

Prioritizing Equity video series: The Experience of Physicians of Color and COVID-19

Elevating the issues around COVID-19

On April 2, 2020, the AMA hosted a panel as part of its Prioritizing Equity webinar series. Health experts and leaders in minority communities across the nation to discuss their experiences with COVID-19.

Featured speakers

- Patrice A. Harris, MD, MA, president, AMA
- Aletha Maybank, MD, MPH, chief health equity officer, AMA
- Winston F. Wong, MD, MS, chairman of the National Council of Asian Pacific Islander Physicians
- Elena Rios, MD, MSPH, president and CEO of the National Hispanic Medical Association
- Siobhan Wescott, MD, MPH, Association of American Indian Physicians
- Brian Thompson, MD, Association of American Indian Physicians
- Oliver Brooks, MD, president of the National Medical Association (NMA)

Transcript

April 2, 2020

Dr. Maybank: Good evening, everyone. My name is Dr. Aletha Maybank. I am chief health equity officer at the American Medical Association [AMA], and I'm over the Center for Health Equity. Our mission at the Center for Health Equity is to strengthen and amplify and sustain, AMA's work, the American Medical Association's work, to eliminate health disparities, improve health outcomes, as well as close gaps. Which we know are rooted in historical and contemporary injustices and discrimination. And our approaches we go forward with are one, embedding equity in our practice and process and action and innovation, building alliances and sharing power via meaningful engagement.

Ensuring equitable opportunities and conditions and innovation for marginalized and minoritized communities, pushing upstream to the structural and social determinants of health and making sure that we're addressing all of those as well. And then creating pathways for truth, reconciliation and healing for AMA's past. So, welcome. I want to thank our esteemed panelists for being here. I want to thank all of you who are tuned in to listen to the conversation tonight.

A few logistics, and it's really just a few. If you have a question, or a comment, you can put it into the chat section of YouTube. And I will, at some point, look at them and ask some of them during the conversation. So if you have questions, put them into that space. I want to introduce our panelists now. We have first and they're probably in different orders for folks but Dr. Patrice Harris, she is president of the American Medical Association, Dr. Brooks, who is president of the National Medical Association. Dr. Elena Rios, who is president and CEO of the National Hispanic Medical Association. Dr. Wong:, who is chairman of the National Council of Asian Pacific Islander Physicians.

We have Dr. Siobhan Wescott, who is with the Association of American Indian Physicians, as well as Dr. Brian Thompson, who is also with the Association of American Indian Physicians. So welcome, everyone. I've been looking forward to this conversation all day. Well, a couple days actually now, so I'm really glad to finally be here and get this started. So I'm going to open up, in saying we know that all physicians at this point in time, have a keen interest in staying well, staying healthy and keeping their families well during this time. It's on top of mind for many physicians, especially those on the front line.

For physicians of color, even before COVID, we know from experience and evidence that there's a greater burden placed on physicians of color. We're more likely to see patients of color, who can be sicker and experience all types of inequities. We know our patients are more likely to experience discrimination. They're also, as physicians, more likely to feel the fallout during economically hard times because this huge gap that we have in wealth in this country.

And so COVID really exacerbates these inequities, not just for the patients, but even for us as physicians. So I just would love for each of you to go around; I'm going to ask Dr. Harris to start first, to just share with us what are you hearing from the members of your organization and your colleagues? And what are the priorities of your organization at this time?

Dr. Harris: Well, thank you, Aletha. And let me just say first, what an honor it is for me to be able to get to know you.

Dr. Maybank: Oh, thank you.

Dr. Harris: I'm so excited about the work of the AMA, the American Medical Association going forward under your guidance as you know that it is our intention to embed health equity and the issues around health equity into our organization, both internally and externally. So I want to say that. I also want to

say what a privilege it is for me to be among this distinguished panel, as we elevate these issues. I was thinking about this and thinking about—I have a background in public health as do you, Aletha—and how we often do after-action reviews.

Dr. Maybank: Yes.

Dr. Harris: So many times on so many issues, how an issue impacts people who are in under resourced communities, communities of color, are discussed in the after-action review?

Dr. Maybank: Yep.

Dr. Harris: They are not discussed before and so it's been my desired opportunity, to do that so that we can be both proactive and predictive because all of us on this panel know, based on prior experiences, what can happen. And so I think that's very important that we are having this conversation now, elevating the issues in our communities now, so that there can be action now. The AMA is very committed to this issue, and certainly we want to make sure that we elevate these issues around COVID. So I have been busy over the last couple of weeks, media and media, media. That's important, not just to be out there, but to give voice to the concerns of physicians.

That's what we do at the AMA, we give voice to those concerns and also try to take some action based on those concerns. So I'm hearing lots of things of course, the most critical need: physicians are crying out for PPE. That's personal protective equipment. We are going out there, we are on the front lines, risking our lives, and so I have been trying to elevate that issue have, having had the opportunity to talk with the president, talk with members of the task force. So that's one issue. The other issue is physicians are worried about their practices, right? Both small and large. And how we survive this.

