LEGAL LANGUAGE SERVICES

TRANSCRIPTION OF TAPE

DESIGNATED AS

Opening Plenary Session

Julie Gerberding, CDC

Lynn Steele: If you'll take your seats we'll get started. I know there were a number of people in the registration line hopefully they'll just let them come in. Hello, I'm Lynn Steele, I'm the Senior Advisor for Education and Training in CDC's Office of Terrorism Preparedness and Emergency Response and on behalf of our Director, Charles Schable who will join us later, I just wanted to welcome all of you to this first National Congress on Public Health Readiness. We're really happy to have this opportunity to convene you, the thought leaders in public health, clinical medicine and healthcare and especially grateful to the American Medical Association for this partnership. They've really helped to convene the medicine and healthcare colleagues and have provided support for such a really lovely professional gathering. This conference really does represent a joint effort of public health and the healthcare communities. The conference planning committee was comprised of representatives form 21 professional organizations including key medical and healthcare organizations like the American Medical Association, the American Hospital Association, American Nurses' Association, American College of Physicians and our federal partner, HRSA and also key public health organizations, ASTHO, NACCHO, the American Public Health Association, APHL, Association of Schools of Public Health and many others and all of the planning organizations are listed on the back page of your conference program. Now you'll notice the small conference brochure. Many people thought we were maybe taking the federal Paperwork Reduction Act a little too seriously. But

that was somewhat purposeful in that the primary goals of this conference really are to talk to, hear, and learn from each other. We will be using a lot of audience response systems to capture your input and hosting other forums where we hope to illicit a lot of discussion. In two state of science sessions during this conference we will present new advances in diagnostics, informatics, and therapeutics that will really add to our armamentarium we hope in dealing with bioterrorism, emerging infections and other health emergencies. The rest of the conference was organized into 16 discussion sections. Each of those discussion sections had co-leaders from public health and healthcare leading, making decisions about their conference sessions, with goals to really ensure they were bridging clinical medicine, healthcare and public health, as well as highlighting successful preparedness activities in communities. Basically we want to understand what we can learn from each other. An example is: Public health is newly facing an impending workforce crisis – what can be learned from the nursing community who has been facing such a crisis for over a decade? What does a community look like that has demonstrated the ability to receive and distribute the strategic national stockpile, an effort that must involve both public health and healthcare participants to be successful. As the sessions became organized by the 16 small groups, it became apparent that many of the organizers suggested New York City as an example of success. We realized quickly that we had to organize a special session for New York City so they have their own Plenary Session following the opening session, and will highlight their community

readiness efforts. So throughout the next two and a half days you will have to make some decisions. There are four discussion sessions, four sessions each, so you'll have to make a choice of which to attend. You should note that all the sessions will be summarized by Charles Schable, the Director of the Office of Terrorism Preparedness and Emergency Response, during the closing session on Thursday afternoon. All the sessions will also be taped and available for purchase for a nominal fee. We will also be working with all of the speakers to get slides posted to the conference website in the following weeks. You should also note that there is a luncheon session tomorrow on Wednesday, entitled Local Detection Global Response. I'm pleased to be able to announce that Mr. Ken Barnard who's the Special Assistant to the President for Bio Defense will be the luncheon speaker. And now it gives me great pleasure to open the conference so we can begin to hear from the leaders from CDC and from AMA on their perspectives on readiness --- Dr. Julie Louise Gerberding, Director of CDC, and Dr. John C. Nelson, the newly elected President of the American Medical Association. Julie became Director of CDC a little over two years ago in July of 2002. Before that she served as Acting Director for the National Center for Infectious Diseases and played a major role in leading CDC's response to the anthrax attacks in the fall of 2001. She originally came to CDC in 1998 as the Director for the Division of Healthcare Quality Promotion and worked on issues involving CDC's patient safety agenda and prevention of infections and medical errors in healthcare. She's an Associate Professor of Medicine at the University of California of

San Francisco, an Associate Clinical Professor of Medicine at Emory University. She received her MD and undergraduate degrees from Case Western Reserve in Cleveland and did her internship and residency and fellowship in Clinical Pharmacology and Infectious Diseases at UCSF. She also has an MPH degree from the University of of California at Berkeley. Julie remains actively involved in medicine both in professional societies on editorial boards, and even as Director of CDC continues to take two weeks out of her schedule to do clinical work at the University of California at San Francisco. Julie is passionate about her role as CDC Director and improving the health of the nation and protecting our communities from infectious, environmental and terrorism threats. With that I'd like to introduce my friend and mentor, and a mentor to many of us, Julie Gerberding.

