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PUBLIC HEALTH AND THE NEW ADMINISTRATION:
THE FIRST 100 DAYS
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>> MICHAEL STEIN: Good afternoon. My name is Michael Stein, and I currently serve as Dean of Boston University School of Public Health. On behalf of our school, welcome to today's Public Health Conversation. These Conversations are meant as spaces where we come together to discuss the ideas and issues that matter most for health. Through a process of conversation and debate, guided by expert speakers, we work to build approaches that get us to a healthier world.

Thank you to the many who helped make this conversation possible, including the BUSPH Dean's Office and our Communications team. I would also like to give special thanks to Deans Fallin, Godwin, Goldman, and Pettigrew for joining us for the second time in the last year. This event is a follow up to our fall PHC, "After the Election, What's Next for Health."

During that event, this same group of Deans discussed the prospect of a second Trump term and the many challenges that it posed for health. Today, 101 days into the second term, we no longer need to theorize. We will reflect on the first 100 days of the new administration, the ongoing threats it has made to population health, and potential challenges on the horizon.

I now have the privilege of introducing and welcoming back today's speakers. Let me introduce all of them and then I will direct questions to each in turn, in this order. Dr. Daniele

Fallin is the James W. Curran Dean of Public Health at the Rollins School of Public Health. With more than 250 scientific publications that have been cited more than 22,000 times, her globally recognized research focuses on applying genetic epidemiology methods to studies of neuropsychiatric disorders including autism, Alzheimer's, schizophrenia, and bipolar disorder and to developing applications and methods for genetic and epigenetic epidemiology, as applied to mental health and development.

Dr. Hilary Godwin is Dean of the UW School of Public Health and Professor in the Department of Environmental & Occupational Health Sciences. She is best known for her interdisciplinary work elucidating the mechanisms of lead poisoning and the impacts of nanoparticles on ecosystems and human health. She is deeply committed to promoting the health of all people, locally and globally.

Dr. Lynn Goldman is the Michael and Lori Milken Dean and Professor of Environmental and Occupational Health at the Milken Institute School of Public Health at the George Washington University and the former Assistant Administrator for Toxic Substances at the US Environmental Protection Agency. A pediatrician and epidemiologist, Dr. Goldman is a renowned expert in pediatric environmental health and chemicals policy.

Dr. Melinda Pettigrew is dean of the University of Minnesota School of Public Health. Her research focuses on the epidemiology of respiratory tract infections, the microbiome, and the One Health threat of antibiotic resistance and she is nationally known for her research and leadership in her roles on the steering and executive committees for the Antibacterial Resistance Leadership Group.

As a reminder for our audience, following the set of questions I will ask each of our panelists in turn, we will move for the final part of the program to audience questions. Please submit questions using Zoom's Q&A function, located in the bottom middle of your screen. I will be looking at those and bringing them forward at the end of this session. So, I'm beginning to circle the panel with questions related it topics that they took up, again, about 100 days ago in our conversation.

So, Dean Fallin, let me turn to you first. Vaccines save lives, yet the controversy about them now seems unending. Let's start at the top of the news feed. Can you tell us your thoughts on this re-litigation of the settled non-relationship between the measles vaccine and autism, and perhaps the false hope of find new, unknown causes by September, as the secretary of HHS suggested.

>> DANIELE FALLIN: Thank you, Michael. It's wonderful to share this space with my colleagues on-screen and all of you out

there as a part of this webinar. The number of participants shows how hungry we are for community in public health right now, and for solidarity. So it's really wonderful to be together.

So, to answer your question, Michael, when we talked, which was only five-ish months ago, December or November, even, right after the election, before inauguration, we talked about a lot of things. I specifically talked about anticipating this issue of vaccines coming up under the new administration, as well as other things like health equity, trust in science, mis- and disinformation, and also about dialogue and finding common ground.

And so we were hopeful, optimistic, but cautionary in a lot of that discussion. To your question, one of the things that's come up right away, which is in my area of expertise, is illustrative of all those things. You framed it in the context of vaccine hesitancy. That's absolutely true. Re-litigation of a question that was taken very seriously by the field, and was asked and answered across the globe in multiple ways.

And we don't see an association between vaccines and autism. For many reasons that we've looked at, but also it's always important when I have this conversation with folks to remind us that most of the evidence points to development of autism happening at the very earliest stages of neurodevelopment, in utero.

Vaccines happening post-birth or a year later don't meet the timing litmus test that we learned about in epidemiology in terms of when an exposure versus an outcome should happen temporally. So that has re-amplified the vaccine hesitancy. You don't have to have a concrete finding to cause problems in terms of our vaccination rates.

The mere question can lead to hesitancy, which has terrible consequences. It's such as a success story. That's what I talked about in December and November, the success story of vaccinations in this country and across the globe. It's disheartening to see that. Unfortunately, we're seeing it in full relief.

We've seen actual deaths from preventable -- vaccine-preventable disease in our country just as we speak, or in the past several months. So that's been a real disappointment. But it also touches on some of these other things a we talked about -- mis- and disinformation, amplifying unproven and harmful strategies is a challenge.

Trust in science -- you mentioned, you know, this promise to have an answer to the cause of autism within four months. And I think when we're all trying to build trust in science and trust in researchers, which most polls would say people do actually trust us as researchers, if we then said we can promise

an answer to a really complicated question in four months, when we don't deliver or we deliver something that is not rigorous, that's going to further degrade trust.

So it's a really concerning promise to have made. I and many of you have probably spent a lot of time talking about what does careful -- not slow, but careful and rigorous science look like. And the last thing that this autism thing has brought up for me -- one that I wanted to mention is, it's also a good example of the university-government partnerships.

A lot of what's happened in these hundred days has been about the relationship between research at universities, and research that is demanding by Congress and our people, and funded through multiple mechanisms, including those of NIH, CDC, and other places. Autism, just like many other areas is facing cuts to training of the next generation of scientists, cuts to how we provide facilities and administration for research, specific topical areas.

There is an overlap in autism with other intersectional positionality like LGBTQ communities. And that's an important area to understand. It's one that autistic people have said they want to understand more about in terms of services and community that can be built with respect to health. And that's an area that's not funded by the federal government now.

It's a good example to talk about this one thing, but it brings up all kinds of things that we previously talked about as places to look with caution. I do want to also mention, in this context and other ones, one of the things I talked about last time that is even harder to do is leaning into dialogue and trying to find common ground.

Last time, I sort of argued for things that we are doing at Rollins and folks are doing at other schools of public health around country around trainings like courage in conversation, leaning into curiosity, sitting in difficult conversations with people you disagree with. Practicing that dialogue.

