AMA Thought Leadership series: Moving beyond a pandemic

Featured topic and speakers

Join the AMA for a timely discussion on how our nation—and America's physicians—will move beyond this pandemic. Tune in to hear expert physician perspectives on what lies ahead—and to learn how to prepare yourself, your practice and your patients for what's next.

Panelists

- **Stephen Parodi, MD**—Executive vice president, External Affairs, Communications, and Brand, The Permanente Federation; associate executive director, The Permanente Medical Group
- **Céline Gounder, MD**—Senior fellow and editor-at-large for Public Health, Kaiser Family Foundation and Kaiser Health News; clinical associate professor, Medicine and Infectious Diseases, New York University
- **Georges Benjamin, MD**—Executive director, American Public Health Association

Host

- **Gerald Harmon**, **MD**—President, AMA

Transcript

Dr. Harmon: Thank you for joining us for our latest webinar and the Thought Leadership Series. Today's conversation will focus on the impact of COVID-19 on our physician workforce, what we've learned and how we can apply these lessons for the next phase of the pandemic. I'm Dr. Gerald Harmon, president of the American Medical Association and a family doctor in rural South Carolina for nearly 40 years. I've had the honor today of moderating today's webinar and to welcome in three special guests, each bringing his or her own unique experiences and perspectives to this urgent conversation. We've learned a lot in our fight against this daily coronavirus over the last two years, we made advancements in how we test, how we treat and how we care for patients infected with the

virus. We've developed three safe and highly effective vaccines for COVID-19 in are remarkably short period of time, making them widely available to all that want them.

And yet, despite the case numbers falling to near the lows we experienced last summer, we know we're still long way from putting the pandemic behind us, both physically, psychologically and emotionally. That's true for the public and it's especially true for physicians and our entire health care workforce who've been under siege, have been asked to shoulder the brunt of the pandemic from the beginning. Soon, the nation's going to reach the one unthinkable tally of one million lives lost to COVID-19 in the U.S. That's just a heartbreaking tragedy. That's unlike anything we've experienced in our lifetimes. Even for physicians, people who experience grief up close and know what it feels like to comfort the dying and their families, it's difficult to find the words to express what we've lost during the pandemic. In addition to being a family physician, I'm also an Air Force veteran. I've served the country in the medical arena and the global world on terror and overseas operations after 9/11.

So as a doctor and a military veteran with combat experience, I've had experience with physical and emotional trauma. I know the signs and what to look for. And it's my opinion, two years into this tragedy that our nation is suffering from a type of battle fatigue from our long fight with COVID and the full impact from this cannot be measured until long after this difficult period ends. And it will end eventually. We're seeing many states lifting public health mitigation measures such as indoor mask wearing. And while this represents a new phase of the pandemic, it's critical that these important decisions about public health be rooted in science and data and not driven by political pressures. Each one of us is eager to bring this painful chapter in America's history to a close, but how we emerge from the pandemic, lessons we learn and apply moving forward, the causes we fight for will go a long way towards preventing the next great health crisis from gripping our country.

The actions we take now can help create a U.S. health system that better meets the needs of all people, not only the brave men and women in the medical workforce but everyone who relies on our health system for the fulfillment of a long and a healthy life. One thing we know for sure is that while the pandemic will someday end, COVID-19 is going to be with us for the foreseeable future. So we got to understand what this means, how to protect the most vulnerable among us, as we take steps to move past this pandemic and into a post-COVID change world. With me today to talk about this are three exceptional physician leaders and experts in their respective fields. We have Dr. Céline Gounder, senior fellow and editor at large for public health, Kaiser Family Foundation and Kaiser Health News. She's also clinical associate professor of medicine and infectious diseases at NYU.

