solving this crisis because there is no greater responsibility for the U.S. government than to protect and defend the safety of the American people.

The stakes in this battle couldn't be any higher. The number of Ebola cases in western Africa is doubling about every 3 weeks. The math still favors the virus, even with

the recent surge in global response.

With no vaccine or cure, we are facing down a disease for which there is no room for error. We cannot afford to look back at this point in history and say we should have done more.

Errors in judgment have been made, to be sure, and it is our immediate responsibility today to learn from those errors, correct them rapidly and move forward effectively as one team, one fight.

Let us candidly review where we stand. When the latest Ebola outbreak in West Africa was confirmed months ago, authorities thought it would be similar to the 1976 outbreaks and quickly contained. That turned out to be wrong. By underestimating both the severity of the danger and overstating the ability of our healthcare system to handle Ebola cases, mistakes have been made. What was adequate practice for the past has proved to fall short for the present.

The trust and credibility of the Administration and government are waning as the American public loses confidence each day with demonstrated failures of the current strategy,

but that trust must be restored, but will only be restored with honest and thorough action.

We have been told: ``virtually any hospital in the country that can do isolation can do isolation for Ebola.'' The events in Dallas have proven otherwise. Current policies and protocols for surveillance, containment and response were not sufficient. False assumptions create real mistakes, sometimes deadly mistakes.

We must understand what went wrong so we can get a firm handle on this crisis: Why was the CDC slow to deploy a rapid response team at Texas Health Presbyterian Hospital? Why weren't protocols to protect healthcare and hospital workers rapidly communicated? What training have healthcare workers received?

And there are things about Ebola we don't know. How long does the virus live on surfaces or on certain substances? How do healthcare workers wearing full protective gear still get infected? Can it be transmitted from a person who does not yet have a high fever? Both CDC and NIH tell us that Ebola patients are only contagious when having a fever. However, the largest study of the current Ebola outbreak

found that nearly 13 percent of confirmed cases in West Africa did not have associated fever.

Now, I respect the CDC as the gold standard for public health, but the need for strong congressional oversight and partnership remains paramount. I want to understand why CDC and the White House changed course on in 2010 on proposals first introduced in 2005 that would have strengthened the federal quarantine authority. We are here to work through and fix these problems.

I restate my ongoing concern that Administration officials still refuse to consider any travel restrictions for the more than 1,000 travelers entering the United States each week from Ebola hot zones.

A month ago, the President told us someone with Ebola reaching our shores was unlikely and that ``we have taken the necessary precautions to increase screening at airports so that someone with the virus does not get on a plane for the United States.''

Screening and self-reporting at airports have been a demonstrated failure, yet the Administration continues to advance a contradictory reason for this failed policy that

frankly doesn't make sense to me, especially if priority one is to contain the spread of Ebola and protect public health.

It troubles me even more when public health policies are based upon a stated concern over cutting commercial ties with fledgling democracies rather than protecting public health in the United States. This should not be presented as an all-or-none choice. We can and will create the means to transport whatever supplies and goods are needed in Africa to win this deadly battle. We do not have to leave the door open to all travel to and from hot zones in Western Africa while Ebola is an unwelcome and dangerous stowaway on these flights. I am confident we can develop a reasoned and successful strategy to meet these needs.

The current airline passenger screening at five U.S. airports through temperature taking and self-reporting is troubling. Both CDC and NIH tell us that Ebola patients are only contagious when having a fever, but we know this may not be totally accurate.

A determined, infected traveler can evade the screening by masking the fever with ibuprofen or avoiding the five airports. Further, it is nearly impossible to perform

contact tracing of all people on multiple international flights across the globe.

So let me be clear to all the federal agencies responding to the outbreak. If resources or authorization is needed to stop Ebola in its tracks, tell us in Congress. I pledge, and I believe this committee joins me in pledging, that we will do everything in our power to work with you to keep the American people safe from the Ebola outbreak in West Africa.

[The prepared statement of Mr. Murphy follows:]

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Mr. {Murphy.} I now recognize the ranking member of the committee, Ms. DeGette.

Ms. {DeGette.} Thank you, Mr. Chairman.

On Monday, the Director General of the World Health Organization called the Ebola outbreak ``the most severe, acute health emergency seen in modern times.'' She warned that the epidemic ``threatens the very survival of societies and governments in West Africa.''

This WHO assessment is no exaggeration. CDC predicts that up to 1.4 million West Africans could be infected with Ebola. Many more will die from treatable illnesses due to the collapse of these countries' public health infrastructures. This is a humanitarian crisis, and we have a moral imperative to help in West Africa. But ending the West Africa outbreak is also a U.S. national security imperative because doing so is the best way to keep Ebola out of the United States.

I was alarmed like all of us were when Thomas Duncan flew to the United States while harboring Ebola, and even more disturbed to learn of his discharge from the Texas

Presbyterian ER with a fever after reporting that he had traveled from Liberia. Even worse, we learned this week that two nurses treating Mr. Duncan, Nina Pham and Amber Vinson, have contracted Ebola. I know, Mr. Chairman, we all join in sending these women and their families our prayers.

These new cases raise serious questions. The Washington Post wrote yesterday that Texas Presbyterian ``had to learn on the fly how to control the deadly virus'' and that the hospital was ``not fully prepared for Ebola.'' We need to find out why this hospital was unprepared and if others are too, and we need to make sure that the CDC is filling these readiness gaps. We should be concerned about the appearance of Ebola in the United States and the transmission to two health care workers, but we should not panic. We know how to stop Ebola outbreaks by isolating patients and tracing and monitoring contracts. The U.S. health care system can prevent isolated cases from becoming broader outbreaks, and that is why I am glad Dr. Frieden is here with us and Dr. Varga will be with us by video, because it would be an understatement to say that the response to the first U.S.-based patient with Ebola has been mismanaged, causing risk to

scores of additional people. I know both of these gentlemen will be transparent and forthright in helping me to understand how we can improve our response when yet another person, and it will inevitably happen, shows up at the emergency room with these kind of symptoms.

I appreciate the steps taken by CDC and Customs to begin airport screenings. These steps are appropriate, and as some call for cutting off all travel, as the chairman said, this won't be reasonable to be able to stop anybody with Ebola from coming into the United States, and we don't want to take steps that would endanger Americans by interfering with efforts to halt the outbreak in Africa.

You know, there is no such thing as fortress America when it comes to infectious diseases, and the best way to stop Ebola is going to be to stop this virus in Africa. Experts from Doctors Without Borders have told us that a quarantine on travel would have ``catastrophic impacts on West Africa.'' Also, earlier this week the Director of NIH, Dr. Francis Collins, said had we adequately funded his agency for over a decade, we would already have an Ebola vaccine. His words are a reminder that key public health agencies have

faced stagnant funding for several years, hampering our ability to respond to this crisis.

Mr. Chairman, 6 weeks ago when I first sent you a letter to ask for this hearing, the scope of the problem in West Africa was beginning to come into focus. Now the situation is dire. Let us work together to make sure that we stop it as quickly as we can.

With that, I yield the balance of my time to the gentleman from Iowa, Mr. Braley.

[The prepared statement of Ms. DeGette follows:]

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Mr. {Braley.} Thank you.

Our duty today is to make sure the Administration is doing everything possible to prevent the spread of Ebola within the United States. Our number one priority in combating this disease must be the protection of Americans, and we have to figure out the best way to do that.

My heart goes out to all those suffering from this horrible epidemic, and I am very proud of the hard work done by American troops, doctors, nurses and other volunteers to combat this disease. Congress must come together, put aside partisan differences and help stop this outbreak.

Today I hope to hear what steps the Administration is taking to prevent the spread of Ebola and respond to the outbreak. I am greatly concerned, as Congresswoman DeGette has expressed, that the Administration did not act fast enough in responding in Texas. We need to look at all the options available to keep our families safe and move quickly and responsibly to make any necessary changes at airports.

[The prepared statement of Mr. Braley follows:]

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Mr. {Murphy.} The gentleman's time is expired. I now recognize the chairman of the full committee, Mr. Upton, for 5 minutes.

The {Chairman.} Well, thank you.

Let me first begin by thanking our witnesses and all of the Members, Republicans and Democrats, for being here today.

You know, it is unusual to convene a hearing in D.C. during a district work period, but on this issue, there is no time to wait. I was likewise glad to see the President get off the campaign trail yesterday to finally focus on the crisis.

People are scared. We need all hands on deck. We need a strategy, and we need to protect the American people, first and foremost. It is not a drill. People's lives are at stake, and the response so far has been unacceptable.

As chairman of this committee, I want to assure the witnesses that we stand ready to support you in any way to keep Americans safe, but we are going to hold your feet to the fire on getting the job done, and getting it done right.

Both the United States and the global health community

have so far failed to put in place an effective strategy fast enough to combat the current outbreak. The CDC admitted more could have been done in Texas. Two health care workers have become infected with Ebola even as nurses and other medical personnel suggest that protocols are being developed on the fly. And none of us can understand how a nurse who treated an Ebola-infected patient, and who herself had developed a fever, was permitted to board a commercial airline and fly across the country.

It is no wonder the public's confidence is shaken. Over a month ago, before Ebola reached our shores, we wrote to Health and Human Services Secretary Burwell seeking details for the preparedness and response plan here at home and abroad, and it is clear whatever plan was in place was insufficient, but I believe we can and must do better now.

We need a plan to treat those who are sick, to train health workers to safely provide care, and to stop the spread of this disease here at home and at its source in Africa. This includes travel restrictions or bans from that region beginning today. Surely we can find other ways to get the aid workers and supplies in to these countries. From

terrorist watch lists to quarantines, there are tools used to manage air travel to assure public safety. Why not here? We can no longer be reacting to each day's crisis. We need to be aggressive and finally get ahead of this terrible outbreak.

The American people also want to know that our troops and medical personnel who are courageously headed to Africa to treat the sick will be protected. We want to know that health care workers here in America have the training and resources necessary to safely combat that threat as well.

So it is not just the responsibility of the United States. The global health community bears the charge to finally get ahead of the threat, develop a clear strategy, train all those who are involved in combating this disease, and eradicate this threat.

We have all heard the grave warnings that this will get worse before it gets better. People are scared. It is our responsibility to ensure that the government is doing whatever it can to keep the public safe.

Diana DeGette and I have partnered together on the 21st Century Cures initiative to help improve the research and

speed the approval of life-saving medicines and treatments, and while much attention has been paid to how this effort can help with diseases like cancer and diabetes, these same reforms can also help in the development of treatments for deadly infections like Ebola. We are all partners in this effort to save lives.

I yield the balance of my time to Dr. Burgess.

[The prepared statement of Mr. Upton follows:]

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Dr. {Burgess.} Thank you, Mr. Chairman, and my thanks to the panel for being here today, and I think everyone here agrees, we must fix this.

America's response to the Ebola virus disease outbreak is not a political issue, it is a public health crisis and a very dire one at that.

The frightening truth is that we cannot guarantee the safety of our health care workers on the front lines. It has been known for some time that health care workers have an outsized risk in Western Africa. They have a 56 percent mortality rate of those health care workers who catch this disease. Two nurses have contracted Ebola in the United States, and indeed, we have to learn from the current situation in Texas and use any information we can gather to better help prepare hospitals and protect our health care workers on the front line. We are here today because we need answers to these questions.

This past August, the Inspector General of the Department of Homeland Security issued a report on personal protective equipment and antiviral countermeasures. They

found that, and I am quoting here, ``The Department of Homeland Security did not adequately conduct a needs assessment prior to purchasing pandemic preparedness supplies and then did not effectively manage its stockpile of personal protective equipment and antiviral medical countermeasures.'' This just illustrates how unprepared we are. We have to get this right.

I would like to yield the balance of my time to Ms. Blackburn from Tennessee.

[The prepared statement of Dr. Burgess follows:]

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Mrs. {Blackburn.} Thank you, Dr. Burgess, and yes, indeed, welcome to all of our witnesses.

Everyone has mentioned we are here to work with you to protect Americans, and that includes the caregivers, and by that I mean the men and women working on the front lines, the Screaming Eagles of the 101st from Fort Campbell.

I will yield back my time and have further questions. Thank you.

[The prepared statement of Mrs. Blackburn follows:]

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Mr. {Murphy.} The gentlelady yields back and time is expired. I would now like to introduce the witnesses--I am sorry. No, first I go to Mr. Waxman. I apologize.

Mr. {Waxman.} Thank you, Mr. Chairman. I am pleased to have this opportunity to make an opening statement before we hear from the witnesses.

I think we have to put all of this in perspective and not panic. Everybody said not to panic, and then they made statements like ``We are going to get tough. We are going to do something about it.'' Well, what do we need to do?

First of all, we have got a problem in Africa, and this is a serious outbreak that could spiral beyond our control. On Tuesday, the World Health Organization estimated that soon there could be up to 10,000 new Ebola cases each week in West Africa, and CDC has warned that the outbreak could infect as many as 1.4 million people by the end of January. So this is a humanitarian crisis in Africa, and we have a responsibility to help because if we don't help there, that outbreak is going to continue to spiral out to other places, and sealing people off in Africa is not going to keep them from

traveling. They will travel to Brussels, as one of the people did, and then into the United States.

We can stop the epidemic from spreading in Africa or in the United States if we isolate the patient and monitor the contracts of that patient, and if we do that, we can stop it there and we can stop it here.

So in Africa, we need to know, are we moving fast enough, responders have adequate resources. Are we effectively coordinating our response with other countries in international organizations?

But here, people are scared, and we shouldn't make them even more frightened. Put this in perspective. We have had three recent cases of Ebola in this country: Thomas Duncan, who entered the United States while harboring Ebola and who flew through Brussels to get here; Nina Pham and Amber Vinson, the nurses who became ill while caring for Mr. Duncan. We should be concerned about these cases, and we need to act urgently, but we need not to panic. What we have to do is learn what we need to do, what mistakes we have made and not repeat them. We want to find out what happened at Texas Health Presbyterian Hospital, how CDC, state and local

health officials and hospitals can improve procedures moving forward.

We should use this as a wakeup call to ensure the adequacy of our own public health and preparedness safety net. We need to be prepared before a crisis hits, not scrambling to respond after the crisis.

In the past decade, the ability to fund research and public health programs has declined here in the United States. Since 2006, CDC's budget adjusted for inflation has dropped by 12 percent. Funding for the Public Health Emergency Preparedness Cooperative Agreement, which supports State and local health department preparedness activities, has been cut from $1 billion in its first year of funding in 2002 to $612 million in 2014. All of these were also subject to the sequestration, and those who allowed that sequestration to happen by closing the government have to answer to the American people as well.

We need to commit adequate funding to public health infrastructure. We need to hold public health systems accountable to standards of preparedness. Based on what we know, it appears that Texas Presbyterian would have not met

those standards, though in fairness, I suspect that many hospitals all over the country would also have struggled to respond. This is a problem we have to solve.

Mr. Chairman, before I run out of time, I want to acknowledge the health care workers and volunteers, those treating Ebola victims in the United States and those who have traveled to West Africa to help during this outbreak. It is dangerous work that they are doing. They are putting themselves in danger to save lives. They deserve our thanks and our praise.

I also want to thank all of our witnesses. You have my confidence, and I appreciate your joining us today to provide answers about how to stop the current Ebola outbreak in Africa and how to improve our public health systems to avoid the next crisis.

I am ending my career at the end of this year, but I have been through so many hearings where when there is a crisis we have Congressmen sit and point fingers. Well, let us point fingers at all of those responsible. We have our share of responsibility by not funding the infrastructure. In Africa, they have no infrastructure. We have to help them

develop it to deal with this crisis, but we shouldn't leave ourselves vulnerable by these irrational budget cuts.

[The prepared statement of Mr. Waxman follows:]

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Mr. {Murphy.} The gentleman's time is expired. Thank you.

I would now like to introduce the witnesses on the panel for today's hearing. Dr. Thomas R. Frieden is the Director of the Centers for Disease Control and Prevention. Dr. Anthony Fauci is the Director of the National Institute of Allergy and Infectious Diseases within the National Institute of Health. Dr. Robin Robinson is the Director of Biomedical Advanced Research and Development Authority within the Office of the Assistant Secretary for Preparedness and Response at the United States Department of Health and Human Services. Dr. Luciano Borio is the Assistant Commissioner for Counterterrorism Policy at the U.S. Food and Drug Administration. Mr. John P. Wagner is the Acting Assistant Commissioner of the Office of Field Operations within U.S. Customs and Border Protection at the U.S. Department of Homeland Security. And joining us today on videoconference from Texas will be Dr. Daniel Varga, who is the Chief Clinical Officer and Senior Vice President at Texas Health Resources.

I will now swear in the witnesses. You are all aware that the committee is holding an investigative hearing, and when doing so has had the practice of taking testimony under oath. Do any of you object to taking testimony under oath? None of the witnesses say so, and Dr. Varga?

Dr. {Varga.} No.

Mr. {Murphy.} Thank you. The chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do any you desire to be advised by counsel during your testimony today? Thank you. Everyone answers no. In that case, would you all please rise and raise your right hand and I will swear you in.

[Witnesses sworn.]

Mr. {Murphy.} You are now under oath and subject to the penalties set forth in Title XVIII, section 1001 of the United States Code. We will call upon you each to give a 5-minute opening summary of your written statement.