Many physicians are seeing fewer patients unless they're in critical care or in the emergency departments. So we'll have to take that into consideration. And as always, these impacts will probably impact physicians of color more than others and so again, I will stop there and just say that we are on the ground again, giving voice to the needs of physicians and patients and look forward to the conversation.

Dr. Maybank: Thank you, Dr. Brooks.

Dr. Brooks: All right. I will countersign many of those areas that Dr. Harris stated, and I also say thank you very much to the AMA having Center for Health and Equity and putting on this webinar and I'm happy to be on a panel of such distinguished experts and representatives of their organizations. When something like a pandemic hits, it will adversely affect the African American community. One of the things that I'm very concerned about is first and foremost safety of my staff. I'm at an FQHC [Federally Qualified Health Center], I'm a chief medical officer.

I need to ensure that my staff are safe as well as I can make them because they are on the front lines. So that is a primary concern. I would also say I'm concerned about the solo and small group practitioners. On the news we hear much about hospitals, clinics, health centers, governmental agencies, you hear very little related to the solo and small group practitioner. And the African American community's solo and small group practitioner is part of the backbone of care. So, they need information. They may not have access to PPE the way a hospital can, ER may pull it from ICU.

If you're a solo or small group, you can't do that. Dr. Harris mentioned finances. They don't have large cash reserves such that they can wait three months to get monies coming from the federal government. And they have fear about these things, but they also have courage. So that's what I'm going to say I've observed also. I've observed that both here at my health center, and I've observed that in the solo and small group practices and speak to them, I call them and they're telling me, "We're in the office, we're seeing them." They're having to layoff some staff, they're having to manage, they're worried about saving their own homes.

Dr. Brooks: But I found that they are still there. And we, at the NMA, represent the African American community and the 55,000 African American physicians in the United States. This is one area in which we are focusing, we need dissemination of information just like this.

Dr. Maybank: Great, thank you. Dr. Rios.

Dr. Rios: Yeah, hi, I thank you very much for inviting me, Aletha and AMA. I think this is a great opportunity to educate those who are participating with us tonight and I have to say on behalf of the National Hispanic Medical Association, we represent the Hispanic physicians across the country who have come from our communities and from Los Angeles area. We've got doctors from the Bay Area, the Midwest, the US-Mexico border, Puerto Rico, New York, the Miami area and Chicago and other areas. We are very concerned about the importance of reaching, especially the elderly in our communities and those most vulnerable who have asthma and respiratory diseases.

As well as we now know there are people are vulnerable that have chronic diseases like obesity and diabetes and hypertension, high blood pressure. I think that one of the most important things that's come up from our doctors and again echoing Dr. Brooks, the small mom and pop private doctors, the doctors in small practices, are having a hard time with having to layoff staff, but also having to figure out how to keep their patients at home and not go to the emergency room and trying to have more home health.

It's not just telemedicine. It's more than telemedicine, telehealth, but we are involved with agencies with telehealth and one of them is Hoy Health—I want to mention them. They're one of our partners. We've also been called by doctors who are interested in volunteering, who are retired or even medical students. And I think that that's great, especially in our communities where the Spanish speaking patients are really in need of Spanish speaking providers. Then one last thing I'll say that I know is

affecting us, is there's a lot of fear in our community.

And it just so happened on February 24, which is right in the middle of when this pandemic hit the United States news media, a public charge went into effect for those persons who are coming into this country who are immigrants applying for their green cards, they are now being looked at as a public charge if they apply for government assistance that has to do with fundamental issues like food, like food stamps or housing and getting housing and it was never that severe to have a public charge be considered for those kinds of things.

And I think that has had a very bad effect, trickling effect in our families who care for elderly who are undocumented or for those who are trying to come across now in the country. I just have to say that that fear adds to the toxic stress that we live in our neighborhoods that we all know about and we're going to talk about. But anyway, National Hispanic Medical Association Physicians are very interested in doing what they can to care their patients and to learn from each other. And we're sharing ideas on our websites and through our own Spanish media.

Dr. Maybank: Excellent, thank you. Dr. Wong.

Dr. Wong: Yes. And I wanted to echo my thanks to the American Medical Association, Dr. Harris and Dr. Maybank for hosting this really important seminar and certainly, our sister organizations with the National Medical Association, National Hispanic Medical Association and the American Physicians Association, really important partners. Actually, it reaffirms to me how much of our organizations have so much in common in terms of fighting for the needs of our communities that have been so vulnerable and marginalized historically.

And I did think about what we were doing at the National Council of Asian Pacific Islander Physicians, right up to the time of when the pandemic was really acknowledged. It was all about social determinants of health. And when you look at the social determinants of health, this applies to Asian Pacific Islanders and Native Hawaiians, and I'm sure to my other sister organizations here, we're talking about issues around discrimination, about language access, cultural barriers, all these issues that we know exist that impede the social equity we want to see in terms of health care, and clinical care.