We have Dr. Steven Parodi, executive vice president of external affairs, communications and brand at the Permanente Foundation, as well as an associate medical executive director for the Permanente Medical Group, which are parts of the California based Kaiser Permanente Health System. And we have Dr. Georges Benjamin. His contributions to organized medicine and public health are really too great to mention here. Dr. Benjamin currently serve executive director of the American Public Health

Association, following his time as secretary of the Maryland Department of Health and Mental Hygiene under former governor, Parris Glendening. Welcome all three of you to this special webinar. And I thank you so much for being here. Dr. Benjamin, we might start our question and answer session with you. Let's look at the topic of surveillance. Surveillance measures such as case counts or percent positivity remain important in understanding the impact of the pandemic on the community. However, as we see mild and asymptomatic infections increase and unreported at home testing become ubiquitous, how can we adapt surveillance measures to address these scenarios? And what improvements could we make to our public health surveillance programs?

Dr. Benjamin: Well, the good news is that we really know how to do this. We really have ongoing surveillance programs for a variety of diseases. And while we started this pandemic with basically doing disease surveillance and case counts based on really controlled testing that happened in hospitals and health departments, now we're going to move to more population-based surveillance efforts. So we'll have laboratories that will be predesignated and providers that we predesignated to send in samples. Those will give us a sense of what's happening. We can also do very sophisticated studies so that we don't lose the variants that are out there. And using mathematical models, we'll be able to do and manage how many cases are out there and really follow the trajectory. But let me also add the fact that we have this really new tool that really isn't quite new. We've done it before for diseases like polio, for example, and that is actually looking at sewage as a environmental measure.

We now know that this virus is excreted in our stool, ends up in our wastewater and we can actually track the increases and decreases through sewage. And it turns out that's a marvelous way of getting an early indicator of when you have a new disease like this, that's an infectious disease entering the community.

Dr. Harmon: Thank you, Dr. Benjamin. Dr. Gounder, I might turn to you and ask you about the variance. How should we address future variants that may be more transmissible? And I know we're talking about even now the BA.2 variant and it could lead to severe illness, including possibly evading protection from our currently available vaccines. And to follow on with that, do we think that maybe COVID could even become a seasonal respiratory illness, kind of like the influenza?

Dr. Gounder: So I think that we have to start by acknowledging that there will be more variants. BA.2, the latest sub variant of Omicron is not the last variant we will have to contend with. And I think we need to acknowledge that reality and then prepare accordingly. And so that includes really investing in surveillance. We have dramatically ramped up the surveillance that we're doing for variants over the past year or more but there's much more work to be done on that front. And there are some specific gaps. Some of that is geographic, some parts of the country are doing a more complete job of surveillance for variants than other parts of the country but we also have a black hole when it comes to transmission in non-human species. We have now seen SARS?CoV?2 being transmitted, not just by what we think is the original host, bats, but also any number of other mammalian hosts. So deer, rats,

mink and so on. And so unless we also extend our surveillance efforts to include animal transmission, we could be flying at least partially blind as to what there may be to come.

Now, variants can be more transmissible, they can be innovating, as you alluded to. I think the good news is that even with a more infectious or transmissible variant, we have very good tools to prevent infection and disease. I think where it becomes more challenging is if we do have to contend with a truly immune-evading variant, Delta and Omicron were partially immune-evading, then we may find ourselves having to change our tools, in particular our vaccines and update our vaccines. Fortunately, our current vaccines have remained effective, particularly if given a booster, we're able to override some of those immune-evading effects. But we may find ourselves at some point in a place where we do need to update our vaccines because of immuno-evasion.

As to whether COVID is likely to become seasonal or not, we don't know the answer to that yet. It may but seasonal may also mean different things in different parts of the country, where seasonal in New York City, where I am, might be from Thanksgiving through January, over those holidays and seasonal in other parts of the country, say Florida or other parts of the south, where they have very hot, humid summers, their seasonal might be the summer months when people go indoors to have that air conditioning to stay out of the heat. And so much of this still remains to be seen.

