NATIONAL CITIZENS INQUIRY

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EVIDENCE

(Translated from the French)

Witness 1: Dr. Didier Raoult
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Jean Dury
Good morning, Doctor Raoult. My name is Jean Dury, I'm a lawyer in private practice and I've been working in the field of human rights for over forty years, and I'm the one who's going to be questioning you today. I'd like to begin by thanking you on behalf of the Commission for your presence here today, and above all, for all the work you've done, which in Quebec has been followed by many, I can tell you!

So, without further ado, I'm going to touch on certain subjects that you know well, and as a preamble, I noticed that you've said on certain occasions that your job is to find therapeutic solutions for new diseases. And I found it important to emphasize this in the preamble today since it will be a path on which we'll travel today because we were contending with a new disease. Now you have to understand that I'm a novice, so I'm not a scientist at all, and if I make mistakes, you can correct me. I have no problem with that.

So let's go back to March 2020, when we were informed that there was what we called a pandemic. I would like to know, for your part, if you are able to explain to the Commission your thoughts on this notion of a pandemic that had just been determined in March 2020. Can you answer this: specifically, was there a pandemic?

Dr. Didier Raoult
First, permit me—forgive me if this appears pretentious or arrogant—to tell you in a few words what I have done previously in my life. I'm talking about it because we're discussing scientific consensus—I am not at all a fringe thinker. I'm the microbiology man. There are probably people here who know that I have been the most quoted in the world over the past 20 years. Twenty years ago, I was tasked with a report by my Ministry to manage the issue of bioterrorism, which I thought at that point wasn't that serious. I have no regrets. So of course, I took the opportunity to write a report, that is still available online, on how to manage future epidemics, right?

So you could say I had a report that's 20 years old, and I therefore had a very well-defined vision, particularly regarding organization, which led me to set up an institute for research and care on infectious diseases, which is the biggest medical research project contract that France has ever had. So I'm not someone marginal. Maybe my attitude, my hair style appears like that of a weirdo to you, but I'm not a misfit. I've published more in all the infectious disease journals than anyone else in the world. So it's not true that the idea of what was put in place represented a consensus.

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It's a very interesting way that will explain—of course, it has to do with what I'm going to explain to you.

For the past thirty years, infectious diseases specialists have essentially played a crucial, even exclusive, role in testing drugs for chronic infections such as AIDS and chronic hepatitis. As a result, the links between infectious diseases specialists and the pharmaceutical industry that was developing those drugs became essential, and a very large proportion of infectious diseases specialists no longer did anything else in terms of research—which isn't proper research: trying to provide patients with protocols that were written by the pharmaceutical industry, with all the results analyzed by the pharmaceutical industry, which "ghost writers" published in the *New England* [*Journal of Medicine*] or *The Lancet* or *BMJ*.

So, if you like, that was the situation. And so, in most states we turned towards people who were known to deal with infectious diseases and who, in reality, had no experience at all in epidemics but in the management of chronic infections—like, for example, Fauci in the United States who has done just that for forty years.

You see, emerging diseases and epidemics are very, very different in nature. AIDS was like that in the beginning. I worked on AIDS at the beginning, in the early '80s, and it subsequently became the management of chronic infections with the development of therapeutic optimization by the pharmaceutical industry. It's a different nature. So the consensus we've been talking about in terms of infectious diseases is, from the outset, a consensus achieved by relying on practitioners who, for decades, have been working to develop or evaluate drugs that have been bought—not developed. They are actually developed by start-ups, bought by pharmaceutical companies, by Big Pharma, and who then put them on the market, and then promote them, including in the biggest newspapers.

All this data, it's data that's very well known, it's not paranoid data. You know, three out of four of the last editors-in-chief of the *New England [Journal of Medicine]* wrote this, the current editor-in-chief of *The Lancet* published this, he also wrote this: that the pharmaceutical industry's weight in scientific production has become colossal, since they are the indirect employers or associated employers, people who do and who have become advisors, experts, et cetera. We are in a situation that is not one of consensus, or of reflection on epidemics, but a reflection that will integrate people who have a very particular way of working on infectious diseases, since the infectious diseases on which most people have worked in Western countries are AIDS and chronic hepatitis.

Secondly, the question of the definition of a pandemic: like all definitions, it is a question of the words used. A pandemic means that it is an epidemic that spreads across the entire planet. Now we can see things a little more clearly. At first, it's an epidemic that struck China, with secondary cases in Europe, Germany and Italy, before becoming widespread. What I'm thinking at the moment, after an analysis we're currently carrying out online which is now in preprint, is that a very important phenomenon happened somewhere after the virus entered France— I don't believe at all that the pandemic virus was manufactured in a laboratory, because that doesn't make sense virologically. Two mutations appeared; one mutation in the mechanism that reproduces the virus, which will multiply the number of errors by a hundred. As a result, this virus will become hyper-mutagenic, whereas coronaviruses had the reputation of not being mutagenic.

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And so, the two previous virus outbreaks that were very similar, SARS in China and MERS-corona—you were unlucky in Canada to have a hospital outbreak of SARS, but it hasn't been reproduced elsewhere—the epidemic was quickly exhausted since the adaptive capacity of this virus, due to its low mutations, was very weak. So this virus which was close to MERS-corona or to SARS, people predicted at the outset that it would develop in

the same way: in other words, that it would disappear on its own. And these two mutations that we will find in almost all the viruses that you've had here and that we've had in Europe—which are in the RNA polymerase and the spike that you've heard a lot about—one has allowed a better adhesion of the virus, the other has allowed a greater speed of mutation—a quite exceptional adaptability, meaning that this virus has given rise to children, grandchildren, and great-grandchildren who each play their role one after the other.

And so this is the point at which we're going to be able to see that this virus is likely to become much more epidemic and change quickly. And so you have a single episode that looks like a normal epidemic, which is the first episode that we have in the world, which gives the typical shape of an epidemic with an acute infection—that is a bell curve—but then new epidemic episodes will appear. I was the first to talk about variants, and people were denying the very idea that there are mutations or variants. It was only when people in England, at the Wellcome Trust, said that there were variants, that the idea of variants was accepted, although this happened three months after I spoke about it.

So we are faced with multiple viruses, and which will have— The meaning of your question is even deeper than you imagine. We have conducted considerable analysis of the variants: that's 60,000 genomes in my centre alone. And what's really interesting is some of the variants have gone pandemic; what we called Alpha, Delta, now Omicron are pandemic, meaning they're found all over the world, while some variants have remained epidemic in particular areas. For example, the one that killed the most people in France is called Marseille-4. It developed in mink and spread to parts of Europe, but did not invade the whole world. Another variant has been detected in Spain and England, and has not become a pandemic but produced a limited epidemic. And why some of these variants became pandemic and other variants caused limited epidemics is quite incomprehensible at the moment.

So a pandemic is simply the observation that a virus is taking hold everywhere, but we don't know why. We're starting to get data, but it's a bit technical. Viruses exhaust themselves if there is not a new fertile mutation, meaning one that restarts the story. Otherwise, the mutations that accumulate spontaneously lead to the end of the epidemic.

Jean Dury
Thank you, Doctor. Before continuing, I have to swear you in. I didn't do it initially, but we can do it retroactively. So everything you said will be under oath, so, well, it's called a solemn oath. So do you swear to tell the truth, the whole truth? Say, "I swear."

Dr. Didier Raoult
Yes, I swear. I would like to add my conflicts of interest, I usually do. I have been working for the development of an electron microscope for Hitachi for several years, and since the beginning of the year, I have been scientific adviser for Orofa, which is a company that does biological diagnostics.

Jean Dury
So I'm going to ask you a question that has gone around the world: we're going to talk about hydroxychloroquine. You found a therapeutic solution, and can you tell us briefly about this episode in your life where you were confronted by your peers and many other doctors around the world, when you advocated for hydroxychloroquine? Can you tell us about this therapeutic strategy that you undertook at that time?

Dr. Didier Raoult
So hydroxychloroquine is part of a group of molecules that was studied in the '80s for their role in the cell.

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Hydroxychloroquine is a weak base, meaning it is basic and not acidic like amantadine. All basic products, which are relatively small in size, enter the cell easily, by diffusion, and concentrate in a very acidic area of the cell called the lysosome. And they modify the pH, the acidity of this lysosome, by changing it from pH 4.7, which is an acid pH, to pH 5.6, which is a little less acidic. And by doing this, they change the physiology of how the cells fight against microbes.