Dr. Frieden, you are recognized for 5 minutes.

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^TESTIMONY OF DR. THOMAS R. FRIEDEN, DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION; DR. ANTHONY FAUCI, DIRECTOR, NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, NATIONAL INSTITUTES OF HEALTH; DR. ROBIN ROBINSON, DIRECTOR, BIOMEDICAL ADVANCED RESEARCH AND DEVELOPMENT AUTHORITY, OFFICE OF THE ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; DR. LUCIANA BORIO, ASSISTANT COMMISSIONER, COUNTERTERRORISM POLICY, U.S. FOOD AND DRUG ADMINISTRATION; JOHN P. WAGNER, ACTING ASSISTANT COMMISSIONER, OFFICE OF FIELD OPERATIONS, CUSTOMS AND BORDER PROTECTION; U.S. DEPARTMENT OF HOMELAND SECURITY; AND DR. DANIEL VARGA, CHIEF CLINICAL OFFICER AND SENIOR VICE PRESIDENT, TEXAS HEALTH RESOURCES

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^TESTIMONY OF THOMAS R. FRIEDEN

} Dr. {Frieden.} Thank you very much, Chairman Murphy, Ranking Member DeGette, Chairman Upton and Ranking Member Waxman. I very much appreciate the opportunity to come before you to discuss the Ebola epidemic and our response to

it to protect Americans.

My name is Dr. Tom Frieden. I am trained as a physician. I am trained in internal medicine, in infectious diseases. I completed the CDC Epidemic Intelligence Service training, and I have worked in the control of diseases, communicable diseases and others, since 1990.

Ebola spread only by direct contact with a patient who is sick with the disease or has died from it, or with their body fluids. Ebola is not new, although it is new to the United States. We know how to control Ebola, even in this period. Even in Lagos, Nigeria, we have been able to contain the outbreak. We do that by tried-and-true measures of finding the patients promptly, isolating them effectively, identifying their contacts, ensuring that if any contact becomes ill, they are rapidly identified, isolated, and their contacts are identified.

But there are no shortcuts in the control of Ebola, and it is not easy to control it. To protect the United States, we have to stop it at the source.

There is a lot of fear of Ebola, and I will tell you as the Director of CDC, one of the things I fear about Ebola is

that it could spread more widely in Africa. If this were to happen, it could become a threat to our health system and the health care we give for a long time to come.

Our top priority, our focus is to work 24/7 to protect Americans. That is our mission. We protect Americans from threats, and in the case of Ebola, we do that by a system at multiple levels. In addition to our efforts to control the disease at the source, we have helped each of the affected countries establish exit screening so that every person leaving has their temperature taken. In a two-month period of August and September, we identified 74 people with fever. None of them entered the airport or boarded the plane. As far as we know, none of them were diagnosed with Ebola, but that was one level of safety.

Recently, we have added another level of screening people on arrival to the United States. That identifies anyone with fever here, and we have worked very closely with the Department of Homeland Security and Customs and Border Protection to implement that program, and I would be happy to provide further details of it later.

We have also increased awareness among physicians

throughout the United States to think Ebola in anyone who has fever and/or other symptoms of infection and who has been to West Africa in the previous 21 days. We have established laboratory services throughout the country so that not all laboratory tests have to come to the specialized laboratory at CDC. In fact, one of those laboratories in Austin, Texas, identified the first case here.

We also have fielded calls from concerned doctors and public health officials throughout the country. We found more than 300 calls and only patient, Mr. Duncan, had Ebola, but that is one too many, and we are open to ideas for what we can do to keep Americans as safe as possible as long as the outbreak is continuing.

We also have established emergency response teams from CDC that will go within hours to any hospital that has an Ebola case to help them provide effective care safety.

[Slide]

There is a lot of understandable concern about the cases in Dallas. I have one slide, if we can show it, of the contact tracing activities there, and I think we provided copies for the members. The two core activities in Dallas

are to ensure that there is effective infection control and to trace contacts. Here you see a timeline of exactly what has happened in the identification of contacts. We have followed each of the contacts. When any become ill or if any become ill, we immediately isolate them so that we can break the chain of transmission. That is how you stop Ebola. I can go through the details when you wish.

We also are working to ensure that there is effective infection control there, and I can go through the details of that.

In sum, CDC works 24/7 to protect Americans. There are no shortcuts. Everyone has to do their part. There are more than 5,000 hospitals in this country. There are more than 2,500 health departments at the local level. We are there to support. We are there with world-class expertise, and we are there to respond to threats so that we can help protect Americans, and we are always open to new ideas. We are always open to data because our bottom line is using the most accurate data and information to inform our actions and protect health.

Thank you.

[The prepared statement of Dr. Frieden follows:]

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Mr. {Murphy.} Thank you, Dr. Frieden. I now recognize Dr. Fauci for a 5-minute summary of your statement.

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^TESTIMONY OF ANTHONY FAUCI

} Dr. {Fauci.} Thank you, Chairman Murphy, Ranking Members DeGette and Upton, Ranking Member Waxman. You have just heard about the public health aspects of Ebola virus disease from Dr. Frieden. I appreciate the opportunity to speak with you this morning for a few minutes on the role of the National Institute of Allergy and Infectious Diseases in research addressing Ebola virus disease.

Of note is that our activities actually started with the tragic events of 9/11/2001, which were followed closely by the anthrax attacks, which many of the members remember, against the Congress of the United States and the press. It was in that environment that a multifaceted approach towards bioterrorism was actually mounted by the Federal Government, one of which was the research endeavor to develop countermeasures. We soon became very aware that naturally occurring outbreaks of disease are just as much of a terror to the American and world public as a deliberate bioterror.

[Slide]

You see on the slide a number of what we call Category A pathogens from anthrax, botulism, plague, smallpox, tularemia, but look at the last bullet, the viral hemorrhagic fevers including Ebola, Marburg, Lassa and others. The viral hemorrhagic fevers are particularly difficult because they have a high degree of lethality and a high infectivity upon contact with body fluids. Therapy is mainly supportive without specific interventions, and we do not have a vaccine.

And so what is the role of the National Institutes of Health--if we could advance the slide--the role of the National Institutes of Health in the research endeavor?

[Slide]

As you can see on the slide, we do basic and clinical research, and importantly, we apply and supply resources for researchers in industry and academia to advance product development. The end game of what we do are diagnostics, therapeutics and vaccines. I am sorry. Could we get the slide back on, the last slide? No, the previous one. I am very sorry. Could we get it back? There. Right there.

[Slide]

This is a multi-institutional endeavor. As you can see

on the slide, the NIH is responsible for fundamental basic research and early concept development, something that we did relatively alone because of the lack of interest on the industrial partners of making interventions. We partnered with BARDA, who you will hear from shortly with Dr. Robin Robinson, and then we partnered with industry as we have done in a moment as I will tell you to ultimately in collaboration with the FDA to get the approval of products. Next slide.

[Slide]

You have heard a lot about therapeutic interventions. I would just like to spend a moment talking to you about a few of them. First, it is important to realize that they are all experimental. None of them have proven to be effective. So when you hear about giving a drug that has a positive effect, we do not know at this point, A< is it a positive effect, or B, is it causing harm, and that is the reason why we need to study these carefully at the same time we rapidly can make them available to the people who need them.

The first one on the list is ZMapp. You have heard of it. That was given to Dr. Brantley and Nancy Writebol. It looks very good in animal models. It still needs to be

proven in the human. There are others such as the BioCryst product, which is a nucleoside analog. You have heard about the Tekmira drug which was developed in support by the Department of Defense, which is also being used in others that you will hear about such as Brincidofovir and Balapiravir. These are just a few of those again that will be going into clinical trials and that are actually being used in an experimental way with compassionate use with approval from the FDA in certain individuals.

[Slide]

Let me turn to this slide here, which is an important one, slides regarding a vaccine. We have been working on an Ebola vaccine for a number of years. We did the original studies shown in an animal model to be quite favorable. We are now right at the phase where we are in Phase I trials that some of you may have heard of, started at the NIH in September 2nd. A second vaccine was started just a couple of days ago by the U.S. military in collaboration with the NIH. When we finish those Phase I trials, namely asking is it safe and does it induce a response that you would predict would be protective, it is important to make sure it is safe. If

those parameters are met, we will advance to a much larger trial in larger numbers of individuals to determine if it is actually effective as well as not having a paradoxical negative deleterious effect. The reason we think this is important is that if we do not control the epidemic with pure public health measures, it is entirely conceivable that we may need a vaccine, and it is important to prove that it is safe and effective.

I would like to close by making an announcement to this committee because I am sure you will hear about it soon in the press. This evening, tonight, we will be admitting to the clinical studies unit, the special clinical studies unit, at the National Institutes of Health Nina Pham, otherwise known as nurse number one. She will be coming to the National Institutes of Health, where we will be supplying her with state-of-the-art care in our high-level containment facilities.

Thank you very much, Mr. Chairman.

[The prepared statement of Dr. Fauci follows:]

********** INSERT 2 **********

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Mr. {Murphy.} Thank you, Doctor. I now recognize Dr. Robinson for 5 minutes for a summary of your statement.

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^TESTIMONY OF ROBIN ROBINSON

} Mr. {Robinson.} Good afternoon, Chairman Murphy, Chairman Upton, Ranking Members DeGette and Waxman, and other distinguished members of the subcommittee. Thank you for the opportunity to speak with you today about our efforts by the government on Ebola.

I am Dr. Robin Robinson, a former vaccine developer in industry, and for the last 10 years a public servant working on pandemic preparedness and many other biothreats.

BARDA was created by the Pandemic and All-Hazards Preparedness Act in 2006. It is the government agency responsible for supporting advanced developments and procurement of novel and innovative medical countermeasures such as vaccines, therapeutic drugs, diagnostics and medical devices for the entire Nation. BARDA exists to address the medical consequences of biothreats and emerging infectious diseases. BARDA has supported medical countermeasure development for manmade threats on a routine basis under Project BioShield in responding to emerging threats like H1N1

pandemic in 2009 and the avian influenza H7N9 outbreak in China last year.

Today we are immersed in responding to Ebola, which is simultaneously a biothreat with a material thread determination issued by the Department of Homeland Security and an emerging infectious disease.

As you have said and my colleagues have said, when it comes to Ebola as a biothreat and emerging infectious disease, the best way to protect our country is to address the current epidemic in Africa, the worst on record.

BARDA works with its federal partners to transition the medical countermeasures from early development, as Dr. Fauci said, into advanced development towards ultimate FDA approval.

Since 2006, we have built an advanced development pipeline of more than 150 medical countermeasures for chemical, biological, radiological and nuclear threats, and pandemic influenza. Seven of these products have been FDA approved in the last 2 years, and today we are transitioning several promising and maturing Ebola vaccines and therapeutic candidates from early development under NIH and DoD support

into advanced development and ensuring that commercial-scale manufacturing capacity for these product candidates is available as soon as possible.

BARDA in concert with our federal partners utilizes public-private partnerships with industry to ensure that we have countermeasures to protect our citizens. Over the past years, BARDA with NIH, CDC, FDA and our industry partners have built a flexible and rapid response of infrastructure to develop and manufacture medical countermeasures. As a result of the Pandemic and All Hazards Preparedness Reauthorization Act, improved framework for medical countermeasures development has been forwarded to federal and industry partners, and last year we made five new vaccine candidates in record time for the H7N9 outbreaks in China. Currently, we are working with a wider array of partners including both small and large pharmaceutical companies, Canada, the U.K., West African countries, the World Health Organization and others to make and evaluate the safety and efficacy of these Ebola product candidates.

BARDA has established a medical countermeasure infrastructure to assist product developers on a daily basis

to respond immediately in a public health emergency. We are using a number of our core service system programs. There is the Nonclinical Studies Network, our Centers for Innovation and Advanced Development in Manufacturing, and our Fill Finish Manufacturing Network to make these products available as soon as possible. Additionally, our staff are onsite at the manufacturer, people in plant, to provide technical assistance and oversight to expedite product availability.

Additionally, we are working with CDC and others across the Federal Government and internationally with our modeling efforts to look at the Ebola outbreak as it becomes epidemic and also what possible impacts interventions may occur.

BARDA supports large-scale production of medical countermeasures and response measure for public health emergencies like the H1N1 pandemic and H7N9 outbreaks. Today we are assisting Ebola vaccine and therapeutic manufacturers with scaled-up production. Specifically, we are supporting the development and manufacturing of ZMapp monoclonal antibody therapy for clinical studies at one manufacturer, expanding overall manufacturing capacity of ZMapp by enlisting the help of other tobacco plant-based

manufacturers, and working on alternative Ebola monoclonal antibody candidates to expand production capacity. Pending the outcome of ongoing animal challenge studies, BARDA is prepared to support advanced development of additional promising therapeutic candidates that Dr. Fauci talked about to treat Ebola patients.

On the vaccine front, BARDA is working with industry partners to scale up manufacturing of three promising Ebola vaccine candidates, one of which we will make an announcement today, from pilot scale to commercial scale for clinical studies in Africa next year. In addition to BARDA's efforts in the Ebola response, we are supporting a number of other response activities including supporting health care system preparedness, developing policies and guidance on patient movements, repatriation, standards of care and clinical guidance, supporting the logistical aspect of deploying U.S. public health service officers to West Africa, and ongoing coordination and communication with national and international communities responding to the threat.

Finally, we face significant challenges, as has been discussed, in the coming weeks and months with the Ebola

epidemic continuing and as these medical countermeasures are manufactured and evaluated, but bottom line is that my colleagues here and our industry partners will use all of our collective capabilities here and abroad to address today's Ebola epidemic and to be better prepared for future Ebola outbreaks and bioterrorism events going forward.

I want to thank the committee and subcommittee for your generous and continued support over the past decade and the opportunity to testify. Thank you.

[The prepared statement of Mr. Robinson follows:]

********** INSERT 3 **********

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Mr. {Murphy.} Thank you, Dr. Robinson. Dr. Borio, you are recognized for 5 minutes.

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^TESTIMONY OF LUCIANA BORIO

} Dr. {Borio.} Thank you. Good afternoon, Chairman Murphy, Ranking Member--

Mr. {Murphy.} If you could just please pull the microphone as close to you as possible. Thank you.

Dr. {Borio.} Good afternoon, Chairman Murphy, Ranking Member DeGette and members of the subcommittee. Thank you for the opportunity to appear before you today to discuss FDA's actions to respond to the Ebola epidemic, a tragic global event. My colleagues and I at the FDA are determined to do all we can to help end it as quickly as possible.

The desire and need for safe and effective vaccines and treatments is overwhelming. FDA is taking extraordinary steps to be proactive and flexible. We are leveraging our authorities and working diligently to expedite the development and manufacturing availability of safe and effective medical products for Ebola. We are providing FDA's unique scientific and regulatory advice to companies to guide their submissions. We are reviewing data as it is received.

These actions help advance the development of investigation of products as quickly as possible, and for example, in the case of the two vaccines that Dr. Fauci mentioned, FDA took only a few days to review the applications and to allow the studies to proceed. As a result, the vaccine candidate being co-developed by the NIAID and GlaxoSmithKline began Phase I clinical testing on September 2nd and the vaccine candidate being developed by NewLink Genetics began similar clinical testing on October 13th. We are also partnering with the U.S. government agencies that support medical product development including NIAID, BARDA and the Department of Defense.

Because of FDA's longstanding collaboration with the DoD, FDA was able to authorize the use of the Ebola diagnostic test under our emergency authorization within 24 hours of request. We authorized the use of two additional diagnostics tests developed by the CDC and these tests of course are essential for an effective public health response.

In addition, we are supporting the World Health Organization. Our scientists are providing technical advice to the WHO as it works to assess the role of convalescent

plasma in treating patients with Ebola.

I recently participated in a consultation focused on Ebola vaccines in Geneva, which included dozens of experts from around the world as well as affected and neighboring countries in West Africa. Participants agreed that promising investigational vaccines must be evaluated in scientifically valid clinical trials and in a most urgent manner. FDA is working closely with our government colleagues and the vaccine developers to support this goal.

It is important to note, though, that while we all want access to immediate therapies to cute or prevent Ebola, the scientific fact is that these investigational products are in the earliest stages of development. There is tremendous hope that some of these products will help patients but it is also possible some may hurt patients and others may have little or no effect. Therefore, access to investigational products should be through clinical trials when possible. They allow us to learn about product safety and efficacy, and they can provide an equitable means for access.

FDA is working with our NIH colleagues to develop a flexible and innovative clinical trial protocol to allow

877 companies and clinicians to evaluate multiple investigational
878 Ebola products under a common protocol. The goal is to
879 ensure accrual of interpretable data and generate actionable
880 results in the most expeditious manner. It is important for
881 the global community to know the risks and benefits of these
882 products as soon as possible.
883 Until such trials are established, we will continue to
884 enable access to these products when available and requested
885 by clinicians. We have mechanisms such as compassionate use,
886 which allow access to investigational products outside of
887 clinical trials when we assess that the expected benefits
888 outweigh the potential risks for the patient.
889 I can tell you that every Ebola patient in the United
890 States has been treated with at least one investigational
891 product. Because FDA is such a--Ebola is such a serious and
892 often rapidly fatal disease, FDA has approved such requests
893 within a matter of a few hours and oftentimes in less than
894 one hour.
895 There are more than 250 FDA staff involved in this
896 response, and without exception, everyone has been proactive,
897 thoughtful and adaptive to the complex range of issues that

have emerged. We are fully committed to sustaining our deep engagement and aggressive activities to support the robust response to the Ebola epidemic.