Our physicians in the communities in small practices and academic settings are really trying to make this fight every day. Then when the pandemic is declared, so much illuminates how much social determinants of health become really the cutting edge issue as far as how we look at the pandemic, how do we prepare for the future? And how do we make sure that the most vulnerable in our communities, don't suffer excessively. We're all in this together as Americans as different nationalities, different stripes in terms of political persuasion.

But we also know that with all medical disasters, it's usually the most vulnerable, that are really going to suffer the worst consequences, not only the immediate sense, but in the protracted sense. So I think it's really important that we keep our eye on the prize in terms of thinking not only to how we manage through this COVID-19 emergency, but also in terms of how we build for a future that assures equity as we confront this and other medical urgent issues. So on behalf of the National Council, I think we're going to be working very earnestly with our sister organizations on this call, as soon as we finish to make sure that our community needs are met.

Dr. Maybank: Right. Thank you, Dr. Wong, Dr. Wescott.

Dr. Wescott: Certainly Thank you, Dr. Maybank and Dr. Harris for being such strong voices for people who are often voiceless and not able to be heard on the national stage and to have you two representing the AMA, it brings me joy in these very hard times. So thank you for that. And for including association of American Indian positions in this conversation, we come from a system, the Indian Health Service and some tribes have been able to take over their own health care. We still are under-resourced, and so if you wanted to talk about underlying medical conditions, putting somebody at risk for COVID, you can talk about health systems having underlying health problems that are systemic and we certainly have them.

So for instance, there's a 20 to 24% vacancy rate just for physicians in the Indian Health Service. So if you're short one physician, one physician can see a panel of 1400 people. That's 1400 people that the other docs have to try and squeeze in. So we're already stretched pretty thin to start with and something like this, really can devastate our communities. We don't have a lot of resources, we don't have access necessarily to nearby hospitals, let alone the specialty care that's clearly needed to survive COVID as we've seen and as it unfolded out in other countries.

And now, here in the US on the East Coast, well, actually on both coasts.

Dr. Maybank: Yeah.

Dr. Wescott: We're concerned but it's having these conversations, keeping the forefront that American Indians we're still here, we count and we want to be a part of the solutions.

Dr. Maybank: Excellent. Dr. Thompson. Would you like to provide? Mm-hmm (affirmative).

Dr. Thompson: Yes, absolutely. I just started by saying sge skä noñh, it means hello and having peace. Skä noñh means peace in my language. I'm from the Onondaga Nation in New York, and I'm up in Syracuse, New York. Approximately four hours from New York City. But the word skä noñh I think is important because it means not only peace within yourself, but peace to others and peace from each person to another person. I think that's so important at this time. But I'm here with the Association of American Indian Physicians, but also in a dual role.

I'm an OB-GYN at a large academic University. With about 10,000 employees working in a high risk obstetrical unit, and it's quite an amazing time right now for health care itself. For Native Americans, we look at over 575 nations within the United States, each of them sovereign, each of them different. And different things that we're dealing with is how do different Indian nations perform their ceremonies that they do within COVID? How does a traditional healer see someone in the hospital, which they're not able to do at this time?

And also looking at just incredible health disparities within Native Americans, but knowing that each Native American within the United States per capita, only receives approximately about \$4,000 worth of care per year. And how do you provide for care like that? Which I think sometimes it's forgotten that the largest Native American population in the United States, is in New York City. With over 110,000 American Indians in New York City, with no center for their health care at all.

But I would also like to say also that from an academic side, working with pregnant patients and seeing high risk pregnant patients, we do see the devastating effects of COVID-19 and how they affect not only mom but how they affect the baby in the relationship with a family unit. But finally, also how it is affecting the physicians within New York State, how it's shutting down practices, how it's affecting nurses and staff and everyone else. But I thank you again for allowing us to be here tonight.

Dr. Maybank: Please go ahead.

Dr. Harris: Something I just thought about, as I think it's very important and the wealth of wisdom and knowledge on this panel is the issue of trust. You mentioned that at the very beginning, but I think it may or may not be the elephant in the room, but many members of all of our communities have an issue with trust, and that is certainly placed sometimes it's misplaced, but in this instance, there are valid reasons for that. But here you have a wealth of information in all of our organizations and within our organizations and from our organizations, I'm sure on our various websites, I want everyone to know that they can get trusted information.

And we will be getting information. I've said to many folks I spent the first couple of weeks of this pandemic convincing African Americans that we could be impacted by this, and this was family and friends, not necessarily out there in the public. So, I am just very excited about the folks on this panel and the knowledge that we have. And I want everyone to know physicians, patients, the public a lot to think alike that they can come to us for trusted information.

And I will just say that on our website, as well the [ama-assn.org/COVID-19](https://www.ama-assn.org/COVID-19), you can get information and particularly for physicians to know about these small business loans, we know small businesses or small practices may be suffering. So I just wanted to say that we all are places of information where folks can get trusted information.

Dr. Maybank: Thanks for that and to build on that a little bit. It's not a totally lighter note, but the missed part of it. There, as you said that we had to spend some time dispelling myths. Are there still myths out there that you are hearing among not only your patients, but also other physicians still at this time? And how have you worked to overcome them?