So I analyzed the role of hydroxychloroquine. All of these things were measured first by another team, an American team that was working on Q fever. And so, I was a specialist in Q fever, which we couldn't manage to treat effectively. I analyzed this drug in the context of Q fever. For 30 years now, Q fever has been treated with hydroxychloroquine coupled with an antibiotic, because the antibiotic in an acidic pH doesn't manage to kill the bacteria, whereas if you raise the pH a little, then the antibiotic kills the bacteria. So it's a molecule that I know very well, that I have prescribed myself—I'm also a medical practitioner.

I've treated thousands of people with intracellular bacterial diseases—Q fever, Whipple's disease—and I've been requested to consult around the world, including in Canada, for advice on how to treat them. And by using this phenomenon, which is that by raising the pH

level of the vacuole, that is, the little sac in which the microbe is found, you change the life of the microbe in the cell. So if bacteria, viruses or parasites enter the cell through a vacuole, which we call phagocytosis or endocytosis, in most cases, the lysosome sticks against this vacuole; they fuse together; they pour enzymes into it, and these enzymes are only active at acidic pH.

So you change the nature of what is happening, and that includes with viruses. And so, long before us, there were people who had written a paper in *The Lancet* saying, "Look, we need to evaluate the antiviral activity of hydroxychloroquine because some viruses enter by endocytosis, including one of the two influenza viruses." And so when SARS arrived, hydroxychloroquine was tested for SARS. At the time, Fauci said: "It's likely that the only drug for SARS-1 is hydroxychloroquine." And the Chinese had tested hydroxychloroquine, just as the Koreans had tested hydroxychloroquine when they had problems with MERS. So it was a phenomenon that was not at all unexplained nor inexplicable.

Simply put, it's not a classic antiviral. Antivirals generally act on the enzymes of the virus itself, or on exchanges, or on the mutation of viruses. In this case, it's a general phenomenon which affects the ability of the virus to leave the vacuole it's entered through fusion with the lysosome. And in preventing this activity, you prevent the virus from multiplying. So it's a well-known phenomenon.

Furthermore, I chose hydroxychloroquine because it was an extremely well-known drug. There have been billions and billions of prescriptions that contain chloroquine or hydroxychloroquine. There was a year, I believe it was 2006, six billion treatments with chloroquine were carried out in countries around the world, since it was the standard treatment for malaria at the time. We used hydroxychloroquine for a year or two. I treated more than 4,000 people; we never had an accident, either cardiac or ocular. Hydroxychloroquine is used constantly by rheumatologists to treat the common disease of rheumatoid arthritis and also lupus, which is also a disease due to antibodies, specifically the same antiphospholipid antibodies that we sometimes see in SARS, and which cause heart damage.

Globally, it's the drug we use to combat autoantibodies, autoimmunity antibodies. It's a very well-known drug, and we know—I did thousands of tests before this adventure—that if you give 600 mg a day of hydroxychloroquine, after a few days you'll have 1 µg/ml of hydroxychloroquine, which is sufficient, according to the first in vitro tests we did, to neutralize the virus.

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So all of this is very basic and understandable science. It's not mysterious, it's just mysterious to people who haven't looked at the literature, who don't know what they're talking about. It's all understandable science. In fact, I immediately reacted to the first statement made by the Chinese, who were the first and only ones to say at the start of the epidemic— The man who managed the first episode of SARS in China said: "There are only two drugs we've tested that are effective: Remdesivir and hydroxychloroquine. And because we know hydroxychloroquine, we know it's not toxic, we know the dosage, we're going to start treating people with hydroxychloroquine." And they announced preliminary results that said there was some efficacy.

So all this was knowledge, there's no improvisation here. So we quickly applied for authorization to carry out a therapeutic trial. As luck would have it, we were able to do a comparative trial with people whom we were able to diagnose, but couldn't treat with our protocol, which wasn't yet ready. Because they weren't included, they served as a control group where we simply measured viral load. That is, did the virus decrease more rapidly with or without our protocol? This was our finding, and it's a paper that's caused quite a stir. In fact, I didn't think that you could unleash such astonishing passions by doing science.

Jean Dury
Yes, in this vein, you often said that most of your detractors knew nothing about science. And I can tell you that it reached a lot of people when you said that because you mentioned that the majority of those making policy regarding COVID came from the National School of Administration. Could you please speak a little to a subject about which so much ink was spilled?

Dr. Didier Raoult
To tell you to what extent science is not what is explained in administration schools—but I understand. The reason why I didn't want to participate in the French Scientific Council is that the politicians wanted to say that they were making political decisions in the name of science, but it wasn't in the name of science, it was in the name of political strategies, which were not scientifically validated.

So for example, we now know that there was no evidence to suggest that wearing masks in the street would reduce the epidemic. We have shown that to be false. The lockdowns had no scientific substance. And besides, the Swedes, who have had no change in their life expectancy, never applied lockdowns. So all of this wasn't science, it was politics. It's all

very well, people have to be political. But, as for me, I didn't want to be exploited as a scientist, to be said to be the one who did it. So I wouldn't have wanted to play the role that Fauci was doing, or what Delfassy was doing: to say that we make political decisions in the name of science. I don't agree, and it's not my role. My role is to talk about science, it's not to make political decisions. I never wanted to do politics. Besides, no one is able to say what my political opinions are. If anyone knew, I'd be interested in knowing what they are, because they vary depending on the situation.

Jean Dury
We are going to talk about a subject that has shaken the planet. It's the subject of vaccines. So it's a big topic. I would like if you could give us at the Commission an opinion on the effectiveness of vaccines, if you would.

Dr. Didier Raoult
You are talking about the COVID vaccine.

Jean Dury
Yes, which have been offered.

Dr. Didier Raoult
Not to advertise, but I wrote a book on vaccines five or six years ago, long before this, and I agree with everything I wrote about vaccines at the time. So on the question of vaccines, we have to try not to get caught up in binary arguments of "I'm for vaccines or against vaccines," which are idiotic.

Jean Dury
With that, I agree. That's not what I'm asking you. I agree with what you've said.

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Dr. Didier Raoult
There are vaccines that work very well, that have made it possible, at least in the one case of smallpox, to eradicate a disease; and others that have made it possible to reduce the

incidence of disease very, very dramatically. There are at least a dozen that work very, very well, that are indispensable. And in France, I played a political role in getting two of these vaccines reimbursed. There are so many. One for the Hæmophilus influenzæ vaccine, the other for the hepatitis B vaccine which were not subject to reimbursement in France for ideological reasons. Since then, the ideology has changed. In the '90s, the people who were hostile to vaccines were rather "New Age," rather left-wing; and now, those who are in favour of vaccines at all costs are rather left-wing.

So the tide turned as to those who were against vaccines. You know that in California, there's a huge drop in vaccination, which was due to left-wing hostility. And at the time, they were teaching at the national health training school that vaccination policy was directed by the pharmaceutical industry, and that the tragedy of the imputed link between hepatitis B and multiple sclerosis was an error linked to pharmaceutical lobbying. When I asked for the science to be re-examined, I was accused of being an ally of the pharmaceutical lobby, which is a laughable accusation—as you can see, times are changing—because it's all a kind of ideological simplification.

Now, to come back to the vaccination for COVID, we are in a situation in which we have over-dramatized an epidemic by making people believe that everyone was going to die from this epidemic. I will remind you that in most countries— apart from the United States, which is the country that has had the most singular management of all for reasons which I believe I know and will share with you—of the people who died, half of them were over 85 years old. Ninety per cent of them were over 70 years old.

So we were in a group of diseases that we know—that is, in the elderly or those who have associated pathologies, immunocompromised, Down syndrome—with a very, very high mortality. Well, with these people, you have to have protective measures, and you had to have them as soon as possible in the EHPADs. EHPADs are what we call nursing homes. Well, we had to take care of these people right away, so we immediately tried to put protocols in place. We reduced mortality by 50 per cent with therapy, but we were forbidden to continue. So the immediate targeting of this disease was therefore essential.

The over-dramatization caused the government to say, "We're not going to require the scientific validation that we normally require for a vaccine." And all of this was pushed very, very, very hard by, in particular—I'm sorry, but it's the reality—by Bill Gates for years. He proclaimed: "We will have to have vaccines in six months." However, it's not possible to validate a vaccine and its effectiveness in six months. It's impossible. So if you want to validate it in six months, well, you can't really assess its action against— That's what happened, we never tested for contagiousness.

So this vaccine was sold as a solution to a panic-stricken population, saying, "Listen, when the vaccine arrives, we are going to have a magic wand and this magic wand is going to be to vaccinate everyone. And then the disease will be over." But if you consider the results now, it's terrible by the way. As nobody remembers, and they remember less and less, nobody sees. You just have to look. You know, there was a very good site, which I looked at very, very regularly: the Johns Hopkins COVID. You only have to look at it to see that the vaccine did not change the impact of the disease. It has not changed; the impact is the same.