[Applause]

Dr. Julie Gerberding: It's real exciting to be here today and to have a chance to speak with you at this opening session. When I was recruited by Dr. Jim Hughes to the CDC in 1998, I didn't bring too many public health tools in my tool box, but I did bring a very strong commitment to the belief that there really should be no boundary between public health and the healthcare delivery system. That's something that I've tried to introduce in every aspect of my roles at CDC and something that I think really culminates with the two of us being here together on this podium. In 1998, in the Division of Healthcare Quality Promotion, it was fairly easy to see the intersection between healthcare and public health. In 2001, during the initial wave of terrorism, it wasn't so easy to find those

linkages and it was really the AMA that reached out and helped us disseminate information to the clinicians across the country. Since that time we've had so many effective partnerships that you - and the other organizations who are here as part of this meeting - have really become essential partners in our overall preparedness efforts. So for me, this meeting is a little bit of a dream come true and I look at it as another giant step forward in what really will be a seamless intersection between our various parts of the health system. So welcome. I'm going to just provide a few perspectives on how important I think this connectivity really is in the time of terror and highlight some of the most important aspects of our intersection as they pertain to what I believe we continue to prepare for in the future. So if I can have my slides on please.

My topic, Health Protection in the Time of Terror is really focusing on clinicians, connectivity, and communication. CDC, as many of you know has been engaged in a strategic evolution that we call the Future's Initiative and part of that process has been clarifying our vision and our goals for the future. We've defined two overarching health protection goals for the nation and we do really perceive ourselves as the leading agency for health protection in our country. One goal pertains to health promotion, the prevention of disease, injury and disability and the vision here is that all people would be able to achieve their optimal lifespan with the best possible quality of health in every stage of life. If you think about where we are today in our health priorities

you know that 95% of our healthcare dollars are spent over here on the right hand side of this graphic on disease care and particularly secondary and tertiary care for chronic diseases. We spend less than 5% of our resources on health protection on keeping people safe and healthy or if they're vulnerable, returning them to a state of safe and healthy living by virtue of reduction in their risk behaviors or their risk environment. So our vision for the future is really one where we have a much more balanced approach to health promotion and disease prevention and clearly when you think of health in this holistic way it's obvious why our partnership is so critically important. There is a role for public health through this entire spectrum of health stages but there's also a role for clinical medicine in each and every one of these stages and I'm very pleased – here on the podium we were talking about how CDC and the AMA can intersect on health disparities and join together in some of the important work going on in our respective agencies.

So it's not surprising to go to the AMA website and see a graphic on medicine and public health. I think our visions are increasingly coming together but of course it isn't just limited to medical aspects of health or health promotion, we also share a vision about preparedness.

CDC's overarching preparedness is for people in all communities to be protected from infectious, environmental, and terrorist threats so it's sort of the juxtaposition of the all hazards approach and broadening of that approach

to encompass areas of threat beyond those that are uniquely associated with terrorism.

Here again, an article that Dr. Hughes, Dr. Koplan, and I wrote together in JAMA, the Journal of the American Medical Association, shortly after the anthrax attacks, is a commentary on the critical role that clinicians and public health agencies together play in combating terrorism and preparing for terrorist attacks in the future.

Now let's just recap a little bit about what the two years since I joined the CDC leadership team and since the large scale terrorism attack occurred in the United States what's been going on since 2001. Well we had the 9/11 event that was followed by the anthrax attacks, that was followed by the small pox vaccination program, followed by several summers of West Nile virus outbreak, followed by monkey pox, of course SARS came into play. There was the influenza outbreak this past year, which started bad and spread rapidly, the Mad Cow program, that pesky cow that annoyed us over the Christmas holidays, and of course the Avian influenza problem, which has re-emerged again in Asia. When you think of each and every one of these threats, these emerging threats it is absolutely critical that the public health system and the healthcare delivery system intersect effectively and we cannot do this alone. It is only through the partnership that we've been able to successfully recognize and respond to all of these threats in this very small world in which

we live and I think our shared recognition of the problem and our shared accountability and responsibility for the solution is what truly ties us together.