Thank you, and I will take your questions later.

[The prepared statement of Dr. Borio follows:]

********** INSERT 4 **********

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Mr. {Murphy.} Thank you, Dr. Borio. Mr. Wagner, you are recognized for 5 minutes.

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^TESTIMONY OF JOHN WAGNER

} Mr. {Wagner.} Thank you, Chairman Murphy, Ranking Member DeGette and distinguished members of the subcommittee for the opportunity to discuss the efforts of U.S. Customs and Border Protection in deterring the spread of Ebola by means of international travel.

Each day, about 1 million travelers arrive in the United States. About 280,000 of them arrive at our international airports. CBP is responsible for securing our Nation's borders while facilitating the flow of legitimate international travel and trade that is so vital to our Nation's economy.

Within this broad responsibility, our priority mission remains to prevent terrorists and terrorist weapons from entering the United States. However, we also play an important role in limiting the introduction, transmission and spread of serious communicable diseases from foreign countries. We have had this role for over 100 years, and in coordination with the CDC, we have had modern protocols in

place for well over a decade that have guided response to a variety of significant health threats.

CBP officers at all ports of entry assess each traveler for overt signs of illness. In response to the recent Ebola virus outbreak in West Africa, CBP in close collaboration with CDC is working to ensure that frontline officers are provided the information, training and equipment needed to identify and respond to international travelers who may pose a threat to public health.

All CBP officers are provided guidance and training on identifying and addressing travelers with any potential illness including communicable diseases such as the Ebola virus. CBP officer training includes CDC public health training, which teaches officers to identify through visual observation and questioning the overt symptoms and characteristics of ill travelers. CBP also provides operational training and guidance on how to respond to travelers with potential illness including referring individuals who display signs of illness to CDC quarantine officers for secondary screening as well as training on assisting CDC with implementation of its isolation and

quarantine protocols.

Additionally, CBP provides training for its frontline personnel by covering key elements of CBP's Bloodborne Pathogens Exposure Control Plan, protections from exposure, use of personal protective equipment, other preventive measures and procedures to follow in a potential exposure incident. We are committed to ensuring our field personnel have the most accurate, updated information regarding this virus since the outbreak began. CBP field personnel have been provided a steady stream of guidance starting with initial information on the current outbreak at the beginning of April this year with numerous and regular updates since then.

Information sharing is critical, and CBP continues to engage with health and medical authorities. Since January of 2011, CDC's Division of Global Migration and Quarantine has stationed a liaison officer at our national targeting center to provide subject-matter expertise and facilitate requests for information between the two organizations.

Starting October 1st this year, CBP began providing Ebola information notices to travelers entering the United

States from Guinea, Liberia and Sierra Leone. This tearsheet provides the traveler information and instructions should he or she have a concern of possible infection.

In addition to visually screening all passengers for overt signs of illness, starting October 11th CBP and CDC began enhanced screening of travelers from the three affected countries entering at JFK Airport, and today we expanded these enhanced efforts at Dulles, Chicago O'Hare, Atlanta and Newark. Approximately 94 percent of travelers from the affected countries enter the United States through these five airports. In coordination with CDC, these targeted travelers are asked to complete a CDC questionnaire, provide contact information and have their temperature checked. Based on these enhanced screening efforts, CDC quarantine officers will make a public health assessment.

Since the additional measures went into effect at JFK, CBP has conducted enhanced screening on 155 travelers who were identified in advance as being known to have traveled through one of these three affected countries. An additional 13 travelers were identified by CBP officers as needing additional screening during the course of our standard

interview process that is applied at all ports of entry. A total of eight of these travelers have been sent to tertiary screening by CDC, and it is important to note that so far all passengers were examined and released.

While CBP officers receive training in illness recognition and response, if they identify an individual believed to be ill, CBP will isolate the traveler from the public in a designated area and contact the local CDC quarantine officer along with local public health authorities to help with further medical assessment. CBP officers are trained to employ universal precautions, an infection control approach developed by CDC when they encounter individuals with overt symptoms of illness or contaminated items in examinations of baggage and cargo. When necessary, CBP personnel will take the appropriate safety measures based on the level of potential exposure. These procedures designed to minimize risk to our officers and the public have been used collaboratively by both agencies on a number of occasions with positive results. CBP will continue to monitor the Ebola outbreak, provide timely information and guidance to our field personnel, work closely with our

interagency partners to develop or adopt measures as needed to deter the spread of Ebola in the United States.

So thank you for the opportunity to testify today and the attention you are giving to this very important issue. I will be happy to answer any of your questions.

[The prepared statement of Mr. Wagner follows:]

********** INSERT 5 **********

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Mr. {Murphy.} Thank you. Now we are going to recognize Dr. Daniel Varga, Chief Clinical Officer joining us from Texas on videoconference. Dr. Varga.

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^TESTIMONY OF DANIEL VARGA

} Dr. {Varga.} Good afternoon, Chairman Murphy, Vice Chair Burgess, Ranking Member DeGette and members of the committee. My name is Dr. Daniel Varga. I am the Chief Clinical Officer and Senior Vice President for Texas Health Resources. I am board certified in internal medicine and have more than 24 years of combined experience in patient practice, medical education and health care administration.

I am truly sorry I could not be with you in person today, and I deeply appreciate the committee's understanding of our situation and how important it is for me to be here in Dallas during this very challenging and sensitive time.

Texas Health Presbyterian Hospital Dallas is one of 13 wholly owned acute-care hospitals in the Texas Health Resources System. We are an 898-bed hospital treating some of the most complicated cases in north Texas in terms of--excuse me--in north Texas. Texas Health Dallas is recognized as a magnet designated facility for excellence in nursing services by the American Nurses Credentialing Center, the

Nation's leading nursing credentialing program.

Texas Health Resources is one of the largest faith-based centers not-for-profit health systems in the United States and the largest in north Texas in terms of patients served. Our mission is to improve the health of the people in the communities we serve, and we care for all patients regardless of their ability to pay. We serve diverse communities, and as such, as provide one standard of care for all regardless of race or country of origin.

As the first hospital in the country to both diagnose and treat a patient with Ebola, we are committing to using our experience to help other hospitals and health care providers protect the public health against this insidious virus. It is hard for me to put into words how we felt when our patient Thomas Eric Duncan lost his struggle with Ebola on October 8th. It was devastating to the nurses, doctors and team who tried so hard to save his life, and we keep his family in our thoughts and prayers.

Unfortunately, in our initial treatment of Mr. Duncan, despite our best intentions and a highly skilled medical team, we made mistakes. We did not correctly diagnose his

symptoms as those of Ebola, and we are deeply sorry. Also, in our effort to communicate to the public quickly and transparently, we inadvertently provided some information that was inaccurate and had to be corrected. No doubt, that was unsettling to a community that was already concerned and confused, and we have learned from that experience as well.

Last weekend, Nurse Nina Pham, a member of our hospital family who courageously cared for Mr. Duncan, was also diagnosed with Ebola. Our team is doing everything possible to help her win the fight, and on Tuesday her condition was upgraded to good, and as Dr. Fauci mentioned earlier, Nina's care continues to evolve. I can tell you that the prayers of the entire Texas Health system are with her. Yesterday, as has been noted, we identified a second caregiver with Ebola, and I can also tell you that our thoughts and prayers remain with Amber as well.

A lot is being said about what may or may not have occurred to cause Nina and Amber to contract Ebola. We know that they are both extremely skilled nurses and were using full protective measures under the CDC protocols, so we don't yet know precisely how or when they were infected. But it is

clear there was an exposure somewhere, sometime, and we are poring over records and observations and doing all we can to find the answers.

You have asked about the sequence of events with regard to our preparedness for Ebola and our treatment of Mr. Duncan. Key events from our preparation timeline are attached to our submitted statement, but here is a brief overview. As the Ebola epidemic in Africa worsened over the summer, Texas Health hospitals and facilities began educating our physicians, nurses and other staff on the symptoms and risk factors associated with the virus. On July 28, an Infection Prevention Nurse Specialist at Texas Health received the first Centers for Disease Control and Prevention Health Advisory about Ebola Virus Disease and began sharing it with other Texas Health personnel. The Healthcare Advisory encouraged all healthcare providers in the US to consider EVD in the diagnosis of febrile illness--in other words, a fever--in persons who had recently traveled to affected countries. The CDC advisory was also sent to all directors of our emergency departments and signage was also posted in the EDs.

On August 1, Texas Health leaders, including all regional and hospital leaders and the ED leaders across our system, received an email directing that all hospitals have a hospital epidemiologic emergency policy in place to address how to care for patients with Ebola-like symptoms. The email also drew attention to the fact that our electronic health record documentation in my departments included a question about travel history to be completed on every patient. Attachments to the e-mail included a draft THR epidemiologic emergencies policy that specifically addressed EVD, CDC-based poster to be posted in the ED, and the CDC advisory from 7/28.

The August 1 CDC Guidelines and Evaluation of US Patients Suspected of Having Ebola Virus Disease was distributed to staff, including physicians, nurses, and other frontline caregivers on August 1st and August 4th.

Over the last 2 months, the Dallas County Health and Human Services Department communicated with us frequently as plans and preparatory work were put in place for a possible case of Ebola. We have also provided the August 27, 2014 Dallas County Health Department algorithm and screening

questionnaire.

At 10:30 p.m. on September 25th, Mr. Duncan presented to the Texas Health Dallas Emergency Department with a fever of 100.1, abdominal pain, dizziness, nausea and headache, symptoms that could be associated with many other illnesses. He was examined and underwent numerous tests over a period of 4 hours. During his time in the ED, his temperature spiked to 103 degrees Fahrenheit but later dropped to 101.2. He was discharged early on the morning of September 26th, and we have provided a timeline on the notable events of Mr. Duncan's initial emergency department visit.

On September 28th, Mr. Duncan was transported to the hospital by ambulance. Once he arrived at the hospital, he met several of the criteria of the Ebola algorithm. At that time, the CDC was notified. The hospital followed all CDC and Texas Department of State Health Services recommendations in an effort to ensure the safety of all patients, hospital staff, volunteers, nurses, physicians and visitors. Protective equipment included water-impermeable gowns, surgical masks, eye protection and gloves. Since the patient was having diarrhea, shoe covers were added shortly

thereafter.

We notified the Dallas County Health and Human Services Department, and their infectious disease specialists arrived on the site shortly thereafter. On September 30th, lab testing confirmed--

Mr. {Murphy.} Doctor, could you--

Dr. {Varga.} --the first case of the Ebola Virus Disease diagnosed in the United States at Texas Health Dallas. Later that same day, CDC officials were notified, and they arrived on campus October 1st. Physicians--

Mr. {Murphy.} Doctor, one moment, please.

Dr. {Varga.} --nurses--

Mr. {Murphy.} Could you hold one moment, please? I know we are going way over time, and we do want to hear these details, but could you wrap it up? Because a lot of members want to ask you questions as well on some of these details, sir.

Dr. {Varga.} Okay.

Mr. {Murphy.} Thank you.

Dr. {Varga.} In conclusion, I would like to underscore that we have taken all the steps possible to maximize the

safety of our workers, patients and community, and we will continue to make changes as new learnings emerge. Moreover, we are determined to be an agent for change across the U.S. healthcare system by helping our peers benefit from our experience.

Texas Health Resources is an organization with a long history of excellence. Our mission and our ministry will continue, and we will emerge from these trying times stronger than ever.

Thank you for the opportunity to testify, and I'll obviously be glad to answer any questions from the committee.

[The prepared statement of Dr. Varga follows:]

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Mr. {Murphy.} Thank you. We will be recognizing each person on this committee for 5 minutes of questions. We will keep a strict time on this as well.

Let me start off here with Dr. Frieden. A second nurse infected with Ebola took a flight to Cleveland after she registered a fever. We have a report that says she contacted the CDC and was told she could fly. Did she in fact call the CDC and ask for guidance on boarding a commercial flight as far as you know?

Dr. {Frieden.} My understanding is that she did contact CDC and we discussed with her her report of symptoms as well as other evaluation.

Mr. {Murphy.} Were you part of that conversation?

Dr. {Frieden.} No, I was not.

Mr. {Murphy.} Was there a pre-plan suggesting limiting her contacts with other persons?

Dr. {Frieden.} The protocol for movement and monitoring of people potentially exposed to Ebola identifies as high risk someone who did not wear appropriate personal protective equipment during the time they cared for a patient with

Ebola. On--

Mr. {Murphy.} Well, let me you ask this. What specifically did she tell you? We know Mr. Duncan's medical team was under the same observation and travel--was not under the same observation and travel restrictions as people he came into contact with, so what specifically did she tell you her symptoms were or what was happening?

Dr. {Frieden.} I have not seen the transcript of the conversation. My understanding is that she reported no symptoms to us.

Mr. {Murphy.} All right. Let me ask another question here quickly. With regard to the new patient being transferred to NIH, will people who come into contact with her be under any travel restrictions? Dr. Fauci, perhaps you know that? I know--

Dr. {Fauci.} Well, according to the guidelines that the people who will be coming into contact with her will be physicians, nurses and others who will be in personal protective equipment and therefore they are not restricted.

Mr. {Murphy.} Why is she being transferred to NIH and away from Texas?

Dr. {Fauci.} To give the state-of-the-art care in a containment facility of highly trained individuals that are capable of taking care of her.

Mr. {Murphy.} Has her condition deteriorated or improved?

Dr. {Fauci.} No, it has not. She--I have not seen the patient yet. I will when she gets here. But at this point from the report that we are getting from our colleagues in Dallas is that her condition is stable and she seems to be doing reasonably well. But I have to verify that myself when my team goes over.

Mr. {Murphy.} And if other people come to Dallas or somewhere else, will they also be transferred to NIH?

Dr. {Fauci.} We have a limited capacity of beds of being able to do this type of high-level care and containment. Our total right now is two beds. She will occupy one of them.

Mr. {Murphy.} Thank you.

Dr. Frieden, when we spoke on the phone the other day, you remained opposed to travel restrictions because, in your words, you said ``cutting commercial ties would hurt these

fledgling democracies.'' Now, is this the opinion of CDC? Is this your opinion or does someone also advise you, someone within the Administration, any other agencies? Where did this opinion come from that that is of high importance?

Dr. {Frieden.} My sole concern is to protect Americans. We can do that by continuing to take the steps we are taking here as well as--

Mr. {Murphy.} Did someone advise you on that? Did someone outside of yourself, somebody else advise you that that is the position, we need to protect fledgling democracies?

Dr. {Frieden.} My recollection is that conversation is that that discussion was in the context of our ability to stop the epidemic of the source.

Mr. {Murphy.} But we can get supplies and medical personnel into the Ebola hot zones and so stopping planes-- and I have you say this on multiple occasions, that we have 1,000-plus persons per week coming into the United States from hot zones. Am I correct on that? Coming from those areas?

Dr. {Frieden.} There are approximately 100 to 150 per

day.

Mr. {Murphy.} Okay. Now, I mean, the Duncan case has seriously impacted Dallas and northern Ohio but what I don't understand, if the Administration insists on bringing Ebola cases into the United States, clearly you have determined how many Ebola infection cases the U.S. public can handle. I mean, NIH can handle two of these beds. Do you know that number overall in this country how many we can handle?

Dr. {Frieden.} Our goal is for no patients with Ebola--

Mr. {Murphy.} I understand, but as long as we don't restrict travel and we are not quarantining people and we are not limiting their travel, we still have a risk, and so these issues of surveillance and containment I don't understand, and this is the question the American public is asking: why are we still allowing folks to come over here and why once they are over here is there no quarantine.

Dr. {Frieden.} Our fundamental mission is to protect Americans. Right now, we are able to track everyone who comes in.

Mr. {Murphy.} But you are not stopping them from being around other people, Doctor. I understand that, and I have

respect for you, but my concern is the American public, and even so, they are not limited from travel, they are not quarantined for 21 days because they still show up with symptoms, they could still bypass all the questions that Mr. Wagner referred to, and this is what happened with the nurse who went to Cleveland. So I am concerned here. Is this going to be a maintained position of the Administration that there will be no travel restrictions?

Dr. {Frieden.} We will consider any options to better protect Americans.

Mr. {Murphy.} Thank you. I now give 5 minutes to Ms. DeGette.

Ms. {DeGette.} Thank you, Mr. Chairman.

Dr. Frieden, I have got some questions for you and Dr. Varga for you, and I would appreciate yes or no answers because I have a lot to move through and only a short amount of time.

Dr. Frieden, in the spring of 2014, Ebola began spreading through West Africa causing increasing concern within the international public health community, correct?

Dr. {Frieden.} Correct.

Ms. {DeGette.} Ebola has an incubation period of about 21 days and is not contagious until the person with the virus begins to be symptomatic beginning often with a fever, correct?

Dr. {Frieden.} Between 2 and 21 days, yes.

Ms. {DeGette.} Ebola is transmitted through contact with a patient's bodily fluids including vomit, blood, feces and saliva, and the virus concentrates more heavily as the patient becomes sicker, presenting increasingly greater risk to those who may in contact with them, correct?