Dr. Brooks: This is Dr. Brooks and I am hearing that COVID-19 does not affect black people. There are a small number of cases in Africa. That's the proof that since it's hot in Africa, so it's a temperature sensitive virus. And the statement I have to that is COVID-19 unlike other things does not discriminate. We can and do get COVID-19, and with our comorbidities, which are risk factors, we're likely more likely to die or be hospitalized because of it. And I will then go to what Dr. Harris has referenced trust.

Studies show that people seek information from their doctor, and have the most trust in what their doctor tells them. So I also tell my patients and tell other physicians to be ready; you need to have the answers and direct your patients to talk to you. There are other credible sources of information. At this point I do feel that the information coming from the CDC is as credible as it can be. The AMA has a website and there's information there. We were just referenced by Dr. Harris information on the AMA website. But that is the message that I am hearing, that I dispell clearly: that COVID-19 does not discriminate.

Dr. Maybank: Anybody else hearing anything?

Dr. Rios: Yeah, I think we've heard a lot from people thinking that younger people are not affected, and in our communities, so many younger people are connected to the elderly at home. It is important that everybody needs to understand that they're all part of our families and younger people do get infected, because they're vulnerable, again, especially those that are now vaping or have asthma or other issues, diabetics at younger and younger ages in our communities. So yes, I think that is one of the big myths.

Dr. Maybank: Absolutely. Anybody else?

Dr. Wong: Yeah, this is Dr. Wong. I think one of the most perverse myths actually is, some of the conspiracy theories with regards to how the virus might have entered into our biologic system, which I think is actually very dangerous with regards to how certain stories are circulated with regards to whether the virus is created by scientists and whether it was launched by certain governments. This is very destructive relative to what we need to keep in mind is, our shared humanity and the fact that this is a question of profound human existence, that has nothing to do with the politics or with regards to ideas about partisanship, et cetera. So I think it's really important to keep those messages really at bay and stick with the biology and science.

Dr. Thompson: I think one of the biggest myths that I think is not only applicable to the American Indian population, but to all populations is that it's also a pandemic within rural America. [Edited for

clarity]

If you look at the Navajo Nation, the Navajo Nation and Arizona, New Mexico and Utah and the lower part of Colorado. It has over 200 cases of COVID-19 right now, that it has Indian Health Service to the Regional Medical Center overwhelmed with patients in our ICU at Flagstaff Medical Center in Arizona. And these are areas that are incredibly isolated communities in the desert, that have COVID-19 that's going through there. If it can happen in rural native communities, it can happen in any rural community within the United States.

It just demonstrates the importance of all the precautions that AMA is promoting, that all of our organizations are promoting, that every physician is reporting or is advocating.

Dr. Maybank: All right. Thank you, Dr. Wong.

Dr. Harris: I think at least on the panel, folks on the panel know I'm a psychiatrist. And so I definitely tried to get all the elephants in the room out. So they're not elephants in the room. But Dr. Wong, I think early on, we saw that there were certain acts of discrimination directed towards Asian Americans. And so I wonder if you might let us know if our Asian American physician colleagues are experiencing any of this increased discrimination or racism?

Dr. Wong: Yeah, thank you for asking that question. It has been very disturbing. I recall that when the epidemic was first being acknowledged, I made a statement on behalf of the National Council of Asian Pacific Islander Physicians that we should be aware of what I termed either implicit bias or incidental bias towards Asians and Asian Americans with regards to being associated as a vector for the disease. Looking back at that statement, I thought it was correct at that time, but I think since then it's actually become even much more dangerous and harmful, in that the virus at various times has been characterized as the Chinese virus, the Asian virus, et cetera.

And what we have seen is that we know that there are incidents in the community, where people who appear to be of Asian nationality are just shouted at, and they're psychologically traumatized by individuals just on the street, with regards to being seen as some sort of danger to other people's health. The physicians we hear, from various sources, they know that our patients are stressed, many of them are not coming in for care because, along with the public charge issues, not really knowing what's available to them in terms of cultural care, the issues with regards to being linguistically accessible in terms of the information out there, it's really been a combination of forces that has really resulted in some really fairly dangerous things as far as our community being served appropriately in the face of the epidemic.

I do think that we need to be consciously using COVID-19 as the appropriate terminology. And we need to actively, actively say that any reference to that in other terms is not acceptable, and we also need to stand up and say for the sake of civil rights and social justice, that discrimination towards

Asian Americans with regards to how the virus is perceived, is unjust and should be protested. And that means everyone from every part of our community should be standing up for that.

Dr. Maybank: Absolutely.

Dr. Thompson: Yes.

Dr. Rios: Yeah.

Dr. Maybank: So, Dr. Harris took the question right off my paper.

Dr. Harris: Great minds think alike, Dr. Maybank.

Dr. Maybank: And I want to expand that also to anti-immigrant policy and then the rhetoric that's around that, and the violence that that potentially is leading to and just violence overall as it relates to hate and your experience of that as leaders of physician organizations, but then those who also are more likely to see patients who may be immigrants, and let me be more specific in terms of immigrants: immigrants of Hispanic or Latin descent, of African descent, also, as well who often are many times invisible and experience the system in a way that people don't even understand or know.