The Homeland Security in this small world has to encompass the global aspects of the threat as well as the very, very local aspects of the threat. When you think about SARS and the hundreds of suspect patients across the United States for every time there was a suspect patient there was a cadre of clinicians and a cadre of public health officials and laboratorians that had to swing into action locally, by locality, by locality and that added up to be I think a very successful first line of defense against SARS in our nation. So we have learned how important this intersection truly is in our overall public health preparedness.

Now a lot of times people ask me "Well, are we prepared?" And the answer to the question is, "It's the wrong question," because preparedness is not a black and white event. It's not yes or no, on or off. Preparedness is a process and it is an ongoing process and it will continue to be an ongoing process of improvement over time: The process of improving the health system's capacity to detect, respond to, recover from and mitigate the consequences of terrorism and other health emergencies. When we have made giant steps forward in preparedness you can still always imagine a scenario that's one step beyond where you are today. I think it's important to look ahead and recognize the need for this ongoing process of preparedness, but it's also

important to look back on where we were just less than three years ago at 2001 and recognize the tremendous progress that has been made across our nation in preparedness. Today what we are doing is refining our understanding of the critical elements of that preparedness and then moving forward throughout this meeting to really look at how we can continue to improve our overall public health preparedness system.

As many of you appreciate, CDC is one of the important federal players in orchestrating an effective homeland security response and our focus is of course on the public's health during any kind of a terrorism threat. We play the role of contributing our expertise, our research, our leadership and our accountability for the public health preparedness paradigm on the state and local health departments have six major responsibilities, which include: preparedness planning and readiness assessment, surveillance and epi response, laboratory capacity, communications and information technology, risk communication and education and training of the public health workforce. Together we bring planning for preparedness, the ability to report on our readiness, and ultimately demonstrable capacity to respond to these threats. The beauty of this investment is of course its multi-factorial benefit. I do take some pride at times in boldly stating that of all the investments we are making in homeland security in our country it is the public health investment that is absolutely guaranteed to pay off. And in fact, it already has paid off and it will continue to pay off even if we never have another terrorist attack. The reason

it's paying off is because our public health infrastructure --- at least our infrastructure's capability to respond to emerging threats --- is evolving in the context of the investments that are being made. All I have to do is visit Pennsylvania in the wake of a hepatitis A outbreak and here the local health officer commented, "Thank goodness for the preparedness in the small pox planning process. There's no way we would been able to administer vaccine this weekend to these thousands of people if we didn't have that planning." I heard the same thing in Chicago with the meningitis outbreak in the gay community. "Thank goodness for the preparedness planning and the communications training that we had. Our overall response rate was remarkable." Just a few weeks ago I was in Los Angeles for a press event heralding the onset of the West Nile virus season in LA County and I heard exactly the same thing from the local health officials there. "Thank goodness for the investments." We've got communication. We've got networking. We know how to identify clinicians. The system is much further evolved than it was three years ago. We have more to do but we have made substantial progress.

So when we're looking at what are the essential response requirements for this small world if we are to achieve health protection, we have to understand the global threats that we face. These are threats that not only affect our health, but affect our economy and our homeland security. They are threats that often come as small world networks. In other words highly clustered

threat areas or highly clustered transmission patterns that jump from one node to another through individuals, like travelers who move from one location to another, or healthcare workers who move from one facility to another, or patients who are transferred from one facility to another, or letters that move through the mail, or viruses that move from animal species to human species. A very small world pattern of threat and one of the most important characteristics of the current threat is that it's fast. Things are happening faster and faster and faster, even with the naturally acquired emerging threats. So in response to this, we've got to be fast. We have to be able to detect these problems rapidly, to respond to them rapidly, to communicate about them rapidly and effectively, to integrate a growing list of partners and agencies and response units effectively, and to most importantly, take the kind of action we need to mitigate the human health consequences of all of these threats. So globalization, connectivity, and speed are the hallmarks of the preparedness that we're trying to achieve.

