

THE BROOKINGS INSTITUTION

WEBINAR

LIFELINES:  
A DOCTOR'S JOURNEY IN THE FIGHT FOR PUBLIC HEALTH  
A CONVERSATION WITH DR. LEANA WEN

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PARTICIPANTS:

**Fireside Chat:**

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## P R O C E E D I N G S

MS. LIU: Good afternoon. My name is Amy Liu, and I am vice president here at Brookings. And I'm director of the Metropolitan Policy Program. It is a true honor to be hosting this conversation with Dr. Leana Wen and inviting you to this important conversation that we're about to have about public health. And, obviously, that is a topic in which we have all come to deeply appreciate since the global spread of COVID-19. It's affected us each, personally, and it's obviously raised our consciousness about the health of our local community and society more broadly.

Yet, for all of our new-found appreciation for public health, I will remember something that Dr. Wen said to me recently. And she said that, you know, understanding a pandemic does not make one a public health expert and that is because the work of public health involves managing what are, really, daily crises -- especially among the most vulnerable of us in our communities. And which is why Dr. Wen's new book, *Lifelines*, is so well timed and needed. In fact, here's a copy of the book and I do recommend that everyone purchase it.

Her book is so well timed and needed -- and it's because of that the book is primarily about explaining what public health is and the lives lost when we ignore it. The book is also a story about Dr. Wen's personal and professional journey. You know, I walked away incredibly awed by her humble beginnings which gave her grit and empathy for many of those she has treated and served. And if you read her book -- which I, again, highly recommend, you'll quickly learn what I mean.

Now, many of you know Dr. Wen from her frequent appearances on CNN and her regular column on *The Washington Post*. I actually had the pleasure of first meeting Dr. Wen when she was the public health commissioner for the City of Baltimore and her bold and relentless work there caught national attention -- including the attention of my team. And when COVID-19 hit, I reached out to Dr. Wen to engage her with our leadership at the larger institution because I found that her direct, local experience addressing the racial disparities in health outcomes, seemed a really missing and essential perspective in the early days of the pandemic spread.

Today, Dr. Leana Wen is a non-resident senior fellow at Brookings. She's affiliated with my program here at Brookings Metro and with my colleagues over at Economic Studies. And Brookings

president, John Allen, is also a big admirer of Dr. Wen and he regrets he cannot join us today.

Now, today's event is bringing together viewers from across the public health and healthcare community -- yes -- but it's also bringing folks together in public policy, social justice, and local change. And for those of you who are new to Brookings Metro, I do want to say a few words about our program and why we are interested in Dr. Leana Wen's expertise.

Brookings Metro's mission is to collaborate with local leaders so that research insights and practical insights translates into on the ground solutions and policies that scale nationally creating prosperous, just, and resilient communities across the country. If you think about that mission, I think one thing that really struck me during the early part of 2020, was how much the responsibility for managing the public health crisis fell on the shoulders of local leaders -- whether frontline workers at local hospitals, local nonprofits serving vulnerable populations, or city and county governments. It was clear that, even at a time of a national emergency, the quality and pace of our emergency response and recovery was dependent upon the capacity of local leaders to step up and to work together effectively with state and federal partners.

So, the nature of that local, state, federal partnership -- the strength of the local public health infrastructure -- is something that is going to matter to all of us going forward.

The second thing that was really relevant to us is that -- is something I quickly learned in reading *Lifelines*, which is that the most chronic health challenges experienced by you community members are actually downstream symptoms of poverty, housing insecurity, economic insecurity. And the solutions to those issues -- finding dignity in work, building wealth and opportunity in historically segregated neighborhoods -- those solutions are created with residents at the local level.

So, Leana Wen's experience in Baltimore, in St. Louis, and other communities are very close to home to us, and I think relevant to all of us who care about making sure public serve -- public health remains a profound and important domain in infrastructure in our communities.

So, I hope to explore all these dimensions with Leana and Dr. -- Dr. Wen, in our conversation. Now, please follow today's conversation using the hashtag #publichealth and if you have any questions that you want -- need to address to Dr. Wen at the -- near the end of our conversation, please do so through the events page. And email your questions there or through Twitter using the

hashtag #publichealth and at mentioning at @brookingsmetro.

Now, without further ado, I'd like to welcome Dr. Leana Wen to the Brookings stage.

Wonderful.

DR. WEN: Thank you. Hi, Amy. How are you? It's this -- the virtual times that we're in, right?

MS. LIU: (Laughter)

DR. WEN: All I have to do is click a button and there I am. But thank you so much for your leadership. Thank you for inviting me to be here with you from my living room but nevertheless being here with -- with everyone today.

MS. LIU: It's -- it's so -- it's so disappointing we can't do this in person but it's always wonderful to have your energy and your expertise with us, even virtually. I want to say congratulations, by the way, to the book. It is wonderful.

DR. WEN: I really appreciate it. Thank you.

MS. LIU: So, before we dive into the topic of public health, I do want the audience to get to know you. And your book opens with your family's journey to America. Your story is an immigrant story.

And I have to say by the way, Leana, my family was also displaced -- my parents were also displaced by the cultural revolution. And they made incredible sacrifices to get themselves and, eventually, my sister and I to the United States. So, talk about your parent's efforts to get your family to the U.S. and what your early years in the U.S. were like.

DR. WEN: Well, Amy, thank you for that question and I -- first, wanted to again thank you for your leadership at Brookings Metro and for the wonderful work that -- that your team is doing every day to uplift the many people on the ground who are doing wonderful work. And so, thank you for that and I hope that we'll get to talk a lot more about public health -- and as it ties, actually, to my new book -- to *Lifelines*, I actually did not intend to write my book as a memoir, which is what it ended up being a large part of.