So secondly, regarding its effectiveness, we saw this very quickly because we asked people who came for testing. We did 1.2 million tests in my Institute and we asked the people we tested: "Have you been vaccinated or not?" And we quickly realized that vaccinated people were just as infected as unvaccinated people. So we knew there was no protection against infection. Everyone knows that now. So the eradication or elimination of COVID was something that we very quickly knew was not true, despite the fact that every time I talked about it, people tried to say: "It's not true."

But you only had to look at the vaccination coverage in England and the rebound immediately after, and you only had to see what was happening in Israel. This is all on Johns Hopkins COVID, you have to just look. Or look at South Korea. There was no COVID before the vaccination, and after the vaccination we see COVID exploding at a time when there was a considerable vaccination rate. So we know very well that it will not protect against the disease.

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The second question is—okay, if we come back to a proposal that is reasonable, at least at first glance—which is one we know about for other respiratory viral infections. We should bear in mind that for respiratory viral infections, we currently have no vaccine that can ensure lasting immunity. There are none. And the diseases themselves, like COVID, you know well that there are people who have had COVID three or four times, so it's not protective. You cannot envision a protective vaccine when the disease itself is not protective because the immune response during a disease is considerable. And there are no examples of non-immunizing diseases for which we have vaccines that provide lasting immunity. That's basic. It is a basic scientific concept. It's because people are ignorant that they don't know that.

We well know that what happens with the flu is the same problem. One, it mutates. Two, it rearranges itself. There is a lot of rearrangement with COVID also. And it's a viral respiratory illness that's not immunizing. You have a flu and then you have another one the

following year, or you don't have it, for reasons that we don't understand. And so the flu continues. And every year, we make vaccines for the flu. And fine, all it does is lessen the severity a little bit in those most at risk. That's the efficacy.

And unfortunately, the subjects most at risk are those who have the poorest immune response. This is one reason why it decreases the mortality a little. It's not totally ineffective, but it's not terribly effective. Even so, the flu vaccine provides some protection against contagiousness for three to four months. And so, this is one of the reasons why it is recommended by most countries for healthcare personnel in direct contact with patients during the seasonal epidemic. This isn't extreme, it's just knowledge.

So this vaccine has been produced under conditions that make it impossible to evaluate all the groups. In other words, you can't test its safety and efficacy in pregnant women so quickly. You don't have time to test it on children. You don't have time to test its efficacy against transmission. So those three major elements. And the only thing you can test —and that has been tested—is whether there are more or fewer symptomatic forms in people who are not vaccinated compared to people who are vaccinated. There were preliminary results within three months showing that—and again, we can't assess the efficacy of this vaccine at six months because it hasn't been tested for six months.

All this is being done in real time in the general population, even though it hasn't been tested. And, of course, it hasn't been tested, so we don't know the results. And when we see the results, well, there's a certain number that don't work. So in terms of effectiveness against contagion, we know that we can't eradicate it. We've got the simple and absolute proof. We've really seen it. This disease cannot be eradicated by vaccination. Afterwards, if you want to prove it, you know, there's always someone who'll make you a mathematical model paid for by a famous foundation to show that it works. And if you simply look at the variations on Johns Hopkins COVID, you'll clearly see that the efficacy surrounding transmission isn't great. We've just published a study on 30,000 people we've treated here. Regarding the efficacy for high-risk subjects, there's a certain efficacy on the severity for the oldest subjects, those over the age of 75. They have fewer severe forms.

Then there are the side effects. I was the first to speak up about this in France. We had a very young care worker who was vaccinated and lost an eye because she suffered a deep retinal vein thrombosis. Then, of course, there was a great reluctance on the part of staff to seek treatment. People say it's because I was the one expressing reservations, which wasn't the case. It's because people were talking. When you have a 25-year-old girl who loses an eye, all her caregiver friends in the hospital find out very quickly, and then people get suspicious. The facts were in. And so that was with the AstraZeneca vaccine. Very quickly, I

announced on my channel when I was doing my shows that I recommended that women under 50 shouldn't be vaccinated with this because they were the people most at risk. They shouldn't.

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Afterwards, England itself banned it, and everyone dropped it. Everyone forgets that I'm the one who said it in the first place, because afterwards, everyone interpreted it as a general position against the COVID vaccine, a general position against vaccines in general, which is stupid. Sorry but I don't want anyone to think I'm stupid. I'm not stupid at all. Well, if I am, I don't realize it.

All that. Then we saw the story of myocarditis in Israel. The proportion of myocarditis is currently unknown, especially because there is a proportion of sudden deaths in young subjects, and particularly in athletes, which has not been explored. For a long time, people denied that it causes myocarditis, but now nobody denies that. There are people for who it's not important.

But we have to assess all vaccines, if you like. That's why I can't answer your question directly as to whether I'm for or against it: all vaccines need to be examined in a balance of the risks and benefits involved. We have the same results as, for example, the Swedish government, which has just published a very well done, intelligent study on the mortality rate of people under the age of 45 with COVID, specifically, from the moment they are sick. We must treat them. In France, we did a terrible thing at the beginning, when we said: "Don't treat the sick, stay at home, don't bother your doctor." Doctors didn't respond. "Just take some Doliprane [an analgesic] and if you're out of breath, go to the emergency room or phone the SAMU [emergency services in France]." This was a huge mistake because if you don't know anything about a disease, you have to start by studying it.

That's what we did, we started by looking at the patients. And so we realized, as the Chinese had written, that the disease presented itself on the respiratory level initially as a drop in oxygen that exhausted the patients, without any increase in carbon dioxide. It's carbon dioxide that leaves you out of breath. In influenza, you have both a drop in oxygen and an increase in carbon dioxide. It's all about gas exchange. And so, when things aren't right, you realize it because you're out of breath. Whereas in this disease, when you're out of breath, it's very late, it's time for resuscitation. For a long time, you've had very low oxygen, you've exhausted yourself fighting to get oxygen, and when you can't fight any more and you're suffocating, it's extremely late.

And so in this disease, you have to measure oxygen concentration very, very early on with pulse oximeters. Everyone ended up buying pulse oximeters. The Ministry finally recommended it, three months after I recommended it. So you have to measure oxygen at home. It's medicine; it's science; it's the experts versus the administrators. It's different worlds, you see. And so if you oxygenate them, you lower mortality in the youngest subjects, because they will recover if they don't have to struggle for ten days to be able to oxygenate themselves. Otherwise, they won't get to intensive care—they will die.

And we know this too because we had our aircraft carrier on which there was an epidemic of 700 people with zero deaths. We had an epidemic on a cruise ship in China, and with those under the age of 70, there were zero deaths. And so in Sweden, when they assessed this, they determined that there was one death for every 10,000 infected people under 45 years old. So if you want to know what the relative risk of dying is when you're under 45, you have to multiply that by the frequency of the disease, and the frequency of the disease during this observation period in Sweden was of the order of 10 to 15 per cent. This means that between the ages of zero and 45, there was perhaps one death per 100,000 people who would die from COVID-19.

So when you introduce a vaccine into this population, if you know from the very beginning that it doesn't play a role in controlling the epidemic, then you have to tell yourself that the vaccine must have less than one death per 100,000 people. And this, of course, you can't test yet. And that's what benefit/risk is all about. There's been devastation in 85-year-olds, so, if you were to say, "Look, if there's one death per 1,000 or per 10,000 in people vaccinated," next to the risk of dying from COVID, well, my God, we can take the risk. The expected benefit is reasonable. But when you have no expected benefit, well, no risk is tolerable. Is that clear?

Jean Dury
Yes. In fact, I just wanted to add that you can be sure I didn't get into a question about whether you were for or against vaccines because I know we've tried to catch you with that on several occasions.

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You answered well. We were talking about the vaccine's effectiveness, not whether you're for or against it.

Now, I'm going to address a subject that, for me personally, is very important, and that's censorship. Just to put it in context, Professor Raoult, in Quebec we have around 400,000 professionals who are subject to 42 or 44 professional orders, and each professional order has an employee who, during the pandemic, monitored social networks to see if there was any deviation, or to see if there was any professional who thought differently from the way the government wanted them to think. When this happened, the professionals would suffer the wrath of these overseers, and often it ended in disciplinary complaints. It wasn't just medical disciplinary complaints, or those who belonged to professional orders related to public health, but it could be a surveyor, an engineer, or any other professional order.