And why that's so important when we're trying to actively listen to folks who have a very different perspective on things so that we can find somewhere where we have common ground and move forward. And I was optimistic about that. I think it's been even harder now, because people's very lives are at stake with some of the decisions that are made.

So it's very hard to listen without judgment to someone who is saying something that you fundamentally feel is harmful. But we have to be tenacious about doing that. That is one of the critical skills for public health. It's one of our ways out and through this particular situation that we all find ourselves in. And hopefully we'll have a little bit of chance to talk more

about how to promote that, what that looks like, and the reality of how hard that actually is to do.

So, I'll stop there for this round and hand it back. But thank you so much for giving me the opportunity to talk about this.

>> HILARY GODWIN: Michael, you're on mute.

>> MICHAEL STEIN: So, let me just come back to a couple of things that you said, talking about common ground, about the partnership with the government. Can you just spend two extra minutes at this moment, Dean Fallin, to talk about the FDA vaccine approval process and where that stands these days?

>> DANIELE FALLIN: So, I can try to say a little bit. So, I think we were all concerned about loss of advisory boards that were apparently disbanded or at least put on pause. And so, what could happen with that. Much of that, even if it's slow, has been reinstated. And I think the other thing that is concerning that we have to think about is what will the level of evidence requirements be.

And so we're paying attention to how that looks. Usually, advisory boards are helpful in shaping that into a reasonable way. The other thing with vaccine approvals -- not so much with vaccine approvals, but with continuing to motivate companies to produce vaccines at scale that we will need requires a level of government support, oversight, for vaccine harms.

So we've had a separate system for managing that because we want to make sure that pharmaceutical companies don't get out of the vaccine game due to, you know, lawsuits and things like that. So we've had this system that is really a rigorous way to manage when folks are reporting vaccine harms.

Many of us worry what happens to that system. Because if we lose the ability to, kind of, work with government and pharmaceutical companies, we might lose their willingness to continue to produce some of these things at scale. So, I don't know if that's what you were also getting at.

>> MICHAEL STEIN: I just wanted to touch on that. Great. Thanks, Dean Fallin. Thanks again for being here.

So, Dean Godwin, three months ago you reminded us about the changes coming with the Project 2025 agenda, and one of the things was government restructuring. And we have now seen the start of a massive government restructuring, or an un-governing. There have been targeted cuts to agencies that work in public health. Can you tell us about what you see that's left of the public health workforce, the risk of further cuts, and the loss of the expertise that all of this represents?

>> HILARY GODWIN: Thanks, Michael. I want to honor the work of our partners in the federal government. Many of those folks have lost their jobs in the last hundred days, and those who

haven't, many have seen their autonomy challenged and their ability to get their work done impaired. And that's work that's essential to fostering healthy lives for people.

It's worth acknowledging that they're bearing the burden of these impacts, which will then filter up to the rest of us. So the federal government expressed its intent to shrink the health and human services workforce by about 25%. So that's about 20,000 people losing their jobs. Many of those reductions in force have already gone into effect, which has decimated the ability of the agencies that they work for to conduct their work, as we had feared that it would.

In addition, we see that a large number of health and human services workers, some of whom are currently on administrative leave, will be fully off-boarded effective June 2nd. So while the crunch in terms of ability to get things done in those agencies is already being really felt, I would say we're in for more to come.

As you mentioned, those are things that we talked about back in November as being possibilities. I'm saddened to see that I think the reality has exceeded my worst fears. And what we're seeing more globally is that in late March, health and human services announced that they would be consolidating the 28 divisions of HHS into 15 divisions and centralizing some of their core administrative functions.

Among those changes, they announced a plan to create a new administration for a healthy America, which would combine several HHS offices and subagencies under a single entity. And I think our concern -- my concern there is both the loss of expertise that could occur during that shift and moving people around, or that people won't get moved at all and we will completely lose the expertise. And also, the potential for that type of work to get more politicized as it moves into this new entity.

In those plans, we also see very specific planning around transferring offices and subagencies, downsizing, and dismantling some of those. And while that HHS announcement in March stated that those changes were designed to make HHS more responsive and efficient while ensuring that Medicare, Medicaid, and other essential health services remain intact, what we're seeing right now is that in Congress, the House Energy and Commerce Committee needs to come up with $800 billion in savings over the next ten years to offset the cost of planned tax cuts.

And the math does not work unless they make cuts to Medicaid. And so we're seeing that being actively played out right now in discussions in the House. And that's because Medicaid accounts for 93% of non-Medicare mandatory spending that's under the jurisdiction of that committee.

We're also seeing proposals to cut funding to SNAP and other critical safety net programs. So, these are all having profound impacts not just on the federal workforce and the work that they do directly, but also on grants and programs that are run out of state and local health jurisdictions, and grant programs in academia.

We've seen specific grants and programs being suspended or terminated. We're also seeing slowdowns in our ability to get funding because the federal staff have been laid off. And then finally, I think it's worth acknowledging that the remaining federal workforce, their capacity has been decreased substantially due to confusing and conflicting communications from the administration.

And all of that has slowed down grant administrative processes and impaired communications between agencies and grantees, all of which have profound impacts on the work that we do across the entire public health system.

>> MICHAEL STEIN: Okay. Thank you. Thank you very much, Dean Godwin. Rather than ask you a second question, because we're already forming excellent questions in the chat, let's turn to Dean Goldman. So, one of the agencies notably affected thus far has been the Environmental Protection Agency, which you know well. So, where does environmental policy now stand, and what do you see as the present and future dangers?

>> LYNN GOLDMAN: At this point in time, there already is quite a bit of damage being done, both to environmental health policy and science. And some of that is at the EPA. Some of it is across other parts of the government. You know, some of my colleagues on this call, Dr. Godwin, Dr. Fallin, they've worked in some of these areas as well.

So they could have as easily been answering this question. But when we spoke a few months ago, I was very concerned, obviously about the Project 2025 agenda. They have been following that agenda very clearly. So we were right in forecasting that that would happen.

There are things that they're doing that we hadn't thought about. The administrator of EPA on March 12th put forth this agenda for the EPA that I could sum up in a few words as saying they're going to do everything they can to thwart enforcement of environmental regulations. They can do that through enforcement discretion and without necessarily changing standards or laws, or regulations.

That's a way they can quickly move forward. But unlike what they did in the Trump administration eight years ago, they are going to be careful about following administrative procedures. So, something that happened eight years ago, they would try to reverse a regulation without going through the normal notice and

comment process that we're entitled to under the law in the United States.