I actually started out writing my -- my book about my experience leading Baltimore's Health Department. And -- and actually I had felt strongly about telling the stories of all these

interventions that are so successful, yet I thought people just did not know about. I wanted to talk, for example, about our B'more for Healthy Babies program that reduced infant mortality by 38 percent in seven years in our city. Or how we were able to save over 3,000 lives from the opioid epidemic as a result of our work on naloxone distribution in our city in a three-year period.

So, that was the initial impetus for the book but, actually, in writing *Lifelines*, I also came to see what you were just mentioning. Which is then, in a -- in a way, my own story and my family's story is, in itself, a testament to public health in a way that I actually don't know that I quite realized going through it.

So, my story -- briefly -- is that I was born in China, in Shanghai. My parents and I ended up coming to the U.S. just before I turned eight and we initially lived in a little town in the middle of Utah -- which is another story altogether -- how you end up from Shanghai to -- to this little town in Utah. But we then ended up in Los Angeles. And I saw, growing up, how my parents -- despite working multiple jobs -- we had trouble making ends meet.

My father was delivering newspapers and washing dishes in a restaurant. My mother was studying to be a teacher at night while also working in a video store and working in a hotel. But there were still times when things were really tenuous for us, and my parents argued all the time about money. We worried about our immigration status and there were times, that I wrote about in *Lifelines*, where we could not find enough for rent and we were evicted.

And, in so many ways, we depended on the social safety net that is provided. And I think it's very difficult some of the rhetoric that's happening now around these -- these programs as "entitlements" when, for us, that was what was necessary to get our -- our feet under us. We depended on Medicaid and Children's Health Insurance Program. We depended on WIC when my mother was pregnant with my little sister. We depended on public housing. I went to public school all the way throughout college.

And, again, not an entitlement but very much this concept of how public health and these -- and these programs were -- they allowed us to get our foot in the door. They were what allowed us to have some type of opportunity so that my parents were able to see my sister and I live out their wildest dreams for what we could achieve.

And so, I also start the book specifically with a very -- with a very particular story about healthcare, which is that there was a boy who was just a couple years younger than me -- I think was about 10 at the time. So, this boy was seven or eight and he was having a severe asthma attack. I knew him. He was a neighbor of mine. His grandmother was too afraid to call for help because the family was undocumented, and she wasn't sure what would happen if she called the medical authority -- if she called 911. She was afraid that maybe the family would be found out -- that they would be deported.

And by the time she actually ended up calling for help it was too late, and this boy died. I mean, he died from an asthma attack right in front of my eyes at that age. And I had this growing sense, at the time, that we're -- we live in a country where #1, health is not seen as the fundamental right that it is. And #2 that we also live in a profoundly unequal society where people are valued very differently based on who they happen to be, how much money that have, and what they came from.

And I felt strongly, even from that early age, about wanting to go into medicine but, specifically, to go into the ER because I never wanted to be in a position where I had to turn someone away because of inability to pay or because of where they came from.

MS. LIU: I want to talk about your ER experience in just a moment. Before we do, I want to talk about your education. You've got into college at the ripe old age of 13 and there were a lot of, I think, very compelling experiences you had back then. But the one thing that I took away was that there were many other low-income students and first-generation students who faced enormous barriers pursuing medical school.

What were those? Because I think about the public policy folks in the room who want to make sure that the path to healthcare or the path to public health careers is truly accessible for all students. What are those barriers that we should be aware of?

DR. WEN: Yeah. I -- I appreciate your -- your asking this and I'll -- I'll tell you again the -- the story of -- of when I spent -- you know, again, I wasn't planning to tell this story in *Lifelines*. This was meant to be a book on leading public health at Baltimore, but I actually ended up writing about this for exactly the reasons that you mentioned because I think there are so many people who are deterred from entering medicine or entering whatever career -- not because they don't have the capability but because they just don't know these unwritten rules of the road.

And so, when I first started in college, you know, I -- I had this dream that I wanted to be a doctor, but I didn't literally know how I could do it. And, in fact, I felt -- I was -- I was too ashamed, if that's the right word, to even talk about going into medicine because I thought, who's going to believe me? I mean, I -- I knew my pediatrician growing up, you know, who treated my -- I had asthma too -- who treated my asthma. But my parents didn't have friends who were doctors in the U.S. I mean, we didn't -- we didn't know what was involved even to getting into medicine.

And so, when I started college, I was in a work-study program and was working in a lab and whenever somebody asked me what do you want to do when you graduate? I always said I wanted to be a lab tech because I thought it was believable. I was working in a lab, my parents had a friend whose daughter was a lab tech and so, I thought I -- I can do this. I -- I -- there is a path that I can envision that I can get there.

It took me a couple of years, I think, to tell my -- to tell my -- one of my -- my mentors, who ran the work-study program, that I wanted to be doctor. And he didn't laugh at me, as I was afraid that he might. And instead, he said let me introduce you to students that have had -- who are now in medical school or in residency.

And that really and profoundly opened my eyes because I met so many other people who gave me advice, again, on these unwritten things. Things like, you should take a test-prep program to -- to study for your MCATs. Or you should -- here's how you do this type of community service because that's what these schools are looking for. Like, I wouldn't have known all these things. I eventually ended up starting a club -- an organization, in my undergraduate because I wanted to help other students have these types of opportunities that we otherwise just wouldn't have exposure to.