Dr. {Frieden.} Correct.

Ms. {DeGette.} Now, the CDC has developed guidance for hospitals to follow if patients present with symptoms consistent with Ebola, and it distributed them to hospitals around the country in the summer of 2014, correct?

Dr. {Frieden.} Correct.

Ms. {DeGette.} Now, Dr. Varga, can you hear me?

Dr. {Varga.} Yes, ma'am.

Ms. {DeGette.} Your hospital received the first CDC Health Advisory about Ebola on July 28th, and this advisory was given to the directors of our emergency departments and

signage was posted in your emergency room. Is that right?

Dr. {Varga.} Yes, ma'am.

Ms. {DeGette.} Now, was this information given to your emergency room personnel and was there any actual person-to-person training at Texas Presbyterian for the staff at that time? Yes or no.

Dr. {Varga.} Was given to the emergency department.

Ms. {DeGette.} Was there actual training?

Dr. {Varga.} No.

Ms. {DeGette.} On August 1st, your hospital received an email from the CDC specifying how to care for Ebola patients and advising intake personnel to ask a question about travel history from West Africa. Is that right?

Dr. {Varga.} That is correct.

Ms. {DeGette.} Now, on September 25th, almost 2 months after the first advisory received by the hospital, Thomas Eric Duncan showed up at Texas Presbyterian with a fever that spiked up to 103 and he told the personnel that he had come from Liberia. Despite this, the hospital sent him home. Is that right?

Dr. {Varga.} That is not completely correct.

Ms. {DeGette.} Well, they did send him home, right?

Dr. {Varga.} That is correct.

Ms. {DeGette.} Now, 3 days later, on September 28th, he took a severe turn for the worst and was brought back by ambulance. The hospital staff, nurses and everybody else wore protective equipment. Is that right?

Dr. {Varga.} That is correct.

Ms. {DeGette.} And then eventually shoe covers were put on too. Do you know how long that took them to put the shoe covers on?

Dr. {Varga.} I don't.

Ms. {DeGette.} Now, because Ebola is highly contagious when the patient is symptomatic, the protective gear has to shield them from any contact with bodily fluids. Is that right, Dr. Frieden?

Dr. {Frieden.} Correct.

Ms. {DeGette.} Now, I have a slide I would like to put up, and I got it from the New York Times today. It is the photo of the people in the various protective gear. So the first one on the left shows what they are supposed to wear when they come in contact with--when they are not having

contact with the bodily fluids. The second one shows what they are supposed to have with the bodily fluids. So I want to ask you, Dr. Varga, is what they were wearing at first before the Ebola was diagnosed, that first set of protective gear?

Dr. {Varga.} I am sorry. I can't see the picture right now.

Ms. {DeGette.} Okay. I was told you would be able to.

Dr. Frieden, what should they have been wearing of that protective gear before the Ebola was diagnosed?

Dr. {Frieden.} I can't make out the details, but the recommendations vary as to the risk including whether the patient is having diarrhea or vomiting and may expose health care workers to--

Ms. {DeGette.} Well, this guy, he had diarrhea and vomiting. So in your testimony, people should have been completed covered. Is that right?

Dr. {Frieden.} I would have to look at the exact details to know what the answer to that question would be.

Ms. {DeGette.} So you don't know whether they should have been completely covered if the patient had diarrhea and

vomiting and he had come from West Africa?

Dr. {Frieden.} If the patient had diarrhea or vomiting, then additional covering is recommended under the CDC recommendations, yes.

Ms. {DeGette.} Now, my other question that I want to ask--and I am going to have to get--Dr. Varga, I am going to have to get your testimony since you can't see my chart.

Now, subsequently, a number of people, health care workers, were put into this group, this protective work. Is that right, Dr. Frieden? People who were being monitored.

Dr. {Frieden.} So health care--

Ms. {DeGette.} And on October 10th, Nina Pham presented with a fever, and she was admitted to the hospital. Is that right?

Dr. {Frieden.} Yes.

Ms. {DeGette.} And then on October 13th, Amber Vinson, who was self-monitoring, she presented with a fever and she was told by your agency she could board the plane. Is that right? I just have one more question.

Dr. {Frieden.} That is my understanding.

Ms. {DeGette.} Now, your--

Dr. {Frieden.} I need to correct that.

Ms. {DeGette.} Okay.

Dr. {Frieden.} I have not reviewed exactly what was said but she did contact our agency and she did board the plane.

Ms. {DeGette.} And she says she was told to board the plane. Now--

Dr. {Frieden.} That may well be correct.

Ms. {DeGette.} Now, your August 22nd protocols say people who are being monitored should not travel by commercial conveyances, don't they?

Mr. {Murphy.} Time is expired. You can answer the question.

Ms. {DeGette.} That is what they say.

Dr. {Frieden.} People who are in what is called controlled movement should not board commercial airlines.

Ms. {DeGette.} Right, and that is people who have close contact with these patients, right? That is what your guidelines say.

Dr. {Frieden.} The guidelines say that people--health care workers with appropriate personal protective equipment

don't need to be but people without appropriate personal protective equipment do need to travel by controlled transportation.

Mr. {Murphy.} The gentlelady's time is expired. We do need to--

Ms. {DeGette.} Mr. Chairman, I just ask for the record the interim guidance dated October 22nd, the interim guidance dated August 1st, and the interim--and the CDC Health Advisory dated July 28th be included in the record.

Mr. {Murphy.} Without objection, we will include it in the record.

[The information follows:]

********** COMMITTEE INSERT **********

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Mr. {Murphy.} And Dr. Frieden, I need you and also the doctor in Texas to get back to this committee as a follow-up to her question because your comment you just made to us was that if she was wearing appropriate protective gear, she is okay to travel; if she was not, she should not have traveled. And you just told us we don't know. We need to find that out. It is an important question.

I now recognize the chairman of the committee, Mr. Upton, for 5 minutes.

The {Chairman.} Thank you again, Mr. Chairman.

I think most Americans realize that it is--that you have 21 days. If you go beyond 21 days, you are virtually no risk of Ebola if you go that far. But it is conceivable then that after 14 or 15 days, you in fact can still get Ebola. Is that correct?

Dr. {Frieden.} Yes.

The {Chairman.} So I want to go back to the restricting of travel, particularly by non-U.S. citizens, these 150 folks a day into the United States from West Africa. So the conditions as you talked about exit screening, all folks from

there are exit screened, so it is perfectly conceivable that someone even after 14 days can exit screen, they are okay, no fever, and in fact, get to their destination, perhaps in the United States, and have the worst. Is that right?

Dr. {Frieden.} Yes.

The {Chairman.} So if our fundamental job is to protect the American public, the Administration, as I understand it, because I have looked at the legal language, the President does have the legal authority to impose a travel ban because of health reasons including Ebola. Is that not correct?

Dr. {Frieden.} I don't have the legal expertise to answer that question.

The {Chairman.} I saw language earlier today--we can share that with you--but he does, from what we understand, not only an Executive Order that former President Bush issued when he was President but also legal standing as well. So if you have the authority, and it is my understanding again that a number of African countries around West Africa, around particularly these three nations, in fact have imposed a travel ban from those three countries into their country. Is that not true?

Dr. {Frieden.} I don't know the details of the restrictions. There are some restrictions.

The {Chairman.} It is my understanding that they said no and including even Jamaica, as I read in the press earlier this week, has issued a travel ban from folks coming from West Africa. Are you aware of that?

Dr. {Frieden.} I don't know the details of what other countries have done. I know some of the details, and some of them have been in flux.

The {Chairman.} Well, I guess the question that I have is, if other countries are doing the same, and as you said, the fundamental job of the United States now is to protect American citizens, why cannot we move to a similar ban for folks who may or may not have a fever, knowing in fact that the exposure rate, 14 days or 15 days, is well within the 21 days and in fact knowing 150 folks coming a day, not 100 percent--you know, it is 94 percent in terms for screening from U.S. airports, it seems to me that this is not a failsafe system that has been put into place at this point.

Dr. {Frieden.} Mr. Chairman, may I give a full answer?

The {Chairman.} I look forward to it.

Dr. {Frieden.} Right now we know who is coming in. If we try to eliminate travel, the possibility that some will travel overland, will come from other places and we don't know that they are coming in will mean that we won't be able to do multiple things. We won't be able to check them for fever when they leave--

The {Chairman.} Do we not have--if I can interrupt you just for a second, do we not have a record of where they have been before, i.e., a passport or travel status as they travel from one country to another?

Dr. {Frieden.} Borders can be porous--may I finish?

The {Chairman.} Go ahead.

Dr. {Frieden.} Especially in this part of the world. We won't be able to check them for fever when they leave. We won't be able to check them for fever when they arrive. We won't be able, as we do currently, to take a detailed history to see if they were exposed when they arrive. When they arrive, we wouldn't be able to impose quarantine as we now can if they have high-risk contact. We wouldn't be able to obtain detailed locating information, which we do now, including not only name and date of birth but email

addresses, cell phone numbers, address, addresses of friends so that we can identify and locate them. We wouldn't be able to provide all of that information as we do now to State and local health departments so that they can monitor them under supervision. We wouldn't be able to impose controlled release, conditional release on them or active monitoring if they are exposed or to in other ways--

The {Chairman.} My time is expired. I now I have a swift gavel over here to my left. But I just don't understand. If we have a system in place that requires any airline passenger coming in overseas with a date of birth to make sure they are not on the anti-terrorist list that we can't look at one's travel history and say no, you are not coming here, not until this situation--you are right, it needs to be solved in Africa but until it is, we should not be allowing these folks in, period.

Mr. {Murphy.} The gentleman's time is expired. I recognize Mr. Waxman for 5 minutes.

Mr. {Waxman.} Thank you, Mr. Chairman.

Dr. Frieden, you have a difficult job. In fact, all of your colleagues who are involved from the different agencies

have a difficult job because this is a fast-moving issue, and you are trying to explain things to people and educate them with limited information and partial authority. In fact, the CDC can't even do anything in a State. They have to be invited in by the State. You can't tell the States to follow your guidelines. You can give them guidelines. So you are dealing with a fast-moving situation and you have to strike a balance about informing the public on the one hand and keeping it from panicking on the other. So let us go to basics.

If people are frightened about getting Ebola, what assurances can we give them that this is not going to be a widespread epidemic in the United States, as you have said on numerous occasions?

Dr. {Frieden.} The concern for Ebola is first and foremost among those caring for people with Ebola. That is why we are so concerned about infection control anywhere patients with Ebola are being cared for. Second, in the health care system as a whole, to think about travel because someone who has a fever or other signs of infection needs to be asked where have you been in the past 21 days, and if they

have been in West Africa, immediately isolated, assessed and cared for.

Mr. {Waxman.} So we have to make sure that we monitor health care workers because they are exposed to people who have Ebola. The questions have been raised, well, what about all these people coming in from Africa from the countries where the Ebola epidemic is taking place, and you have been asked why don't we just restrict the travel either directly or indirectly from anybody coming in from those countries.

I would like to put up on the screen a map to show the passenger flows from those countries. That map shows that if you--I will hold it up here. If you are looking at those particular countries in Africa, they can go to any country in Europe. They can go to Turkey, Egypt, Saudi Arabia. They can go to China and India. They can go to other countries in Africa and then from those other countries come to the United States. So I suppose we can set up a whole bureaucratic apparatus to be sure that somebody didn't really travel from Nigeria or Cameroon or Senegal or Guinea or Sierra Leone to be sure they didn't really get here from any of those countries. That could be our emphasis, but it seems to me

what you are saying is that we want to monitor people before they leave those countries to see whether they have this infection, and we want to monitor them when they come into these countries to see whether they have this infection. Is that what you are proposing to do?

Dr. {Frieden.} That is what we are actually doing. We are able to screen on entry. We are able to get detailed locating information. We are able to determine the risk level. If people were to come in by, for example, going overland to another country and then entering without our knowing that they were from these three countries, we would actually lose that information. Currently we have detailed locating information. We are taking detailed histories and we are sharing information with State and local health departments so that they can do the follow-up they decide to do.

Mr. {Waxman.} Dr. Fauci, do you agree with Dr. Frieden on this point?

Dr. {Fauci.} I do.

Mr. {Waxman.} You wouldn't put a travel ban in. It sounds like, you know, we always seal off our borders, don't

let those people come in. Now, that is usually a reference to the immigration matter, not public health particularly, or it might be a tangential issue, but we know certain countries where the epidemic is originating. Why not stop them from coming in?

Dr. {Fauci.} Well, I believe that Dr. Frieden and yourself just articulated it very clearly. It is certainly understandable how someone might come to a conclusion that the best approach would be to just seal off the border from those countries but we are dealing with something now that we know what we are dealing with. If you have the possibility of doing all of those lines that you showed, that is a big web of things that we don't know what we are dealing with.

Mr. {Waxman.} So what we know is this epidemic can spread if there is contact with body fluids from somebody who is showing the symptoms of Ebola or someone who has been exposed to that individual. If we had a travel ban, wouldn't we just force these people to hide their origin and wouldn't we also not know where they are coming from if they are going out of their way to hide it? A ban or quarantine would hinder efforts to fight the epidemic in West Africa, and the

worse the epidemic becomes in West Africa, the greater it is going to be a problem all over the world including the United States.

Mr. {Murphy.} The gentleman's time is expired.

Mr. {Waxman.} Is that your position? Dr. Fauci, is that your position?

Dr. {Fauci.} Yes.

Mr. {Murphy.} The gentleman's time is expired. Now we recognize the vice chair of the full committee for 5 minutes.

Mrs. {Blackburn.} Thank you, Mr. Chairman.

Dr. Frieden, I want to be sure I heard you right. You just said to Chairman Upton that we cannot have flight restrictions because of a porous border, so do we need to worry about having an unsecure southern and northern border? Is that a big part of this problem?

Dr. {Frieden.} I was referring to the border of the three countries in Africa, Liberia--

Mrs. {Blackburn.} You are referring to that border, not our porous border?

Dr. {Frieden.} --Guinea and Sierra Leone.

Mrs. {Blackburn.} Mr. Wagner, would it help you all,

the Border Patrol, if we secured the southern border and eliminated illegal entry?

Mr. {Wagner.} Well, travelers coming across the southern border like the northern border, we are going to, you know, query their information in our database. We are going to ask them their travel history, where they are coming from, how they arrived in the country there--

Mrs. {Blackburn.} Yes or no is sufficient. I need to move on.

Dr. Frieden, I want to come back to you. I would remind you that a week before last when I was at the CDC, and I thank you for letting me come down to follow up with you all on some of our committee work, that I recommended a quarantine in the affected region and hold people there, and I still think that that is something that we should consider. Quarantining people for 21 days before they leave that region, it helps every country.

I want to go back to an issue that you and I talked about at the CDC and a subsequent phone call, and that is the medical waste, and you assured me that standard protocols were being followed for disposal of this waste, and we know

that 20, 25 years ago, hospitals could incinerate their waste. EPA regulations now prohibit that, and the waste has to be trucked, and they outsource the care of this medical waste and it results in that going to central processing centers. So let me ask you this. Is Ebola waste as contagious as a patient with Ebola?

Dr. {Frieden.} Ebola waste or waste from Ebola patients can be readily decontaminated. The virus itself is not particularly hardy. It is killed by bleach, by autoclaving, by a variety of chemicals.

Mrs. {Blackburn.} Okay. Is Ebola medical waste more dangerous than other medical waste?

Dr. {Frieden.} The severity of Ebola infection is higher so you want to be certain when you are getting rid of it that you--

Mrs. {Blackburn.} Okay. Is the CDC assessing the capabilities of hospitals to manage the medical waste of Ebola patients and does the CDC allow offsite disposal of Ebola medical waste?

Dr. {Frieden.} My understanding is to the latter question, yes, we worked very closely with both the

Department of Transportation as well as the commercial waste management companies to ensure that capability.

Mrs. {Blackburn.} So we have an added danger in having to truck this waste and move it to facilities. Are the employees of the processing centers being trained in how to dispose of Ebola waste?

Dr. {Frieden.} We have detailed guidelines for the disposal of medical waste from care of Ebola patients.

Mrs. {Blackburn.} All right. You and I talked a little bit about my troops from Fort Campbell that are going to be over there, and I have some questions from some of my constituents. Are the American troops going to come in contact with any Ebola patients or with those exposed to Ebola or included in any of these controlled movement groups?

Dr. {Frieden.} As I understand it from the Department of Defense, their plans do not include any care for patients with Ebola or any direct contact with patients with Ebola. That said, we would always be careful in country because there is a possibility of coming in contact with someone with symptoms and being exposed to their body fluids, and that is why the Department of Defense is being extremely careful to

avoid that possibility.

Mrs. {Blackburn.} We are still going to rely on self-reporting.

Dr. {Frieden.} No. We are taking temperatures at many locations within the country. We are having hand-washing stations--

Ms. {Blackburn.} So you are moving away from self-reporting? Because originally it was--you said our structure was built on self-reporting when I visited with you earlier, and I found a quote from you from December 2011 at the George Comstock lecture in TB research, and I am quoting you: ``Hippocrates was right: patients lie. About a third of patients don't take medication as prescribed and a third don't take them at all. You can either delude yourself and think that patients are taking their medications or not. In TB control, it is a simple model. If we see people take their meds, we believe they took their meds.''