And I think we've seen that in some other areas as well, the way that grants have been cut and some of the universities have been treated, that there hasn't been -- at least the lawyers are claiming -- adequate adherence to administrative procedures, which is the law. The Administrative Procedures Act is a very powerful law. And they've also done things to try to undercut alternative energy sources, whether it is electric cars through the California waivers, or the efforts to control coal ash in coal mining areas. Just let the world be contaminated with coal ash. They just won't enforce those rules, or they will stop some of them.

And so I think it's a clear signal to the oil and gas, and coal, other fossil fuel industries that they're hoping to see them grow. However, these measures are running counter to very powerful economic forces such as the fact that solar and wind energy are becoming cheaper and cheaper and cheaper. The batteries are becoming cheaper.

And so there's a lot of incentives for industry to move forward with greener energy. But they're doing everything they can to support this agenda. I think an interesting thing, when you hear about what's going on, for example with vaccines, we know there are a lot of people in the country who have vaccine hesitancy and that the president included in his campaign a lot of statements about vaccines.

But yet -- so, there's a reason to say, maybe people in the electorate don't understand the issue the same way that public health understands it. I wouldn't say that about the environment. I don't think that people were voting for more air pollution. I think that people have been showing their preference for cleaner fuels and a cleaner environment at all kinds of levels for that kind of thing.

The thing they're doing is they're cutting back on access to information. So EPA's data that they have been displaying on their web page showing things like where are the dirty chemical plants in the country, and even the observatory that monitors carbon dioxide levels in the atmosphere and has shown how it's changing over time, shutting that down so that information isn't available.

Even some of the public web pages from the National Weather Service. The research that we've seen impacted so far that has been all of EPA's grants having to do with environmental justice, but also health of children. So, we were talking about something that I as a pediatrician care about a lot. Canceling those grants, they're no longer an agency priority.

I can't believe there's not an up-swelling of public opinion that we're not worried about children. There is also an issue about the intersection of the different agencies that impact on the health of the environment. So, some of them are actually in Health and Human Services, like the ATSDR, which has been in the CDC, and even NIOSH, which does occupational safety and health.

And Hilary mentioned those agencies are being stripped down and moved into the Make America Healthy Agency. It's Not clear how they will function there. CDC's child lead poisoning program has been eliminated completely. When we have lead now emerging as a problem across our country in various communities, there are no people from the CDC to go and help state and local people with that.

And at the same time, we've decided that it's okay to eliminate the new EPA rule on lead in drinking water. That's something that EPA has been working on for many, many years. And it's really important. It has to do with lead-contaminated pipes that led to the problem in Michigan and it's going to continue to be a problem across the country.

Right now, there is a lot that's going on on the air pollution front with trying to block a number of air pollution rules that the Biden administration put out, trying to block rules about methane, which is actually a greenhouse gas. Again, blocking the California extension that allows California to push for electrification of motor vehicle fleets.

And there's a lot of controversy about whether they're going to be able to do that, how can they do that. The thing I wanted to end with and one of the things I found to be the most surprising is what's happening with the premier journal in environmental health called Environmental Health Perspectives, edited by Jill.

But this journal is not only an incredibly important channel of communication in the U.S., but also globally. And there have always been people on the fringe who hate it, because every time people publish an article that says this pollutant or that pollutant has a health effect, it can lead down the road to a regulation.

And basically, the budget has been cut and an announcement just came out earlier this week that they can't accept submissions anymore. I think this is a terrible problem. And it really calls into question for me also what is their policy about how a journal should support themselves anyway.

Because this has been one of the journals that's open access. It's extremely highly cited. It's one of the -- it may be the most significant issue journal in environmental health. And yet they've been attacking -- writing letters to them. Is

this a sign that publishing is just bad in terms of their policies, or is it not well thought through?

It certainly is a concern, because obviously we want to have the funding, but we also need to have the avenues to publish our work.

>> MICHAEL STEIN: Thank you. Thank you, Dean Goldman. Let me turn to Dean Pettigrew. A different topic. The US funding of global health work has been decimated as well, presenting clear humanitarian crises. Could you please tell us how the WHO and others have responded to the immediate needs of the global health community as the US has pulled back? And could you also walk us through some of those international changes that may be putting Americans at risk for infectious disease now?

>> MELINDA PETTIGREW: Thank you for that question. Back on January 20th, I believe -- it seems so long ago -- the U.S. reinitiated its withdrawal from the WHO. And this was ostensibly based on concerns over COVID handling. There are 194 member nations. The United States is historically the largest donor to the WHO. Estimates vary.

But play a key role. So the WHO plays a key role in global surveillance for infectious diseases and noncommunicable diseases. They are the central coordinating body for global health response, they handle vaccine distribution, pandemic response. Without the U.S.' financial and political support, the WHO's capacity to respond to health crises is likely to be significantly diminished.

There have been other major cuts and disruptions, significant outs to USAID, there's concern about PEPFAR. You asked about vaccines and vaccine policy. In one of the first weeks in May, experts who advise the WHO are supposed to recommend strain selection for the upcoming influenza season in the northern hemisphere. The decision on which strains to recommend for the vaccines is normally made by seven WHO influenza collaborating centers.

Normally the CDC and the FDA would be there at the table and help decide which strains go into the vaccines. It's really not clear what involvement the U.S. is going to have with that now. So if the CDC and the FDA don't attend, they won't be able to influence which strains go into the vaccines.

So this will put Americans at risk. The vaccine strains may be misaligned. They may be delayed. The strain selection is going to be needed for COVID vaccines, also. It's really not clear how that's going to happen.

Also want to mention that there are concerns about weakened global surveillance. This is both in chronic and infectious diseases. The U.S. depends on this international system. Many systems were initially funded with U.S. support. Countries with

less robust health infrastructure are going to be less able to detect threats or provide timely information to global health authorities.

We've also cut ties that facilitated the sharing of data. Dean Goldman mentioned the lack of data, the lack of access to publishing and information. If we can't share data we won't know what's coming and people won't share these emerging threats with us.

There's a lesser-known program in peril that I wanted to briefly mention that's in the global space. And that's the Demographic and Health Surveys. These were nationally representative household surveys conducted every five years. They provide data for 90 countries. That program was funded by USAID and other donors.

They were the only source of information about HIV infections. They were used to target interventions. They fed into the 2030 -- will feed into the 2030 Sustainable Development Goals. Many of our public health researchers rely on these.

The lack of funding will have broader impacts in the context of humanitarian crises, including those exacerbated by conflict, climate change, displacement, poor mental health, the spread of infectious diseases. That can trigger refugee crises that could strain the global public health system and U.S. resources.

This is going to bump up against changes to U.S. immigration policy and our policies around refugees. I'd like to also quickly mention PEPFAR. I got into this work because of HIV. As a reminder, with the president's emergency plan for AIDS, it was started under George W. Bush and saved 26 million lives. It's helped support public health infrastructure in 50 countries.