So there was a lot of censorship, and of course, I mentioned that this was something I'd been working on since I was very young. And now that I've given you a bit of a context on what's going on in Quebec, I'd like to get your opinion on what's going on in your circle and what you think of the benefits—that is, not the benefits, the opposite—of censorship in Europe at the moment.

Dr. Didier Raoult
I wasn't expecting, if you will, this degree of censorship. I could see it coming because I was doing a whole series of seminars very regularly in my Institute, and I had already compared, if you will, the information provided by the traditional media, the newspapers, in this case, therefore, *The New York Times*, *The Washington Post*, *The Guardian*. At the time, this had been analyzed by *Our World in Data.* And I compared this to information from Google and social networks. We could see that the traditional media focused on two or three areas, if you will, whereas the social networks were much broader in terms of causes of death.

So if you look at the mainstream media reports covering three causes of death, that is, terrorism, suicide, and homicide—that was before the COVID era because after, it became all about COVID—in 70 per cent of articles talking about death, they were about these three types, while these three kinds of death represented perhaps less than 5 per cent of causes of death depending on the country. On the other hand, the social networks only talked about them 20 to 30 per cent of the time. So the understanding of mortality in social networks was much closer to reality than that of the mainstream media. So the bias of the mainstream media was extremely clear to me after this discovery, and that bias has absolutely incredible power—the same in France.

But what was really interesting, and something I wasn't aware of, was indeed censorship on social networks. My first intervention on hydroxychloroquine in China, reporting on

what was happening in China, was labelled “fake news” on Facebook and “fake news” on the Ministry of Health website. Afterwards, I said, “Wait, I’m reporting something that was officially said in China. You can’t say it’s fake news. You can say the Chinese are lying if you want,”—that was the big thing—“but you can’t say it’s fake news.” So, everything that has been instituted over the last few years by fact-checkers, fake news, et cetera, in reality is information control. It’s censorship.

And then, as we’ve seen on social networks, people regularly have their videos deleted on YouTube. That wasn’t the case for me because I was a bit too big for them to really do that to me. Besides, every time I talked about something, I was careful to rely on texts that were written and known. I expressed very few personal opinions. In reality, I was explaining what I believed we knew based on information that was published. But it was absolutely enormous. Moreover, since he bought the Twitter network, we can see this more clearly now with Elon Musk’s willingness to remove and report on efforts that have been made to censor communication on networks. So this is a very striking development.

[00:45:00]

I can tell you I’d only read about this evolution in Hannah Arendt’s work on totalitarianism, and I recommend that you read it because it’s extremely disturbing. She explains totalitarianism very well; it’s very different from dictatorship. In a dictatorship, they force you to obey, but in totalitarianism, they want to force you to think the way they tell you to think. I feel that we’ve entered a phase in the West which, in my opinion, is very, very close to totalitarianism, and which can be very, very well studied with respect to the establishment of Communism. If you read [Arthur] Koestler’s *Darkness at Noon* or you read about Nazis, that’s how it’s done, it’s propaganda. “You’ve got to think like that, you’ve got to recognize when you’ve said something else, that you’ve got it wrong, you’ve got to be self-critical.” But we know all this, we just didn’t think the world we lived in was going to become like this.

As such, we need an extremely strong democratic reaction to prevent what was described in *1984*, in other words, the establishment of the Ministry of Truth. We also had the Ministry of Truth, and it’s interesting because the Ministry of Scientific Truth, if you like, has its own ways of measuring things. Among scientists, our measure is the number of citations we have or a construction based on the number of citations called the “h-index.” So, I had visits organized with the intention of destroying the Institute and the work I was doing, by eight people who are senior civil servants of the Republic, mandated by two ministers, as well as upper management of the equivalent of the FDA, and I had fun taking all their scientific output and letting them know that, “There are months when I published

or was cited more than all of you combined. So, you can't tell me that this is science, that isn't science. It's ridiculous, it's ridiculous." So clearly, it's not in the name of science.

But there are other things I've discovered. So, there's a site called PubPeer, which is an online denunciation site which analyzes your studies, including analyses done by anonymous people who have no scientific knowledge, and then bombards the newspapers in which you've published to say that you've cheated, that you broke the rules. So you see, there wasn't just censorship, there was an absolutely incredible aggression that I'd never imagined possible.

And then there was cheating, really, because "Lancet-gate" is nothing other than cheating. In other words, that unknown people managed to get 80,000 medical files of patients treated with hydroxychloroquine and that 10 per cent of them died, and published this in *The Lancet*. I can tell you, and you can mark my words, I was *The Lancet*'s only editorial consultant. Once again, I'm not a minor figure; I've been *The Lancet*'s only French editorial consultant for some 15 years.

So I sent a paper to *The Lancet* in which we report 3,000 cases, and okay, the paper isn't reviewed because it was about chloroquine. I receive for review a paper by rheumatologists from a world association of rheumatologists, reporting a million treatments with hydroxychloroquine over several months or years, in rheumatic patients, and showing that there are no cardiac incidents. They reject both papers and at the same time publish a paper in which they say that there are 10 per cent deaths out of 80,000, whereas they had in their hands the rheumatologists' paper with one million without deaths.

So, if you will, this is extraordinary. This means that censorship was exercised not only at the level of the press, but at the level of the scientific press like I'd never seen before. What happened was unheard of—and therefore, that led me to have a political reflection on how to clarify this? How do we deal with this? You're a lawyer.

Personally, I'm struck by all the drama we've seen in recent years with the pharmaceutical industry. Maybe that will change with Purdue. In the United States, an estimated 100,000 deaths a year have been caused by OxyContin: Purdue, advised by the pharmaceutical industry's top consulting firm. Perhaps some people will go to prison. But for Vioxx, which is estimated to have killed 60,000 people, there hasn't been a month's imprisonment.

So, if you will, our society needs to reflect. The only penalty there is—and in the United States, they still penalize them—they take money from them, they take billions from them. In France, they don't even go this far, or only take extremely small amounts.

[00:50:00]

I don't know if they penalize them in Canada when they realize that they lied, concealed the results.

This is all happening. Again, you have to stop saying it's conspiracy or paranoia. You just have to look. There are lots of sites that measure the number of— I don't know how many, Pfizer must have had 20 billion in fines in recent years, Merck, the same. So these are fines for cheating, fraud, bribery, illegal financing of doctors for prescriptions. All this is perfectly well known. So quite simply, society hasn't taken measures that are commensurate with the deaths that have been identified. These are indirect homicides and should be treated as indirect homicides, okay?

And they are not, because there's a false naiveté that suggests that the pharmaceutical industry is not like all other industries. Yet, it is an industry just like the car industry, which cheats with diesel, or like tobacco. It's all the same. The aim of an industrialist and an industry leader is to make money so as not to go bankrupt because otherwise he's obliged to put people out of work. States protect them. And all this has to be regulated because the pharmaceutical industry is no different from any other industry. There's no conspiracy or paranoia here.

It's hard to see how we could regulate Pfizer's sales in 2022. It's $80 billion, including $22 billion in profits. You can't let that go unchecked. You just can't. It's a challenge to all human intelligence. The whole thing has to be contained. You can't imagine: in Europe, we have not been able to get the status of the European Commission's negotiations to spend 41 billion dollars. There's no visible trace of it. It's a world that shouldn't exist. In a regulated world, such things don't exist. So there's a real fundamental problem here, which is that first we say "but it's for the good of mankind," so, we agree that it's for the good of mankind and therefore, we throw out all the rules.

I'll give you another rule to which I'm very attached. In my Institute, from the outset, one of the major undertakings was to create our own professional conduct and ethics committee, because I think this is one of a number of things that has been hijacked. We've ended up distorting ethics, which is never more than the morality of the doctor-patient relationship, into something that is purely regulatory and administrative.

Let me tell you something. We do not accept so-called non-inferiority trials, meaning trials in which a molecule is tested that cannot be of any benefit to the patient. It's meant to show that the new molecule or strategy is no worse. In Quebec, we would have said, "It's no worse than the molecule that already exists," alright? But in reality, patients are never informed that they are taking a risk because what we're testing is whether the new molecule is less risky than the old one. We decided that in our Institute, we wouldn't do or take part in any non-inferiority studies, unless on the paper that we give the patient we say: "You're taking an unknown risk." That's one thing.