Dr. Harmon: Great, great insight. You're exactly right. The season's almost in the eye of the beholder for sure. No question of it. Dr. Parodi, I'm going to call on you, if you would think about it, how can we continue to communicate and I do this almost daily, even in my practice today, that vaccines and boosters are important, especially as we start thinking about moving past the pandemic? And a couple of other questions that to follow up, could our COVID vaccine boosters become part of our yearly vaccinations as much as the annual flu vaccinations? And then I may give you a follow-up question about legal challenges and mandates for health care workers but Steve, if you could answer whether we need to communicate that vaccines and boosters are important as we move past the pandemic, I'd appreciate your insight on that.

Dr. Parodi: Yeah. And this is a great question, Dr. Harmon. And when I think about it, there are multiple levels of communication need to be happening. So one is what's happening in our own offices on a day-to-day basis and laying the groundwork of an understanding that there's evolution of what's going on with the variants, with the virus. We know that immunity, even vaccine-based immunity has a time duration to it. And that it's time limited. And to set the expectation that it ... Don't be surprised, there will be another vaccine probably coming in your future. And even laying the groundwork, I can tell you just in my personal practice, the conversations are, it may be annual, at least for a time limited period. That expect new recommendations, not just for adults but bringing that into our pediatric practices and explaining those variations, knowing that we are in different series levels. The six-month-olds to five-year-olds are going to be in a different place than, say people that are between five and 12.

And so being able to lay those expectations out in our individual practices is number one. The second thing is syncing public health messaging with health system messaging and doing that at the federal state and local levels. I think that's a huge opportunity where over the course of this pandemic, it's been tough, right? The recommendations have been coming fast and furious. As we move into hopefully a more sustainable phase, being able to coordinate those messages, so the general public is hearing the same thing on the airwaves, as well as in our offices is going to be key and actually returning some of those messages too. Actually the regular vaccine distribution system that we have used, tried and true the United States, which is through physician offices, through our clinics and our public health clinics, having signage that is understandable, reaching out on social media in addition to traditional forms of media, I think is also key and important to counter disinformation, misinformation and having that trusted voice there.

And by the way, it's not just physicians, it's incorporating other practitioners, nurses are trusted voice. So arming them with these messages I think is going to be key. When I think about, is this going to become annual in nature? I think we know enough now that we referenced BA.2. I wouldn't be surprised if there's the next variant around the corner, to be able to message that we expect, just like influenza vaccines that we vary what gets put into the influenza vaccines that may very well occur here with COVID-19 vaccination. And because of waning immunity, that you may need vaccination on annual basis, at least for the foreseeable feature. Those would be the things that I would reinforce and I think that we can do collectively as public health and as health systems.

Dr. Harmon: Thanks Dr. Parodi. That aligns with what I'm seeing in my practices. And I might ask Dr. Gounder or Dr. Benjamin about their perspective on vaccines and with particular, maybe a commentary on vaccine requirements for health care workers. We've had it ... In my local health care system, it's been federally supported in the Supreme Court system about health care workers being expected to participate in vaccine programs. Would you comment on that? Should businesses require employees to be vaccinated? There's also been some ruling about that. And I have local issues here in my school district where the teachers have been expected to be vaccinated as well. We know the vaccines are eligible for those ages five and up. It strikes me as a public health issue that we vaccinate as many eligible as we can in order to provide the best immunity and the best public health protection. But Dr. Benjamin, if you and Dr. Gounder would comment on that, I'd appreciate your thoughts.

Dr. Benjamin: Right. Let me just say, I do. We absolutely have to normalize these vaccines. I'm a strong proponent of health care workers being vaccinated. When I was practicing clinically, absolutely was vaccinated and I've carried that practice now throughout my life, it protects me, it protects my patients, it protects my loved ones. So when you have a disease that is so highly infectious and has potential to be so highly lethal, it's absolutely essential that health care workers in the environment in which we practice, where people are so vulnerable, that they absolutely need to be vaccinated.

Now, the issue around workers, it depends on what you do certainly. There may be people that may not need to get periodic vaccinations as a mandate. I would still recommend it clinically so they can protect themselves and their families but if you work in a meat packing plant, for example, you're working in very close quarter to others. You need to be vaccinated. If you're working in a setting, in a school where children are there, and those children are highly vulnerable, those teachers need to be vaccinated as well. If you're sitting at home, Zooming all day and somehow you can protect yourself, you have a less of a need to protect others, but you've got grandma, you've got family members, and again, my clinical recommendation would be that they do that. Dr. Gounder, your thoughts.