There have been stop work orders. USAID was the main partner. They received a waiver to do live-saving HIV services. But without USAID and most of its staff, there are real questions about how PEPFAR will be implemented.

The reductions to CDC staff -- they contributed to PEPFAR. PEPFAR is a part of the U.S. law that's continuing as long as Congress appropriates funding, which they did in March. But it's unclear how that work is going to go forward. And reductions or the rollback of PEPFAR is going to do significant damage to HIV efforts.

There have been some models put out, impacts predicted. By 2030, 1 million additional children would be infected with HIV. Half a million additional children die of AIDS. 2.8 million additional HIV orphans. This is a real moral, practical dilemma. And public health is about relationships. It's about trust.

These programs took decades to develop. And once they're destroyed they can't easily be replaced. And I also want to

remember how interconnected things are -- health, health funding, health infrastructure. This is something we know in public health. So there are all these downstream ripple effects.

And some of this work is going to continue without the U.S. in a diminished form. The global pandemic treaty was finalized in April without the U.S.' involvement. That's going to impact access to data, pathogen access and benefit-sharing. There's so much stuff going on on multiple fronts.

And so in light of the funding cuts, WHO is increasingly relying on donors. The Gates Foundation is stepping up. There's a vaccine integrity project announced here in Minnesota. That's funded by Christy Walton. People are stepping up. But it's not enough to replace federal funding at this time.

And so the other challenge with philanthropists is they have their own set of priorities. And this is going to limit the scope of the response. So we're looking at some real challenges. And I guess I'll stop there.

>> MICHAEL STEIN: I want to make just a few -- since several of you have brought up vaccines, can we make clear to our audience, you expect flu vaccines and COVID vaccines to be offered, yes? Even if they're not perhaps aligned with U.S. population needs through the WHO? We expect them to be continuing, though? Anyone.

>> Are you asking do we believe the U.S. government will continue to align with the WHO?

>> MICHAEL STEIN: No. Do we think that there would be some reason to think that vaccines are going to be unavailable to the population in the next year.

>> LYNN GOLDMAN: I don't see that, but I see an erosion in, for example, will we hear the WHO recommendations? We're not a part of developing them. What will happen to the advisory committee on immunization practices? One thing that wasn't mentioned is that the CDC, under this administration, posted a lot of personal information about the people who have served on that committee.

Basically, the information that comes out of their conflict of interest reports. And they did it in a way that invited doxing and harassment of some of those people. And so I don't see -- and just as at the EPA, a lot of science advisory committee members are being fired and replaced.

People are being put on these advisory committees who are not necessarily, you know, even in favor of or understanding the science behind epidemiology, behind vaccinations. I think we'll have a free market where the companies will make these. They'll be available. We'll have some way of communicating what needs to be done to clinicians.

But it's definitely going to break down the standards of practice that we have now if we have the ACIP, for example, no longer providing clear guidance.

>> MICHAEL STEIN: Do we expect a new policy on requiring placebo testing of new vaccines? Is that going to happen, and is that going to have effects for new vaccines, the use of vaccination?

>> LYNN GOLDMAN: RFK said that. I'm not sure you can get that through an IRB. But I guess they could try to dramatically change who is on the IRB. Our IRB would never allow it. But it shows the extent to which some of our political leadership is willing to dive down into science issues and even research ethics questions that are not necessarily things that they're very familiar with.

>> MICHAEL STEIN: We're going to come around to some positive things. I know this is a tough conversation for people to listen to, because there's a lot of negativity. I think we're going to lay out, sort of, the broad issues and introduce maybe some positive spins on these first hundred days for those of you who are listening.

Just to keep moving us through the things that have happened in these first hundred days, again, thanks, Dean Pettigrew. So, let me turn back to Dean Fallin again.

Talk a little bit about the importance of health equity as the centerpiece of public health as we understand it, and how the unequal distribution of care and benefits remains problematic for all Americans and how health equity speaks to that. Could you start us on that, Dean Fallin?

>> DANIELE FALLIN: Sure. I'm going to start with a little bit of context that is relevant to everything we've heard. We're hearing a lot of really heavy things. And I think for all of us, it's how do we move forward in this moment. And we could spend time talking about what are the areas of opportunity. I talked about dialogue. There are certainly many places where we hopefully can find alignment with Make America Healthy or some of the other initiatives of the current administration.

And we should do that. There are also places where there are things in jeopardy, like you've heard, whether it's HIV, or vaccines, or climate, and many others where that may not fall into where we can find common ground with the current administration, but it's so critical to the public's health that we have to figure out how to fill those gaps.

You will hear about and hopefully are a part of that happening in many areas of HIV surveillance, or maternal and child health work, those kinds of things. We will need to fill those gaps with limited resources that are different than the government resources that were available.

We also need to figure out how to protect our own mental health in this time. That's another thing we could talk about. To answer your question, where that leads in context is we have to get back to anchoring in our purpose. Why did each of you on this call, not just my peers that we're talking to, but each one of you listening today because you care about public health -- what was it that drew you to this field?

What is it about public health that is so meaningful, that created such passion in you? And I think whatever that story is for you, I bet at some point it's anchored in a concept of health equity. The whole idea of health and public health is to have access and the opportunity to health for everyone.

That means when we learned Epidemiology 101, that means addressing people where they are in communities that are being affected. It's respiratory illness amongst people working in coal mines, we focus on them. If it's Mpox happening in communities of men who have sex with men, we work with those communities to help alleviate that issue.

Over and over we can think about the who, what, and where of public health is a health equity question. And so I say this to say we are hearing attacks on "DEI" that are then bleeding over for some into these concepts of health equity. And I think we have to stand our ground. This is a really fortunate area.

There is no separating health equity from public health. And if we think about our purpose, it has to do with this thinking that we all deserve health as a human right. And we all need to work on ways if want to change the metrics in anything, we meet people where they are and who they are. So that's my soapbox.

>> MICHAEL STEIN: That's good. This is an important piece we shouldn't forget as we move forward. Thank you. Thanks very much. Let me go back again -- since there are many people who work in the field, may have been laid off during these times, are feeling the effects of the increased politicization of the federal agencies that still exist.

Let me bring back for Dean Godwin, talk to us a little bit more about the CDC. What's happening with workforce reductions there, how it spills down to the local level, who and what has been lost. And if you could also, maybe talk a little bit about the CDC, which has never been perfect in all its judgments, but has been a trusted voice for listeners to pass along information.

How do we judge things with the changes that might be happening in the CDC, and could the CDC -- are you worried that the CDC becomes a sort of, an additional force for disinformation? So, workforce issues and the change in the workforce that exists within the CDC, can that leave us in a jeopardized state?