Secondly, we're very concerned by these developments: normally, the Declaration of Helsinki, which hasn't been followed here—I don't know if it's been followed in Canada—stipulates that if a doctor earns money by prescribing a new treatment that hasn't been evaluated—which was the case for all vaccinations, we were in a phase III trial, it was still in the field of research—the patient has to provide consent. And so if we ask a patient to accept, we have to tell them whether or not we're getting money. I can tell you that in France at least, when it comes to therapeutic experimentation, there's no doctor or principal investigator who says: "I'm being paid and I'll earn more money if you say 'yes' than if you say 'no.'' It's not clear in the files we give them.

And the third thing, which is something that is absolutely terrible: I don't know if it happened in Canada, but back home, there were a number of professions for which vaccination became compulsory. But this collided with the fact that people were being asked for their consent since we were in an experimental period. But it's stipulated, including in the Declaration of Helsinki, that you can't ask someone to consent if saying "no" penalizes them in comparison with saying "yes."

[00:55:00]

You know very well that when a therapeutic experiment is carried out, you have to write on the consent form—and we didn't say this for the vaccine, it's an exception to all ethical rules—"Listen, you won't have any sanctions, penalties, or problems with your care if you say 'no'." So it's genuine consent, not an obligation. From the moment it ceases to be risk-free consent if you say "no," it's an obligation; and so this obligation, theoretically, in an experimental phase cannot be imposed.

There's a real problem here that's been generalized worldwide. In other words, in a product that hasn't been fully evaluated, that's going to be evaluated on prescriptions as a whole, well firstly, the states have assured the pharmaceutical industry that it won't be

prosecuted. So on the one hand, the states will assume the dangers and penalties if there are prosecutions. And on the other hand, well, the study wasn't finished. Volunteers would have been found because there was considerable initial appetite for the vaccine.

We were the first vaccination center in Marseille so once more, we had to put things in place and stop the "for or against vaccines" nonsense. There were people crying to be vaccinated. At the beginning, we started by vaccinating the oldest people, but there were people who were ten years younger than the initial vaccination age, which was over 70, so there were people in their 60s or 50s who were crying to be vaccinated, so there was an appetite for this vaccine. There were people who didn't want it, but there were people who really wanted it. There was considerable emotion involved because once more, this calm analysis of benefit and risk—for benefits that were not known—could not be carried out. All the benefits were hypothetical.

Jean Dury
You mentioned a subject that captures everyone's imagination: conspiracy theorists. I'd just like to say that, in Quebec, in cases where I've personally acted and the subject has been raised, I've always objected, saying, "There is no definition." It's a journalistic discourse and it's impossible to frame the term "conspiracy theorist" in a court of law and have a judge say what a conspiracy theorist is. So, I'll just mention that I'm going through this right now in Quebec.

Dr. Didier Raoult
The Minister of Employment too, I assure you!

Jean Dury
I speak of in court. For me, the courthouse is where I act. I've always objected, I've always won, I've always challenged. And I'm against the idea of going to court to define the word "conspiracy," and it's very difficult to define, by the way. You mentioned consent, and we're very concerned about that too because the Supreme Court of Canada ruled that no one can be treated without consent. And I can tell you that this principle has been unfortunately disregarded in the case of the vaccine.

I'll close by telling you what I heard on social networks, that in May—around May 23, I believe—at the World Health Organization, there's going to be a meeting to establish laws

that will oblige countries to follow all WHO recommendations when next there's a pandemic. Are you aware of the current situation?

Dr. Didier Raoult
No, no, no, I don't follow that closely. Once again, I'm very, very concerned about the financial power in the 21st century—and I'd like to make a comment about this—and the considerable conflict of interest that Bill Gates has in this affair. Bill Gates, through his two foundations, Gavi and Bill & Melinda Gates, is the leading funder of the WHO, ahead of the United States. He has a policy that he has always declared and he has personal investments in those stated goals, which make this the biggest conflict of interest in the world. So here's a real question and one day it will have to become clear. Here too, I agree with you: in 10- or 20-years' time, when people look at this, they'll be laughing at us. We can't have healthcare run by a billionaire who thinks he's God and invests in the areas he predicted we should invest in.

[01:00:00]

I think we have arrived at a problem which is staggering, I find it so big.

Now there's something I'm going to tell you that I find very interesting and fascinating. Doesn't it all come full circle? You probably know, because you're neighbours, that in the United States, there has been the biggest drop in life expectancy of any country in the entire 20th century since the beginning of the COVID episode; but it started even before that, about ten years ago. So at present, life expectancy in the United States, which is like the blink of an eye in terms of history, is lower than in Cuba, lower than in the Maghreb countries, and lower than in China. Yet it is the country that spends the most on healthcare. And it's the country with the most pharmaceutical companies.

So I don't know what conclusion you draw from this. But what's very interesting is to see that countries which only use generic drugs—none of the molecules invented during the 21st century—have a life expectancy that hasn't stopped increasing. And the countries in which this disease has taken its heaviest toll are the countries in which the pharmaceutical industry is most powerful: in Western countries, and in particular, the United States. But I will never wager anything on the United States because it's so multifaceted that anything is possible.

I think they need to reinvent the law against Rockefeller for the pharmaceutical industry and for GAFA [Google, Apple, Facebook, Amazon]. I don't think we can let monopolies get to

be this size without breaking them up because they're becoming too powerful and too dangerous for democracy. The Americans invented that. The same goes for white collar crime and conflicts of interest. I learned all this when I did my post-doc at Bethesda. That's when I became aware. How could we have ignored that? You know, the chap who during this crisis became editor-in-chief of *Clinical Infectious Disease*, which was the *American Journal of Infectious Disease*: he was on Gilead's board. How is it possible to have been so negligent about conflicts of interest? It's a terrible thing.

So I believe that a certain number of basic principles of liberal democracy have been bypassed or forgotten in the name of "we're doing all this for your own good." I don't believe that. Just as I don't think there's such a thing as a free lunch, but that was also something a great American economist said.

So I think we need to return to a controlled liberal democracy, that is, with checks and balances that are commensurate with the powers that be and with transparency. For example, we've just done a study that I am having difficulty getting published in the major journals, but which is original in terms of a study. In it we've included 100 per cent of all the patients we've treated in the Institute, just over 30,000, whose therapeutic data is external to the IHU [l'Institut Hospitalo-Universitaire], that is, external to hospital pharmacies. The phenomenon we're studying—mortality—is external to us. We used national statistics where we examined name by name and then, according to the treatment, we compared the mortality. And all this data is already available on a data bank that anyone can view, 100 per cent. Our analysis is our own, but raw data are raw data.

Until now, we've never been able to get the raw data from all those analyses claiming that this works or that doesn't, particularly from the pharmaceutical industry. As you can see, it's a first to get Pfizer's results because the Texas court required Pfizer to make them public. Otherwise, I believe—I may be talking nonsense, you know better than I do—that in the United States, as this is considered a trade secret: the results of these expert reports can remain undisclosed to anyone—apart from the FDA—for ten years. This means that other researchers cannot look at them, see what has been removed, what has been eliminated. If it hadn't been for this situation, a story like Vioxx, again with an estimated 60,000 deaths, would never have happened. So the fact that there's no transparency about therapeutic trials is totally immature.

So we cannot simply live as if, we cannot do, we cannot believe that the role of the pharmaceutical industry is to do good for humanity. I know one of your commissioners is a theologian, but I'm sorry, this isn't about the goodness of God or humanity. It's about money.

[01:05:00]

So we need to get back to figuring out how to control, what controls are possible so that there are no attempts to buy each other off, no special rights, no financing. How do we control this? We need to be adults and consider that this is the same thing as "Dieselgate," it's the same thing as tobacco, it's always the same thing. And so we have the impression that these lessons are totally forgotten or simply that we act like they don't exist.

Jean Dury
So as far as I'm concerned, Doctor, these are the questions I had to ask you today. Thank you very much for being here and for being questioned. Are there any questions? Please remain at the disposal of the Commission, which may have questions for you, Doctor. Thank you for your time.

Commissioner Massie
Hello, Professor Raoult. My name is Bernard Massie. I'd like to thank you very much for taking the trouble to come and give us these absolutely detailed explanations, which allow us to really understand the situation we're in. I've been personally following you since February 2020, and I'd like to thank you personally for being a voice of reason and serenity in this madness, and for enabling us, through rigorous science, to really come to grips with what we're dealing with. That's my comment.