Dr. Gounder: I think we, as public health providers, as health care workers, we take on certain responsibilities, duties as part of our profession. I think it is a privilege to be a doctor, a nurse, a health care provider. We are led into people's lives in a way that is really unique. And I think that comes with certain responsibilities to protect those that we're caring for, the vulnerable. And so it is different. It is a different kind of professional calling from others. And there are certain things we're called upon to do, certain risks that we run, certain kinds of work hours that we're expected to show up for that are simply different from other professions. And so to me, being asked to get vaccinated, sort of along with being asked 80 hours a week or being at risk for a needlestick injury and all that comes with that, I think that is what it means to sign up to be a health care provider. And if that's not something you're willing to sign up for, it's really probably not the right profession for you.

With respect to mandates, without getting into whether I support or I'm opposed to mandates for certain settings, for certain kinds of people, what we do know is from the experience with influenza and influenza vaccination, is that absent a mandate, we have never gotten above about 50% of adults vaccinated for the flu. And so that is the reality. And so no matter how many incentives or encouragements or whatever education we provide, absent a mandate, it's going to be very difficult to get to anywhere near most people in this country vaccinated.

Dr. Parodi: And I just want to sort of comment on this because we implemented a vaccine mandate at our institution just like yours. Want to call out that yes, mandates do drive adherence. That being said, there's a whole lot of work that goes underneath that. And there's still a bunch of winning the hearts and minds of individuals. And I got to tell you, it was complicated. It was tough to be a vaccine advocate, particularly with the third dose of the mRNA vaccines or the second dose of the J&J vaccine. So I don't want to sort of downplay the need to do that one-on-one type communication. We want to retain our workforce. We know that our workforce and you referenced this earlier is tired. They're burned out. And so we've got to be able to explain the why, as much as explain that there is a mandate.

Want to speak directly about the employer mandate, which unfortunately was struck down by the Supreme Court. What came of that though, is that I think there's a greater connection between public health and the employer community, both at the local levels. And I can speak to, at the national levels,

talking to CEOs at the Business Roundtable and others, that they are keenly interested in protecting their workforce. And while there may not be a mandate, I would hate to lose actually the connections that we now have going forward and being able to forge those connections and use those to push out the information that we were referencing earlier. That is another means to get the word out. So even absent a mandate, working with employers, being at the employer sites to give the vaccines as much as requiring them to come to us, bringing the vaccine to them is equally important. One last thing, there's organized labor. And being able to work with organized labor to make those connections, if those are available in a given community is another point of leverage for both the public health and health systems.

Dr. Harmon: Dr. Parodi, you're right. And if there are any silver linings and there are very few but there are some silver linings to the pandemic and our response and our education afterwards it's that we've learned to have relationships between public health infrastructure, employers, business leaders, health care officials across the country. Absolutely. We need to maintain those relationships. We've learned a lot going forward. We've also, to your point, found that not only can a physician be a trusted source of information and a health care advisor for the public at large and our patients but it can be other folks that are influential, other members of the health care team, including community leaders who have been rigorous in their study of the science, have been following the data, and I think they also have taken on the role of trusted advisors that helps improve the public health of the nation.

And I would also comment, Dr. Gounder, that when you talked about, it's a privilege to be a doctor, it sends chills up my spines. It's a privilege to be a health care worker because it is such a privilege to be able to take care and earn the trust and keep the trust of our patients who give us their most vulnerable patients, their most vulnerable family members, their most prized possessions and they trust their lives to us. So it is a responsibility and part of that is becoming vaccinated and becoming a safe, a repository of health care for them. When they come to me, they want to know that I'm doing my best not to spread illness among them and their loved ones. So all of those are very good points. And I appreciate it.