>> HILARY GODWIN: Okay. There's a lot there. And I could go to a lot of different places. I will start with the area that I know best, coming from environmental health and safety, which are the cuts to NIOSH, our National Institute for Occupational Safety and Health, which Lynn referred to.

Not because it's the most important, but because I think it's a good example of what we're seeing. So, NIOSH is sort of the basic research counterpart to OSHA, which sets policies and standards. But they're based upon the research that's funded and performed by NIOSH.

So, NIOSH is absolutely critical. The cuts that are going into effect in terms of workforce for NIOSH on June 1st are going to reduce their workforce from about 1400 people to about 150 people. We've also heard that their extramural funding for a number of different programs, but including their education and research centers, which fund training for health and safety professionals across the country, is being halted.

So, I'm trying to dig deep in here to find -- in response to what are we going to do that's positive in response to this, because it's devastating. And it's devastating because while industrial hygiene has really well-paying jobs, part of the way that we've been able to recruit fantastic people into that field, which is absolutely essential to healthy workplaces, is because we have had great support for training for those folks through the ERCs.

So we're struggling with trying to figure out how to deal with that. Washington State, man are we blessed, because we have funding from our state legislature, which hopefully will stay, that also helps to support those research and training activities and essential services in environmental and occupational health and safety.

But we're going to have to figure out how to do that with a much-reduced budget and still meet the needs of our state. So we're struggling. We're trying to figure out what that might look like. I met with an amazing group of faculty from our school yesterday who were deeply committed to healthy workers and healthy workplaces to talk about are there opportunities to partner in new ways with the private sector.

Companies still will need health and safety programs. And will still benefit tremendously from having healthy workers and having workplaces that promote their health and safety. And so how might we pivot to try and work more directly with that private sector in the years to come in a way that will provide continuity in terms of both the knowledge base, but also the people who are needed to support that industry.

So, those are hard conversations and require -- at a time when people are feeling pretty de-moralized and pretty down

trodden, require us to pivot to a more generative space, which is hard. It's just hard right now. So that's one side.

The other side is, I think what I'm seeing is the time that we set aside for those generative activities to say, at some -- we are facing this unprecedented turmoil and change and tumult in our profession.

What are we going to do as agents of positive change to create the healthy future we want to see despite all of that. Stepping into that more generative space allows us to create a little sphere of joy in what is otherwise a pretty challenging time. So, it's not like -- I don't have a great overall solution. I know there was another part to your question, Michael.

>> MICHAEL STEIN: No, that's great. That's very helpful, Hilary. Thanks so much. You know, I heard somebody tell me we have an unprecedented use of the word unprecedented these days. So, it feels -- each of these is a brand new topic. I'm sort of covering the field from topics that we discussed a bit ago.

There are excellent questions. I will get to many of them, so hang on, audience. We're coming to your questions as well. But let me turn now again to Dean Goldman, please. A different topic. So,

Since the Dobbs decision, reproductive issues have been overshadowed by the onslaught of other concerns, but mifepristone remains in the news and courts, as does the care of pregnant women. The Braidwood case involves contraception well. Where are we in reproductive health at the moment?

>> LYNN GOLDMAN: We're in a similar place to where we were before, except there's the possibility and the reality that the administration can pivot some of the cases that have been in the courts, have been about Biden administration legal interpretations that Trump has been able to change overnight. How do you define gender discrimination? Does that include discrimination against trans people?

Under Biden, it did. There was litigation about that. But now under Trump, it doesn't. So the litigation is moot. And actually, even Braidwood, which was brought by this Catholic healthcare organization that objected to having to cover PrEP under the Affordable Care Act rules, because it was recommended by the U.S. Prevention Services Task Force.

And what they've tried to do is say that the task force itself is not constitutional, because these are executive branch-appointed officers. And it seemed -- well, one, the Trump administration actually defended against Braidwood. No one was sure that they were going to do that. We think it's because they do value keeping power within the executive branch. It seems that the court may be leaning against Braidwood, but we'll see how that goes in terms of when their decision comes out.

We could end up continuing to have a task force, even with an administration that gets recommendations that it does not choose to implement. Because it is not a self-forcing mechanism.

I mean, I would say, Michael, in terms of the other issues, a way to think about it -- I served in the Clinton administration. And Vice President Gore set the job of inventing government, trying to fix bad government regulations. And the status quo prior to January was not perfect by any stretch of the imagination.

A lot -- we fixed -- when I was there, fixed the asbestos rules. There were three different sets of rules that OSHA, EPA had. And they were a mess. They were just a mess. And we were able to make them much more performance-based. And we improved things a lot in terms of the cost of compliance with these rules.

And actually doing a better job protecting people. But the approach that's being taken now, which is not an intelligent approach. They're not digging into all the rules and trying to fix them. But there will be an opportunity, because problems like toxic chemicals and pathogens -- all of the things that we've been talking about don't go away just because a lot of people at CDC and EPA are fired.

The problems remain. And there will be a need to rebuild. And I'm thinking that maybe us academics, public health, others, that we could be engaged in a process for being very thoughtful about as these functions are rebuilt, can we be smarter about how we do it. Can we do it better.

Because it has been frustrating for me over the years. We defend the NIOSH and the NIOSH ERCs and the relationship there between EPA and ATSDR and all these different environmental agencies. And the four food safety agencies and all of that. But no one would have designed it that way in the first place.

And maybe we could have a role. When there's the opportunity to bring back public health protection in a stronger way, and better. And ways that are even less burdensome for people. Because there's a lot of unnecessary burden because of all the duplication of efforts across the government.

(Crosstalk)

>> MICHAEL STEIN: No, I think we'll talk a little more about that as we move forward. There have been a bunch of questions about what are the opportunities of the reconstitution period that will follow whenever this assault ends. Let me get to a last question for Dean Pettigrew, and then a broad question. And then I'm going to go into the audience questions.

So, Dean Pettigrew -- this has come up in a bunch of the questions that have come through chat as well. So, communicating with wide audience about public health still remains fraught, as

everybody here has spoken about. And everybody accuses everyone else of partisanship and misinformation and incompleteness.

So, is consensus possible anymore? Are there better ways for public health officials or academics to inform, explain, share expertise, offer advice? Can you talk a little bit about possible consensus? Is there hope there among the opportunities at the moment?

>> MELINDA PETTIGREW: That's a great question. One of the challenges that's been alluded to is that we're really -- we're not reading the same things. We are not communicating in the same spaces. There was an interesting paper published this week in Science. It looked at citations among Democratic and Republican committees between 1995 and 2020 or so.