One more story here, which is that when I -- when I was applying to medical school, I talked to my career counseling office, and I went to a large public university where there were many thousands of people who were pre-med to start with and that got whittled down and maybe only a handful got -- got into medical school. And so, I'm not blaming the -- the pre-med office for this but what I heard when I'm told that my grades, my MCAT scores, et cetera -- they said there are many people who have scores like yours and they apply to 40 medical schools, and they don't get into any of them.

MS. LIU: Mm-hmm.

DR. WEN: And I said this to Dr. Garcia, my -- my mentor, who said back to me -- well, in that case, you have to apply to 41 medical schools.

MS. LIU: (Laughter)

DR. WEN: And I'm so grateful that I had someone like him in my life and throughout my -- my career who saw -- who believed in me when I wouldn't have known even to believe in myself. And so, I think then again, there were so many things like this. And I talk in *Lifelines* too about how, when I was applying to medical school too, I couldn't fathom the types of -- the -- the resources that were required -- the tuition that was required to go into medical school. And I didn't have any support from my parents who were really struggling at that time too. And I only ended up applying to programs that -- that had full scholarship and was very fortunate to have gotten in. But how many other students are dissuaded from even trying for a career in these fields because --

MS. LIU: Yeah.

DR. WEN: -- there are just so many barriers every step of the way.

MS. LIU: So, you did your residency in Boston, and I think that's where you got a chance to work in the ER. And there's a line early in the book where you say that "working in the ER was also where I saw the limitations of healthcare."

What do you mean by that? And what are the stories of the patients that you confronted and met that really gave you that lesson to hit home?

DR. WEN: Yeah. *Lifelines*, ultimately, is a -- is a book of stories and ---

MS. LIU: Mm-hmm.

DR. WEN: -- I wanted to also share the stories of my patients. And there was -- I talked, for example, about a patient of mine who was also a young boy with asthma, who I got to know very well in the emergency department. And in ER, it's not a good thing when you get to know your patients very well. It's not the patient's fault but rather that there is something wrong with this healthcare system that the patient feels like they have to keep on coming in. And, in this case, this was a boy who kept on coming in for asthma exacerbations.

But what he needed was not a better inhaler or more steroids. What was going on was that he and his mother were experiencing homelessness. They were often going in between people's



homes -- their family's or friend's, where different people smoked. Or they were going to shelters where there was a lot of mold all around them. At some point they were living across the street from an incinerator.

And I just felt, in that moment -- look, I want to do everything I can for this patient but it's not so much the medical care that I'm able to provide in the ER. It's all these other factors that we, in public health know as the social determinants of health. It's this understanding that housing is also healthcare, that the air that you breathe, the educational opportunities you and your family have access to -- all of that constitutes healthcare as well.

And I think it's that -- it's part of that understanding of I want to do everything for my patients, and I can't within the confines of the four walls of the hospital that compelled me to be in public health. And by the way, I didn't even know this field of public health, right? This was not something that I had initially set out to do. I never had a class in public health in medical school. It was an understanding over time.

I initially thought that what I wanted to do was to work in health policy and that is still a lot of -- of what I do now. It -- because -- it's these global policies, these national policies that make a difference in our patient's lives. And, if I want to provide for the best care for my patients, I also have to advocate for these better policies. But I also came to see that many of these policies are actually very local and that's why -- when I had the opportunity to become the health commissioner for Baltimore -- I thought this is my chance to work on these policies that very much touch on people's lives.

For example, one of the things that -- that we did was to expand our program on -- on community asthma treatment in Baltimore. Because we know that many students are missing school when really, they just need treatment for their asthma -- something that can actually be easily done outside of the confines of the ER or without the child having to miss school or their parent having to miss work.

And so, that -- so, we've set up programs, for example, to expand telemedicine -- including in urban areas -- to have follow up visits for children who go to the ER and then they get a follow up visit from a community health nurse or a social worker to see how they're doing. Because if what they need is actually better housing, they don't need to go to the ER -- and, in fact, the ER is not the right

place to get that.

And so, I think it's very much this -- how I came to public health is very much through the lens of being a practitioner in the ER. And that lens of being a practicing clinician continues to inform all the work that I do in -- in public health and policy now.

MS. LIU: Yeah. Let's talk about that time in Baltimore. And I think, for all of the folks who are -- are viewing in -- you know, Dr. Wen became the commissioner of public health I think around 2014 -- 2015, under Mayor Stephanie Rawlings-Blake.

And one of the things you did right away -- like any, I think, leader of a new agency -- is you did a 100-day listening tour. And I think you walked out with three big concerns that were expressed -- expressed by residents. You want to describe that? I think it --

DR. WEN: Yeah, so --

MS. LIU: -- set your agenda. Yeah.

DR. WEN: (Laughter) Absolutely. Well, I -- I had the opportunity when -- when I was appointed the health commissioner for -- for Baltimore, to work for then Mayor Stephanie Rawlings-Blake.

And one thing that Mayor Rawlings-Blake liked to say is that, if everything is a priority, nothing is a priority.

MS. LIU: (Laughter)

DR. WEN: And I think this is really profound because so often -- especially when we are in a field like public health, where everything is tied to one another -- sometimes you can get decision paralysis and say well, if health is affected by housing and food and economics and education and -- and that's also tied to the criminal justice system and to either -- to all these issues that -- where do you even begin.

So, I very -- I very much appreciated that practical perspective from the mayor saying -- look, you got to focus on a few things. You can't do 20 things well. Focus on three things. It doesn't mean that you don't do the other things, but you've got to be clear about your priorities.