I would comment on something else that we've talked about. We don't understand a lot about COVID. We don't understand a lot about the variants. We do understand that vaccines are probably our very best protection right now against serious illness and contracting the disease. I want to talk about long COVID, the post-COVID syndrome that we're all starting to see a little bit about now as we're two years into the pandemic. Long COVID, we're still learning more and more. I saw some recent studies that suggest that even those that are relatively mild with the disease of COVID may have some cognitive and or neurologic deficit. So I wonder if you might comment on that. I don't know if that would fall in the purview of Dr. Gounder or Dr. Parodi or Dr. Benjamin but I'm worried about long COVID. A lot of my patients are asking me about it now and what to do and should we have special treatments and or screening for long COVID available.

Dr. Parodi: This is a really important topic. And it's one that's ripe for study and it's going to require commitment actually. And I'm glad that there are now commitments to actually fund long-term studies to look at the effects. We know that at least 15%, if not more of individuals who have an episode of COVID and aren't vaccinated or at risk for developing post-acute COVID syndrome. And within, I know number of systems, this really ultimately is falling to the primary care physicians where they're initially diagnosing and then relying on specialty care to at least rule out anything that might need additional intervention. Fortunately many of the parts of the syndrome appear to be more time limited but we don't know right now.

It's clear that these individuals need supportive care in various forms of fashion but I think the thing that I get for intervention right now that we need to emphasize is the need for vaccination. We know vaccination is protective against development of post-acute COVID syndrome. It is one of the other arguments, I think we need to be making much more publicly to our patients and to the general public that we need to protect against this. As a health system writ large, I think we actually do need to build this into our operating plans for what might be another wave of individuals and illness that we are going to have to care for on a longer term basis in our clinics. And what that planning needs to look like really is why we need to study.

Dr. Benjamin: Yeah, … the image of polio was the old iron lungs. And the image of COVID is going to be all these people with long COVID. The fact that this virus attacks almost every single organ system and it has various impacts on it makes it very difficult to even get a really good case definition. But I know the NIH is studying it right now. And I think as they get a better sense of both the impact and the spectrum of this disease, we're going to get a better sense of how best to treat it, how best to identify people with it, but the big challenge is the long-term cost. The challenge that primary care physicians in particular are going to have with people who come in with "unusual symptoms," odd symptoms, things that don't seem to connect the dots. But in retrospect, if you ask, "Have you ever had COVID? Were you ever vaccinated?" You're going to find that a lot of those are going to be related when we do the look back.

And I think that's the thing, the message we've got to get to the broader public, particularly the public that's reluctant to get vaccinated is that this is not the flu, this is not a cold, this is a 48-hour disease, this is a significant disease that a large percentage of people who are unvaccinated get. You can get it again and it can cause this very, very bad prolonged chronic disease, which ultimately in some cases can cause a significant disability.

Dr. Harmon: That's right, Dr. Benjamin. Dr. Gounder, I bet you have had some substantial experience in developing more with long COVID in your institution.

Dr. Gounder: Yes. So at NYU, we have a long COVID clinic but I think what is very frustrating in this moment is we still don't really have a good handle on the pathophysiology of what causes long COVID. We have some hints. And so much of the treatment at this stage is largely about managing

symptoms. I do think, with respect to research on long COVID, there are some areas that really should be urgently tested in terms of therapeutics, including not just how well vaccines prevent long COVID and whether boosters might help further reduce the risk but also some of the therapies that we currently have. So, for example, if you test positive for COVID and you are rapidly initiated on Paxlovid, which is one of the new antiviral drugs for COVID, how much does that reduce your risk of progressing onto long COVID? Does monoclonal antibody treatment also reduce your risk of progressing to long COVID? And there are a number of immune modulators that have also used for the treatment of severe COVID, would those also reduce your risk of progressing to long COVID?