What's happening with the communities around the anti-immigrant rhetoric that is happening?

Dr. Rios: I have to say that people I think have realized there's been a wake up call over the last two or three years with the unaccompanied children, minors coming from Latin America and the horrible conditions of the detention centers, not only at the US-Mexico border where there's been an incredible increase in positions volunteering, especially with our Catholic charities and with the doctors on the ground in El Paso and Laredo, the Rio Grande Valley, even in San Diego and all the border cities.

But I think there's also been an understanding that detention centers are all over the country, and in states where people didn't realize there were immigrants shelters, where this year, we found ... Or last year, I guess it was, we found that young children weren't allowed to have flu vaccines. Hopefully that'll be something that changes with COVID-19.

Dr. Maybank: That's an important consideration.

Dr. Rios: And in terms of immigrant patients in our hospitals and our clinics, doctors and nurses that are there are, I think ... Are very, very aware of how they have to be more careful in working with them. But, every once in a while you do hear about the implicit bias of, especially of the doctors that come from other places that don't come from our Latino communities and don't understand and don't know about our values and especially the strength in our culture and our families.

Dr. Brooks: Yes, I'm here at Watts Healthcare Corporation, and almost 50% of our patients are Latino.

Dr. Rios: Yeah.

Dr. Brooks: So, you said implicit bias, there's explicit bias going on nowadays, team. When you have something like public charge—which was mentioned earlier in the preambles—where people are told that there may be consequences to seeking care, and then when you have the bias of anti-immigration, that may drive people underground. So now you have a population that is underground, therefore, maybe not working, uninsured and also afraid to seek care. So what will happen to that population, is they will be more likely to not get tested, and not get treated.

Then what happens it affects us. So it's actually interesting in the global picture, these attitudes that some in our population are greater United States population have, may actually end up coming back to harm them, though they felt some degree of comfort, marginalizing a group of people.

Dr. Maybank: Absolutely.

Dr. Wescott: Physicians on the front line are in a certain peril from potentially contracting disease but also, just today it was announced that Dr. Anthony Fauci has had credible death threats. [Edited for clarity]

Dr. Rios: Yeah.

Dr. Siobhan Wescott: So his security has already had to be bolstered. So even the voice of reason at the national level is feeling the heat. And that's not the way to survive a crisis like Dr. Brooks said, it may make somebody feel good for a second to vent and seemingly blame someone but it does not help move forward and getting us through this.

Dr. Maybank: Absolutely. So what more is needed to support physicians and especially physicians of color at this time? There's been a lot of action activity and I'm a public health person by heart and training, and I'm now more so in the health care space. I definitely see the differences in context of how people come to the problem and issue of the pandemic, and see a lot of opportunities for growth. But I'm always curious because sometimes folks aren't listening to each other. And I think we're particularly challenged right now when our national leadership and our public health leadership is pretty much invisible and has been made invisible.

They're different in the way that it has been in the past for some of our responses to these major epidemics and disasters that happened to this country. Usually, we're actually pretty good overall. Not that we don't have the inequities that happen, we do. But overall, we're a little bit—a lot better than being able to respond and so, folks aren't always talking in the way that I think are meaningful at this

time. So what more is needed, from your perspectives, just to support physicians, whether they're in the health care side or the public health side?

Dr. Rios: Yeah. I actually think that there needs to be more coordination at the local level. We have public health departments, they need more funding. We also need services for physicians that are connected to the community. So we need more mental health care and services. Obviously, we need more health workers at all levels, the community health workers, promotoras. But we also need more Latino doctors, African American doctors, Native American doctors, definitely in our communities. And I think there needs to be a whole new approach to recruitment and mentoring and preceptorship within our medical education system, starting at high schools and all the way up.

And I just think there are a lot of community issues that could be made more just more familiar to our communities. That it's not just one person. It's not just stigma, domestic violence, HIV, AIDS, all these issues that people don't talk about, are really being felt by so many in our communities and physicians get to hear the stories, but the public health departments don't have them out there in the open. I think suicide is another one, but just all kinds of anxieties. And I think that COVID-19 and our sustainable efforts to continue building up our health equity is important.

Dr. Harris: Dr. Ross, I so agree with you in this sort of after-action review, I believe the top issue is going to be the lack of coordination. And that that is going to tell a significant story in the after-action review, and just as you were speaking, I was thinking we should commit right now—I will commit—that we will do our own after action review at this group.

Dr. Maybank: That's awesome.

Dr. Harris: And we should push to be a part of the overall after-action reviews on a lot of this and Aletha in public health; woefully underfunded for decades. Mental health: woefully underfunded for decades. So I think we can commit to that, I'm sure we will. The other issue right now though I think is important is data. I'm sure all of you ... And I know Aletha, you and I have actually had a couple of conversations about this. We need to have the data about how this is impacting our communities.

Dr. Rios: Right.