And so, I did a listening tour in our city and the three things that emerged I thought were actually very clear. One was that I had to focus on the opioid epidemic. We were facing, at that time, a crisis when it came to -- to number of -- of overdoses skyrocketing. We knew that expanding treatment

access was really important. And so -- and also, addiction tied into every other aspect of our city. So, that had to be a top priority.

Another is focusing on youth health and wellness. The single most important thing we can do -- I believed for the future is to focus on our children. One of my mentors is the late congressman, Elijah Cummings, who often talked about how children are messengers to a future that we will never see. And that everything that we do really has to have children first and -- first and foremost. And so, that also had to be a key priority.

And the third, because of who we are, it is -- it is focusing on caring for the most vulnerable and helping the most vulnerable. And -- and improving health while also -- while also striving for equity at the same time.

And so, those were the three things that we focused on. And -- and I'd say too that, you know, so much of public health and the work of public health also is about making other people care about your vision -- about your work. Because COVID may -- may have changed things. And I think things might be different now and it -- and as we emerge from the pandemic. But certainly, prior to COVID, when is that last time you heard a local or state or federal official running for office on a public health platform. Right?

When you talk about what it is that people care about and what they're running on, they are things like jobs, public safety, and education -- not necessarily public health. Well, it's our job in public health to make the case that, whatever it is that they care about, ties directly back to public health. If what they care about is jobs, don't you want to have a healthy work force? If what you care about is education, what about the ability of school health to be able to treat physical health, as well as mental health, for our students? If what you care about is criminal justice, well, are we really doing the right thing for people if we are incarcerating individuals with a disease of addiction? Or having police officers treat individuals who are homeless and who are -- who are experiencing homelessness and have a mental health crisis?

I mean, all these issues directly tie to public health, but I think it's also our job to make the case for it too.

MS. LIU: That is a perfect segue to one of the questions I was going to ask you, which is

the fact that I thought one of your most effective ways of leading was the fact that you built these incredible partnerships with other actors in the community so that you can address public health much more systemically.

So, one of groups that you worked closely with was law enforcement. In a time when we are today hearing about calls to defund the police or restructure the police, you were able to actually partner with police and reform their practices toward more public health considerations. Can you describe that?

DR. WEN: Yeah. I mean, I understand that this is a very sensitive topic for many people right now and I want to give you my perspective on it, understanding that people come to this through a variety of lenses and in a variety of ways. And so, this not a judgement on how other people are approaching the issue, I want to give you mine -- which is that, again, as a -- as a practitioner, as a physician, I'm very practical.

I -- I believe that you should do what you can with the position that you have. And, at that time in Baltimore, when I first started in my role, I was first appointed in late 2014 -- in December of 2014. In early spring was when Freddie Gray died while in police custody. And then we had the civil unrest that engulfed our city subsequently. So, it was not lost on me at all that we had a major issue when I came to the relationship of the -- the police department with our community and with other agencies.

I also, though, believed that there is a way to see public safety and public health as working in partnership with one another -- not at odds with one another but in partnership. And so, several things that we worked together with the police department on -- although, it was not always smooth sailing, right? There were always -- because the goals you -- they should be the same in public health and public safety but sometimes the methods, sometimes the approaches are -- are very different.

But one of the things that we did initially was to start training police officers on using naloxone or Narcan, the opioid antidote. And actually, at that time, it was not commonplace. We were one of the first places in the country to being doing this. And I remember going to one of the early trainings with the police department, where officers were looking at us in the health department like we were asking them to dissect rats or something. I mean, they were just like, I do not -- you know, I don't touch medications. What are you asking me to do to look for pulses, like -- it was just was so outside of

their -- of what they were used to.

But what changed things was that there -- first of all, there was an officer who spoke very openly about how his brother had addiction and how his brother's life was saved with naloxone. And this officer became an early and very frequent speaker to -- to his -- to people on the police force. Which I think actually gets to a core tenet of public health -- which is this idea of the most trusted messenger. Me talking to police officers -- clearly, I was not the most trusted messenger. They didn't see me as one of them, but they did see their fellow officer as one of them.

And then what happened was that, within the first month, four officers used naloxone to save four lives. The officers began to compete with one another on who could save the most number of lives. And a year into this program, I went back to do another training, and I asked people what do you do when you walk into a scene of an overdose? You know, what -- what do you do? In the previous year, they would have said oh, we want to look for paraphernalia. We wanted -- you know, wanted to figure out -- what -- what happened. Instead, this time, they were talking about airway breathing circulation and giving -- and giving Narcan and calling 911. I mean, just the -- the entire process I thought the mentality had really changed.

And again, I'm not saying that we were able to reform the police department through teaching Narcan, but rather that this and many of our other efforts -- we then had another police commissioner, Kevin Davis, was very reform oriented -- who also started partnering with us and nonprofits in the area, to start a -- a homeless outreach team, where officers would partner with social workers to specifically those experiencing homelessness. And again, not incarcerate individuals but offer other types of resources.

We started a program called LEAD, Law Enforcement Assisted Diversion, modeled after the program in Seattle -- together with the State's Attorneys Office, with the Public Defender, with -- with the police department, where individuals caught with small amounts of drugs would be offered treatment instead of incarceration.

You know, again, I'm not saying that all of these efforts were straightforward. And I'm certainly not claiming that we somehow changed the culture within the police department. But, rather that, there are the tangible steps that we can take if we are really focused on our goal -- which is to

improve health and -- and reduce inequity.

MS. LIU: One of those -- just the things that I -- I learned a lot in your book and I think one of the things that I thought the culture shift you made was trying to convince -- including law enforcement -- that addiction is a disease. It's not something to blame the person. And in some ways, law enforcement's response -- in partnership with you -- was not to incarcerate the person but to treat the disease. And I think it's -- and I think it's a really -- it's a good starting point as you said.

