Achieving A Fair and Effective COVID-19 Response: An Open Letter to Vice-President Mike Pence, and Other Federal, State and Local Leaders from Public Health and Legal Experts in the United States

Sustained human-to-human transmission of the novel coronavirus in the United States (US) appears today inevitable. The extent and impact of the outbreak in the US is difficult to predict and will depend crucially on how policymakers and leaders react. It will depend particularly on whether there is adequate funding and support for the response; fair and effective management of surging health care demand; careful and evidence-based mitigation of public fear; and necessary support and resources for fair and effective infection control.

A successful American response to the COVID-19 pandemic must protect the health and human rights of everyone in the US. One of the greatest challenges ahead is to make sure that the burdens of COVID-19, and our response measures, do not fall unfairly on people in society who are vulnerable because of their economic, social, or health status.

We write as experts in public health, law, and human rights, with experience in previous pandemic responses, to set forth principles and practices that should guide the efforts against COVID-19 in the US. It is essential that all institutions, public and private, address the following critical concerns through new legislation, institutional policies, leadership and spending.

ADEQUATE FUNDING AND SUPPORT FOR THE RESPONSE MUST BE PROVIDED

- Federal, state and local governments should act immediately to allocate funds to ensure that necessary measures can be carried out and that basic human needs continue to be met as the epidemic unfolds. Mitigating the impact of COVID-19 will be costly. Uneven distribution of resources will compromise collective control efforts and lead to unnecessary suffering and death. A major emergency congressional appropriation must be made for epidemic control and signed by the President, with quick disbursement to state and local actors on the frontlines of the response. In addition, these must be new funds that do not cannibalize existing health and safety net programs, nor social service programs, which are integral to protecting the public health in the long term.

- The federal government and federal, local, and state agencies must minimize disruption to government activities throughout the epidemic to continue providing public services to those who need them. Government must have a coordinated plan for keeping its operations running in the event of work absences. Priority should be given to essential services and support to the public, for example ensuring that Social Security, veterans’ and other benefits are not disrupted.

SURGING HEALTHCARE DEMAND MUST BE MANAGED AND PATIENTS AND HEALTHCARE WORKERS PROTECTED

- Our healthcare system will face severe burdens under all plausible scenarios. Hospitals must receive direct funding and adequate resources for enhanced surge capacity in order to handle the front-line response. Particular attention and funding must also be directed to primary care facilities and community health centers, especially those that are currently under-resourced even under normal circumstances. These front-line sites of healthcare provision need to act as gatekeepers to prevent the overburdening of tertiary hospitals and other acute care facilities and require support to allow them to fulfill this crucial role.

- Healthcare workers and other first responders will be critical to the response. We must ensure their safety and give them fair working conditions. Healthcare workers must, for example, be given adequate
protective equipment, be afforded reasonable respite, and be protected from discrimination arising out of their work with infected patients.

- **Healthcare facilities must be immigration enforcement-free zones so that immigration status does not prevent a person from seeking care.** The COVID-19 response should not be linked to immigration enforcement in any manner. It will undermine individual and collective health if individuals do not feel safe to utilize care and respond to inquiries from public health officials, for example during contact tracing. Similar enforcement-free zones have been declared during hurricanes and other emergencies, including after the September 11 terrorist attacks. These policies should be clearly and unequivocally articulated to the public by the federal, state, and local governments.

- **Policymakers must work directly with insurance companies to allow all insured individuals to adhere to public health recommendations.** It will be critical for policymakers to ensure comprehensive and affordable access to testing, including for the uninsured. Control efforts will be less effective if some fail to seek appropriate diagnosis or care due to large out-of-pocket costs or copays. Out-of-network or other insurance provisions cannot be allowed to disrupt local triage and patient allocation plans.

- **If therapeutics or vaccines are developed, policymakers must assure that they are affordable and available to all.**

- **People residing in close living quarters are especially vulnerable to COVID-19 and will need special attention both to minimize transmission risk and address their healthcare needs in the context of an outbreak.** These populations include those living in nursing homes or other congregate facilities; incarcerated populations in prisons, jails, and other detention facilities along with corrections officers and other personnel; the homeless living on the streets or in homeless shelters.