Now when the anthrax attacks occurred, Dr. Hughes had the wisdom to call in numerous consultants from a whole cadre of organizations and provide perspectives to CDC to help us build a faster and more robust response capability. We learned a lot of lessons from this input. We learned about the importance of collaboration and commitment. We learned about how we needed to develop new competencies at CDC. We learned the incredible importance of the laboratory system to provide the background of any kind of

threat response. We learned about community and I would say we learned about candor and common sense as well. But there were some aspects of the lessons learned that are particularly noteworthy to this audience and these are the lessons learned that I want to emphasize today. The first and foremost is the importance of the clinical community in any kind of preparedness and response effort so let me say a few words about that.

We know that the prepared clinician is the frontline of defense for recognizing many of the emerging threats and terrorism threats that we're concerned about. It was the infectious disease doctor in Florida who had the foresight to recognize that those gram-positive rods in the spinal fluid were not contaminants and clearly represented most likely anthrax. And that clinician got the sample to the appropriate laboratory and alerted the Public Health Department of the nature of this threat. It was an alert clinician who recognized that West Nile virus was causing encephalopathy in organ transplant recipients indicating the importance of that mode of transmission in the context of large-scale West Nile outbreaks. It was Dr. Urbani, the Italian physician, who was looking at the SARS outbreak in Viet Nam and reported back to the World Health Organization that 56% of the healthcare workers in the French hospitals were afflicted with SARS. He sounded the alarm and certainly woke me up to the fact that this was not flu, this was a serious health threat unlike any that we had seen before, and sadly Dr. Urbani died as a consequence of SARS in his commitment to protecting healthcare workers in

Hanoi. And it was an alert clinician who recognized the small lesion on the hand of a child here represented a pox infection and connected that pox infection with the sick prairie dog that the child was handling. So the clinicians are the frontline wherever they are in the healthcare delivery system and we have to ensure that we've done everything we can to help them be prepared to detect and respond. The clinicians have many other roles.

This is a reminder of one of the giant steps we've taken in the last three years to prepare our nation for terrorism and that is the ongoing development of the Strategic National Pharmaceutical Stockpile, which has medical materials and countermeasures deployed in strategic locations across the United States. As our stockpile of countermeasures is evolving --- including vaccines and antidotes and medical equipment and respirators and all of the other critical assets that Secretary Thompson has really focused our attention on --- we have recognized that yes, we can get the stockpile anywhere in the country in 12 hours and yes, we can offload the stockpile effectively. That element of preparedness has been successful. But we're not done until every person in that jurisdiction can receive the countermeasure that's contained in the stockpile and that's what we're focusing on right now: to scale up the capacity of our distribution system to assure that every person in an infected jurisdiction can receive a timely countermeasure if indicated by the nature of the threat. And it is the clinician who ultimately will be the arbitrator of the countermeasure delivery --- these are medical products, these are medical

assets, and they, in large part will be managed by medical personnel. It is also the clinician who makes decisions about management of individuals who are involved in an exposure situation and helps to determine who is exposed, who is not exposed, who needs treatment, who's the worried well, and how do we cope --- not only with the medical interventions but with the psychological interventions that we learned head on in the middle of anthrax with the worried well and the confusion about who needed prophylaxis and who didn't. It's the clinician who has to stand in front of the patient and make those decisions.

We have been engaging really for sometime now in a concentrated effort to provide information to clinicians in advance of these emerging threats and the AMA has been an absolutely critical partner in this. The Bioterrorism preparedness curriculum, many of the other materials, the small pox recognition response materials that went out to millions of clinicians across the United States, really form a pattern that we would define as just in case education --- trying to get information out to people just in case they see something that needs to be reported or responded to, or just in case there is actually an evident threat in their community.

We also have put a great deal of energy into the just in time communication strategy and by this I mean in the context of an event --- pushing information out to clinicians as rapidly as we can through whatever channels we have

available to us through the web, through the clinician hotline, through the clinician list serve, the clinician conference calls, through the press briefing using every means we have including the tried and true MMWR, which during anthrax we were able to abbreviate and create in short form because we found that out that doctors actually didn't really like to read the MMWR in its entirety. So we learned a lot of things about how to improve our education and resources for clinicians and we are still learning. I'm pleased to tell you that this fall CDC is taking all of our information lines and converting them into a single number "CDC Info," which will have special services for clinicians and special referrals for clinicians who are managing acute medical problems.