Let's go back and talk about Freddie Gray. Freddie Gray's death at the hands of law enforcement was -- is one of many, many unfortunate deaths we have seen over the course of recent years and obviously, a long overdue recognition of the role of racism in society. You, at your time as a public health commissioner, essentially called out racism as a public health issue. And you talked openly and forcefully about how structural racism has a direct effect on public health. Can you talk more about how you got to that awareness and what public health officials can do in partnership around that?

DR. WEN: Yeah. I mean, I think this is a -- a long overdue reckoning. I'm very glad --

MS. LIU: Mm-hmm.

DR. WEN: -- that we are now speaking, as you said, openly about how racism is public health issue. Look, back in 2015 when I was first talking about it in Baltimore, I got a lot of raised eyebrows. Not because people were, you know, they weren't antagonistic toward this idea -- certainly not in our city, in Baltimore. But rather I think it just wasn't really something that people spoke about. And so, I almost had to back into it -- as in, I talked about health disparities.

And so, for example, why is it that African Americans have a much higher rate in our city of hypertension, diabetes, obesity, and heart disease? Well, 1 in 3 African Americans live in a food desert compared to 1 in 12 whites. Why do these disparities in food access exist? Well, a lot of this has to do with bread lining and -- and housing policies and structural inequities and racism that happened before, right? So, I had to back into this and talk about it from the perspective of disparities.

I think now there's much more recognition that just like poverty -- just like violence can be recognized as public health issues -- that racism can be as well. And I actually think that it's important for us, in addressing it as a public health issue -- because, when we look at other public health issues, there is a way to treat it and there's a way to prevent it if we recognize that it's an issue in the first place. And

so, I -- I like this concept not because -- not only because we need to put attention to the issue and call it out, which I do think its important too -- but it allows us to take action when we see this as something that we can do something about.

So, for example, one thing that we did in Baltimore was to say it's not enough for us to only talk about improving health, we also need to have equity metrics as well. And specifically, I mentioned our program B'more for Healthy Babies -- that involves home-visiting programs for pregnant women, breast-feeding supports, giving -- helping families with housing, teaching the ABC's of safe sleep, and so forth. Well, we were very proud of the fact that it reduced infant mortality in our city by 38 percent in 7 years through this vast public-private partnership involving over 150 partners. But we were also even prouder, I would say, of the fact -- or as proud of the fact that, as we improved health for all, we also specifically reduced the disparity between black and white infant mortality by over 50 percent in that same time period.

I think there is sometimes this misunderstanding that focusing on disparities or talking about equity means that someone has to lose -- that you're taking years of life from one group and adding it to another. But that is not the way that this works. And, in fact, the whole point of equity to me, is you focus on the most vulnerable but then all boats rise because you're able to help everyone.

Just one more thing I -- I wanted to address on this point -- and I talk about this particular story in *Lifelines* as well -- that, you know, I had declared the opioid overdose issue to be an emergency in our city. And I remember that I was at a community meeting where a gentleman stood up in the back of church and said to me, I would like to understand why is it that the opioid epidemic is now an epidemic. Why is it now an emergency when it's been in a state of emergency my entire life? He said people have been dying from the crack epidemic, from the opioid epidemic, from heroine all the years that I've been alive. And so, why is it that it's suddenly this emergency?

And the way I addressed him was to say, you know what, you're right. You're right in pointing out that when it was predominantly black and brown people in inner cities who were dying, that we were not calling this emergency. We were not even calling this a medical issue. We were saying, basically, that this a moral failing. And so, if you end up getting sick, if you end up getting incarcerated, if you end up dead, it's somehow your fault. It was a choice that you made rather than a disease that

needs to be treated.

But now that it's white people in rural areas -- the suburban areas -- who are dying from opioid overdose, now we're calling it an emergency. That's not right and that's not just. And we need to focus on this and say -- and call it out. And call out the structural racism that got us to where we are. But we also need to recognize that this is a moment for us to change the narrative and to move the needle when it comes to actually addressing addiction as the disease that it is. And so, I think it's --

MS. LIU: Yeah.

DR. WEN: -- both. I think you have to address these longer-term issues and call out the structural racism that underlies where we are but I also think that we have to take action as well. Because, to perpetuate the inequities once we recognize them, would be even worse -- now that we -- now that see them.

MS. LIU: There's no doubt that since the pandemic and the -- the murder of George Floyd and the death of many young black and Latino men and women in the past year, that there's been a real call to make sure that we emerge from this pandemic addressing the structural racism and inequality in our communities.

And I just want to say on this point, that our staff yesterday released a new report that dug into a little bit more why black and Latino and Hispanic men and women have experienced the largest drop in life expectancy since the pandemic. And we've known that there was a disproportionate impact of COVID-19 on these communities, in hospitalization rates, and death rates -- and now we're seeing it in the numbers in terms of life expectancy.

And what the -- this is a report authored by Andre Perry, Ariel -- I'm looking at the report now -- Ariel Gelrud, Anthony Barr, Carl Romer -- that looked at why did our black and Latino populations and persons experience such a dramatic, disproportionate impact on their lives shortened.

And the factors -- these -- these social determinants of health, came down to access to healthcare. And access to healthcare is predicted by the nature of jobs that many of them work in. And many of those jobs are in part-time work or other work that don't offer healthcare -- health insurance. Or they live in overcrowded homes or conditions where multiple generations live under one household, making them even more vulnerable.