Now, Dr. Frieden, relying on self-reporting and making certain that people tell us the truth before they leave and then we catch the fever at the right time if they have a temperature. We have got to do better than this. We can do

better than this. We are here to work with you and we expect a better outcome. I yield back.

Mr. {Murphy.} The gentlelady's time is expired. I now recognize Mr. Braley for 5 minutes.

Mr. {Braley.} I would like to thank the panel for joining us today.

Dr. Frieden, I was happy to hear you say we will consider any options to protect Americans. I think that is the purpose of everyone here in this room today. But I do want to ask you about Texas. Are you familiar with the concept of sentinel-event reporting?

Dr. {Frieden.} Yes.

Mr. {Braley.} Has CDC done a root-cause analysis of what happened at Texas Presbyterian and come up with an action plan on what we learned from that incident? We have the detailed hospital checklist for Ebola preparedness, which we have heard about here today. Have there been any recommendations on changing, modifying or updating this in light of what happened at Texas Presbyterian?

Dr. {Frieden.} We have a team of more than 20 of some of the world's top disease detectives in Texas now. We were

there. We left the first day the patient was diagnosed. We identified three areas of particular focus. The first is the prompt diagnosis of anyone who has fever or other symptoms of infection and a travel history to West Africa, and Dr. Varga spoke about that issue. The second is contact tracing, and the graphic that I provided earlier outlines what we are doing there very intensively. The State of Texas and the country are doing a terrific job along with our staff making sure that every single contact of the first patient, Mr. Duncan, is monitored, their temperature taken by an outreach worker every day for 21 days. They are most of the way through that risk period. So of the 48, none have developed symptoms, none have developed fever. We are now looking at the contacts, health care workers who may have had contact as the two individuals who became infected did, and our thoughts are with them, and we are delighted that NIH is supporting the hospital in Texas and also that Emory University is doing that as well, and the third area is after identification and contact tracing is effective isolation, and we are looking very closely at what might possibly have happened to result in these two exposures.

Mr. {Braley.} And I assume if there are any new recommendations based upon that analysis, this protocol that was sent out will be updated and redistributed?

Dr. {Frieden.} We always look at the data to see what we can do to better protect Americans.

Mr. {Braley.} Thank you.

Dr. Fauci, you were kind enough to share with us this graphic, and in it you mentioned a company in Ames, Iowa, called NewLink, which is working on one of the vaccines that just went into Phase I clinical trials this week, correct?

Dr. {Fauci.} That is correct.

Mr. {Braley.} And I had an opportunity to talk to two of their employees yesterday, and I know that they are working around the clock trying to help come up with a vaccine that will meet the protocol and the standards for scalability that I think everyone is looking for. The WHO, the Department of Defense, HHS and the public health agency in Canada have called this vaccine one of the most advanced in the world, and they have requested contracts with HHS to expand the manufacturing, to add a third site for manufacturing, to complete the scientific studies required to

scale up manufacturing, and complete the additional safety study to provide newly manufactured vaccines that are equivalent to the original vaccines, and they have also identified companies to work as subcontractors.

Dr. Robinson, can you tell us what HHS is doing to make sure that those contracts are moving forward as quickly as possible?

Mr. {Robinson.} Thank you, sir. We have reviewed the proposal. It looks very favorable, and we will be in the next several weeks finalizing the negotiations with them. Prior to that, we actually have been helping them with their submissions to the FDA and providing assistance onsite and also at the manufacturing sites and working with them to expand their production with other companies including a very large company here in the United States.

Dr. {Fauci.} And also, Mr. Braley, the HHS is also involved in the other end of it because the trials that were started were not only in collaboration with the Department of Defense but we admitted our first VSV patient at our clinical center in Bethesda for a Phase I trial. So it is not only in the testing but also in the ultimate production.

Mr. {Braley.} And it is my understanding, Dr. Fauci and Dr. Robinson, that the ultimate goal is to also expand this clinical testing into some of the affected regions in Africa as well once we have an understanding of some of the concerns that were identified earlier in your testimonies.

Dr. {Fauci.} That is quite correct. In fact, when I was saying that after we get through Phase I on the trial, I was talking about both vaccines that GlaxoSmithKline and the NewLink both. If they are safe and induce the response we feel is appropriate, we will expand both of them into larger trials in West Africa.

Mr. {Braley.} And then Mr. Wagner, a question from you. We have heard a lot today about the issue of travel restrictions. Can you sort of walk us through the strengths and weaknesses of that approach from your standpoint in border security?

Mr. {Wagner.} Well--

Mr. {Murphy.} The gentleman's time is expired so if you could give a quick answer?

Mr. {Wagner.} So we have the ability to use the data that the airlines give us to be able to see where travel is

originating from. There are instances where travelers may go to different locations. We might not see that, but through our questioning and our review of their passport, we can identify that they have been to these affected regions or if they come through one of the borders. If they fly to Canada or Mexico it is more difficult for us to do it but the possibility is there, but the possibility is also greater that we would miss one, so I do agree with what the experts, you know, say. It is easier to manage it and control it when we know where people are coming from voluntarily and not intentionally trying to deceive us.

Mr. {Murphy.} The gentleman's time is expired. The word is ``voluntary.''

I now recognize Dr. Burgess for 5 minutes.

Dr. {Burgess.} Thank you, Mr. Chairman, and I would like to stay with what Chairman Upton was talking about on the travel restriction.

The Secretary of Health and Human Services under the Public Health Service Act has the authority to issue a travel restriction. Under the pandemic plan that was adopted in 2005, the President has the ability to issue a travel

restriction. Two thousand five was geared toward the pandemic avian influenza but it was amended in July of this year to include the hemorrhagic fevers. So I believe that authority very clearly exists. Now, the question is why the Executive Branch and why the agency will not exercise that authority. Mr. Chairman, I think perhaps this committee should consider forwarding to the full House a request that we have a vote on travel restriction because people are asking us to do that, and I think it is--they are exactly correct to make that request.

Dr. Frieden, the first nurse who was infected over the weekend is now being transferred away from Presbyterian, and yet her condition has been serially reported in the news media as she is stable and she has been improving, so is the reason that she is having to be removed because the personnel are no longer willing to stay at Presbyterian to take care of her?

Dr. {Frieden.} Texas Presbyterian is really dealing with a difficult situation. They are working very hard. Because of the events of the past week, they are now dealing with at least 50 health care workers who may potentially have

been exposed. The management of those individuals, making sure that if any of them develop any symptoms whatsoever, even the slightest, they come in immediately to be assessed so that if they develop Ebola, we hope no more will but we know that is a possibility since two individuals did become infected, others may. That makes it quite challenging to operate in hospital, and we felt it would be more prudent to focus on caring for any patients who come in, health care workers or others who might come in with symptoms.

Dr. {Burgess.} I don't disagree, and you and I have talked about this, and I am fully in favor of individuals who have been diagnosed that they do be taken care of in centers. Dr. Fauci, you know that if somebody wants to do research on the Ebola, they can't just go to a regular university setting and do that. They must go to one of the laboratories where they have the capability of protecting the personnel who are not only doing the experiments but other personnel surrounding in the lab. Is it possible to get--I had a picture from the Dallas Morning News which had the CDC recommended personal protective equipment. I think we have it there, and this not only shows the personal protective

equipment but it also details the order in which it should be put on and removed. I would know that shoe covers are not included in this graphic but you do see a fair amount of exposed skin around the eyes and the forehead and of course the neck. Now, Dr. Frieden, this is going to be hard to see, but this is your picture in western Africa, and as you can see, there is head-to-toe covering and goggles, and I believe if I understand the circumstances correctly, you were just about to be dosed with a near-toxic dose of chlorine. Is that not correct?

Dr. {Frieden.} Yes.

Dr. {Burgess.} Well, and that is why you can't have skin exposed because it is impossible to do the disinfection, if you will, after taking care of an Ebola patient or being in an Ebola ward. It is impossible to do the disinfection if there is skin exposed because exposed skin would be killed by the chlorine and that would not be good for the person delivering the care.

I mentioned this in my opening statement. I am so concerned. We know the numbers in western Africa are going up on Ebola. We know the case rate is going to increase. We

know that 10 percent of those cases are health care workers, and we know that 56 percent of those health care workers in western Africa will succumb to the illness so that is a pretty dire warning for anyone who is involved in delivering health care, and I would just submit--well, Dr. Robinson, let me ask you. What kind of stockpile of this personal protective equipment do you have available to the health care workers who are on the front line? And bear in mind, no travel restrictions so a new patient could come in tonight and go to any hospital in this country and present themselves. Are you going to be able to quickly deliver a stockpile of personal protective equipment like this?

Mr. {Robinson.} So we know from talking to the manufacturers, there are no shortages right now and that they are willing to deliver within 24 hours or less.

Dr. {Burgess.} Let me just task this question, Dr. Frieden. You know, what did you think the first patient was going to look like when you knew you were going to have a patient zero at some point or that it was a possibility. We had the gentleman who died in Nigeria at the end of July who could have gotten on a plane to Minneapolis. What did you

think that was going to look like? What was patient zero going to look like? And now you seen what it really looks like--

Mr. {Murphy.} The gentleman's time is expired.

Dr. {Burgess.} --what is the matchup there?

Mr. {Murphy.} You can go ahead and answer quickly. Thank you, Doctor.

Dr. {Frieden.} Our goal has been to get hospitals ready. The specific type of personal protective equipment to be used is not simple and there is no single right answer, but there is a balance between protective equipment that is more familiar or less familiar, that is more flexible and less flexible, that can be contaminated more easily or less easily, so the use of different types of protective equipment is something that obviously we are looking at very intensively now in Dallas in conjunction with the health care workers there.

Mr. {Murphy.} Thank you. I now recognize Ms. Schakowsky for 5 minutes.

Ms. {Schakowsky.} Thank you, Mr. Chairman.

I have so many questions. I just want to begin, though,

by thanking the health care professionals that are on the front line, and I would like to ask unanimous consent to put into the record, Mr. Chairman, a letter from Randi Weingarten from the American Federation of Teachers, which represents a bunch of--many nurses into the record. I would also like unanimous consent to put in the record the diary of Paul Farmer from Partners in Health, who has among other things said the fact is that weak health systems are to blame for Ebola's rapid spread in West Africa, and we know that West Africa has 24 percent of global disease burden, 3 percent of world health workforce, one doctor in Liberia for 90,000 people. So I would like to focus on what we are going to do to help that infrastructure, but in my limited time I want to focus on our infrastructure here.

We have a vast infrastructure--hospitals, community health centers, I want to point out too where people may present themselves, nurses, nurses' aides, no one better than the United States, but do we have the ability to train and equip, as we talk about in military terms, and do we have the ability really to train and equip?

Let me just put a couple things on the table. In terms

of the nurses, I still don't feel like we have a good answer of why nurse one and nurse two contracted Ebola. Is it because there was a problem with not following the protocols or is there something wrong with the protocols? And how are we going to ensure that even if we have the best protocols in the world that everybody knows how to use them?

Congresswoman DeGette showed the various protective gear that our nurses are supposed to have, and yet 2 days apparently went by when they were not wearing shoe covers, that their necks were not covered, that skin in fact, as Dr. Burgess was talking about, was in fact exposed, even as we knew that he had Ebola.

So how are we going to make sure despite how we are going to check at the airports--I am from Chicago. I talked to our health director today. I know what we are doing. But there is still the chance that someone could present anywhere. So how come the nurses in Dallas weren't protected and how are we going to make sure that everybody can be?

Dr. {Frieden.} So first just to clarify one thing, those first couple of days, the 28th, 29th, 30th, were before the diagnosis was known so he had suspected Ebola. The test

was being drawn and assessed but he had not yet been diagnosed with Ebola, and in our team's review--

Ms. {Schakowsky.} Is that--excuse me one second. Congresswoman, were you saying otherwise? Can I yield?

Ms. {DeGette.} If the gentlelady will yield, but he presented with Ebola symptoms. He had been to the emergency room just a couple of days earlier saying he had been from Africa, and I believe the CDC protocols that were given to the Dallas hospital said that people should be wearing that protective covering even before the official diagnosis. I would certainly hope--thank you for yielding, Ms. Schakowsky.

Dr. Frieden, I would certainly hope that here going forward if a patient shows up saying he is from Africa and he is vomiting and he has diarrhea, that you wouldn't say well, we don't have the lab results in yet, you would start treating that person like they had Ebola.

Dr. {Frieden.} Absolutely. I just wanted to clarify that those first couple of days, the 28th and 29th, he was being isolated for Ebola. The diagnosis was confirmed on the 30th. On the 30th we sent a team there--

Ms. {Schakowsky.} Okay.

Dr. {Frieden.} And when we looked at the--to answer your question--of those first couple of days, there was some variability in the use of personal protective equipment. The hospital was certainly trying to implement CDC protocol--

Ms. {Schakowsky.} I know, but going forward, how are we going to assure that just trying, you know, how are we going to educate people, nurses? The nurses are saying across the country that they have not been involved and that they are not trained properly or have the equipment.

Dr. {Frieden.} Three phases. First, think Ebola in anyone with travel history and symptoms. Second, any time a patient is suspected, isolate them, contact us, and we will talk you through how to provide care while we get the test done, and if it is confirmed, we will be there within hours with a CDC Ebola Response Team.

Ms. {Schakowsky.} Okay. My time is expired.

Mr. {Murphy.} Just in response to that, when did you come up with that plan that you just stated to Ms. Schakowsky, the plan in terms of training for nurses? When was that decided?

Dr. {Frieden.} We look at our preparedness continuously

so awareness has been something that we have been promoting in extensive ways since the outbreak--

Mr. {Murphy.} I mean, she was asking specifically for those nurses. When was the plan put in place for the Texas hospitals and says you need to follow this protocol from this point on?

Dr. {Frieden.} The day the diagnosis was confirmed, we sent a team to Texas.

Mr. {Murphy.} Dr. Gingrey is recognized for 5 minutes.

Dr. {Gingrey.} Well, first of all, I want to thank, of course, Chairman Murphy for calling the subcommittee back to Washington to hold today's hearing on our collective response to the ongoing Ebola outbreak and commend my colleagues on both sides of the aisle, your near-unanimous attendance to this hearing.

Since my time is very limited, of course, I would like to get directly to my questions, and this is kind of a follow-on maybe to what Ms. Schakowsky was asking, and I don't think we ever got around to an answer on that, and I am going to direct the question to Dr. Frieden and to Dr. Varga, maybe first to Dr. Varga.

As we know from new reports yesterday, there has been a second health care worker who has contracted Ebola, Ms. Amber Vinson. Now that she is receiving isolated treatment at Emory University containment unit in Atlanta, we must examine the protocol breakdowns that resulted in the contraction of Ebola by these two nurses who were directly in contact treating Thomas Duncan.

Dr. Varga, in your written testimony you say that the first nurse, Ms. Pham, to contract Ebola was using full protective measures under the CDC protocol while treating Mr. Duncan. Has your organization in Texas identified where the specific breaches in protocol were that resulted in her infection or, alternatively, the inadequacies of the protocol? Dr. Varga, that question is for you.

Dr. {Varga.} Thank you, sir. We are investigating currently the source of this obvious exposure and contraction of the illness. We have confirmed that Nina through her care with Mr. Duncan was wearing protective patient equipment through the whole period of time. As Dr. Frieden already mentioned, with the diagnosis of the Ebola confirmed, the level of personal protective equipment was elevated to the

full hazmat style. We don't know at this particular juncture what the source or the cause of the exposure that caused Nina to contract the disease was.

Dr. {Gingrey.} Dr. Varga, I am going to interrupt you just for a second because of limitation of time. I want to now go to Dr. Frieden.

Dr. Frieden, as Dr. Varga just stated, health care personnel were following CDC protocols while treating Mr. Duncan, which include the use of so-called PPE, personal protective equipment. Do the CDC guidelines, your guidelines, on the use of PPE mirror current international standards that by the way are being adhered to, those international standards, in West Africa in those three countries, Sierra Leone, Guinea and Liberia?

Dr. {Frieden.} The international standards are something that evolve and change. We use different PPE in different settings. There is no single right answer, and this is something we are looking at very closely. Our current guidelines are consistent with recommendations from the World Health Organization is my understanding.

Dr. {Gingrey.} I would think that there would need to

be, Dr. Frieden, and I commend you for the job that you are doing and I know these are tough times for all of us, but I think some consistency is what we need, and that brings me to my next question and my last question, and again, it is to you, Dr. Frieden.

This issue of elevated temperature, you know, is it 100.4, is it 101.5, is it 99.6? I think there is some great confusion because initially when people were screening, Mr. Wagner, at the airports in West Africa, the temperature threshold was 101.5, and then I think now the screenings that we are doing at these five major airports including Hartsfield International in Atlanta, it is now 100.4. When Mr. Duncan came for the first time to the Texas Presbyterian Hospital, his temperature was, what, 100.1, and within 24 hours, of course, it was 103. So when mom and dad are out there when their child has a temperature and this fall is flu season and they are going to the doctor, they are going to demand being checked for Ebola. Give us some guidelines on what is elevated temperature and when should parents be concerned?