I'd like to ask you a few clarifying questions. I've followed a lot of your conferences, and among other things, I've noticed that you regularly cite the data available on the Johns Hopkins site and *Our World in Data*. I've always had a certain, well, we follow this data and assume that it's collated as rigorously as possible. I've always had a certain reserve in view of the work you've done at the IHU [l'Institut Hospitalo-Universitaire] with Bernard La Scola, in particular, to demonstrate that the presence of an active or infectious viral load obviously depends on the number of PCR cycles performed to detect the presence of an active virus. And I know that in Quebec and in other parts of the world, PCR replication cycles have perhaps been exaggerated, let's say, to such an extent that I've always wondered a little about the famous epidemic curves, which are essentially based on the presence of positive signals, the accuracy of which is ultimately questionable.

How do you analyze this data, given that, well, it's the data we have access to? I know you've been very rigorous doing this in your Institute, which gives you perhaps a much

more accurate picture of what happened in the epidemic phases. How do you work with these sites to extract information that can be useful in understanding the broader picture?

Dr. Didier Raoult
I agree with you. I can tell you one thing, though: this, too, may be something to think about. When I started, we had an Institute that was over-equipped, probably the best-equipped microbiology laboratory in the world. Our equipment was exceptional. And so, when things started happening, we were already doing 300,000 PCR tests a year. All we had to do was add PCRs for COVID at the start, which wasn't a particularly difficult thing to do, and we managed to do up to 5,000 a day. In France, the policy was created by people who didn't even know what a PCR was, or who performed very few of them. It was based on the fact that "we don't do testing." Instead, we tested those who were identified as highly likely—predictive value—of having a significant positive test, and this became absolutely ridiculous. I pointed this out three times. It provides an almost magical illustration of this crisis. Listen carefully, because it's so big, it's like a novel.

So in the beginning, the Ministry said: "Since there are so few tests, we can't do any tests. In my lab, I was told, "We can already do 200, 300, 400." You know, when we repatriated people from Wuhan and there were no cases in France yet, there were 300 people needing testing and we returned 300 results in two hours, so we knew how to do it. But at the time, people were saying: "In France, we can't do tests, we can't do more than 30 tests." And in Paris, we couldn't do more than 30 tests, which led to hostility. And so, the public health authorities said: "For the time being, the only people who need to be tested are the Chinese from Wuhan who have a fever. The others don't need to be tested."

[01:10:00]

And so, an 80-year-old Chinese man presented himself at a Parisian hospital with a fever, illness and cough, but he wasn't from Wuhan itself, he was from the Hubei region. And they didn't test him; they sent him home. He came back. When he came back, same thing, he still didn't fit the criteria of people to be tested, and he was sent back home. And he came back in respiratory failure. He ended up going to Bichat, where he was treated by the team of Yazdan Yazdanpanah, who was responsible for managing this crisis in France, and who is a specialist in AIDS and hepatitis of course, and who gave him Remdesivir. He died of kidney failure as a result of the Remdesivir. And, icing on the cake, this case was published three times: once in *New England*, one as a case report, once in *Lancet Infectious Diseases*, and once in the *International Journal of Infectious Diseases*. That says it all about the ineptitude, ignorance, and cynicism of having published. I would be ashamed to mention it. Listen, it's

such a considerable medical error, it's such stupidity to have this man who died without treatment, without anything, who was sent home even though he came from the area where the epidemic was taking place. It leaves you wondering if you are dreaming.

And so, it's true that we've moved on from that—in the end, I was the one who convinced the President of the Republic that we had to do tests. This was one of the things I was able to convince him of. We had to do testing because that's how infectious diseases are diagnosed. But, you know, with the tests, you now see the opposite extreme. But if you look at the two major studies that were supposedly used to evaluate hydroxychloroquine—*Recovery* by the English and *Discovery* by France—within the framework of the WHO . . . Have you read them? —maybe it's not your job to do so, but it's my job. Well, in these two studies, as in many studies that were done at the outset, there are people who never had confirmatory diagnostic tests. And yet these people have become the world's reference.

I would never in my life have dared to say that someone had been diagnosed with an infectious disease without having had a test. If you look at the criteria, they were like, "Look, does the doctor think he has this?" And they didn't even know what the major signs of COVID were at the time, which were loss of smell and loss of taste, which had really significant predictive value. But at the time, they didn't know that. And so, they included people who were coughing and said, "There, they've got COVID." And so, those were the two big studies that everyone relied on. It's such a huge mistake. You see, this isn't methodology, this is medicine.

So we didn't even have the diagnoses. In most cases, people didn't know how to make the diagnosis, especially in big cities where there were too many cases for them to take action. And then in the second part, when this started to spread in France, we did millions of tests. People came to us to have their positive tests confirmed. And in 25 per cent of cases, we found that the test was actually negative. The rates that had been reported were the result of—you know, PCR contamination. That's one of the reasons why you can get titres with distilled water. You can have a positive PCR for COVID if you're not working in conditions that prevent you from doing so, and you obtain PCR titres that are not reasonable. So, I agree that this is unreliable. The only thing that is reliable, and interesting, is kinetics. And it's always like that, when you do scientific studies, and the means of inclusion aren't satisfactory, the only thing you can interpret are the movements, all other things being equal. So, the tests may be as bad as ever, which is speculation, I agree with you. However, an increase reflects an increase in cases. Am I making myself clear?

Commissioner Massie
Yes, it's very clear. Thank you very much. I had another question about the famous definition of a pandemic. And, well, you mentioned, quite rightly, that it's a definition, it's a question of words. And my concern, in listening to the lectures you've given, is that, basically, an infectious agent like a coronavirus won't necessarily evolve in the same way depending on the specific environment in which it's found, in terms of animal reservoirs, climate, or the level of health of the population.

[01:15:00]

So how can we have the illusion of managing this kind of infectious disease situation on a global scale without taking into account the local particularities that are probably decisive for the evolution of the pandemic, and which should normally call for more localized management based on each of the cases that will occur locally? So epidemic versus pandemic, isn't there a confusion here that makes us dream of magic wands, for example?

Dr. Didier Raoult
Yes, there's no doubt that the WHO uses the word pandemic as if to wave a red flag and say, "This is very dangerous." I agree with you. From my point of view, one of the major problems we've had in France is that we've neglected the zoonotic role of what we call mustelids, that is, mink farms. Taking this into perspective is one of the reasons why I don't believe in the Wuhan [laboratory virus] escape at all. Anything is possible. If, in fact, there's proof of that, I'll change my mind because I'm a scientist. But, on the whole, emerging diseases are born when there is a very, very large concentration of a possible target animal, either man-made concentrations like farms or the only ones that have such natural extraordinary concentrations, which are bats and murids (rodents).

So rats: there are huge colonies of rats and bats, you've seen that; there are caves in which you have a million bats rubbing their wings on each other. And in there, we find hundreds of strains of coronavirus, and the fact that at some point, one of them recombines—because everything recombines and modifies itself constantly—and causes a virus to emerge is quite possible. That's what happened with mink. Now, there are plenty of strains that have been brought in from mink, with, incidentally, a selection process. Mink have a number of specific characteristics. And it's true that it was neglected in France, although it had been acknowledged in Holland and Denmark. For once, the WHO was on the ball because in May/June 2020, the WHO said: "Be careful with mink farms because there are a lot of mink in close proximity." There are also people who think that it emerged from mink farms in China—the Chinese are among the biggest mink breeders. And so in Denmark, they killed

17 million minks to prevent spread. France was a long way behind in this field and didn't control mink farms at all for a very long time.

And I asked all levels, including the highest, to access the samples from the mink farm from which developed the second part of the epidemic, creating a virus specific to France: the biggest killer in France. And it took six months for me to get a sequence from the Pasteur Institute, without us ever receiving the samples to do the sequencing ourselves. And it was this sequence that was the very root of the epidemic which started up again in the summer of 2020. So we know it came from there, because epidemiologically it was the place, it was the time, and the strain was the same. So we know it's true. So mustelids and minks in general have been neglected. Now, it's becoming increasingly likely that Omicron has a real specificity, that is sensitivity to rats and murids, whereas the others were not. So the idea of Omicron goes back a long way. It took at least a year to emerge in humans, if we look at the genesis of the sequences. And so for a year it was floating around without being diagnosed. And for the moment, the most plausible hypothesis is that it was a mutation that appeared in African murids, which is very possible.

So in any case, it's true that these zoonoses and epidemic rebounds were unpredictable because we didn't really know how sensitive the different animals were, although among mustelids, there's the ferret, and the ferret is the experimental model for all pandemic respiratory viral infections. So it's no surprise that the ferret is sensitive to this. In fact, ferrets had already been tested with previous coronaviruses, so it's no surprise that minks were susceptible. And when you have several million minks in a farm, the speed at which viruses advance and mutate is considerably colossal. It creates an absolutely extraordinary biodiversity.