So again, I think the issues around what -- how do we take -- how do we lean into this moment to address housing insecurity? To address employment security? Healthcare access? Those are all important dimensions of how we can rise to this moment. And I just appreciate that the team took a look at this, and I would encourage all of you to do the same.

Let's talk about the solutions then. I think there has been such a conversation about the need for transformative change. And we have an administration that's pouring tons of dollars into local communities to rebuild public health and to address the historic, systemic barriers that have been exposed by COVID-19. I want to unpack that a little bit more.

But I think one of the things that I was really struck by in your book is that -- is this issue about pragmatism. And I'm going to find the quote here. You -- where is this? You talk about the fact that -- is it -- is it progress -- let me see. Oh, yes. Progress takes time. Incrementalism makes a difference.

Progress takes time. Incrementalism makes a difference. And there is so much pressure to focus on systemic change. But I think one of your lessons that you offered readers is that systemic change takes time. So, don't ignore incrementalism. Is that what you're saying? And what does that look like from your experience?

DR. WEN: You know, there is a -- a fable that I -- I cite in the book and this is the story of -- of what it means to go upstream. And so, this fable involves three friends that are walking along a river with a quickly moving tide. And they're seeing that there are children who are drowning. So, one friend rushes in to try to save these kids but is able save 1 in 20 of these kids and there's still many more children who are drowning.

The second friend runs upstream and sees a dam that's broken and -- and is trying to fix the damn.

And then the third friend keeps on running and then the first two shout after him well, what -- what are you doing? And he says well, I want to see who's throwing in these kids in the first place.

Now, this is a story to illustrate what it means to go upstream and to try to focus on these systemic, larger issues. I think that's really wonderful and really admirable and need to be done. And

there are people who really should focus on this and as you mentioned, Amy, this is a moment. This is a moment when so many people are finally focusing on this in a way that we should have many, many years ago.

But I also don't think that that negates the importance of the people trying to fix that dam or trying to save the children by pulling them out one at a time too.

You know, I'm an ER doc at the end of the day and, if somebody is coming into the ER, it's my job to try to help them to the best of ability. They might have many medical problems going on. I may only be able to address one and save their life in that moment but that doesn't mean I stop trying just because things are too complicated -- just because there are other people who can help with these other problems as well.

So, I -- I think one of the things I really wanted to discuss in *Lifelines* is we all have our place and we all should do what we can -- not letting perfect be the enemy of the good. I am not saying, by the way, and I do not want this to be misinterpreted as the people who are running up to save the children -- to prevent them from being thrown in the first place -- that that's wrong. Rather, that it takes all of us. There are people who absolutely should be focusing on these systemic issues -- the systemic solutions -- and long-term change. And we need to put efforts toward that too.

There are other people whose role it is, like mine, who are a lot more practical, on the ground -- we want to be helping our patients right now. And I think there is very much a role for helping the person in front of you too. We all need to work on this together and it takes a combination of these long-term approaches also with short-term actions too.

MS. LIU: I'm going to turn to some of our audience questions in just a moment. So, if you have been listening to this and have a question you want to ask Dr. Wen, again, please do so through Twitter using the hashtag #publichealth and @ mention BrookingsMetro. Or again, do so through the events webpage.

I want to now pivot your experience and apply it to the current crisis and the delta variant which is extending our recovery. I woke up to two pieces of news this morning. One was that the Texas governor was going to ban any vaccine mandates, even in places of private employment. And that Biden's ratings are down now, in part because people just want this pandemic to be over. What's your

take? What's your take, Dr. Wen, on what we all need to do now to get to the other side of this prolonged crisis?

DR. WEN: I mean, it's a very important questions and I'm sure it's top of mind for everyone right now. I just wrote a *Washington Post* Op-Ed last week about -- about this -- about how --

MS. LIU: Mm-hmm.

DR. WEN: -- we need to come to terms with the fact that we are living with COVID for the foreseeable future. That it's not -- it -- that -- but that doesn't mean that the pandemic needs to be the top priority in every decision that we're making about school and work and social activities and travel. We can turn it from what has been an existential crisis into a manageable concern if we have three things. And we're actually not that far from at least two out of the three things.

One is we need to have vaccines available for everyone, including for younger children. And that's because so many parents, including me who have young kids, are taking so much caution right now and not necessarily because of ourselves, but because of -- but because of our kids. And so, I think that's -- that's important.

The second is we need to have oral outpatient treatment available. Again, not that far from it. Merck just applied to Emergency Use Authorization for molnupiravir, an antiviral that can also help to turn COVID, again, from something that is a deadly disease into something that -- that we can potentially -- that we can potentially live with.

And then the third thing is we need to have widespread accessible, available rapid testing. We are not that close from having it at the moment. I mean, we -- it's still very difficult to get a rapid test, more expensive depending on where you live in the country. We are no where near where the United Kingdom, for example, as gotten with having basically everyone -- every family -- being able to get a test at the time that they need. And -- and families can request the -- the test free of charge from -- from the U.K. government.

I mean, all of these are really important and -- and I think we are able to get to a place where we could live with the virus if we're able to achieve vaccines, treatment, and testing. Again, we're not that far but I do wish that our federal government would put as much attention into increasing testing as we did around vaccinations.

MS. LIU: This is a question that comes from one of our viewers that sent it in in advance and it was question that I was going to ask too. Which is that we are in a rebuild better moment, right? The president has issued a Build Back Better Agenda with investments through American Rescue Plan -- to states and localities -- to address the immediate needs to the pandemic to rebuild public health and then to also address systemic issues that existed prior to the pandemic.