So I think there's some obvious things like that to try drugs that are already approved for other purposes, that should also be tested in the treatment of long COVID. And then understanding that it may be a while yet before have really definitive answers as to how best to prevent, with the exception of vaccination, how best to prevent long COVID, how best to treat it, is it curable? I think you are going to have a lot of people who continue to suffer, who may not be able to work and how do you then care and support those people? And so that does mean needing to think about disability, supporting people in that fashion. We also know that it's the most vulnerable people in society, people we also call our essential workers who are more likely to be infected, they're also more likely to be low income, less likely to have insurance and may not easily be able to access care for ongoing chronic symptoms of long COVID.

And just this week, in fact, as we're speaking, a program for uninsured persons in this country to access treatment and diagnosis has evaporated. The funding is no longer there. And next week we will no longer have funding for providers to administer vaccines to uninsured persons. And so these are very important gaps that will definitely have an impact on people who have long COVID and who are under or uninsured.

Dr. Harmon: Dr. Gounder, you're right. We know and those of us on this webinar today, we know that historical injustices were magnified with black, indigenous and other people of color communities severely, disproportionately impacted by COVID-19 to your point. And we're concerned now about funding for further testing and treatment available that it could even further disproportionately impact those marginalized communities. What strategies can we do beyond, of course, what we're going to do, push for continuing funding for that, what strategies among this group could you all recommend that might eliminate policy and systemic barriers and ensure that our COVID-19 response is equitable across all our communities?

Dr. Gounder: Well, I think we need to fund public health. I think the health care system is really designed to provide clinical care to individuals. It's not designed at least right now, to provide population health and to really ensure equity and the care of vulnerable populations. And so I think there's a lot that the public health sector could be doing if appropriately funded, staffed, and empowered to do that. So I think that is one important area. I think the other is understanding that

Americans are very individualistic and you may not be able to get vaccination rates as high here as in other countries. And so that means thinking a bit about, if you're looking at things through an equity lens, how else can we achieve equity? What are the other tools at our disposal? And which of those tools do not rely on individuals to take action, do not rely on individuals to seek something out or comply?

And those kinds of interventions are more structural. So things like, as I was mentioning around disability is one. Providing people with paid sick and family medical leaves so that they, if they're sick, can stay home and still make rent, so that if their child is sick, they can stay home with their child, than not be spreading the virus in school. I think unfortunately, a lot of families find themselves in a Catch-22 where they have to go to work sick, they have to send their child to school sick because they have no other affordable option.

Another example of a structural kind of intervention that's really important for preventing COVID is improving indoor ventilation and air filtration. It is not perfect but neither are the vaccines. All of these interventions are additive, synergistic, and by making those kinds of improvements, you can also reduce the risk of transmission in public settings, including schools, government buildings, workplaces. And again, does not require individuals to take action. But these are structural interventions that do cost money in some form and so that does mean having people at a government level or for an industry to decide this is a priority and to pull resources to make these things happen.

Dr. Parodi: I'm worried. I'm worried right now that given all of the other attention being given to other issues that are rightly so occurring in this world right now, the lack of funding for just basic testing, for basic surveillance is a real issue. And we can't lose our site on the fact that the pandemic is not yet done. Secondly, funding that was earmarked or targeted towards public health right now is held up at the federal level. That needs to be restored, needs to be built back into some kind of funding mechanism, because we know that the public health infrastructure is not what it needs to be. But let me just build on something. And again, this is maybe a silver lining, is that the community health centers, the FQHCs, the health systems, public health and actually community centers came together to form vaccine stations, testing stations.

And what I saw happen was the ability to actually start sharing information about health related outcomes, social determinants of health and getting patients, in my case, patients, community health centers, clients, directed towards resources that they needed, whether it related to food insecurity, related to safety related issues that were being identified at those nexuses where people who are coming to get just a vaccine. What I'd like to see built is an infrastructure where there is actual health information exchange occurring between public health, a health system like ours, or physician offices and community clinics. We don't want to lose that opportunity. So I think funding that would allow for that to occur at national state levels is something that we want to build upon some of the learnings that we got from this whole pandemic effort.

Dr. Harmon: Amen, Dr. Parodi. Dr. Benjamin, I bet this is music to your ears to know that our panel of experts is so supportive of increasing our public health infrastructure. Any specifics you might like to suggest that we could look forward to in a world of post-pandemic?