- **Other critical healthcare programs must be maintained during this crisis.** People with chronic conditions depend on continuity of care to maintain their health. Whether it is dialysis for kidney disease, chemotherapy for cancer, or opioid agonist therapy for opioid use disorder, lapses in these programs can have disastrous implications for patients.

**CLEAR, EVIDENCE-BASED COMMUNICATION IS CRITICAL TO MANAGE PUBLIC FEAR**

- **Science needs to guide messaging to the public, and no government official should make misleading or unfounded statements, nor pressure others to do so.** Honest, transparent, and timely reporting of developments will be crucial to maintaining public trust and cooperation. Suppression of information and attempts to manipulate it during the SARS epidemic in China exacerbated the crisis. Clear, coherent, and uncontradictory messaging based on the best science will improve compliance and effectiveness of voluntary self-isolation, and other voluntary social distancing measures.

- **Government and institutions must also actively prevent discrimination and scapegoating of individuals or groups.** In the context of COVID-19, Chinese-American and other Asian-American communities have already begun to face attacks on individuals linked to fears about the virus. The

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2 Kavanagh, A.M., Bentley, R.J., Mason, K.E., et al. Sources, perceived usefulness and understanding of information disseminated to families who entered home quarantine during the H1N1 pandemic in Victoria, Australia: a cross-sectional study. *BMC Infect Dis* 2011; 11(2).
Centers for Disease Control and Prevention (CDC) has pointed out that such fears and misconceptions create "more fear or anger towards ordinary people instead of the disease that is causing the problem." Local, state and federal officials should speak out against discrimination and stigma, and not use the outbreak to stoke xenophobia against Asian-Americans, other immigrant communities, and religious groups, for example.

- Leaders should refrain from offering false assurances and should act aggressively to correct misinformation, especially that which can incite panic and lead to hoarding of supplies and protective equipment. Governments must also provide comprehensive advice on best practices during epidemics, including proper personal hygiene and stocking up on, but not hoarding, needed supplies such as personal medications.

SUPPORT AND RESOURCES MUST BE PROVIDED FOR FAIR AND EFFECTIVE INFECTION CONTROL

- The highest priority needs to be placed on allowing people to voluntarily cooperate with public health advice about prevention, by providing robust social and economic support and clear education. Where social distancing measures are recommended, the government and relevant institutions should help ensure that people are in a position to comply, without excessive or unfairly distributed hardship. For example:
  - To enable people to cooperate with social distancing and other measures, policymakers must ensure that people are protected from job loss, economic hardship, and undue burden. If people are asked to avoid public transport or work, policymakers and employers should give them an explicit incentive to stay home, either with payments or by compensation for lost wages, as has been done elsewhere. Individuals will not cooperate with self-isolation or other voluntary social distancing measures if they are unable to provide for themselves and their families. For low-wage, gig-economy, and non-salaried workers, staying home from work has especially critical implications for economic survival.
  - The elderly and disabled are at particular risk when their daily lives and support systems are disrupted. Many have limited resources and depend on others to assist with care. Policymakers must explicitly accommodate these populations when making self-isolation recommendations.

- Policymakers should base decisions on social distancing measures and closures on the best available science. Employers, institutions, and schools should proactively determine adaptations and accommodations for closures (e.g. tele-communication or virtual education). These measures have been effective in mitigating the transmission of influenza. The abundance of evidence about influenza can help inform control efforts, but it will be important to recognize differences in the epidemiology of the diseases.

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6 For example, Britain’s Health Secretary Matt Hancock sent guidance to tell employers that staff who have been asked to self-isolate must be able to clock that time as sick leave. See "Coronavirus UK: will I get paid if I take sick leave?", Guardian (Feb. 26, 2020), https://www.theguardian.com/world/2020/feb/26/coronavirus-uk-will-paid-take-sick-leave.
• **Special attention must be paid to the needs of people in long-term care or confinement, who are particularly vulnerable.** People in nursing homes or long-term care facilities, as well as those who are incarcerated or homeless, are at special risk of infection, given their living situations. These individuals may also be less able to participate in proactive measures to keep themselves safe, and infection control is challenging in these settings. Arrest and short-term incarceration can help amplify epidemics, and broader criminal justice policies should take into account the impact that policing and arrest policies have on health.