Dr. Harris: I want to hear if others think we should push. Now as Aletha knows, I am also okay, but what bad could happen if we do this? And one of the things I worry about but it's not worrying me enough not to ask for the data. But we will also have to be vigilant to make sure that data is used correctly and not used to blame and shame and marginalize, but I do think and would like to hear what, and I know Aletha had some ideas about this and others about our actually lack of collecting the data that we need, particularly around our communities.

Dr. Brooks: Well, first of all, we did countersign support of the AMA initiative to get data on race and ethnicity. I look at COVID-19 and any pandemic in three phases. Phase 1 is preparation. Phase 2 is the war and phase 3 is the aftermath. So right now we're in phase 2, we're in the war right now. We need the data to know for example, it may turn out that African Americans have something unique that they do more readily acquire, so I may need to test more. I may need to know what the trends are, as it's coming with race and ethnicity as we're having in New York, and then it flew over to New Orleans started more or less in Seattle.

I don't have any race and ethnic data—I've no idea. The more we do testing, the more we will have data. So we're not testing enough. It is clear there are three prongs to pop to a pandemic. There's the economics, there's the science and the public health. So the public health is different than the science. That's the data. We have a fair amount of the science as best we can; how it spreads and whether these therapies work and how long on a ventilator, etc. But here's the public health data with race and ethnicity. It is not there and we need it, and we need it now.

Dr. Maybank: Absolutely. And what is great is that there is now movement across the country. There have been some really great and key articles over actually this last week, we're starting to see the activation, there was a letter by a few Congress folks to HHS to really put some pressure on the health departments to report this data. And I will say in addition to the testing data, we also just need the data on deaths and hospitalizations. And for the most part, people collect that data. So the race and ethnicity data is—it's not that it's not available. It's just more it's not accessible, or it's not being shared.

Let alone we haven't really analyzed it but at least shared. I did see today on through social media and Twitter, that I think it's Michigan State is now reported their race and ethnicity data by deaths and it does show a disproportionate amount of blacks who have died. A higher died from COVID. So this is really important in terms of one, just understanding from the public health perspective as you mentioned, what is happening, we need to know what's happening, two, resources, three, communication and education and four, how do we build systems to ensure that in the future, over and over again that these shouldn't be questions we shouldn't have to continually ask for race and ethnicity data.

So what's the culture change that needs to happen? And then what are the system changes that need to happen? So that it is ensured that we get this data, it's presented and it becomes just part of the norm moving forward. We're at 6:42. So I know there are probably some questions in that chat box that I need to look at. But I do have another question before we go to everyone else. So I'm going to use this as an example. So there was a particular royal, and they have now moved to this country or moved to Canada. And she was videotaped, and she was asked about her pregnancy.

And at some point in the interview, somebody asked, "How are you doing?" And she said, "Nobody ever asked me that question." So I want to ask, how are you all doing just as individuals through all of this? It's a lot but I just want to know just more personally, how are you doing?

Dr. Thompson: I'll go ahead and start with that. I'm doing well myself. But I think like every other physician or if you're a health care worker that is going through this, we worry more for our family. So my wife has very bad asthma. And what I think a lot of people don't realize about OB-GYN when you think of exposure risk, you think of the ICU setting, and you think of the emergency room, but think of the delivery room. And that's where I live. Is in the delivery room. It's quite an exposure to see patients when their babies have to be isolated from their moms, that bothers me very much.

The heart of an OB-GYN is building that family unit. And we're taking that family unit and splitting it right now. So I worry for my family, but I also worry for my people. I work in Syracuse, but there's a large Native American presence around upstate New York in Syracuse. And how are they doing? And not being able to see them, because I don't want to pass anything on to them. But one thing that's unique for the Native American population, is that there are native nations that are on both the Canadian side and the American side and that border is closed.

I'm used to going back and forth to Canada, almost on a weekly basis, and I can't go see people, because you can't get past that border. That virus doesn't respect borders. But unfortunately right now, I can't get over to see people that I know and check on.

Dr. Maybank: Who else? how are you doing? Thank you Dr. Thompson.

Dr. Brooks: So if no one else will speak up, speak very briefly. I'm not even allowed to know how I'm doing because I have so many the other responsibilities.

Dr. Harris: No, no, Dr. Brooks.

Dr. Maybank: Oh no, Dr. Harris is not going to accept that.

Dr. Brooks: Okay, well, I'm doing okay. I feel stretched. I am most concerned about my family, and then my staff. Because when you have to treat people who are potentially infected, you have to make sure that your staff are protected. I feel that their health and safety is my responsibility along with my family, and then the responsibility of the African American community. So I feel that there is this heavy weight on my back. And when I wake up in the morning, it's not there. But I realized when I walk out the door, it's going to be right there at the door waiting for me to put on. But I do feel when I come home, pretty much I can take it off, at least half of it. So, overall, I'm feeling okay.