And they found that Republicans -- Democratic committees were 1.8 times more likely to cite scientific research in their committee work. Interestingly, only 5-6% of the scientific research citations were shared between Democratic and Republican committees. So we're not looking at the same information. So there's a question of, we're getting our information from different sources.

And then there's a trust issue. People need to trust the information that they're getting. And I think Dani mentioned the CDC, or perhaps somebody else did. The majority of people trust the CDC. That was also broken down on partisan lines. We're seeing an uptick in trust of the CDC amongst Republicans and Democrats foresee they're going to trust the CDC less because of all the stuff that's going on.

So, it's a really challenging environment. But you asked if there was any potential for consensus. And I do think there is consensus on issues. There's broad support for issues like preventing chronic diseases, maternal and child health, pandemics, reducing infant mortality.

And so these are spaces that we can work in. Then there are other areas as Dani mentioned that are polarized. This is where the work is going to be really hard. Dani mentioned this need to discuss, dialogue, speaking across difference. We also have to remember that even within these broad categories -- this is hard in public health, because we think about populations.

These groups are not monolithic. Really going to have to think about tailoring communication strategies. And that's going to require a lot more listening to what people's challenges, concerns are. There are a lot of people that have felt abandoned by the systems. They don't feel like they're listened to in the way that they're actually being heard.

And so we're going to have to do that work. I think in term of areas for hope, that's where I think the next generation of public health leaders, the students is a place where I'm

optimistic. They are much more savvy with social media than perhaps some of us on this call. And so I think we should also be listening to them for ideas.

How do we engage them with our ideas? I think we can create structures in academic public health and around the curriculum, provide spaces for dialogue. We can provide information about public health communication, effective strategies. And I think we also need to work with the students and emerging public health leaders. They are going to be much more agile and adept at managing a lot of these communications, which are taking space increasingly in social media. So, bit of optimism. But it's really challenging moving forward.

>> MICHAEL STEIN: Yeah. I think what we've seen a lot is the, sort of, force of what some people have called old power. And that these new forms of social media, which involve, sort of, broad segments of the population that get together in their own ways is a sort of new form of power. And sometimes that power is in the interest of public health, perhaps, and sometimes it's against the interest of what many of us on the call would consider public health.

But in any case, there are different forms of power and ways for people in the general population to get involved in this. So, again, let me stop for a moment and ask you, for our new public health graduates, it is that part of the season in our academic institutions, and for our alums, particularly for those who worked until recently in government positions and are still going to face a tight market in '25.

Tell us how you see their prospects even as they retain their sense of purpose about the importance of public health. How can public health come back stronger during and after this political pummeling that's going on right now? How do you speak to our graduates and alums these days?

>> DANIELE FALLIN: It echoes things you've already heard from Melinda, Lynn, and Hilary. First is the important work will still exist. Lynn mentioned this. If we stop paying to attention to things, doesn't mean they don't happen. Our work of public health will exist and actually be greater in some areas.

It also is an opportunity -- I think it was Lynn or others, including Hilary and Lynn who said -- but there will be opportunities to do things better, to learn from the mistakes we made even before this current crisis, to reshape what will come next. And our students are really savvy. They're closer to their purpose. I mentioned earlier why did you get into this field.

They're closer to that first a-ha moment and passion. They are closer to the new ways of communication and persuasion. And they are creative and innovative in ways that my 50 something-year-old self is still hoping to do, but much better

at it. All of those things give me real hope and are exciting because our students now are going to be a part of that reshaping of the public health future in the U.S. and globally.

One thing I want to highlight that it sounded like Hilary's team was doing with respect to workplace health is we have already as a field, but even now really focused on multi-sector engagement of our students and alumni.

And absolutely we will continue to feed the government workforce. There are local and state, and tribal workforces, and federal workforces that do still exist, although depleted. But there are corporations who are recognizing the importance of doing both employee health, as well as the community that they serve health engagement.

And there are all kinds of other sectors -- tech, pharmaceuticals, all kinds of things -- that are using the skills that our students are gaining to really influence the public's health. We've got to keep broadening the horizons of where employment opportunities exist. And more than employment opportunities, where are impact opportunities for our folks.

>> MICHAEL STEIN: Others, advice for those in the field?

>> LYNN GOLDMAN: The view of public health, graduates going in government, at least at my school, that hasn't been true for a long time. And we're in Washington. I looked over the last few years worth of data and it's in the range of 10-15% who go into government jobs, even though that's the perception that that's who we're training.

But I would not minimize the impact of all the people losing their jobs in the government on the job market. And I do think that we're reaching out to our upcoming graduates, trying to work with them to intensify career services. I think all the schools are probably doing that. I see the ASPPH, our organization, doing that. To be realistic, the market is going to be tough, because where maybe before they could apply for a job at pharma, now they've got competition from somebody who's been at FDA or CDC.

It could be a leg up. Or they could appear to be overqualified. How that will work out just depends on where they are. A lot of the people who have immediately lost their jobs have been people who were recent hires, who were on probation still. And they're just easy to, without any due process, to let go of. Those are the people who are probably the most competitive for the jobs of our most recent graduates. Some of them are our recent alumni.

And so, I think we have to be realistic that this is a tough time for our graduates. And we have to double down on helping them. And even though we can eventually see recovery coming, that doesn't mean that this May, this June, this July,

it's not going to be one of the toughest times in terms of helping them get placed into jobs.

>> HILARY GODWIN: I would agree with everything that Dani and Lynn have said. And, emphasize that our public health degrees -- particularly undergraduate public health degrees and MPH degrees are designed to prepare students for a broad range of careers. And as a result, we really have focused on transferable skills that I think are valuable in a broad range of different sectors and types of jobs, intentionally.

Things like how to authentically engage with stakeholders, proficiency in data science. So, I think, you know, I am confident that our students are graduating with skills that are going to be useful for a broad range of different careers. I think our job within schools of public health are to help them make those connections in perhaps sectors where we haven't been placing as many students in the past.

But particularly private sector areas, where the private sector is likely to step into a vacuum created by lack of federal funding and support, and research, and expertise. So, I think that's one. And some of what we've been talking about with our students and our faculty is how do we help students think about the differences in how to present themselves, but also the skills -- some fine-tuning of the skill sets of applying for private sector jobs versus government jobs, and helping them be very intentional about thinking about which of those skills they might want to emphasize more now than ever.

I also have been saying to students something that I think is worth sharing, which is that it's pretty unusual even for us old timers to be in the jobs that we were in when we first graduated with our degrees. (Laughing) And so while they may have dreamt of working for the CDC, they could also view their first job out of their degree, or first couple of jobs as a continuation of their training.