• **Mandatory quarantine, regional lockdowns, and travel bans have been used to address the risk of COVID-19 in the US and abroad. But they are difficult to implement, can undermine public trust, have large societal costs and, importantly, disproportionately affect the most vulnerable segments in our communities.** Such measures can be effective only under specific circumstances. All such measures must be guided by science, with appropriate protection of the rights of those impacted. Infringements on liberties need to be proportional to the risk presented by those affected, scientifically sound, transparent to the public, least restrictive means to protect public health, and regularly revisited to ensure that they are still needed as the epidemic evolves.  

• **Voluntary self-isolation measures are more likely to induce cooperation and protect public trust than coercive measures, and are more likely to prevent attempts to avoid contact with the healthcare system.** For mandatory quarantines to be effective and therefore scientifically and legally justified, three main criteria must be satisfied: 1) the disease has to be transmissible in its presymptomatic or early symptomatic stages; 2) those who may have been exposed to COVID-19 must be able to be efficiently and effectively identified; and 3) those people must comply with the conditions of quarantine. There is evidence that COVID-19 is transmitted in its pre-symptomatic or early symptomatic stages. However, the contribution of infected individuals in their pre-symptomatic or early symptomatic stages to overall transmission is unknown. Efficiently identifying those exposed will be increasingly difficult as community transmission of the virus becomes more widespread, making quarantine a less plausible measure as community spread proceeds. Whether individuals can comply will be determined by the degree of support provided, particularly for low-wage workers and other vulnerable communities. While quarantines are in effect in many places already, their continuing and new use by federal, state or local officials requires real-time assessment and evaluation to justify them as the science and the outbreak evolve, through a transparent, open decision-making process including external scientific and legal experts.

• **Public health officials must provide safe and humane conditions to individuals who are quarantined whether in homes, facilities, or communities.** Government must ensure that anyone isolated or quarantined has access to the basic necessities, including food, water, medicine, and sanitation supplies. Assistance should be provided to individuals who are in need of support to maintain daily living, and attention must be given to religious and communication needs. The failure to do so will undermine

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trust, adherence to the intervention, and the overall effectiveness of quarantine. It will also be imperative not to impose inhumane or discriminatory conditions, as occurred on the Diamond Princess cruise ship, where passengers were quarantined to protect the population on land but were isolated in a high transmission setting. Furthermore, safe and humane conditions need to be provided to all quarantined individuals and do not differentiate between social or economic strata, or in the case of the Princess Diamond, between passengers and workers.

- Where mandatory measures are used, steps must be taken to ensure that people are protected from job loss, economic hardship, and undue burden. Government and employers must recognize that low-wage, gig-economy, and non-salaried workers who are unable to work because of quarantine or movement restrictions or other disruptions to the economy and public life face extraordinary challenges. They may find it impossible to meet their basic needs, or those of their family.

- Individuals must be empowered to understand and act upon their rights. Information should be provided on the justification of any mandatory restrictions as well as how and where to appeal such decisions. They should be afforded procedural due process, including universal access to legal counsel, to ensure their claims of discrimination or of hazardous conditions associated with their confinement are adjudicated.

- The effectiveness of regional lockdowns and travel bans depends on many variables, and also decreases in the later stages of an outbreak. Though the evidence is preliminary, a recent modeling study suggests that in China these measures may have mitigated but not contained the spread of the COVID-19 epidemic, delaying it locally by a few days, while having a more marked, though still modest, effect at the international scale, particularly if not combined with measures that achieved at least 50% reduction of transmission in the community. Travel restrictions also cause known harms, such as the disruption of supply chains for essential commodities. The authors of a recent review of research on the subject concluded that “the effectiveness of travel bans is mostly unknown” and “when assessing the need for, and validity of, a travel ban, given the limited evidence, it’s important to ask if it is the least restrictive measure that still protects the public’s health, and even if it is, we should be asking that question repeatedly, and often.”