Dr. {Frieden.} Well, first, parents should not be

concerned about Ebola unless you are living in West Africa or the child has had exposure to Ebola, and right now the only people who have had exposure to Ebola in the United States are people who either are providing care for Ebola patients or the contacts of the three Ebola patients, and I outlined those in this sheet. For our screening criteria, we are always going to try to have an additional margin of safety and so we look at that, and we would rather check more people and assess, so we are going to always have that extra margin of safety for our screening.

Dr. {Gingrey.} Thank you, and I yield back.

Mr. {Murphy.} I now recognize Ms. Castor for 5 minutes.

Ms. {Castor.} Thank you all for tackling this important public health issue of the Ebola virus, and I want to thank the experts at the Centers for Disease Control and the NIH and medical professionals across the country, especially those at Emory University Health Care who have been proactive in containing and treating the virus.

I agree with President Obama and all of you. We have to be as aggressive as possible in preventing any transmission of the disease within the United States and boosting

containment in West Africa.

But I also think we need to pause here. This is a wakeup call for America that we cannot allow NIH funding to stagnate any longer. Earlier this in the Budget Committee, I offered an amendment to the Republican budget to restore the cuts to NIH, the budget cuts that have been inflicted over the past 2 years and repair the damage of the government shutdown of last year. Unfortunately, it did not pass on a party-line vote. We will only save lives if we can robustly fund medical research in America and keep America as the world leader.

So I would like to turn to some of that research that is going on now because it is going to be research that will be our longer-term response to Ebola. It will be the vaccines to prevent the disease and the drugs to treat it. So I want to walk through a basic point here, that the development of vaccines and treatments for Ebola is different from the development of many other drugs. There is not a large private market for Ebola drugs, so the development requires leadership of our country, and NIH, as Dr. Fauci has testified, has been working on a vaccine for many years, and

he reported today they have now moved into some Phase I clinical trials.

Dr. Fauci, can you explain to us why government support is so important for developing Ebola vaccines and treatments?

Dr. {Fauci.} Well, when you have a product that you want to develop that is not a great incentive on the part of the pharmaceutical companies because of a disease whose characteristics is not a large market. We had the experience when you are dealing with emerging and reemerging disease be it influenza or be it a rare disease that could either be used deliberately in bioterror or a rare disease like Ebola that if you look prior to the current epidemic, there were 24 outbreaks since 1976. The total number of people in those outbreaks was less than 3,000. It was about 2,500. So we were struggling for years to get pharmaceutical partners ourselves who were doing the fundamental basic and clinical research, and then we did get some pharmaceutical partners like we have now with GlaxoSmithKline and the NewLink Corporation, which is the reason why we are now moving along. So that one of the reasons why we have BARDA, so I showed that slide, Ms. Castor, where the NIH and the researchers at

this end, and then you have to push the envelope further to the product to de-risk it on the part of the companies. Companies don't like to take risks when they don't have a--

Ms. {Castor.} So can you quantify a timeline for an Ebola vaccine to be on the market? Is it feasible for any vaccines to be approved in time to assist in the current outbreak?

Dr. {Fauci.} Well, your question has a couple of assumptions. The first is that the vaccine is safe and it works. The second is going to be, how long is this outbreak going to last at its level. If you look at the kinetics and the dynamics of the epidemic, it looks very serious. Our response to it--when I say ``our,'' I mean the global response has not kept up with the rate of expansion. If that keeps up as the CDC has projected, we may need a vaccine to actually be an important part of the control of the epidemic itself as opposed to what the original purpose of it was, was to protect health care workers alone, but now if you have a raging epidemic--and to be quite honest with you, Ms. Castor, I cannot predict when that will be.

If you have a lot of rate of infection, a vaccine trial

takes a much shorter time to give you the answer. If it slows down, it is a much longer time. If you have a lot more people in your vaccine trial, it takes less time. If we have trouble logistically, which we might, of getting people into the trial, it might take longer. So I would like to give you a firm answer but we can't right now.

Ms. {Castor.} In addition to the vaccines, part of controlling the virus is early diagnosis and treatment. I know there are some diagnostic tests that are being developed. Can you speak to the prospects of improved diagnostics that can assist in this effort?

Dr. {Fauci.} Right. Well, there are a couple of us, and when I say ``us,'' I mean agencies that are working on diagnostics. Dr. Frieden's group at the CDT has actually played a major role in leadership. We have several grants and contracts out to try and get earlier and more sensitive diagnostics.

Ms. {Castor.} Thank you.

Mr. {Murphy.} Thank you. I now recognize Mr. Gardner for 5 minutes.

Mr. {Gardner.} Thank you, Mr. Chairman, and I thank the

witnesses for joining us today and the work that you are undertaking.

Dr. Frieden, I want to clarify something that you had said earlier. I believe you mentioned that there are approximately 100 to 150 people a day coming into the United States from the affected areas?

Dr. {Frieden.} That is my understanding, yes.

Mr. {Gardner.} And to Mr. Wagner, you had mentioned that we are screening 94 percent of those people?

Mr. {Wagner.} As of today with the expansion to the four additional locations. That covers about 94 percent.

Mr. {Gardner.} Okay. So of the 100 to 150, 94 percent are being covered. That means that somewhere between 2,000 and 3,000 people a year are coming into this country without being screened from the affected areas?

Mr. {Wagner.} Well, they would undergo a different form of screening. We are still going to identify that they have been to one of those three affected regions, and we are still going to ask them questions about their itinerary. We are going to be alert to any overt signs of illness and coordinate with CDC and public health if they are sick, and

we are also going to give them a fact sheet about Ebola, about the symptoms, what to watch for, and most importantly, who to contact--

Mr. {Gardner.} Would we be checking their temperature?

Mr. {Wagner.} We will not be checking their temperatures or having them fill out a contact sheet about--

Mr. {Gardner.} So there are 2,000 to 3,000 people entering this country a year without checking their temperature, without having the contact sheet that 94 percent of those affected people--

Mr. {Wagner.} They are going to arrive at hundreds of different airports throughout the United States.

Mr. {Gardner.} Okay. I want to talk a little bit more about the travel restrictions.

Dr. Frieden, how many non-U.S. military flights, commercial flights, are currently going into the affected countries?

Dr. {Frieden.} I don't have the exact numbers.

Mr. {Gardner.} Does anyone on the panel know how many commercial flights are going into these areas? Mr. Wagner, you don't know?

Mr. {Wagner.} From the United States or from anywhere?

Mr. {Gardner.} From the United States into those areas.

Mr. {Wagner.} There are no direct flights, commercial flights, from those three affected areas to the United States.

Mr. {Gardner.} And into the area, into West Africa.

Mr. {Wagner.} There are flights into West Africa.

Mr. {Gardner.} How many?

Mr. {Wagner.} That I don't have offhand.

Mr. {Gardner.} Anybody on the panel know how many? How many coming back into the United States?

Mr. {Wagner.} There are no commercial flights coming directly into the United States from those three areas.

Mr. {Gardner.} And what about Europe?

Mr. {Wagner.} There are hundreds of flights a day coming from there.

Mr. {Gardner.} Okay. So people traveling from West Africa to Europe to here?

Mr. {Wagner.} That is generally how they would get here.

Mr. {Gardner.} And 94 percent screening. How many

flights are required daily, every other day or weekly to get the supplies and personnel to the affected areas?

Dr. {Frieden.} The quantity of supplies is quite large. I would have to get back to you in terms of the numbers. But there is huge quantities needed, but it is not just supplies. It is also personnel who need to move back and forth.

Mr. {Gardner.} Well, if you could get back to me with that number, I would appreciate it.

Now, Dr. Frieden, Nigeria--are you aware if Nigeria has a travel ban from the countries affected with the outbreak right now?

Dr. {Frieden.} I believe that is not the case.

Mr. {Gardner.} They do not? Okay.

Dr. Frieden, one of the issues that has been brought up regularly to me back in the district when I go home, what should I tell my local hospital and local doctors that they need to do to address Ebola?

Dr. {Frieden.} The single most important thing they need to do is to make sure that if anyone comes in with fever or other symptoms of infection, they need to ask where they have been for the past 21 days and whether they have been in

West Africa.

Mr. {Gardner.} And the training that a small local district hospital would receive, is that the same kind that a major metropolitan hospital would receive?

Dr. {Frieden.} There are a variety of forms of training. We support hospitals. Hospitals are regulated by States, not by CDC.

Mr. {Gardner.} Dr. Frieden, what do we need to do? We are entering the flu season now, as somebody else on the panel had mentioned. What do we need to do to make sure that people understand that there could be similar conditions, similar circumstances so that we don't have a situation where people are indeed panicked?

Dr. {Frieden.} The key issue, it is, as you point out, getting into flu season. By all means, get a flu shot. And for health care workers, any time someone comes in with a fever or other signs of infection, take a travel history. That is really important.

Mr. {Gardner.} Dr. Frieden, I just want to go back to what I said at the beginning. You mentioned that we can't have a travel ban because you are afraid of the impact that

it would have but you don't know how much personnel, equipment and flights are currently in use.

Dr. {Frieden.} My point earlier on was that if passengers are not allowed to come directly, there is a high likelihood that they will find another way to get here and we won't be able to track them as we currently can.

Mr. {Gardner.} But we are talking about supplies, equipment and personnel, how many? How many flights? How many personnel? How much equipment?

Dr. {Frieden.} The point I made earlier was if we are not able to track people coming directly, we will lose that ability to monitor them for fever, to collect their locating information, to share that with local public health authorities and to isolate them if they are ill.

Mr. {Gardner.} Mr. Chairman, I yield back.

Mr. {Murphy.} The gentleman's time is expired. Thank you. I now recognize Mr. Welch for 5 minutes.

Mr. {Welch.} Thank you.

I want to follow up on some of Mr. Gardner's questions. First of all, I want to understand this. There has been one person that came to the United States and then he infected

two health care workers in Dallas, correct?

Dr. {Frieden.} At this point, none of the 48 contacts he had before getting isolated have developed symptoms and they are mostly well past the maximum incubation period, although not completely out of the woods.

Mr. {Welch.} All right. And for everybody on the panel, it is Code Red. We have had very few--two instances of infection here in the United States but this is such a highly contagious disease that we are on full alert, correct?

Dr. {Frieden.} It is a disease that has a--it is a very severe disease. It is not nearly as contagious as some other diseases but any infection in a health care worker is unacceptable.

Mr. {Welch.} That is right, and there is an enormous, enormous amount of public concern and apprehension about this so we appreciate the full-on efforts that you are making. There has been some lessons learned from what happened in Dallas. The hospital has been forthcoming about mistakes that were made, and now what you are telling us is that there has been information provided to all our hospitals in the country about what protocols to follow, correct?

Dr. {Frieden.} Correct.

Mr. {Welch.} Now, just on a practical level, does it really make--is it feasible that all our hospitals are going to be in a position to provide state-of-the-art treatment or does it really as a practical matter make sense for hospitals to contact you when they have a potential infection for you to come and then for us to have centers to which that individual who is infected can be treated?

Dr. {Frieden.} Every hospital needs to be able to think it may be Ebola, diagnose it, to call us as they do--we have had hundreds of calls--and then we will send a team to determine what is best for that hospital and that patient.

Mr. {Welch.} And then what we have also heard--Ms. Schakowsky asked this question--this is absolutely a public health infrastructure issue where it gets out of hand, correct?

Dr. {Frieden.} Public health measures can control Ebola.

Mr. {Welch.} Right. And they have had effective measures in Nigeria where they have been able to contain it but they have no public health infrastructure in these three

countries where the epidemic is now getting some headway, correct?

Dr. {Frieden.} Exactly.

Mr. {Welch.} And then in the United States, of course, we are fortunate to have a pretty good infrastructure but we do have to have an answer, I think, to this question that is being asked about travel. That is a concern that people have because it is seen as a quote, easy answer, and I just want to understand what the debate is within the medical community. For a lot of us sitting up here, we are hearing from our constituents. It sounds like something that we can do and that will eliminate any possibility of an infection coming here, but that may be a psychological answer but not necessarily an effective medical answer.

All of us have been asking you to give your explanation, and anyone else can come in, as to why from a medical standpoint you have concluded that a total travel ban is inappropriate and not effective.

Dr. {Frieden.} First off, many of the people coming to the United States from West Africa are American citizens, American passport holders, so that is one issue just to be

aware of, but--

Mr. {Welch.} All right. And then by the way, I don't have much time, but our health care workers, even if there some risk of infection, if we are going to encourage people to go and do the important work including our military personnel, we have got to take them back and make sure we can treat them if in fact they do get the illness, correct?

Dr. {Frieden.} People travel, and people will be coming in.

Mr. {Welch.} And as I understand it, you say there is basically a tradeoff. If you have a full-on ban, there is going to be ways around it and then you are going to lose the benefit of being able to track folks who may be infected and then that could lead to a greater incidence of outbreak, so it is a tradeoff. Is that essentially what is going on?

Dr. {Frieden.} We are open to any possibility that will increase the safety of Americans.

Mr. {Welch.} Right. So are there some midpoints that in terms of travel restrictions as opposed to a travel ban that may make sense to you in coordination with your colleagues, particularly Mr. Wagner?

Dr. {Frieden.} We would look at any proposal that would improve the safety of Americans.

Mr. {Welch.} All right. This isn't about funding so I am not going to ask you because I think we would know what your answers would be, but I just want to share my concern that was expressed by Ms. Castor.

Mr. Chairman, we may want to have a hearing at some point about what is the funding requirements to make certain that the infrastructure this country needs to be in place before something happens is robust, it is strong, we have got people who are trained, they are ready to do the job and they have everything that they need. So that is not today's hearing but I think it is a question that we should address because with 20 percent across-the-board funding at NIH, I find that to be a reckless decision with 12 percent at CDC. I think that is definitely the wrong direction. I think this Congress has to revisit our priorities on making certain that we have the public health infrastructure to be prepared to protect the American people.

Mr. {Murphy.} If I could just say, we are planning a second hearing, and in preparation for that we will also ask

if NIH does have the flexibility now to transfer funds as well as HHS.

I now recognize Mr. Griffith for 5 minutes.

Mr. {Griffith.} Thank you, Mr. Chairman.

I believe we should have reasonable travel restrictions. Dr. Frieden, in answering a question of my colleague from Colorado, MR. Gardner, you indicated that Nigeria didn't have any restrictions, and that is accurate, but I have in my possession, and I would ask that it be submitted to the committee for the record, a letter from delegate Robert G. Marshall of Manassas, Virginia, to Governor Terry McAuliffe, Governor of the Commonwealth, and in that he cites the International SOS, a prominent medical and travel security services company with more than 700 locations in 76 countries reports that African countries have imposed total air, land and water travel bans by persons from countries where Ebola is present. The countries include Kenya, Cape Verde, Cameroon, Mauritius, South Sudan, Namibia, Gambia, Gabon, Cote d'Ivoire, Rwanda, Senegal, Chad and Kenya. South African development community members, 14 countries, only allows highly restricted entry from Ebola-affected regions

with monitoring for 21 days and travel to public gatherings discouraged.

[The information follows:]

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Mr. {Griffith.} I find that interesting, Dr. Frieden, because some of those countries have had previous outbreaks of Ebola themselves. Wouldn't you agree that some of those countries have had to face Ebola before?

Dr. {Frieden.} I would have to check the list carefully to know, but I will take your word for it.

Mr. {Griffith.} All right. I will tell you that this is a concern to a lot of our constituents and to mine as well, and I was checking my Facebook page recently when I saw that a Facebook friend of mine, a father from Virginia, asked for prayers for his daughter because she lives in the apartment complex with the first nurse, Nurse number one, as I think somebody referred to earlier, and was very concerned, and while I think I know the answer, I would like to get your answer so that I can reassure this father and that is, his question is, if I count to 21 days and my daughter is not infected, at that point can I exhale and breathe a sigh of relief?

Dr. {Frieden.} Not only can he do that but he can do that now because the first nurse only exposed one person, one

contact, and that was only in the very early stages of her illness, so at most, one person from the community was exposed.

Mr. {Griffith.} And I appreciate that. He also asked a second question. He said there is some suggestion coming out of Dallas that the patient's dog may be infected and may have infected other dogs through actual contact or by feces. Can the virus be transmitted by dogs? And I will tell you that I did some homework on this because I thought it was an interesting question and found a CDC publication from March of 2005 that did a study on dogs in Africa in the affected areas and a study in France as a control group, and they found that while dogs show antibodies for Ebola, they are asymptomatic, but the study went further to say that there is really a lot of questions about how Ebola is transmitted, and in some instances, Gabon in 1996 and 2004, Republican of Congo likewise in 2004 and the Sudan, that there is a question mark as to whether or not, or how that Ebola outbreak occurred. It wasn't in the normal or standard ways. It wasn't human to human. And this report indicates that dogs might be--might be--I don't want to scare folks--might

be suspect.

I guess my question to you is, isn't it true that we really don't know a whole lot about the various outbreaks of Ebola and so when we are trying to assure the American people just like previously we didn't think it would come to this country and then we thought if it did get to this country, we wouldn't have any problems controlling it. Now we have got all kinds of people being monitored. Isn't it true there are still a lot of questions about how Ebola is spread?

Dr. {Frieden.} Although we are still learning a lot about Ebola and every other organism that we study and that we control, we have a lot of information about Ebola. We have a good sense of how it is controlled, and we have looked at the issue of exposure to animals. We know that in parts of Africa, consumption of forest-living animals can be a cause. We don't know of any documented transmission from dogs to humans but that is why the authorities with our agreement have quarantined a dog, and we will helping them to assess that situation.