Now I've been talking about the clinician but I do want to remind everyone how important other clinicians are. These are the animal clinicians or the veterinarians because the prepared veterinarian also plays a key role in our frontline of defense against terrorism threats or other threats. I do have a picture here in the upper left hand corner of a civet cat to remind you that it is not a cat. I am a cat person, that animal has nothing to do with cats however, it is at least punitively a potential cause of SARS, and certainly illness in animals of interest to the veterinarian community and can have human health consequences. It was the veterinarian in New York that recognized that the dead crows were a harbinger of the West Nile virus infection and certainly helped us recognize that this is a new virus and not the typical St. Louis encephalitis virus that we had originally thought.

It's also very important to appreciate the incredible responsibility and role that the laboratorians play this represents the number of anthrax specimens that were processed by laboratories across the country and our laboratory response network as the anthrax attacks evolved. Given all the false alarms and all the environment sampling, more than 50,000 samples were processed for anthrax, representing incredible demonstration of a need for surge. But also an explanation why we have made so many investments in the LRN and are so pleased with not only the increase in the number of laboratories both domestic and internationally that are included in the laboratory response network now, but their capability that has expanded to nearly 100% --- capability for all of the tests available for category A agents --- so enormous strides in laboratory preparedness.

Now let me concentrate on the second major theme that came out of some of the lessons we've learned from these many emerging threats we've been combating. And that's the lesson of connectivity. Certainly all preparedness ultimately is local but it is the local Public Health Department, the local healthcare organizations, and importantly the local clinicians and laboratorians that are our strongest link, but each can't do this alone. Their strength really comes because of their connectivity. Often this connectivity is word of mouth and pick up the telephone and call. No matter what we do to amplify this connectivity, ultimately the face-to-face recognition, the

networking, the human element of connectivity, is what pays off. And I believe one of the important values of the planning process that we've been engaged in for the past two or three years really is the fact that people are convening at the local level, getting to know each other and having a much more robust network of connectivity to reach out to each other when some health emergency appears.

CDC is supporting connectivity of course by taking advantage of our modern technology and the CDC Bio Sense Project. Now remember, Bio Shield is a federal project to purchase and develop countermeasures on an emergency basis to more rapidly develop and, hopefully in some cases, take these threats off the table. Bio Watch is the system of environmental detection in several cities around the country that samples air for a certain category of agents and then sends those samples to the laboratory response network for evaluation and ultimately for triage if there's an indication for a public health response. But we can't have Bio Watch in isolation or you'd have nothing but chaos in the system and so we have to support Bio Watch with other means of threat assessment. And one of these is Bio Sense, which is our electronic capability to collect health information from existing resources and interpret trends in that data as additional point of information in the context of local health. Right now we're getting about 500,000 laboratory reports everyday from national sources. We get the clinical information from the Department of Defense and the VA Medical Centers from around the country. We have about 80%

market share of over the counter drug purchases in the country, a large attachment of information from nurse hotline calls, and several other evolving national data sources coming together into our Bio Intelligence Center to create the capacity to detect trends in health events from this existing data. Our investment in Bio Sense that we anticipate in the next year --- waiting for our budget to pass as proposed in the President's budget --- is an opportunity to extend this national data acquisition process to the local communities. So that the local health agencies are connected to the clinical enterprise and are getting their own people's health information as a very important and sensitive and specific element of this overall system. We have modeled several health events. We've retrospectively assessed the potential of Bio Sense to pick up things like food born illnesses and outbreaks. Of course it's fairly easy to detect a food outbreak, but Bio Sense can detect these events earlier than the usual reporting means and certainly earlier than CDC recognized and reported on this year's flu outbreak, so we are beginning to see progress. And as the system evolves we believe it will be one more tool for helping to identify early threats. Maybe not so much the anthrax or the small pox but perhaps the food born illness, the botulinum, the hemorrhagic fever or the other kinds of naturally acquired emerging threats in the community.

We are also connecting internationally through a series of investments to enhance our borders and our quarantine stations both as response modes but also as detection modes, to expand CDC's field laboratory and epidemiology

programs internationally at sentinel sites, to bring the business community with international workforce into our secure networking system so that we can communicate with our business colleagues that may have their ear to the ground and recognize something going on in a part of the world, but also need information urgently in times of crisis so that they can respond. So ultimately this connectivity that CDC is building for detection and response is something that is very integrally tied to the medical community and hopefully ultimately will be a very useful tool for the entire health system.