Dr. Wong: This is Dr. Wong, I'll take a shot at this. I have to tell you, I have a small clinical practice. And earlier this week, I had a candid conversation with the organizers that the clinic, Neph QAC, where I see patients. And I felt very torn, because I know my patients, they're Cantonese speaking, they're older, they feel isolated and they have a connection with me which I very much try to honor. But I actually had to have this conversation with the clinic and with myself with regards to: am I exposing them or myself to additional danger by being in the clinic setting given that I'm actually closer

to 65 than I am 60, I.e potentially I'm more prone to a bad outcome if I were to get COVID.

So I think what it is, we are torn with regards to being in the front lines and also understanding our role as individuals and as health care leaders, to play the most judicious role for our entire community. So had to put aside my really earnest desire to be bedside with my patients, but to think about them in a broader context.

Dr. Maybank: Thank you.

Dr. Rios: I've been okay too and I think that just like everybody else worrying about your staff, worrying about your people around you, worrying about your family. But I think, also just worried about all the doctors and nurses out there on the front lines that are from our communities, and that are special, very special. We can't lose anybody. There's so few, and I know there's even fewer Native American doctors and nurses, but I mean for Latinos, we're still only 5% of all the doctors in the country or 6%. And it's been like that forever.

And I think we really need to have more focus on the importance of our community's health care workers at all levels. My mother was a nurse and she worked in at AltaMed, a very large clinic in East Los Angeles as a home health case manager. And I think we need even more of those types of people that go to the homes and that take care of our community, where they are, so they don't have to go to the hospitals and emergency rooms where they're most vulnerable. And I think that we have a lot of responsibilities to make sure that we can grow the next generation.

Dr. Wescott: Right, I'll just add I'm doing okay, I think representing academic medicine, I'm working remotely, I have the road in the mountains to keep me company here in North Dakota. But I worry about our med students including, I think Dr. Thompson's niece is at our school, they've all been pulled for rotation so that they're safe, although some of that is going to change depending on the dynamics of the needs in health care as the situation evolves. But with that amount of uncertainty, even when you're going to be able to take your STEP exams, that is unbelievably stressful.

I think I would have thrown a hissy fit in med school. They're like, "We don't know when you might be able to take it." I would not have accepted that and that's what our students are going through. So I really am here to be supportive and that makes me feel better because it's hard to do what's really what's needed to just stay where you are. Don't go out unless you have to. And I do it to keep everybody else safe.

Dr. Harris: I'll be brief. I miss my dad. I haven't seen my dad—he's 86. I'm snacking too much on OfficeX, but I am overall trying to practice some self care. I'm sad at the depths that we are experiencing and I worry a lot about our colleagues. But certainly I imagine all of us getting up the next day and fighting to make sure that our colleagues have PPE. And that we have tests, and engaging and things like this, making sure that credible information is out there and that we are thinking about

those who are under-resourced and communities of color, make it easier to get through.

Dr. Maybank: Absolutely. And I take that time in that moment, because I think it's really important for us to have space for ourselves, to be able to share because oftentimes as physicians and as leaders and those on the frontline, and we were nurtured this way in med school, right. And as and during residency, you put on that tough face, and you go out there and you do what you got to do, and we're going to do that. But at the same time, we need that space to be able to say how we're doing and if we're not doing okay, we need that space to say, "We're not doing okay." Okay, I have a few questions. Thank you everyone for sharing.

So there has been definitely the importance and acknowledgement of the challenge of what is happening with our incarceration system. Have any of you been doing work in this space? Can you tell us about some of the patients that you've engaged potentially maybe they're formerly incarcerated or you know families that are connected to those incarcerated and overall, what do you think we should be doing as a country as it relates to incarceration and COVID?

Dr. Harris: So I have not seen anyone but I know, we did at the AMA receive an invitation to discuss this and certainly we have lots of policy at the AMA around making sure that folks receive the care that they need. This is an issue I know we will continue to amplify. This is another issue where we need to make sure we have proactive conversation about and not just as part of an after-action review. So I don't have any specific individual experience, but I know this is an important issue and we all must address.

Dr. Wescott: And speaking on behalf of all minority positions, we know that our population is overly incarcerated, and they're literally impossible to practice social distancing in jails and prisons. So I agree with a lot of the countries and I think we're just starting to move that in that direction in the US where they're releasing non violent prisoners, because they're literally sitting ducks.

Dr. Maybank: Absolutely, and I ... Go ahead, sorry, Dr. Thompson. Go ahead.

Dr. Thompson: I was going to say, I think just from a humanistic standpoint is, when I see a patient who's incarcerated who's pregnant, this is treating them like anybody else and saying, "How are you doing today? Are you doing okay? Is there anything that I can do to help you today? Anything that I can do to help you with your care? In just that simple acknowledgement of them as a person, remembers it. Sometimes they don't receive that in the busyness of an emergency room or the busyness of a pandemic that's going on, but just treating them like we all want to be treated as a human being as and as a person.

Dr. Maybank: Thank you. And I do think this is an opportunity potentially for the physician community to have a voicing, in a way that we haven't before. I saw an article by Dr. Mary Bassett. She used to be Commissioner and health department in New York City and now at Harvard, and put forward an

opinion, and I do think there are physicians coming forward to really acknowledge the health concerns, is absolutely critical. And what needs to happen at this time to ensure the safety and health of those who are incarcerated, as well as those who are formerly incarcerated is absolutely critical.