Many of us learn some of our most useful skills on the job. And be thinking strategically about what will be needed in terms of expertise to rebuild the new public health system. That is going to have to emerge. It's not going to happen in the fall. I think it's a ways off. But that also, the expertise that they might bring from the private sector in terms of focus on agility and innovation, and technological expertise -- those are things that will make for a much stronger public health system when we're ready for them to rebuild it than what we have right now. I would never have chosen this pathway towards the stronger system, but we will need them when we get to that point.

>> MICHAEL STEIN: So let me push the group a little bit. So where do you see the private sector stepping into the holes that

are left behind, in the short run? Will there be a job compensation or substitution in the private sector?

>> LYNN GOLDMAN: They've always been eager to hire many of our graduates. We teach them excellent skills in data sciences, communication, and management. The kinds of things that are transferable in a lot of health and healthcare situations. I don't see them necessarily expanding those.

But I do think that we're seeing, across the country, a transition in terms of the aging of the Baby Boomer generation and openings in the job market that are a consequence of that. And many millennials starting to retire, which is amazing. (Laughing)

So, I think that there are jobs, because our students have been getting these jobs. But as I said before, I think there will be more competition. And there might be a need for them to be more creative and broader.

For example, in government jobs that are not public health, but there are many government jobs that are adjacent to public health that people with public health degrees with be very effective in doing. And so we're going to do our best to provide the support, but as Hilary said, eventually down the line we're going to be hoping that they will find that they have mobility and maybe if that first job isn't exactly the job they wanted, they will have mobility into the next position.

>> HILARY GODWIN: I can give specific examples of ones that come to mind. I think this is exactly what some members of the administration say they don't want, but I think that we will probably see, due to the degradation of federal research funding for clinical trials, I think we will likely see some of that work shifting more to the private sector and to pharma that has been conducted for good reasons in academic settings.

And so they are going to need the kind of expertise that our biostats and epi folks have. That's an obvious one where that need is not going to go away. Another really obvious one is disaster resilience and response. The natural disasters are increasing in frequency. They're not going to go away just because of a lack of federal funding and support for that.

So that's going to create a vacuum. And there will be some private sector entity that will come in to fill that space. And our graduates are well-positioned to be helping to set up that new sector as it emerges.

>> MICHAEL STEIN: Very helpful. That's great. Melinda, Dani, any other thoughts on jobs for the job listeners?

>> MELINDA PETTIGREW: I agree with everything that's been said. I've been hearing lots more conversations about other degrees. And so if people can't go immediately into the

workforce, they have these transferable skills, how could a public health degree be combined with something else.

So, talking about going to law school and having that public health lense with a law degree. Additional education in medicine, those types of things. So I don't know how much that will play out, but definitely having conversations about that.

I do want to -- just to reiterate something Hilary said earlier, I think we just really need to continue to communicate. When I listen to people talk about their career paths, it's never linear. So people move around. None of us thought we would be sitting in these roles. And the world is changing very fast now. And I think the pace of change is picking up.

And so I do think that our students are very creative. And so they come up with these job categories that aren't even on my mind, like Instagram influencer and those types of things. So I do think there'll be more work in the private sector and pharma, those types of things.

I also think we're going to see interesting new professions coming out based on the passion and creativity of the students that we're training and all the new tools that are at their disposal.

>> MICHAEL STEIN: That's great. A little generational positivity. We could use that here. So, the columnist David Brooks said, you know, this administration has all the wrong answers to all the right questions. So, are there some right questions that this administration as asked of public health, or put the other way, can you talk about something positive in these first hundred days that we've learned in the feel of public health?

>> LYNN GOLDMAN: I have one thing. (Laughing) So, as somebody who cares about kids and toxic chemicals, the fact that under FDA food law it's been okay that industrial chemicals that make food brightly colored can be put in food marketed to our children without having been tested. And that some of them end up being toxic, but because of how the law is written, they're on a list called generally recognized as safe, which is crazy.

And that the secretary of HHS has said these six ones of these are going to be banned. And then he said I'm going to work with the industry to voluntarily get them out of the food supply, which is a little less powerful. However, I do know when you threaten to ban a chemical, that oftentimes people will work with you to voluntarily reduce them.

I had that experience myself as a regulator. And it does make me happy to see an agency leader who cares about this. This has been a travesty for years and an example of why our current system is not perfect by any stretch of the imagination. And so

like David Brooks said, it's the right issue. They might be approaching it in the wrong way.

I think probably the law needs to actually be changed, possibly. But I do think that it's crazy to use our children as experimental animals. We're just going to expose them to these chemicals and then find out if it does anything bad to them. That is nuts.

>> DANIELE FALLIN: We cohosted a Gallup poll in December, after the election but before the inauguration to ask Americans across the country, what do you want this new administration to prioritize in health. And the top three were chronic disease, safe food and water, and access to healthcare.

And those top two I think are opportunities to align with what we're hearing. In terms of asking the right questions, the struggle is whether we're getting the right answers. But those questions do seem to be aligned deeply with what a general set of Americans think are important to pursue.

I think it's back to this leaning in in dialogue. It is our responsibility to help figure out how to shape getting the right answers, because some of those questions are high-priority questions for the general population. So I think that's good news. I think that's an opportunity.

>> MICHAEL STEIN: People have noted, Dani, that your comment about honoring the common ground idea for these conversations is important. Are there strategies that any of you are using, either with contrary opinioned people, or even within your worlds that might be closer to your opinions to manage these? What strategies are you using?

>> DANIELE FALLIN: So, we had a series of trainings for our faculty, staff, and students here. And now have a fellows program of ambassadors who then continue to do these trainings and support folks. And then some practice in small groups of doing this work.

And one of the things that was cool about that that we could take further, which gets to your point is, these are hard. They're really hard because even as I'm talking to you I get fired up when I'm really frustrated with someplace that isn't going the right direction. Or I get really sad. Or I get nervous. Whatever those things are.

One of the aspects of that training was about self-management, self-awareness and regulation as you enter these difficult things. Because if we're not monitoring ourself and being able to show up in that difficulty, managing ourselves well, it's hard to do a good job in that dialogue.

And that's not usually part of those trainings. But that was really powerful for our teams to start with that and then move to the active listening, and showing up with empathy, and

looking with curiosity on what you can do together, which are more typically part of those trainings. And then the practice part. It's not enough to do a 90-minute training. You've got to find ways to practice this if we want to do this work.

>> MICHAEL STEIN: Anyone else on that topic? Otherwise, I'll keep going through some of the good chat questions. So, one of the listeners thought that we were suggesting that public health was just another career path and we should just be looking around for other careers, finding some other job. I don't think any of you quite meant that, the fact that we opened the conversation to there would be opportunities outside of the 10-15% from Dean Goldman's school that might enter the government, right? None of us are abandoning public health. It's the important work to do. Thank you.