The COVID-19 outbreak is unprecedented in recent American history, and there is no playbook for an epidemiological event of this scope and magnitude. To mitigate its impact, you must act swiftly, fairly, and effectively. We urge you to take these recommendations seriously and act urgently so that we are best protected from the damage of this unprecedented microbial threat and the possible harms of an uninformed or poorly conceived response.

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The letter will be sent to federal officials midday on Monday, March 2nd, but it will remain open for sign-ons at https://forms.gle/gxwhVkm3PnvFMCCr7. The online version of the letter will be updated every 24 hours as new endorsements come in. Please include your name, title and affiliation, which you can fill in at the bottom of the form at the link above. If you do not see your name listed 24 hours after you submit, please email covid19.openletter@gmail.com.

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178. Amelia Reese Masterson, Researcher, Community Alliance for Research and Engagement, Yale School of Public Health & Southern Connecticut State University
179. Carole H. Browner, Distinguished Research Professor, Center for Culture and Health, Semel Institute for Neuroscience and Human Behavior, Department of Anthropology, Department of Gender Studies, University of California, Los Angeles
180. Mary Crippen, Outreach Manager, Bronx Regional Health Information Organization
181. Caroline Jean Acker, Professor Emerita of History, Carnegie Mellon University
182. Erika Sabbath, Assistant Professor, Boston College School of Social Work
183. Dean Schillinger, University of California San Francisco, Professor of Medicine; Director, UCSF Health Communications Research Program
184. Ana Santos Rutschman, Assistant Professor of Law, Center for Health Law Studies, Saint Louis University School of Law
185. Agnes Usoro, Johns Hopkins University, Department of Emergency Medicine
186. Elizabeth Pendo, Joseph J. Simeone Professor of Law, Saint Louis University School of Law
187. John R. Stone, Professor, Creighton University, Dept. of Interdisciplinary Studies, Graduate Program in Bioethics, Dept. of Medicine, School of Medicine
188. Jacob Gross, Tufts University, Vice President of Tufts Public Health Society
189. Naomi Rogers, Professor of the History of Medicine, Yale School of Medicine
190. Jesse A. Goldner, John D. Valentine Professor of Law Emeritus, Center for Health Law Studies, Saint Louis University
191. Parveen Parmar, Associate Professor, Clinical Emergency Medicine; Chief, Division of Global Emergency Medicine, Keck School of Medicine, University of Southern California
192. Robert L. Cohen, NYC Board of Correction
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194. Mardge Cohen, Boston Health Care For the Homeless
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198. Christina Nicolaides, Professor and Senior Scholar in Social Determinants of Health, School of Social Work, Portland State University (PSU); Adjunct Associate Professor, Department of Medicine, Oregon Health and Science University (OHSU) and the OHSU-PSU School of Public Health
199. Lee Riley, School of Public Health, University of California, Berkeley
200. Eva Raphael, Dept of Family and Community Medicine, UCSF
201. Eric Nilles, Director, Program on Infectious Diseases and Epidemics, Harvard Humanitarian Initiative; Assistant Professor, Harvard Medical School; Attending Physician, Department of Emergency Medicine, Brigham and Women’s Hospital
202. Steven Galinat, JD Candidate, Temple University Beasley School of Law
203. Mary E. Wilson, Clinical Professor of Epidemiology and Biostatistics, School of Medicine, University of California, San Francisco; Adjunct Professor of Global Health and Population, Harvard T.H. Chan School of Public Health, Boston, Massachusetts
204. Trude Bennett, Associate Professor Emerita, Department of Maternal and Child Health, Gillings School of Global Public Health, University of North Carolina at Chapel Hill
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209. Gregory R. Wagner, Harvard T.H. Chan School of Public Health; National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention (retired)
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212. Mary E. Bushman, Research Fellow, Center for Communicable Disease Dynamics, Department of Epidemiology, Harvard T.H. Chan School of Public Health
213. Jason Harris, Chief, Division of Global Health; Associate Professor of Pediatrics, Harvard Medical School
214. Robert, Dubrow, Professor of Epidemiology, Department of Environmental Health Sciences, Yale School of Public Health