Dr. Maybank: So something for us to think about what we're doing and how we're organizing as Dr. Harris' mentioned, this is on our plate right now and agenda and more work and opportunity to be done moving forward. We are now at 6:55. And there are a ton of questions that we are not going to get to. But this is a good sign, because that means that there is interest and I think there is opportunity to definitely do more and have more conversations, and they can be more targeted and more specific. And so for those who are tuning in, please feel free to at this point in time while you're still open in five minutes, put forward some more suggestions on what would you like these conversations to center around?

Who would you like to be part of these conversations that we're hosting? Over the next ... I have no idea how long this is going to last. But, I mean, this is something that we can still do even beyond COVID and I hope so, that we're able to come together. I guess, in inclusion, and somebody mentioned it earlier of how do we envision the future of medicine? So as we're in the thick of things and we're more reactionary to some level, but at the same time, somebody is going to start rebuilding the system, especially folks who have more power, and potentially money. And voice are going to start rebuilding systems.

And we I feel have to find our way, or we start helping to build these systems at the same time. So what do you think needs to change in terms of policy or structure, as we envision the future of medicine post-COVID. And now in this new normal, what really needs to change in terms of systems and structures?

Dr. Rios: Well, I can say just a couple things. Honestly, the social determinants of health have to be expanded. The concept, it's now here, where we are seeing everybody from hospital systems to insurance companies, to the governments at the local and national level, talking about and providing support for programs for food and insecurity, for transportation, childcare. We need to expand it to looking at our communities and the whole idea of health equity, racial ethnic health discrimination, disparities needs to just be dealt with, through this social determinants of health and having more public health programs for our communities.

With all the issues that everybody's been talking about, I think that's something that we need to structure and I would include increasing more affordable insurance, having an expansion of Medicaid in more states and having more language services and cultural competence training in our health facilities.

Dr. Brooks: I would add to what she's saying is that a \$2.2 trillion bill just passed.

Dr. Rios: Yeah.

Dr. Brooks: I can't count that high. Okay. We need to get our piece of it. And we need to figure out how to utilize that to the best of our abilities. We need to reduce co-morbidities. So a strong focus is an Office of Minority Health in the US government, quadruple fund that. Have it as its goal, as its mission to reduce disparities. And lastly, I'll say, there's a term Gestalt, the whole is greater than the sum. You all just bringing us all together, we meet regularly, we have a group that says we will work together to petition the government for exactly what we need.

And you ask the same question of us six months from now and we have a coordinated strategy that will have an answer, and we'll have advocacy behind it with all of us there.

Dr. Rios: Mm-hmm.

Dr. Maybank: Thank you.

Dr. Thompson: I would also like to say in terms of the Indian Health Service, which is distinct from some of the other health services that are offered, the Indian Health Service has funded at only approximately 50% per person of what someone who's receiving Medicaid will receive. Imagine if all of our patients receive half of Medicaid, that's what every native patient is receiving for their care within the United States and being in a rural setting. But finally I'd like to say, for all that don't know, that all the people who are on this line, we meet together to strive for every single physician, every position of color, every patient of color, and it is something that we enjoy, and we continue to do.

Dr. Wong: Something very quickly.

Dr. Maybank: Oh, go ahead. Dr. Wong.

Dr. Wong: This was regards to what my colleagues have said, I agree 100% of what they said. But one thing about telehealth. We need to really invest in this infrastructure to enable our communities that are marginalized because of various factors, economic, linguistic, cultural, they need to be on that highway, as much as any other community. So, I just want to call that out specifically. How are we going to look at telehealth being able to address social determinants, and to address the needs of vulnerable communities?

Dr. Maybank: Thank you. Dr. Harris.

Dr. Harris: I'll just say you've made a perfect point about this as a new normal. And we will have opportunities here. We want to be thoughtful. I imagine there will be some folks who will say, "Oh, this happened, and we need to do this." We don't need to take years and we have a lot of answers. But we do need to be thoughtful and make sure our voices are heard.

Dr. Maybank: Absolutely. So it seems like we do have some action items from this that several folks have brought up. One, to meet together. Definitely as collective organizations on a regular basis to coordinate, to do a hot wash. What we call a hot wash, you called it an after-action.

I think that's really important. So we have some things to do, which is absolutely great. So I want to really thank all of the panelists, thank you for your participation. Thank you for your leadership. Thank you for being present and always responsive as well. And just thanks to everyone who has been listening in over the last hour, apologies for not being able to get to all the questions, but it was such a rich conversation. But we will make sure that we have more opportunities so that we can hear more folks' voice and we'll have more space for questions.

So everyone have a wonderful rest of the night or evening wherever you are in the country. And please, be safe and be well.

Dr. Wong: Be well.

Dr. Brooks: Thank you for moderating.

Dr. Rios: Thank you.

Dr. Maybank: Bye.

Dr. Brooks: Bye bye.

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