Now the last point I wanted to address from the lessons learned category is one of the most important and that really is the lesson of communication. I hope people can appreciate that since 9/11 CDC has been making an overt investment in accelerating and expanding our communications capabilities. We know how important fast communication is. We are utilizing our emergency operation center as response management unit but also as a strategic information center to help coordinate the flow of information to the outside of the public health system. We have very specifically set up clinician teams in addition to numerous other teams of people who are part of our overall emergency communication system so what we do now is --- rather than having the scientists have to drop everything and create messages --- we have the scientists give their science to communications experts who translate it into messages that are specific for various target audiences like clinicians, laboratorians, veterinarians, public health people. In SARS, the Asian

community, the travel industry --- whatever the population who needs information might be, we create a team to identify their needs, identify the channels that they prefer to receive their information, and try to be as responsive as we can. To do this of course, we can't go through the government clearing process so we do put a lot of information out as interim guidance so that people recognize that it will evolve and improve as we learn more and as the database enlarges.

We have seen some consequences of our investment in communication. You can track various health outbreaks for example West Nile in the summer or SARS in the spring of 2003 but one thing we have noticed since we built our press room and have begun doing more regular press briefings, the number of press calls we're getting about an expanding array of health issues, not just emergencies but other health promotion and disease prevention events has continued to stay up and is up even today. People in the media relations office like to remind me of this because they're staffing has not gone up in proportion to the calls.

We also recognize that as an agency we communicate but as individuals we also have a responsibility to be spokespersons. Many of you know that I feel high admiration for Mayor Giuliani in his role as a communicator in New York City during the World Trade Center and anthrax attacks I feel that he stepped up to the plate and exhibited all the essential elements of effective

crisis communication. He was first with messages. He was credible when he delivered his messages. He was correct when he delivered his messages and most importantly he communicated with empathy for the experiences of the people in his City and the nation so he is a very admirable spokesperson.

Some research has helped us evaluate who people want to hear information from during a crisis. At the time of bioterrorism attacks this data – these data were collected by a group in Harvard and it turned out that Dr. Koplan, the Director of the CDC, was the preferred communicator among all the various federal officials. 48% of people said that they would prefer to hear information from the Director of the CDC as a trusted source of information and advice. That was very helpful to us, but an even more helpful piece of information came out of this survey, because guess who people most wanted to hear their information from? Their local doctor! So if there was ever a reason for CDC to reach out to the local clinician and provide information and support and training, this is it. Because people trust most their doctor in the time of a crisis. That is really what has prompted us to initiate really a new paradigm of communication --- emergency risk communication --- and I'm mentioning this here because you can find an enormously useful curriculum of emergency risk information on the CDC website. Also the communication specialists at the state health departments and many local health departments have participated in this curriculum training and have many tools and capabilities to support each of you who in your local role as leaders, very

often will be the spokesperson, or will be the wise communicator. And if you don't think that's true, just pay attention to the cable network news and look at the number of local clinicians who end up in the news. They're on the news because that's where the media turn to for the local frame of issues.

So I've tried to highlight what I think are three extremely important aspects of preparedness for terrorism and other threats and three that are particularly important to us here at this meeting as we look at ways to take even more steps forward. But there is one other C word that I can never give a talk without mentioning because at this point in our lifespan of terrorism preparedness is probably one of the most ominous C words. And that's complacency, which is really the enemy of preparedness. We have had many months go by without a terrorism attack thankfully, and we are at that stage now where many people are disbelieving that such an attack will ever occur. I think it's very important to just think back to your own response to watching the World Trade Centers come down, or learning that there might be an anthrax exposure in your community, and say, "Is there anything today that's any different than it was in 2001 that would deter such a threat from occurring a second time?" I think those of us in the business believe the answer is no. The only deterrent we have is preparedness --- and to the extent that we can prepare and mitigate and take threats off the table, we will be able to combat terrorism effectively. So we are the frontline and I think we have to maintain our vigilance. We are not here to be alarmists or to create unnecessary fear in

the community but we have a responsibility to prepare. We have an accountability to work together as partners and to make wise use of the investments that we have. I think we should also celebrate the progress that we've made because we are living in a different world of health in 2004 than we were in 2001. So thank you for the opportunity to be here and I look forward to the rest of the meeting. Thank you.