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217. Eva Harris, Professor, Division of Infectious Diseases and Vaccinology; Director, Center for Global Public Health, School of Public Health, University of California, Berkeley
218. Jean Lim, Associate Professor, Icahn school of medicine at Mount Sinai
219. JD Davids, Health Journalist, The Cranky Queer Guide to Chronic Illness
220. Sarah S. Bradley, Professor of Practice, Portland State University School of Social Work
221. Raina Plowright, Assistant Professor of Epidemiology, Department of Microbiology and Immunology, Montana State University
222. Juan C Salazar, Professor and Chair, Department of Pediatrics, UConn School of Medicine; Physician in Chief, Connecticut Children's Medical Center
223. Professor Rebecca Jordan-Young, WGSS, Barnard College; Director, Science and Social Differences Working Group, Columbia University
224. Jane E. Koehler, Professor of Medicine, Div. of Infectious Diseases, UCSF
225. Akiko Iwasaki, Professor of Immunobiology, Molecular Cellular and Developmental Biology and Dermatology, Yale University School of Medicine
226. Eugene Shapiro, Professor of Pediatrics and of Epidemiology, Yale University
227. Seth Alan Clark, Attending Physician; Assistant professor of Medicine and Psychiatry and Human Behavior, Alpert Medical School, Brown University
228. Nicole Angotti, Assistant Professor of Sociology, Department of Sociology and Research Fellow, Center on Health, Risk and Society, American University
229. Charles S. Dela Cruz, Section of Pulmonary, Critical Care and Sleep Medicine, Department of Internal Medicine; Director, Center of Pulmonary Infection Research and Treatment, Yale School of Medicine
230. Alexander M. Capron, University Professor & Scott H. Bice Chair in Healthcare Law, Policy and Ethics, Gould School of Law and Keck School of Medicine, University of Southern California
231. Richard Bucala, Chief, Division of Rheumatology, Allergy & Immunology; Professor of Medicine, Yale School of Medicine
232. Susan L. Bickford, Professor of Mathematics, El Camino College
233. Donald Weinbaum, President, New Jersey Public Health Association
234. Arthur Reingold, Professor and Division Head, School of Public Health, University of California, Berkeley
235. Ruslan Medzhitov, Sterling Professor, Department of Immunobiology, Yale University School of Medicine
236. Joseph L Graves Jr., Professor of Biological Sciences, Dept. of Nanoengineering, Joint School of Nanoscience & Nanoengineering, North Carolina, A&T University and UNC Greensboro
237. Eran Bendavid, Associate Professor of Medicine, Stanford University
238. Howard P. Forman, Professor of Public Health, Radiology, and Management, Yale University.
239. Richard Skolnik, Former Lecturer Yale School of Public Health and the Yale School of Management
240. Michelle Poulin, Social Scientist, Gender Innovation Lab, Africa Region, The World Bank
241. Steffanie Strathdee, Associate Dean of Global Health Sciences, Harold Simon Professor, Co-Director of the Center for Innovative Phage Applications and Therapeutics, Department of Medicine, University of California, San Diego
242. Mary E. O'Brien, primary care physician, Columbia University
243. Jesse J. Waggoner, Assistant Professor (Department of Medicine, Division of Infectious Diseases), Associate Professor (Department of Global Health), Rollins School of Public Health and Emory University School of Medicine
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245. Sara Yeatman, Associate Professor and Chair, Department of Health and Behavioral Sciences, University of Colorado Denver
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290. Natalia Linos, Executive Director FXB Center for Health and Human Rights, Harvard University
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300. David Stupplebeen, Epidemiologist/Evaluator, Hawai‘i Health & Harm Reduction Center and Junior Specialist, University of Hawai‘i at Mānoa
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310. Jennifer Adamski, Assistant Professor & AGACNP Program Director, Emory University School of Nursing
311. Carolyn Miller Reilly, Clinical Associate Professor and ABSN Program Director, Emory University School of Nursing
312. Daniel E. Geller, Clinical Instructor, Nell Hodgson Woodruff School of Nursing, Emory University
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314. Rachel Sachs, Associate Professor of Law, Washington University in St. Louis
315. Brinda Emu, Associate Professor of Medicine/Infectious Diseases, Yale School of Medicine
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317. Arnab Mukherjea, Assistant Professor of Health Sciences (Public & Community Health); Adjunct Faculty Member, Pre-Professional Health Academic Program (PHAP), Department of Health Sciences, California State University, East Bay