Mr. {Griffith.} And it is also true that while we have no evidence of transmission from human to dogs, we really

don't know if there can be. We have what we call in the law--I used to be a lawyer--you have a lack of evidence as opposed to negative evidence. We don't have clear evidence that you can't transmit it either. And what is interesting is, that raised the question for me about, okay, we have got no restrictions on travel of human beings, how about the dogs? I called Customs. They said, well, our experts are there, and then after pushing them a little bit, they said that is USDA. We call USDA, and Dr. Frieden, they said that would be CDC.

So I understand all your reasons, and while I don't agree with completely, I understand the concerns about humanitarianism, et cetera, but don't you think we ought to at least restrict travel of dogs?

Dr. {Frieden.} We will follow up in terms of what is possible and indicated.

Mr. {Murphy.} I now recognize Mr. Yarmuth for 5 minutes.

Mr. {Yarmuth.} Thank you, Mr. Chairman, and before I begin my questioning, I would like to submit for the record an article titled ``Will America's fragmented public health

system meet the Ebola challenge?'' by Mark Rothstein, who is the Director of the Institute of Bioethics at the University of Louisville Medical School. I would like to submit that for the record. Thank you.

[The information follows:]

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Mr. {Yarmuth.} I would like to thank the panel for their testimony and answering the questions, and this has been a very enlightening hearing. I also want to acknowledge at the beginning that the Kentucky Air National Guard, which is based in my district, is in Senegal right now providing the infrastructure for the 101st in their efforts, so I want to acknowledge their participation in this effort.

At the risk of displaying my ignorance, we apparently know that you cannot detect the Ebola until the same time it becomes symptomatic when it becomes contagious. Is there any other kind of test that would indicate whether anything is going on in the body? I know that sometimes my doctor will say, well, you have got an elevated white blood cell count, something is going on there, and may not know exactly what it is. Is that true of the Ebola or would that not indicate that something is going on?

Dr. {Frieden.} At this point we don't have a test that would identify it before someone has symptoms. In fact, the test only turns positive when they are sick, and the test is for the virus itself and that is why--that is another reason

besides the patterns of disease that we are confident that it doesn't spread. We can't even find tiny amounts of it in people's bodies until they get sick.

Mr. {Yarmuth.} Is there any research being done as to a possible test, earlier test for this?

Dr. {Frieden.} There is a lot of research being done to try to understand and diagnose and treat and prevent better.

Mr. {Yarmuth.} Good. I am a media person by background. That is where I spent most of my career, so I am very sensitive to how the media treat situations like this, and certainly the media can be a very important part of providing public information about a potential threat to public safety as this is. But they can also go overboard, as we know, and I am curious because I see every day comments in the media about the spread of Ebola and outbreaks of Ebola, and while yes, technically it has spread from one person to two health care workers, I know that the public may hear that very differently and perceive there to be a much broader and widespread incident of Ebola in the country, and I see things like, for instance, in the Washington Post the picture of the woman at Dulles Airport who looks like she is mummified

because of her concern of contracting Ebola, and I know that now one survey showed 98 percent of the American people are aware of the Ebola situation and not even 50 percent know there is an election coming up in 3 weeks. So the media has certainly let the public know that there is something going on.

My question to you is, has the media coverage so far been helpful or harmful in your efforts to have the public have an appropriate concern and awareness of what the situation is?

Dr. {Frieden.} Well, anytime health care workers become infected and ill in this country, it is unacceptable, and our thoughts are with the two infected health care workers in hoping for their recovery. So it is certainly understandable that there is intense media interest. It is new to the United States. It is a scary disease, had a movie made about it, and it is important to have that attention so that we as a society pay attention, and doctors in hospitals and community health clinics and primary care practices think of the possibility of Ebola that we generate the societal will and resources to both protect Americans and stop it at the

source because it has got to be stopped at the source to make us completely safe.

Some of the coverage, I think many would agree, may exaggerate the potential risks or may confuse people about the risks. There really is a lot we know about Ebola. CDC has an entire branch, entire group of professionals who spend their careers working on Ebola and other similar infections. They go out and stop outbreaks all the time. We have stopped every outbreak of Ebola until the current one in West Africa. There is zero doubt in my mind that barring a mutation which changes it, which we don't think is likely, there will not be a large outbreak in the United States. So I think we welcome the attention. It would be important at times to put it in perspective.

Mr. {Yarmuth.} I appreciate that. I agree totally.

One final question in the last 30 seconds. Are you--is there any additional authority that CDC would find more helpful in conducting or meeting the responsibilities? I know most of yours is guidance and information, but is there any specific authority that Congress could grant you that would make your job--would make it easier for you to do your

job?

Dr. {Frieden.} We are looking at a variety of things, emergency procurement, for example, to see in conjunction with the Administration whether there are some changes that might allow us to respond more quickly and effectively.

Mr. {Yarmuth.} Thank you. I yield back

Mr. {Murphy.} I recognize Mr. Johnson for 5 minutes.

Mr. {Johnson.} Thank you, Mr. Chairman, and Dr. Frieden, thank you for being here. I thank all of you on the panel for being here today.

You know, this is not about politics, it is not about international diplomacy. It is about public health and protecting the public safety of the American people particularly our health care workers, who if I understood correctly, you have acknowledged are some of the high-risk folks to be exposed.

You know, I want to--one of my main concerns, Dr. Frieden, is that we don't know what we don't know. Throughout testimony and questioning today, I have heard you say multiple times ``I don't know the details of this, I don't know the details of that,'' and I think what the

American people are wanting is some assurance that somebody does know the details.

So let me ask you a question. Do we know yet how the two health care workers in Dallas were contracted the virus? Was it a breakdown in the protocol? Was it a breakdown in the training of the protocol? Do we know whether or not the protocol works?

Dr. {Frieden.} The investigation is ongoing. We have identified some possible causes. We are not waiting for the investigation to be completed--

Mr. {Johnson.} So we don't know?

Dr. {Frieden.} We are immediately--

Mr. {Johnson.} Okay.

Dr. {Frieden.} --going to take safety measures.

Mr. {Johnson.} I get that. We don't know. You know, the people in Ohio are concerned, especially now that we know that one of those health care workers traveled through Ohio, even spent some time in Akron with family members. I applaud Governor Kasich's immediate actions to try to address the situation.

You know, in my experience as a military war planner,

26-1/2 years in the military, and I know we have got military engaged in this process overseas, we don't wait until the bullets start flying to figure out whether our war plan is going to work.

Dr. Frieden, when did the CDC find out that there was an outbreak of Ebola in West Africa?

Dr. {Frieden.} Late March.

Mr. {Johnson.} Late March. Has there been--one of the things that we do in the military is that we conduct what is called operational readiness inspections. We give real-world scenarios in controlled environments, no notice so that those who are going to be responsible for executing a war plan knows what to do when the first shot is fired, no panic, no second guessing; they know what to do. Has the plan to address an Ebola outbreak ever been tested by the CDC in a real-world environment?

Dr. {Frieden.} Not only has the plan been tested but outbreak control has been done multiple times in parts of Africa. What had not been done is in this part of Africa which had never seen--

Mr. {Johnson.} No, I am talking about here in America.

Dr. {Frieden.} In America also we do a series of preparedness plans, for example--

Mr. {Johnson.} Which--do you know of any hospitals in eastern and southeastern Ohio that have participated in any kind of real-world scenario of an Ebola outbreak?

Dr. {Frieden.} I can't speak to that specific example, no.

Mr. {Johnson.} Okay. Let me go a little bit further. You mentioned earlier that 150 per day roughly are coming in from West Africa. I think Mr. Wagner indicated 94 percent screening. Let me give you a scenario. Let us say a person comes in to the country from West Africa, and let us assume that everything in the screening process works right. They are maybe in day 14 of having been exposed to Ebola in West Africa. They show up here in America with no symptoms. They go through the screening process, and so they go on about wherever they go--Akron, Cleveland, Cincinnati, Los Angeles, wherever. Day 17 or 18 they start getting ill and they start seeing a spike in their temperature. If they walk into any emergency room in Appalachia Ohio and start throwing up, having symptoms, does your plan identify that and does your

plan tell that hospital emergency room what to do in that scenario? They don't know that person came from Liberia or any other place.

Dr. {Frieden.} We have detailed checklists and algorithms that we have distributed widely, provided repeated training and information so that health care providers throughout the country have a detailed checklist of what to do step by step by step to determine whether the person has Ebola, if they do, to call for help and we will be there.

Mr. {Johnson.} Mr. Chairman, I yield back.

Mr. {Murphy.} Thank you. Mr. Green is next in line, but we are looking for him, so Mr. Matheson is next for 5 minutes.

Mr. {Matheson.} Well, thank you, Mr. Chairman. I have a number of questions. I will try to move through them quickly.

Dr. Frieden, as was mentioned by a couple people in their opening statements, it strikes me that controlling the outbreak in West Africa is really one of the real key issues to keeping Americans safe. There are reports that indicate we may still be losing some ground in Liberia, so I guess I

would ask the question, what would enhance the international community's ability to gain control of the situation in West Africa in terms of actions and resources?

Dr. {Frieden.} The fight against Ebola in West Africa is challenging. The health systems are weak. What we are finding is that it is moving quickly and there is a real risk it will spread to other parts of Africa. Therefore, the key ingredient to progress there is speed. Because the outbreak is increasing so quickly, the quicker we surge in a response, the quicker we blunt the number of cases and the risk to other parts of the world including the United States decreases.

Mr. {Matheson.} And are you resource-constrained in that context?

Dr. {Frieden.} Congress has provided money or approval or agreement to use money for the Department of Defense. USAID has resources going in. At CDC, we received through an anomaly $30 million for the first 11 weeks of this fiscal year, which we appreciate.

Mr. {Matheson.} Let me ask you, you have a number--CDC has a number, an unprecedented number of people in the field

right now in West Africa and in Texas. How many people do you have deployed doing airport screenings?

Dr. {Frieden.} I would have to get back to you with the exact number. We are working both to oversee the screenings in West Africa and make sure they are done correctly and to screen individuals here, collect information on them and transfer that information--

Mr. {Matheson.} I need you to get that number and also find out if those resources are best used there or elsewhere with your limited number of people. That would be interesting to hear.

Following up on Mr. Yarmuth's questioning, is there a development of a more rapid test to determine if someone has Ebola than what we use today?

Dr. {Frieden.} A more rapid test would be very helpful. The U.S. Navy has a pilot test in development. We are currently testing that in parts of West Africa. It is simpler, quicker and would be very helpful, even if it isn't quite as sensitive in West Africa, but we are working with a number of commercial manufacturers also on a more rapid test than there is currently.

Mr. {Matheson.} It seems to me that when it comes to infection control and prevention and hospital epidemiology standards, I think they vary widely from hospital to hospital in this country. What legislative or regulatory actions could strengthen these systems? I mean, how can we reduce this variability among hospitals in our country?

Dr. {Frieden.} Infection control in our hospitals generally is a challenge and something that CDC works hard with hospitals and State health departments and State governments to improve. Hospitals are regulated by the States within which they operate, and the issue of what could be done to improve infection control is complex. CDC has a large program hospital infection prevention and there we support regional efforts to share lessons and figure out new ways to do things better to prevent infection, and that kind of center of excellence model is a very important one.

Mr. {Matheson.} But you are suggesting that while you can provide the information and the expertise and the guidance, the actual implementation and responsibility is still a State function more than a federal function. Do you think we should be looking at that issue?

Dr. {Frieden.} In the United States, we have a federalist system. The CDC provides information and input. There are roughly 5,000 hospitals in the country. We are not a regulatory agency.

Mr. {Matheson.} Right. One other line of questions. There is no good news about Ebola but at least it is not an airborne--transmitted as an airborne entity. It is clear that we don't want to understand its ability to be transmitted, and while the focus is on Ebola and rightly so for this hearing, there are other airborne transmissible pathogens that ought to be of great concern to everyone including this Congress that exist around the globe today, MERS being one of them. Is this experience we have had with Ebola, how do we learn from it to make sure we are prepared for other human-to-human-transmissible pandemics that may be more--may be a higher rate of transmission than Ebola?

Dr. {Frieden.} I think there are two major lessons, first, to prevent it at the source. If we had had the basic public health system in place in these three countries a year ago to find it, stop it and prevent it would, it would be over already, and second, within our country, to continue to

support hospital preparedness, community preparedness and fundamentally the public health measures to find, stop and prevent health threats.

Mr. {Matheson.} Okay. Thanks, Mr. Chairman.

The {Chairman.} [Presiding] Mr. Long is recognized for 5 minutes.

Mr. {Long.} Thank you, Mr. Chairman, and today we have referred to--people on the panel, people up here have referred to Nurse One and Nurse Two, and these are two young women that have dedicated their lives to helping other people, sick people, and to refer them as Nurse One and Nurse Two just doesn't set well with me. It is kind of reminiscent of Dr. Seuss Thing One and Thing Two. These are not things. So for the record, I would like to state that the first nurse to contract Ebola was Nina Pham, and the second nurse was Amber Joy Vinson. These are young women with families. I know one in particular has a fiancé. And so I think that it would serve as well to remember that these are human beings that have dedicated--young women that have dedicated their lives to helping other people, and for them and nurses everywhere and their families, I would just like to open with

that.

Dr. Frieden, you said in your testimony earlier that only by direct contact can you contract Ebola. Do you stand by that statement?

Dr. {Frieden.} Direct contact with someone who is ill or died from Ebola or their body fluids.

Mr. {Long.} And it is not airborne, Congressman Matheson just said, and you agreed it is not an airborne-- cannot be contracted airborne.

Dr. {Frieden.} Ebola spreads person to person, not by the airborne route, so it is not like--

Mr. {Long.} Do you need personal contact?

Dr. {Frieden.} Yes.

Mr. {Long.} If you need personal contact with bodily fluids, why is there an airliner in the Denver Airport right now that Frontier Airlines has scrubbed four times? Aren't they wasting money? Why can't they get that back into service? If you have to have bodily contact, close contact, why scrub that airliner?

Dr. {Frieden.} I understand that people are very concerned about Ebola. It is a scary disease. I can't

comment--

Mr. {Long.} So it is just for public perception? I mean, they really don't need to be doing that, right?

Dr. {Frieden.} We have detailed guidelines along with the EPA for how to clean airliners.

Mr. {Long.} Do you need a fever to be contagious?

Dr. {Frieden.} You need to be sick. Generally the first symptom of illness is fever.

Mr. {Long.} So do you need a fever to be contagious?

Dr. {Frieden.} Late in the disease when people are deathly ill, they may not have fever but they would be likely be unable to walk at that point.

Mr. {Long.} This 21-day period that you need to show symptoms within 21 days from exposure, during that period could you be contagious the third day of that point?

Dr. {Frieden.} Only if you were sick, only if you had symptoms.

Mr. {Long.} Okay. And the incubation period is anywhere from zero to 21 days?

Dr. {Frieden.} Two to 21 days, generally within the first 10 days or so.

Mr. {Long.} You said here today that there are 100 to 150 people a day coming from West Africa into the United States. You are opposed to travel restrictions, which the constituents in the 7th District in Missouri are very much in favor of travel restrictions. I predict you are going to put on or the President is going to put on travel restrictions. I don't know if it is going to be today or tomorrow or 2 weeks or a month from now but I think that they are coming and I think sooner rather than later. If there are 150 a day, and you rationalize, well, we don't really need to worry about that because they could get across borders, they could go by land and then get here. With that 100 to 150 a day, don't you think that number might be reduced to five or ten a day if we did put on travel restrictions?

Dr. {Frieden.} I can't comment on what numbers would--

Mr. {Long.} If someone had to make an effort other than going out to their local airport and jumping on a plane, if they really had to try to get here, don't you think that number would dramatically drop?

Dr. {Frieden.} I know that people do come back, and right now we are able to screen them, collect their

information--

Mr. {Long.} What if they don't come back? A lot of people come in this country and we lose track of them. They don't come back. What happens then? My point is, if you have got 150 a day coming in or you have five coming in a day, I and my constituents would rather have five a day coming in, and this thing of checking for temperatures like it is going to help is kind of like scrubbing a plane that doesn't need to be scrubbed.

But I would like to recommend the folks reading this copy of Bloomberg Business Week ``Ebola is coming, coming to America. The United States had a chance to stop the virus in its tracks but it missed.'' That issue came out before Mr. Duncan came to this country and before he was diagnosed with Ebola. There is some good reading in there that I would recommend.

I would also recommend to you if you want to Google a hospital from hell, it is swamped by Ebola in the New York Times just a few days ago, hospital from hell, if you get a chance to read that. I think that everyone would be in favor of the travel restrictions we have talked about here today,

and today OSHA, Occupational Safety and Health Administration, just today said that Customs and Border Patrol immigration enforcement agents are at risk of coming into contact with Ebola.

Mr. Wagner, are we prepared for that? Are your agents, are they protected to the fullest extend what they need?

Mr. {Wagner.} We--

Mr. {Long.} This just came out today.