>> HILARY GODWIN: To that, Michael, I was more suggesting for many of us -- not everybody -- but we viewed private sector as a lesser than opportunity. And it's a time for us as a discipline, I think, to just reassess our existing biases. We all have them. And to think about what are the opportunities by working in the private sector to have dramatic and positive impacts on people's health, to accomplish the kind of goals that we're all interested in, and also to gather some important skills that we haven't emphasized as much within the field of public health traditionally, and bring those back to our discipline to make our discipline stronger. So that was more what I was suggesting.

>> MICHAEL STEIN: Great. I just wanted to clarify that for the listeners. We are pro public health on this call. But talking about, sort of, teaching and new skills, and maybe these are old skills. But do we think that public health programs should be teaching political advocacy so that students are politically engaged, able to defend and promote public health, savvy in that way?

Is that something that is a new part of your curriculum, an old part, a part that's growing? Shouldn't it be in the curriculum? How do you all think about teaching political advocacy per se?

>> LYNN GOLDMAN: For us, it's old, but it's not in our MPH core, not something that everybody learns. It is in the core of one of our departments, prevention and community health. And it kind of is part of the overall teachings that they do on communications, on marketing, on working with communities.

And I would also say in health policy we teach it, but in a different way. We teach about how the political system works, the role of advocacy in that. And to be honest, many of our faculty do work for hire that supports advocacy efforts.

But -- like research that provides data that's useful say in the context of reproductive health, or Medicaid cutbacks.

How is that going to impact the health of people across the country. We do a lot of work like that, which is different than being the advocate, but it's advocacy-adjacent work that is kind of important for us to be doing.

>> HILARY GODWIN: Yeah. I 100% agree with you, Lynn. That's part and parcel of what we have been teaching. But in the same sense that I also feel like we've been teaching communicating to diverse audiences, and yet we're also in this moment saying, but are we reaching all of the diverse audiences?

And so in the case of advocacy, I think my sense has been we have been trying to confer that skill. And, we could be doing a better job overall as a discipline of helping our students place that in a larger context of how to create societal change, and the many different pathways for creating societal change, so that they feel like they have a really robust toolbox and an understanding of which tools to use when.

And I don't say that with like I've got it all figured out. I feel like it's something that I keep coming back to over the last couple months. I feel very challenged by the current circumstances of what is the appropriate response in the moment to many of the different things that we're experiencing. And I think we as a community would benefit from this broader discussion about what are some of the strategies we maybe don't use as commonly but that we might pivot to in this moment. I feel like that's a rich conversation that I would love to be having as a public health community.

>> MELINDA PETTIGREW: I can jump in. Like Lynn, I think we do a lot of that work here. And how it looks is different. So students in health policy might go to the legislature as part of a class and those types of things. In community health, they do a lot of work out in the communities.

I think in getting to Hilary's point, what I'd love to think about more is what's in this academic structure. One of the things we struggle with is we have a lot of -- this is a professional degree. And a lot of the classes that we have are taught by academics who have been in academia for a very long time. So, really thinking about how we get more outside experts who are working in these spaces involved on a closer basis with our students and in our classes so that they can have these experiences.

So it's not just being taught by the scholars, but the people who are out there doing the work. So, thinking creatively about who's teaching our classes, or how we're partnering with people doing the work in the classroom would be something I'd love to hear more ideas about, because that's a bit challenging

with some of the structures that we have in place. And I think we could be doing more and better in that area.

>> DANIELE FALLIN: Building on that, what we've tried in the last year and a half is bringing our own government affairs professionals to come meet with our students to explain to them what they have seen as pervasive in an advocacy setting. And it speaks to the idea of what does it look like to someone who's not a nonbeliever yet in public health when you make these arguments and what are the right avenues to spend your energy on. And they're at most of our universities already.

>> MICHAEL STEIN: We're coming to the last few minutes. Can we turn back again to this topic of language a little bit? Is there something about these terms that we use so easily on this call -- political advocacy, health equity, etc. -- that are throwing people outside of our world off and tipping them away from us?

Is there a need for us to explain things differently, use different words? Any other thoughts on that topic? It's obviously enveloped our DEI conversation and what those words mean. Any final thoughts about language? Which has to do with persuasion as well.

>> LYNN GOLDMAN: I think the polling that Dani and her group is doing is really important. But I also think there's been a lot of intensive self-examination going on in public health about to what extent the loss of trust in public health is our fault. That the way we have communicated has been out of touch.

And I think that we do have to be honest. And sometimes we have not been in touch. I had last year with one of these reproductive health issues, somebody who works at my school who said that I should refer to people who are pregnant instead of as being women who are pregnant, person, which I think a lot of people do not actually well-connect with that kind of terminology. I'm just going to be frank.

I know offends a lot of people. I know a lot of people don't want to hear that. But even to say a pregnant person with a uterus -- and who's going to be pregnant if they don't have a uterus? We've gotten wrapped around how we're using words in a way that is not necessarily the clearest way or even the most acceptable way to communicate to everybody.

But I also think that we have been unaware of the extent to which the pandemic impacted people economically. And that the need that a lot of people have had to try to find someone to blame for that. And I've been mystified by all of the focus on where did it come from. Did it come from that lab in Wuhan. The NIH was supporting. Why is that so important?

From my perspective I don't care where it came from, I just want to save people's lives. But for many people, they felt so injured. And the sense of -- rather than just blaming a virus, to find people to blame. And I really don't think that we understood that that was happening in real time.

And so there's a lot of healing that needs to be done. And it doesn't mean it's our fault that we ended up in this place. I just want to say that.

>> MELINDA PETTIGREW: I've been thinking about words. I agree. There's some words that we use and they really immediately shut down the conversation. We need to think about that and be more open to changing the words. People who work in gun violence may have had to use the term youth violence instead of using the word guns.

There are places where we can change our language. I also worry about when we change the words and it erases people's history and identity, and culture. And there are times when words really matter. And so I think there also has to be a careful consideration of where that line is.

And there's room for change. And then there's also -- I think sometimes if we change the words it'll negatively impact the science. It will alienate some of the most marginalized groups that we want to represent. So maybe case by case basis, but each of us has to reflect on where those lines are for us. There's space for flexibility and where we have to take a stand, I think.

>> MICHAEL STEIN: What a perfect place to end. Self-reflection and flexibility. So that's a great place to wrap up the discussion. So, thank you very much again for joining us today. To our esteemed panelist, to our audience, it's been an honor to speak to this group again. Maybe we'll try one more time in the months ahead, bring you back later in the year. But it's lovely to see you. Thanks for being here today. Have a good afternoon, everyone.

>> Record --

(Session concluded at 2:30 p.m. ET)