What do you -- how -- the question is this, how can communities begin rebuilding the local public health infrastructure? What did you see was the status of that infrastructure prior to COVID, given your experience in Baltimore? And what -- what needs to be invested now?

DR. WEN: Oh, this is such a good question and one of the things that COVID-19 has done was to unmask underlying problems. It didn't create the problems because health disparities didn't start with COVID. Lack of investment in public health didn't start with COVID. But COVID certainly brought them out and unveiled them -- unmasked them.

Now that we have seen them, I hope that there is renewed attention to addressing disparities and equity as we talked about also addressing the underinvestment -- undervaluing of public health.

One thing that I talk a lot about in *Lifelines* is -- is this idea that public health saved your life today, you just don't know it. That public health works when it's invisible and, as a result, we don't see it -- we don't think about it until something happens. But the consequence of this though is that we end up neglecting it and it ends up becoming the first item on the chopping block.

And so, I hope that there is renewed recognition that, as Congressman Elijah Cummings used to say, the cost of doing nothing isn't nothing. That there is a cost of inaction and that cost of inaction, in many cases, is people's lives. And those lives tend to be in people who are the most vulnerable -- who face the greatest barriers to care already, who come from disadvantaged communities.

And so, I think that there is -- what my advice for local health officials, first and foremost, is do not equate public health with COVID-19. Do not equate public health with infection control. While that is top of mind for everyone right now, there are so many other issues that tie into what health departments really do. And one of the problems is that, for so many years we have been robbing Peter to pay Paul.

When there is a new emergency that comes up, all the resources in the health department are redirected to that new emergency rather than to focus on existing problems. And so, these existing problems get worse and worse.

I do think, of course, that we should focus on COVID as the emergency that it is, but let's really strengthen the underlying infrastructure. Let's talk about the work that the health departments that are already doing that's so critical in restaurant inspections, in senior centers, in maternal and child health, in STI and HIV prevention and treatment. These core services have really been neglected over the years -- neglected even more during COVID and they need to be strengthened more than ever.

And so, as you -- the local officials look to strengthen your local health departments -- do as much as you can to improve the work force to -- to insure that people are staying so that we don't lose the -- the crucial -- the -- the individuals who understand how local, state public health work. And, very importantly, focus on these other health issues as well.

MS. LIU: And are -- have you been taking a look at how -- whether or not local jurisdictions, whether it's cities or counties, are beginning to invest some of their new-found federal dollars in ways that isn't just addressing COVID specifically but rebuilding that infrastructure? Are there models that are emerging?

DR. WEN: You know, I would be curious to hear from others if there are --

MS. LIU: Yeah.

DR. WEN: -- such models. I am concerned that, because COVID is top of mind, that the funding --

MS. LIU: Mm-hmm.

DR. WEN: -- is going to be used for this emergency and also, that it's going to be outsourced. You know, I understand that -- I very much understand that so many local health departments are already at their wits end trying to do all the work that they had before and COVID. And so, trying to design a system for using these new funds isn't easy.

I don't want though for the opportunity to be lost and for the funding to be outsourced to academic institutions and nonprofits and consulting companies. As great as they are -- but you also have to be building that local health infrastructure as well, that only health departments can do.

And so, I hope that the funding is not getting outsourced to build other systems instead of this core neglected system.

MS. LIU: A number of questions from our viewers are really about your leadership. And so, let me ask a few on that. One viewer asks, how -- how was doing all of this work over your professional career as a woman and as a woman of color?

DR. WEN: Well, I -- I appreciate the question and I think, Amy, (Laughter) could very well answer this as well.

You know, I -- I actually spent a lot of time in *Lifelines* talking about being a mom. I have two little kids. I have a son who just turned four and a daughter who's one and a half, which makes her a pandemic baby. She was born in April of -- of 2020. And, you know, I -- I explore the -- this issue of work-life balance, for example. And talked a lot about how, you know -- I guess earlier in my career, before I had kids, I thought about work-life balance as, like, a one-time decision.

As in, when you're taking a new job, you think about what is the balance of work versus time with my family as opposed to, it's actually a daily decision of -- do I bring my son to preschool versus do I take this meeting? Do I cook my kids dinner and have dinner with them or do I finish this paper, right? Like it's a constant --

MS. LIU: (Laughter)

DR. WEN: -- series of decisions. And I -- I, you know -- and I think also -- and I also talk of a lot about in the book about being an Asian American, which is something that, actually, I hadn't really thought very consciously about until the pandemic when other people see me as being Asian American. And unfortunately, I've been targeted because of being Chinese American.

And so, I think these are all -- I don't know that is exactly the answer that -- that our viewer was looking for. I don't have a good answer here, except that these are all things that I continue to -- to wrestle with. Both in terms of my personal life as well as my professional identity.

MS. LIU: Another viewer asked -- or acknowledged how rare it is to have a medical professional in the middle of the public health field. And, in fact, that often times -- in fact, this person said it's refreshing to meet someone in the medical field who actually has a good background in public health. So, the question is do you feel having an M.D. has been helpful in your discussions with others

about public health? Does it bring credibility to it, and do you recommend that for others?

DR. WEN: Yeah. It's a -- it's -- I mean, it's definitely a very interesting question. You know, I -- I think it's important for all of us to see our role in public health. Public health professionals, epidemiologists -- very easy to see that as your role because that is your professional identity. A lot of clinicians maybe previously did not necessarily see themselves in public health but now do. Certainly, working on the front of COVID, helping patients to navigate issues of risk -- you're then involved in public health.