[01:20:00]

It was known from the outset that keepers on mink farms were infected and that keepers could infect someone in their family when they came home with an infection acquired from mink.

So all this was knowledge. It was simply politically unmanageable. And on top of that, when I started saying about the vaccine, "You're not going to eliminate a disease that's epidemic in mustelids by vaccinating humans, it doesn't make sense." What's more, we knew that felines were susceptible, and then we knew that rats were susceptible. So you can't eradicate a zoonosis that has so many different targets, it's not possible. So accepting that it was a zoonosis and not a one-off event called into question the strategy of eradicating or eliminating the virus, which suddenly became laughable. If you say to people, "You realize

that with all the animals that are capable of getting this, you're not going to vaccinate all the mustelids and catch the badgers, the ferrets to vaccinate them, it's not possible," nor will everyone hide from dogs. We don't know if dogs can then become vectors, but there are dogs that have caught it from their owners, you see. So the possibility of animal reservoirs is considerable.

Commissioner Massie
Perhaps I will allow myself one last question. I know you don't like making predictions. You have said it frequently. But in your opinion, at what stage of the pandemic do we find ourselves at the moment? There is, for example, Geert Vanden Bossche, who raises a terrible possibility that we would not only have a more transmissible variant, but possibly a more pathogenic one. Well, it's disputed, it's debatable, it's not impossible because, well, his hypothesis is that there is a very targeted immunological selective pressure with these vaccines that we used on the only target, which is the spike protein. It creates an immune pressure that can ultimately lead to an adaptation that will bypass the more global immune response of natural immunity. But it would seem from what we are observing at the moment that Omicron, although it is very transmissible and we have a whole series of variants, it seems, in any case, to balance out; or, in any case, we do not seem to see any emergence of variants which would be particularly more pathogenic, as you had with Marseille-4, for example.

Dr. Didier Raoult
I never predict anything, it's not part of my nature. I observe, if you like. Therefore, the only reflections one can have, at least that I am likely to have, are comparative reflections. So I watch what goes on.

So there are works that you probably don't know, and others that you certainly won't know, that have been done by my great friend and collaborator. He's my first student, you see; it's hardly new, it's been forty years. He's Michel Drancourt, who still works with me, because I don't have as bad a temper as people say. Pretty much everyone who was able to stay with me has stayed with me.

So together, we invented a field called paleomicrobiology, that is to say, the study of past epidemics. This also brought me terrible conflict, albeit scientific battles, because we were the first to use these techniques. And we used them to show that the plague of the Middle Ages was due to *Yersinia pestis*, at a time when there was the same fantastical thinking: "There's going to be something even more serious, even more deadly." So there was NSF

[National Science Foundation] funding that was attempting to demonstrate that the Black Death of the Middle Ages was due to a hemorrhagic fever virus and not the plague at all, and this had a lot to do with ignorance. And, I'm pleased to say in a French-speaking country, this ignorance was due to the fact that around 80 per cent of the epidemiological studies carried out on the plague in the 19th century were done by French speakers and published exclusively in French, so English speakers were unaware of them. So, of course, Yersin was a French speaker. Balthazar, who discovered the whole plague cycle, was French; Montlaré, who worked all his life on the plague, especially Garmontrand, who made telluric reservoirs, was French and wrote only in French. And so this literature was only known by French people, people who had studied in France or who read French. Still, it caused a lot of conflict.

So we invented a technique based on the dental pulp. Dental pulp is vascularized like the spleen, it's full of blood. And so, when people die, it clogs up, and dust remains inside, which is a kind of blood culture, if you like, preserved by time. So we were the first to use this. Everyone uses it now, even for genetics. It had been incredibly criticized on the grounds that, theoretically, DNA couldn't be preserved for so long. So once again, it was theory versus practice. But Michel continues. Michel continued with proteins. But now he's doing that all by himself. We did the plague together. The first evidence he had through protein analysis and serology of an infection by this group of coronaviruses, the betas, dates back to the 16th century.

[01:25:00]

That's published, okay? And he's just finished a paper that's in the process of being accepted; in the infirmaries of Napoleon's armies in 1804, he has found another infection.

So this is to tell you one thing. Epidemics used to stop on their own. So we're in a megalomania of human scientific power, which means that it won't stop unless we decide that it will stop. It'll stop anyway. If it does stop, then we begin to understand: In reality, the mutations we see in organisms end up exhausting them. There are many mutations that have no use, that are not mutations that kill microbes or viruses. And we've been able to show that for SARS, for example, there's one mutation maintained every fortnight [two weeks] on average. And when there's an average of seven mutations, the SARS clone disappears. It has lost its energy and disappears. This explains why most epidemics last two or three months: because they accumulate mutations which, over time, prevent them from being effective.

And there's an extremely well-known model for people interested in epistemology, in the history of science, and that's the story of myxomatosis. I advise you to read this, because—as for Wikipedia, it's incredibly rigged, there too is censorship. It's incredible, it's become a propaganda tool. If it's become about propaganda, it's over. It's all bought by the industry or influencers. But myxomatosis was imported into Australia to kill rabbits—there were too many rabbits—and then it killed so many rabbits that it killed all the rabbits. We wondered what had happened. And what happened was that, spontaneously, the myxomatosis virus became less and less lethal, meaning that there's a reverse selection process known as "laziest selection," which means that the least aggressive viruses are the ones that come to the forefront after a while. So we get the impression that there are alternating cycles between priority for the most aggressive, which is the start of the epidemic, and priority for the least aggressive, which is the continuation and installation of the cycle.

That's what we saw, for example, with the flu. For example, the Spanish flu was a monstrous thing that killed young people, devastated the world, and is still used as a reference by catastrophists. Yes, but the flu doesn't do that anymore. So from time to time there's a new major variant that's deadly, but it's never been deadly like the Spanish flu. So the natural evolution of viral cycles is to disappear.

So in terms of the plague, which we've studied a great deal in particular because we've done a lot of work on old plague samples, we can see that it's not exactly the same variants that arrive, and then, for one reason or another, they disappear. On this point, I disagree with the immunologists and the idea of "herd immunity," which would mean the end of the epidemic. As long as there are cases, there are cases. As long as there are still susceptible cases, there may still be human cases. So I believe that the end of the epidemic is not due to population immunity, but to the end of the viral cycle. The virus exhausts itself, if you like, through the accumulation of useless mutations; and it either has a new favorable mutation, bounces back, and refashions another epidemic with a unique variant which is itself another virus, or on the contrary, it exhausts itself and then eventually disappears, or becomes like the rhinoviruses.

This may be the future of coronaviruses because there are four endemic coronaviruses circulating everywhere, which more frequently give rise to a total absence of manifestations than to manifestations. In Africa, we didn't work on coronaviruses, but others did. There are areas where eight per cent of people carry coronaviruses in their nose all year round. They're not sick. Some of these coronaviruses are believed to have been the cause of epidemics, of a whole host of epidemics, particularly in the 19th century, and also what we found in the 16th century.

[01:30:00]

Little by little, these viruses became viruses of the upper respiratory tract, that is, rhinoviruses—rhinitis viruses, if you like—and then they stopped being very aggressive. Nevertheless, if you catch a rhinovirus at the age of 85, you now have, I don't know, a three per cent chance of dying in Marseilles hospitals—these are a few of the things I know. It's not totally harmless, but in cases that are very, very fragile, it can still kill people; but in the general population, these are common infections that don't kill. So it's possible that the natural evolution of these viruses is gradually to have, on the contrary, a decline in their pathogenicity, but it is then something that can be reawakened by a mutation on another occasion.

Commissioner Massie
Thank you sincerely. I'm going to ask my colleagues if they can address any questions to you in English because they don't speak French. I think you'll be able to answer them and we'll do the translation. Do you have any questions?

Dr. Didier Raoult
No problem; although in Quebec, I know it's frowned upon to speak English. Anyway, I will make an effort.

Commissioner Massie
We'll forgive you. Do you have any questions you'd like to ask, Janice?

Commissioner Kaikkonen
Good morning, bonjour. I'm going to speak in English because my French has really lapsed, but I'm going to pass my question on to Bernard, Doctor Massie, who might be able to translate it for me if you don't understand what I'm trying to say. So you mentioned the financially powerful in the context of transparency and who is controlling who, kind of like the old cliché, "follow the money." But as we know, it's very difficult for people to make good decisions about their health and well-being when authorities are oppressing the populace through lockdowns and mandates. So how do we prepare now, should governments try these same measures again in the future?