Mr. {Wagner.} We issue them personal protective gear and we train them on how to wear it and what circumstances to wear it, but they encounter all different kinds of travelers with a whole host of different potential communicable diseases. So you know, we are aware and we do train to recognize signs of overt illness and we have the protocols with health professionals to get those travelers into that care and to protect our employees.

Mr. {Long.} To me, they fall in the same category of the nurses. They are there to save us and help people and protect people in this country, so God bless, and I will yield back.

The {Chairman.} The gentleman's time has expired. The

gentlelady from North Carolina, Mrs. Ellmers.

Mrs. {Ellmers.} Thank you so much, Mr. Chairman, and I have a number of questions.

I would like to start with Dr. Varga in regard to the two nurses that were exposed. My understanding is, one of the nurses, the first nurse, Ms. Pham, was exposed in the emergency room. Is that correct?

Dr. {Varga.} I am sorry. Could you repeat the question, please?

Mrs. {Ellmers.} The first nurse was exposed in the emergency room. Is that correct?

Dr. {Varga.} No, that would not be correct. Nina was one of our ICU nurses and came in contact with Mr. Duncan when Mr. Duncan was transferred from the emergency department up to the ED.

Mrs. {Ellmers.} So that was sometime from September 28th to the 30th. Is that correct?

Dr. {Varga.} That is correct.

Mrs. {Ellmers.} Okay. And then the second nurse, Ms. Vinson, was she also an ICU nurse?

Dr. {Varga.} That is correct.

Mrs. {Ellmers.} Okay. So they were exposed after the point that we would have already started recognizing that Ebola was being questioned. Is that correct?

Dr. {Varga.} No, that is not correct. The nurses in the MICU from the time they had first contact with Mr. Duncan were in personal protective equipment according to the CDC guidelines. Nina cared for Mr. Duncan--

Mrs. {Ellmers.} Okay. Dr. Varga, I am going to stop you right there. So they were already using universal precautions but also had--were using some of the more isolation? And just answer yes or no.

Dr. {Varga.} Yes.

Mrs. {Ellmers.} Okay. To that, I would like to move on to Dr. Frieden. This of course--and I will just back up. On October 2nd--excuse me--October 6th, I sent a letter to the CDC, to CBP and HHS calling for travel restrictions. So there is no question I believe travel restrictions need to be put in place, and now after having this subcommittee hearing, I believe even more strongly that we need them, and I just want to back up to a couple questions for Dr. Frieden and Dr. Fauci. Do we know the--are there multiple strains of Ebola?

Dr. {Frieden.} There are five different subspecies. This outbreak is one particular subspecies, Ebola Zaire, and all of the strains that we have seen have been closely related.

Mrs. {Ellmers.} Okay. So we know that it is isolated to one particular strain?

Dr. {Frieden.} Yes.

Mrs. {Ellmers.} Now, you had mentioned, and I believe the quote was, unless it mutates, there will not be an outbreak here in the United States. Is that correct?

Dr. {Frieden.} There will not be a large outbreak here barring a mutation.

Mrs. {Ellmers.} Well, the question I have is, when the nurses we reusing the protective gear then, how is this that this has happened? It tells me that something is changing here, and are we currently looking into this situation right now?

Dr. {Frieden.} We are absolutely looking for other mutations or changes. What we have seen is a very little change in the virus. We don't think it is spreading by any different way.

Mrs. {Ellmers.} And you have already said a couple of times that you don't believe that this is airborne and yet there again I know how nurses are. I was one for 21 years before coming to Congress. You are protecting yourself. You are protecting your patient. You are protecting your family. They followed precautions, I am sure, and now we are having this conversation, and I am very concerned about that.

Dr. {Frieden.} We are confident that this is not airborne transmission. These nurses were working very hard. They were working with a patient who was very ill, who was having lots of vomiting, lots of diarrhea. There was a lot of infectious material, and the investigation is ongoing but we immediately implemented a series of measures to increase the level of safety.

Mrs. {Ellmers.} Okay. I am going to move on.

Dr. Borio, in the discussion of fast tracking a test for Ebola, where is the FDA on that? Is there a fast-track process right now that you know of?

Dr. {Borio.} For diagnostic tests?

Mrs. {Ellmers.} Yes.

Dr. {Borio.} So there are three diagnostic tests that

are authorized for use under our authorities, and we have also taken some practice steps by contacting manufacturers, commercial manufacturers, who we know have potential interest in technologies to be brought to bear here, and we reached out to a handful who might be interested in working with us.

Mrs. {Ellmers.} Okay. So you are in the process of looking towards a fast-track process?

Dr. {Borio.} Yes. We would expedite every such test.

Mrs. {Ellmers.} Great. Thank you.

And then Dr. Frieden, lastly, you know, there again, I am speaking on behalf of my constituents and every American in this country. I just don't believe that it is acceptable that the quote that you had given us, we won't be able to track them as the reasoning for why we should not implement travel restrictions. I do believe we can, and Mr. Wagner, as far as our Customs and Border Patrol, do you believe that there is a way that we can implement tracking?

Mr. {Wagner.} Tracking?

Mrs. {Ellmers.} Tracking of individuals if we do not allow them to come--

Mr. {Wagner.} Yeah, we have ways to determine a

person's itinerary and travel history through the questioning or review of the passport. It is easier when they are coming on a direct ticket from those places--

Ms. {Ellmers.} True, true, but as you pointed out, they are coming from--

Mr. {Murphy.} The gentlelady's time is expired.

Mrs. {Ellmers.} Thank you, Mr. Chairman. I thank you for indulging my over time here.

Mr. {Murphy.} I now recognize Mr. Scalise for 5 minutes.

Mr. {Scalise.} Thank you, Mr. Chairman. I appreciate you holding this hearing, and I want to thank all of the panelists for coming and participating, and I have talked to a number of health care professionals as well and listened to the panel as well. I want to join with Chairman Upton in urging the President to immediately institute a travel ban until such time that they can firmly and scientifically prove that Americans are safe from having more Ebola patients coming into the United States, and Dr. Frieden, you expressed disagreement with that. Have you all had any conversations within the White House about a travel ban and whether or not

the President has the authority, because many of us have said the President does have the authority to do it today.

Dr. {Frieden.} From the point of view of CDC, we are willing to consider anything that will reduce risk of--

Mr. {Scalise.} But have you considered that and have you ruled it out or have you not considered it at all? Have you had conversations with the White House about a travel ban? That is a yes or no question. Have you had conversations with the White House about a travel ban?

Dr. {Frieden.} We discussed many aspects--

Mr. {Scalise.} How about a travel ban? Have you had that conversation--

Dr. {Frieden.} We have had discussions on the issue of travel to and from West Africa.

Mr. {Scalise.} And have you all ruled it out?

Dr. {Frieden.} I can't speak for the White House. I can tell you that--

Mr. {Scalise.} You can speak for the CDC. If you were in those conversations, maybe they had their own conversations without you but if you were involved in conversations with the White House about a travel ban, did

they rule it out? Are they still considering it?

Dr. {Frieden.} From the CDC's perspective, we will consider anything that will better protect--

Mr. {Scalise.} So are you going to answer the question about your conversations with the White House? Is the White House considering a travel ban?

Dr. {Frieden.} I can't speak for the White House.

Mr. {Scalise.} Do you know if they have ruled out a travel ban?

Dr. {Frieden.} I can't speak for the White House.

Mr. {Scalise.} Have you had conversations with them about it?

Dr. {Frieden.} We have discussed the issue of travel.

Mr. {Scalise.} All right. I would urge you at a minimum, if you have ruled out a travel ban, if you don't think it is the right way to go, there are a lot of people that would disagree with you. At a minimum, you ought to look at least immediately suspending visas to non-U.S. nationals seeking to travel into the United States from Sierra Leone, Liberia and Guinea. Have you all considered that or discussed it or ruled it out?

Dr. {Frieden.} At CDC, our authority is to quarantine individuals who require the isolation of individuals.

Mr. {Scalise.} But you said you don't think there should be a travel ban. What about at least looking at suspending visas to non-U.S. citizens? Have you looked at that?

Dr. {Frieden.} CDC doesn't issue visas.

Mr. {Scalise.} But you can make a recommendation to the White House that it would be in the best interest of the American people to have that kind of suspension issue, can't you? Are you not aware of that?

Dr. {Frieden.} We would certainly consider anything that will reduce risk to Americans.

Mr. {Scalise.} Let me ask you this. Do you have a high level of confidence that our U.S. troops that are over there right now--I have got estimates that are around 350 U.S. troops are already in those three affected countries. Up to 3,000 troops are going to be sent over by President Obama. Do you have a high level of confidence that those U.S. troops are protected with all the protocols in place so that they will not contract Ebola?

Dr. {Frieden.} We have worked very closely with DoD on their protocols and--

Mr. {Scalise.} So do you have a high level of confidence that they are protected?

Dr. {Frieden.} I would not say that there is zero risk. They are in those countries but they are not participating in high-risk activities that--

Mr. {Scalise.} Are you consulting with DoD? Who establishes the protocols in that case? Is the CDC involved in that?

Dr. {Frieden.} They are following the CDC's protocols but they follow their own--

Mr. {Scalise.} Let me ask you about the protocols because I have read reports that some people with some of the other organizations that have been over there for a while--you have got the group Samaritan's Purse, a gentleman by the name of Sean Kaufman, who is involved with some of the doctors that have been over there that have gotten infected. They have been working for decades in some cases. He said that he warned your agency that the guidelines that you had on Ebola were lax and his response was, ``They kind of blew

me off,'' meaning your agency blew him off when he was warning you that your protocols were lax. Are you aware of that?

Dr. {Frieden.} I saw that quotation. We take all suggestions--

Mr. {Scalise.} Have you identified who blew him off in your agency?

Dr. {Frieden.} I don't know that that occurred.

Mr. {Scalise.} Well, I would hope that you would go and find out because there is a real concern. You know, one of the biggest concerns I get from the hospitals in my district that I have talked to, and I have talked to a number of hospital officials, medical officials, professionals in my district. They are concerned that they haven't had consistent protocols. There has been at least four just in the last few weeks where the protocols keep changing. Now, with the nurse, the first nurse that was infected, I believe you personally said that the protocols were breached originally. Have you backed away from that?

Dr. {Frieden.} We are looking at what might--

Mr. {Scalise.} You said the protocols were breached.

Were the protocols breached with the first nurse that was infected? Yes or no.

Dr. {Frieden.} Our review of the records suggests that in the first few days of--

Mr. {Scalise.} If you didn't know for a fact, you shouldn't have said it.

Mr. {Murphy.} The gentleman's time is expired.

Mr. {Scalise.} Do you withdraw that statement, or do you still stand by the statement that protocols were breached by the first nurse?

Dr. {Frieden.} There was a definite exposure that resulted--

Mr. {Scalise.} Were protocols breached, yes or no?

Mr. {Murphy.} The gentleman's time is expired.

Mr. {Scalise.} Yield back.

Mr. {Murphy.} Thank you.

It is the tradition of this committee that the ranking member and the chairman have a final 2-minute wrap-up. Ms. DeGette, 2 minutes.

Ms. {DeGette.} Dr. Frieden, would it be fair to say that it looks like the first nurse, Ms. Pham, was exposed in

the first couple of days before the diagnosis came in?

Dr. {Frieden.} That is our leading hypothesis at this point.

Ms. {DeGette.} Thank you.

Now, Dr. Varga, we have still got you, I hope.

Dr. {Varga.} Yes, I am here.

Ms. {DeGette.} Have you now seen my chart from the New York Times about the protective gear?

Dr. {Varga.} Yes, ma'am.

Ms. {DeGette.} Do you know which of these types of protective gear Ms. Pham and the other health care workers were wearing during those first 2 days?

Dr. {Varga.} Ms. Pham would have been wearing or Nina would have been wearing the second garb. The folks in the ED most likely would have been wearing the first picture.

Ms. {DeGette.} Okay. Thank you. So it is your testimony you don't really know how Ms. Pham was--well, either one of these wonderful nurses were exposed. Is that correct?

Dr. {Varga.} That is correct.

Ms. {DeGette.} Okay. I just want to say one last

thing. I think that we have had a lot of discussion today about a lot of issues, and my takeaway is this--and Dr. Frieden, I guess I would--I am going to make a statement and I would ask you to comment on it. It seems to me that aside from trying to stop this Ebola in Africa, the thing we can do here is number one, we can give better training to the people in our emergency rooms and our first responders, not just send them out emails or bulletins. Number two, we can have more robust protective gear at an early stage if somebody looks like they might have a risk for Ebola, and number three, I think it might be really useful to put CDC on the ground much earlier. Here, they didn't come into this Dallas hospital until after the diagnosis. So there was 2 days when people were moving in and out of Mr. Duncan's room and we don't know exactly what happened. Dr. Frieden, could you comment very briefly on that?

Dr. {Frieden.} I will agree completely on the training. We are looking very carefully at the personal protective equipment issue. We consult immediately every time, and there have been more than 300 consultations for hospitals that have thought they might have a patient with Ebola. Only

Mr. Duncan was confirmed to have Ebola.

We can't be everywhere. Everyone has to do their part but we will do everything we can to support the front lines.

Ms. {DeGette.} And Mr. Chairman, I would ask for both this protective gear chart and also our map of the flights to be included in the record, and I would also ask--

Mr. {Murphy.} Without objection.

[The information follows:]

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Ms. {DeGette.} I would also ask all of our witnesses if they would continue to keep this committee updated as to changes in procedures or developments that are made as we go along, and I would ask unanimous consent to put in the other members' opening statements in the record.

Mr. {Griffith.} Mr. Chairman, I had previously asked for unanimous consent for the letter that I quoted from.

Mr. {Murphy.} Yes, that was granted.

Mr. {Griffith.} I don't think we ever agreed on it but--

Mr. {Murphy.} It is so ordered.

Mr. {Griffith.} Thank you.

Mr. {Murphy.} I now recognize myself for a final 2 minutes.

So having listened to all your testimony, a couple of things that stand out for me. One, I appreciate Dr. Daniel Varga's statement of honesty that we made mistakes. I didn't hear that from any of you, and that troubles me. Because what has happened here, is your protocol depends on everyone being honest 100 percent of the time. I am not a medical

expert. I study behavior as a psychologist. People are not honest 100 percent of the time.

Secondly, it relies on tools for taking temperatures, which have their own reliability issues, a one in 21 chance during those 21 days it may register something, and a person can mask it with some analgesics, so that is not helpful.

We also have to recognize human behavior, that protocols may not be followed. That is why you have a failsafe system of basically a buddy watching you put on your garb, watch you take it off, making sure you use other things, and I think the example of how this failed was, there is an assumption in the travel--Dr. Frieden, you said CDC granted her travel with the assumption that she used all the right protective gear but we have looked at this, and you are not aware of what she wore and it does not appear she wore the proper ones. So to this extent, these are my recommendations based on what we have heard in this hearing.

I believe we need an immediate ban on commercial non-essential travel from Guinea, Liberia and Sierra Leone until we have an accurate and thorough screening process and we treat this disease. Number two, a mandatory quarantine order

for any American who was treated an Ebola patient or has traveled to and returned from the Ebola hot zone countries. This includes a prohibition of domestic travel because of an assumption, and without this assumption of what they wore was donned and removed properly. Number three, immediate training and thorough training for U.S. health care hospital workers to include a review of personal protective equipment used in the treatment of possible Ebola-infected patients, their wear and removal. Number four, identify and designate specific medical centers equipped and trained to treat potential Ebola patients and expansion of those as soon as possible. Number five, identify gaps in statutory language that may prevent CDC and any other federal agency including BARDA, FDA and NIH from taking more aggressive and immediate action to protect public health from Ebola including letting us know of any abilities now to transfer funds immediately or any other action Congress needs to facilitate your needs. Number six, accelerate directives on development and deployment of clinical trials for all promising Ebola vaccines, investigational drugs and diagnostic tests. Number seven, acquisition of additional airplanes and vehicles

capable of transporting American medical and military personnel who may have contracted Ebola in Africa to return to the United States beyond the current capacity of two. Number eight, additional contact tracing and testing resources for public health agencies, and number nine, to provide information to Congress regarding any resources needed to assist health interventions, aggressive health interventions in Africa so we can stop Ebola there.

I appreciate all the members coming back today for this hearing, and I particularly appreciate the testimony of the panel. I ask unanimous consent that the members' written opening statements be introduced into the record. Without objection, the documents will be entered into the record.

[The information follows:]

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Dr. {Burgess.} Yes, I have a document to enter into the record, the Office of Inspector General, Department of Homeland Security, and then the photograph that I demonstrated earlier today.

Mr. {Murphy.} So ordered. That will be included in the record.

[The information follows:]

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Mr. {Murphy.} Again, I thank all the witnesses and members--

Ms. {Schakowsky.} Mr. Chairman.

Mr. {Murphy.} --who have participated in the hearing.

Ms. {Schakowsky.} Mr. Chairman, I just want an acknowledgement that the things I wanted included in the record--

Mr. {Murphy.} Yes, those are included as well.

Ms. {Schakowsky.} Thank you.

Mr. {Murphy.} We will also have a hearing in November. We will follow up. We will notify members of the participants in that and when that will be.

I ask all members to submit questions for the record and ask that the witnesses please agree to respond promptly to the questions, and with that, this hearing adjourned.

[Whereupon, at 2:56 p.m., the subcommittee was adjourned.]