But I would go much further too and say that teachers are in public health. That police officers are in public health. That all of us, as individuals, going through this pandemic have been in public health as well. And so, I would say that all of us have an important role to play.

You know, I was just on -- on CNN last night to comment on this -- on the -- the story of several Wisconsin parents suing their school district because their children got infected by COVID and they believe that their kids got infected as a result of lack of masking policies in their schools, lack of contact tracing, et cetera. These parents -- and so many parents along the way -- have been instrumental in promoting public health to help their children and others around them too.

And so, I think this really calls for a re-envisioning of public health. We're not diluting public health by saying that other people are part of it too. There are still people who have very specific expertise in public health. But rather it's recognizing that we all have a role to play in it. And how do we then, as -- as the original public health practitioners -- garner even more support along the way.

MS. LIU: Talk -- talk to me about your observation about the fact that so much of this local and yet, what we're also seeing is that states are stepping in and sometimes -- in our work, we call it preemption. Where the states are overriding local policies when it comes to public health protections or even economic recovery.

What is your observation about how do localities navigate that landscape, and do you have a recommendation of how to improve the state and local dynamic?

DR. WEN: Hmm. We could spend our entire time --

MS. LIU: (Laughter)

DR. WEN: -- focusing on --

MS. LIU: Or and --

DR. WEN: -- on this topic.

MS. LIU: -- and feel -- and feel free to just draw on your experience in Baltimore, Maryland on that if there's --

DR. WEN: Yeah.

MS. LIU: -- if there are lessons there.

DR. WEN: You know, I think so much of public health is very local, and I strongly believe that people who are on the ground understand best about what their communities need and what policies are -- are best. But actually, I would say two things that may be a bit unusual -- may not be necessarily what one might expect in my response.

One is that a strong federal government -- and very clear messaging from the federal government -- actually empowers a local response. Let's talk about, for example, mask requirements. When the CDC says that masks are required indoor settings, it actually gives a lot of cover for local officials to be able to implement these -- these guidelines. Because otherwise they may feel like they have to go up against businesses. They may feel like they have to be the boogeyman, in a way. And when you have the cover of federal -- of federal policies, it gives cover to local officials.

President Biden's recent announcement that OSHA is going to be changing their rules to require vaccines or testing for employers with other 100 workers, that helps to give cover for local business that were going to do this anyway. And -- or wanted to do this anyway, but it helps for them to say oh, well, it's not necessarily something we wanted to do but the federal government, they wanted to do this. And so, I -- I say this because I do think that part of a cohesive local and -- and state response requires guidance and direction from the federal government.

The second thing -- and when it comes to very practical advice for local officials that I think people are going to find surprising coming from -- from me, is I think right now, it's time to get back to public health and actually deemphasize COVID. I think one way, right now, to try to take the air out of so much of the politicization of -- of public health, is -- unfortunately public health has been equated with COVID.

And there are definitely parts of the country where that's a good thing -- as in, people are



finally recognizing the role of their health departments, they are celebrating public health. It's great, you know, it's -- they're happy about this.

But there are so many other places where, because public health is so politicized -- in fact, it has gone in a very negative direction. And I fear that there are going to be knock-on effects to other aspects of public health. For example, there are legislatures restricting the ability of health departments to enforce quarantine authority. And what about patients with multi-drug resistant tuberculosis who need to be quarantined?

MS. LIU: Mm-hmm.

DR. WEN: How is that going to work?

MS. LIU: Mm-hmm.

DR. WEN: Or what about people who, you know -- we have long had vaccine mandates in all fifty states for childhood immunizations. Are we now going to have a problem of not having other diseases being -- having vaccines being used because of the politicization of vaccines?

And so, I -- my advice actually to local officials, is to focus on all the work of your local health departments that you do that are not political, that are not partisan. Understanding COVID should not be partisan or political either. But because it is, talk about the work that you do in providing supports for moms and babies. Talk about the work that you do in providing housing for women experiencing domestic violence -- people experiencing domestic violence. Talk about the work that you do in restaurant inspections and providing services for seniors. I mean, talk about the work that you do that goes beyond whatever is seen as a hot button issue right now.

MS. LIU: I'm going to close with a conversation about Congressman Elijah Cummings. In one minute, you talk a lot about him as a -- as giving you leadership advice. What is one thing you learned from Congressman Elijah Cummings?

DR. WEN: You know, I named Eli after Congressman Elijah Cummings and I miss him all the time.

MS. LIU: Oh.

DR. WEN: One thing that he used to say a lot was about pain, passion, and purpose. That your pain is what fuels your passion that becomes your purpose. And that idea of pain, passion, and

purpose is very much what drives me in my work, and I think, in this time of a pandemic -- in this time of so much instability and -- and upheaval all around the country and the world -- is what we keep in mind. That these painful experiences are what also fuel our passion and our purpose moving forward.

MS. LIU: I think on behalf of everyone here, Dr. Wen, I want to thank you for your local leadership and your national leadership in guiding us through. For all of you who've joined us, I do highly recommend that you purchase a copy of *Lifelines*. I think we will all learn a lot from it. Thank you for joining this afternoon. Thank you, Dr. Wen. I know we'll all stay in touch. Thanks.

DR. WEN: Thank you.

MS. LIU: I know you need to leave. Thank you so much for your time. That was great.

DR. WEN: Thank you very much.

MS. LIU: Good luck with --

DR. WEN: Okay.

MS. LIU: -- everything. (Laughter)

DR. WEN: Thanks so much. All right. Take care.

MS. LIU: Okay.

DR. WEN: Bye-bye.

MS. LIU: Okay. Bye. Karen, all good?

\* \* \* \* \*

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