Dr. Didier Raoult
Well, I don't know. One more time, you're trying to ask me to make predictions. I would not. What I'm seeing here is that people don't believe now, so it's going to be more difficult. Many, many people have been really, really, disappointed by the fact that there was a lot of decisions that were not supported by anything. For example, because you speak in English, you may have been aware of this, because it is probably one of the most important documents in this story: it is the Johnson leaks. So we have now the conversation between the equivalent of the Ministry of Health in the U.K. and Boris Johnson on the political decisions they took for lockdowns, for restrictions. And they discuss together, and I wonder if you have read that. It is really fascinating. And the reason why they decided is, finally, Boris Johnson says, "Well, the Prime Minister of Scotland has done that, I don't want to hurt her so we are going to do that in England as well." So this was the rationale, the scientific.

These people are clowns! This is not serious, they're clowns, the head clown is followed by all the clowns. So the main thing is that people are following one another; and one of the reasons is because finally, two years after, everybody understands that it was not a good decision, they can always say: "but everybody was doing this," so they don't need to think. I don't know if they can think, but they don't want to think. Only Sweden, in Europe, had a different position. I don't know why they are so good but they get their own decision, based on their own analysis. All the others just followed the first clown that starts to walk, the first clown was mainly in the U.K. because the U.K. gets the reputation to be the very best in medical research.

Commissioner Kaikkonen
Thank you, merci.

Commissioner Drysdale
Good morning, sir. You have commented about a wide variety of topics, from medical to censorship to government actions, so I want to talk to you overall about them.

[01:35:00]

So first, can you explain to me—in layman's terms "in short" because we're short for time—what is the definition of a pandemic?

Dr. Didier Raoult
Well, there is no definition of the pandemic. Theoretically, "pan" will say "everywhere," an "everywhere epidemic," so this is the definition. So as I told you, it's kind of a red signal to say, "well, it's terrible." This is how the WHO uses it, but if there is a definition, "pandemic" is a disease that is epidemic everywhere. This could be your definition.

Commissioner Massie
Professor, can I ask you to answer in French for the audience? And they will have the translation. I know it's complicated.

Dr. Didier Raoult
The first question is: how will the public react to the next display by governments and the press in a comparable situation? I can't predict that, but in any case, what I see is that people are a lot less gullible now than they were three years ago. And there is something that is very, very, very important. I hope that this will be part of your analysis and your comments: the leaked emails from Boris Johnson and his Department of Health about the measures taken, crisis management policies, and in particular, lockdowns. They discuss, and there is no scientific basis for this, but they say: "Since the First Minister of Scotland said that lockdowns were necessary, so as not to offend her, we will lockdown too." So, when people say it's in the name of science, that tells you the nature of the reasons why they've made these decisions. And the nature of the reason is for following, sorry, that's a neologism. They follow each other, and when one has started, the others say, "If we're accused or have a trial tomorrow, we can always say, 'We did what the others did, you can't say we decided that.'" So the decision not to do as the others do is potentially more damaging, and requires thought and decision-making based on established data, as opposed to saying, "Look, there's no reason; they're doing it, so we're doing it." And since the leaders in medical research were the English and the Americans, as soon as this decision was made, everyone followed them, except the Swedes. The other question is about the pandemic, which I think I've already answered in French. There's no real definition, apart from the fact that it's a signal that something is very serious. But theoretically, a pandemic is an epidemic that occurs in every part of the world.

Commissioner Drysdale
Then, to follow along and continue on that, again, you discussed many things in your presentation and you talked about the COVID-19 pandemic; and Doctor Massie and yourself talked about PCR testing, you know, the variability or the unreliability of the PCR

test. You talked about that the average age of death of a victim of COVID is actually higher than the life expectation age. You talked about that often COVID-19 was called the cause of the death and it was not sure whether that was the cause of the death. We heard testimony—as a matter of fact, in Toronto—from a paramedic who said someone jumped off of an eight-storey building and they swabbed the remains and said it was a COVID death. So when I think about COVID-19 and I think about the definition of a pandemic, and I think about the variability across the world, you know, Sweden you mentioned, France you mentioned, United States, et cetera. So there's a lot of variability, there's a lot of questioning about how they diagnosed it, and I want you to compare that to something else you talked to. And I want you to talk a little about pandemic. The other thing you talked about is government response. You talked about censorship, and that's universal around the world, as I understand it. It happened in France, in England, in the United States; it happened all over the world.

[01:40:00]

We have heard significant testimony from across Canada about how our institutions failed. You know, basic fundamental beliefs in our institutions, informed consent failed. You talked about that yourself. You talked about the courts failing us. And with all of that, here comes the question. Was the real pandemic COVID-19 or was it the effect that it had in ripping apart the fabric of our society—because that was universal across the world?

Dr. Didier Raoult
I don't know. I cannot write the story. What I can tell you is that the trouble that we get here is that, first, I agree with you: some of the deaths have nothing to do with—the only young person that died of COVID-19 in Buffalo died of an overdose.

Commissioner Massie
Professor Raoult, I'm going to ask you to answer in French. And I've been asked to translate my colleague's question for the audience here, so I'm going to summarize the long preamble of Ken, who apparently speaks more than I do. To put the question, with what has been deployed around the world to manage this pandemic, do we really consider it to be a pandemic in terms of an infectious disease occurring everywhere at the same time? Or is what we've witnessed merely a response from our institutions that has caused a major disruption in the organization of society?

Dr. Didier Raoult
There are two things we can say because there are examples of countries—Scandinavian countries, certain African countries—where there has been no decline in life expectancy. These countries have managed effectively. As you know, the greatest loss of life expectancy has been in certain Eastern European countries, such as Bulgaria, and in the United States. There are two phenomena that seem very important to me. Firstly, the way in which the epidemic was handled, that is, calmly focusing on those at risk, learning how to treat it as the disease unfolded. As I said, we used oxygenation and anticoagulants because there was substantial deep vein thrombosis. So we had to detect people with coagulation anomalies. So we had to practise medicine.

So what's happening, and this is a real general issue, is that more and more administrators—in our case, it's the ENA [École nationale d'administration], in your case, I don't know what it is—think that, in the end, medical practice isn't that important anymore: "We don't really need doctors." In fact, we've been putting the brakes on the training of doctors for the last 30 years in an incredible way. There are plenty of places where there are no more doctors. So I think it's likely to get even worse because the state is in danger of thinking that artificial intelligence is going to replace even more doctors. The state ended up thinking—in France, this was very clear—for example, it was the Director General of Health who spoke directly to the population to tell them how they should look after themselves, to tell them what they should do, and not go through the doctor.

And so the whole relationship that was built up— So whenever there's medicine involved—for example, I have a lot of links with Africa; the Africans understand very, very well what I'm saying because in Africa, you can't leave someone who's ill without care. It could be someone who practises traditional medicine or it could be a health officer or a doctor, but when someone is sick, you have to take care of them. It's the first time I've heard ministerial instructions saying that you shouldn't look after the sick. It's something completely new, and it's indicative of a deterioration in our perception of medicine. That's one thing.

The second thing is, of course, what's happening in America; and I don't know what your figures are in Canada, and I apologize for that, but you have an obesity epidemic which is the cause of excess mortality in young people. Obesity is a considerable cause of excess mortality for all respiratory infections, and it's very easy to understand if you ever look at a cross-sectional drawing of an obese person on his back and you look at his respiratory capacity.

[01:45:00]

Just from that, you'll be able to understand that his tolerance level to a respiratory infection is much lower, and on top of that, there are immunological phenomena. And so, the decline in life expectancy in the United States began ten years ago with two phenomena: obesity and drugs. And drugs, for reasons that were favoured by the U.S. government saying, "You've got to be happy right away." They polled patients to see whether they had immediate relief, and for immediate pain relief, you give opiates. And when you are given opiates, a certain number of you become drug addicts, and the mortality rate from opiates in the United States is terrifying. So I agree, there's a fundamental problem in society, meaning that not everyone is equal when it comes to disease. In other words, there are people in our country who are essentially over 85, and I think it's the same in Sweden. In the United States, it's not at all the case because, of course, obesity in the United States today is not at all the same as it is in France. But here too, it's the same thing: what are the countermeasures against drinks? We all know that obesity is caused by sugary drinks. What are the restrictions against sweetened beverages? There are no countermeasures against sweetened beverages, as far as I can see.

Jean Dury
That's the end of the questions, Doctor. We'd like to thank you very much for the information you've provided, which will undoubtedly help us prepare a brief containing a number of recommendations. In fact, that's the purpose of this Commission. So thank you very much.

Dr. Didier Raoult
You're welcome. Goodbye.

[01:47:05]

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

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