[Applause]

Lynn Steele: Thank you, Julie. It's now my pleasure to introduce Dr. John Nelson, President of the American Medical Association, who's a passionate advocate for America's physicians and their patients. He's a Board Certified Obstetrician and Gynecologist, still in active practice in Sale Lake City and as a practicing physician, Dr. Nelson understands the day to day challenges of providing patients with the best care. Having seen his own liability insurance cost more than doubled in the past few years, he's especially committed to achieving medical liability reform. His other passions include expanding healthcare coverage and choice for all Americans, improving clinical quality and patient safety, enhancing early detection and prevention of disease and addressing violence as a public health threat. Dr. Nelson comes to his AMA Presidency with a proven record of leadership in his home state of Utah and the nation. He has served three terms on the AMA's Board of Trustees. Has been President of his State and County Medical Societies and worked as Deputy Director of Utah's Department of Health. Dr. Nelson was also a charter member of the perspective payment assessment commission a

forerunner of Med Pak, that advised the Secretary of Health and Human Services on Medicare issues. More recently he has served on the National Advisory Committee for the Agency for Healthcare Research and Quality. A devoted family man, Dr. Nelson has been married to former Linda Braumley for 36 years. They have eight --- that's not a typo --- eight wonderful children and are the proud grandparents of five grandchildren. I give you Dr. Nelson.

Dr. John Nelson: Good afternoon. What a pleasure it is for me to be here --- a real live doctor like many of us. What an honor it is to be with Dr. Gerberding. Now a couple of things I noticed: She was introduced as 'Julie Louise Gerberding.' That's great. That's a lovely name, very well put together. My middle name was only used when my mother was angry with me. I want you to know we're not angry at you --- none of that stuff. The second thing I really was impressed with was the alliteration --- I saw all those C's. I had not planned to – C has not been a particularly friend of mine because my kids are all in college and they are trying to convince me that those are good --- but I put this together. This is the best I could do. You've demonstrated "the capacity to convert chaos and confusion to constancy, credibility and caring by creating clinical congruit of care and coordinating our communities' concerns." Okay, that's the best that I can do.

[Applause]

Dr. John Nelson: But seriously, Dr. Gerberding I would say that the three C's that are really important to me are constancy, credibility and caring. Ladies and gentlemen,

I really believe that the CDC and this great doctor have done that in the term of chaos so I give you an A for all those C's.

[Applause]

Dr. John Nelson: Well today is kind of a historic perspective getting all of us together in one room for two days I hope an exciting time to share. To talk about what's in our hearts, what we know, what we can learn from each other. There has been for reasons or not clear to me a relationship between public health and practicing clinicians. It's not as close as it could be, not as close as it should be and I'm not even sure why. If you go back to ancient times when I went to medical school Hippocratic oath – Hippocrates was not in my class --- we used to swear by the gods of Escalapius and Hygiea. Let's think about them for a minute. Escalapius was the son of Apollo. Escalapius became a physician who eventually became the Greek god of medicine. His daughter was Hygiea. She was the goddess of good health the ward against plague and her Roman name, Solis protector of the public health. Now today's physicians don't swear by either god of course and of course, all we remember is Escalapius' great staff, which is on our caduceus as a symbol that's come to define our profession. The staff and the snake have met [UI] originally Escalapius' standard it's now ours. But Hygiea kind of faded out of the picture. We must make sure we do not let each other fade out of each other's picture and therefore of course work together. If any physicians are here because we know it's long past time to rediscover and embrace that special relationship. We no longer can be the family divided. Those of you who

know me know I'm passionate about almost everything but I put my name MD and NPH like Dr. Gerberding to show the world my feeling is that public health and clinical medicine go together and I'm committed to making sure that organized medicine gets back to its public health roots and espouses those in all that we do. We want to make sure we belong together now let me tell you a little history about the American Medical Association in 1847 that was a good year. Do you know what happened in 1847?

[Tape deactivated]

[End of Recording]