Dr. Benjamin: Well, I think in the broader sense, that was that we need to create a health system with everybody in and nobody out. We've talked about the importance of having this system. We're the only industrialized system in the world that does not have coverage for all of our citizens. We have to make sure that happens. Secondly, when we have these kinds of tragedies of a new disease entering the community, we always know what's going to happen, we always know who's going to be impacted first and yet we don't go into the hood with those services right away. We kind of make the people come to us. So had we taken the testing into the hood, had we initially taken vaccinations into the community, those kinds of things would've been dramatic in terms of their effort to at least begin the process of dealing with the disparities.

We know that both exposure, because of the jobs these folks did, and susceptibility, because of the disparities for chronic diseases, put those folks more at risk, should they have been infected? And of course, that played out just as it played out for H1N1, for SARS-1, and quite frankly, for all of the disease threats that we have. And so we've got to build systems that are in those communities and are stronger. So Steven talked about the importance of our Community Health Center Network. We strengthened it during this pandemic. We need to make sure that the resources stay there for that safety net program. We need to improve our telemedicine capacity. We had this big debate about whether telemedicine should be funded and how much we should do. We put our foot in the water and then the pandemic hit.

And we discovered the wonderfulness of utilizing telemedicine tools to provide medical care for folks. We need to make sure that doesn't go away. We have to refine it some so that there's some things that we can improve on it, but we need to make sure that physicians have the capacity in our offices to engage their patients appropriately. And then, I got to tell you, we got to find a way to free up physician time and effort because physicians quite frankly, are still spending too much time on paperwork, on administrative tasks, when we really ought to have their expertise and wonderfulness at the bedside, using that physician-patient relationship to engage their patient patients, to talk to their patients. When I was in medical school, I was always taught, and I know all the three of you were as well, that if you sit there, keep your mouth shut, ask an open-ended question and listen to your patient, you can tell what's wrong with them without a single test. And that is still true.

So a good history and appropriately targeted physical examination will win the day every day. And we need to give physicians the time, tools to do that with their patients. And if we do that, we can improve health and bring down the cost of health care.

Dr. Harmon: Dr. Benjamin, you're right. That's also sending chills up my spine. That's what I was taught. And I still believe it every day. And I know all of us do as clinicians. 15 seconds on each you. If

you had any advice for the clinicians, the public who might be looking at this webinar and if you were king or queen for the day, what would you do to help us recover from the pandemic? Dr. Gounder, what would you do, doctor?

Dr. Gounder: Yeah, I think what we have seen in public health is this cycle of panic and neglect. And I really hope that we can in the future really support and invest in public health for the long-term as something that we need every day.

Dr. Harmon: Amen. Dr. Parodi? Your thoughts, sir? I appreciate your expertise.

Dr. Parodi: I'm going to leave you with four words. I think we need to take care of each other. We need to come together. So much of the narrative has been divisive. And we have the opportunity now to come together for each other within the health care system and for our patients and the general public.

Dr. Harmon: Yes, sir. We really do. Dr. Benjamin, closing comments from you, sir?

Dr. Benjamin: Yeah. I just think we've got to depoliticize the process of delivering health. Health is an equal opportunity provided for people. Disease does not know political leanings and I don't care who you are, what your political leanings are, if it hurts people or it kills people, it's mine. And I hope that we can help people improve their health and wellbeing. And if anything didn't tell us the importance of what we do, COVID did.

Dr. Harmon: Well, thank all of you. This has been incredibly helpful for me personally, as a physician, as president of AMA. And I hope for all of us who might be viewing today, what we've heard from all of our experts is their perspectives, their insight, their experiences and all of these things that if we can move together in the post-COVID world and we're not yet post-COVID but we're at least moving into a world that we'll have COVID as a part of, let's take this as a source of trust, a source of advice, a source of help for all of us. And I heard the words from my colleagues that I'll take to heart and certainly embrace. Thank you, each of you for all you do, have been doing and will continue to do. It's an honor to be among all of you. Thank you.