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<th>No.</th>
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<tr>
<td>318</td>
<td>Douglas D. Richman, Distinguished Professor of Pathology and Medicine (Active Emeritus); Director, The HIV Institute; Co-Director, San Diego Center for AIDS Research; Florence Seeley Riford Chair in AIDS Research (Emeritus), University of California, San Diego</td>
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<tr>
<td>319</td>
<td>Lori Peek, Professor, Department of Sociology and Director, Natural Hazards Center, University of Colorado Boulder</td>
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<td>320</td>
<td>Janne Boone-Heinonen, Associate Professor of Epidemiology, School of Public Health, Oregon Health &amp; Science University</td>
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<td>321</td>
<td>Nino Ricca Lucci, Labor Organizer, UAW Region 9A, MPH Student, Columbia Mailman School of Public Health</td>
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<td>322</td>
<td>Kathryn M. Barker, Postdoctoral Research Fellow, Center on Gender Equity and Health, Division of Infectious Diseases and Global Public Health, Department of Medicine University of California, San Diego</td>
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<td>323</td>
<td>Mitch Stripling, National Director, Emergency Preparedness &amp; Response, Planned Parenthood Federation of America</td>
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<td>324</td>
<td>Esther K. Choo, Associate Professor, Center for Policy and Research in Emergency Medicine, Department of Emergency Medicine, Oregon Health &amp; Science University</td>
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<td>325</td>
<td>Molly Dondero, Assistant Professor of Sociology, American University</td>
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<td>326</td>
<td>Mariya Masyukova, Assistant Professor, Department of Family and Social Medicine, Montefiore Medical Center/ Albert Einstein College of Medicine</td>
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<td>327</td>
<td>Corey Davis, Teaching Professor, Brody School of Medicine, East Carolina University</td>
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<td>Rajesh T. Gandhi, Massachusetts General Hospital, Professor of Medicine, Harvard Medical School</td>
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<td>329</td>
<td>Gary V. Desir, Paul B. Beeson Professor of Medicine Chair, Internal Medicine, Yale School of Medicine Chief, Internal Medicine, Yale New Haven Hospital</td>
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<td>John Harley Warner, Avalon Professor of the History of Medicine, Yale School of Medicine, and Professor of History, Yale University</td>
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<td>331</td>
<td>Scott C. Weaver, Professor and Chair, Department of Microbiology and Immunology, University of Texas Medical Branch</td>
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<td>332</td>
<td>Connie Celum, Professor of Global Health and Medicine, University of Washington</td>
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<td>333</td>
<td>Laura Ferguson, Assistant Professor, Keck School of Medicine; Director, Program on Global Health</td>
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<td>334</td>
<td>Phillip FIuty, Harm Reduction Program Manager, The Mountain Center</td>
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<td>335</td>
<td>Vasilis Vasiliou, Susan Dwight Bliss Professor of Epidemiology, Department Chair of Environmental Health Sciences, Yale School of Public Health</td>
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<td>336</td>
<td>Kristine Qureshi, Professor &amp; Associate Dean, University of Hawaii at Manoa, School of Nursing and Dental Hygiene</td>
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<td>337</td>
<td>David M. Morens, Bethesda, Maryland</td>
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<td>338</td>
<td>Azita Emami, Robert G. and Jean A. Reid Executive Dean, University of Washington School of Nursing</td>
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<tr>
<td>339</td>
<td>Sydney A. Spangler, Assistant Professor, Lillian Carter Center for Global Health and Social Responsibility, Nell Hodgson Woodruff School of Nursing and Hubert Department of Global Health, Emory University</td>
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<td>340</td>
<td>Ana V. Diez Roux, Dean, Dornsife School of Public Health, Drexel University</td>
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<tr>
<td>341</td>
<td>Usha Ramakrishnan, Interim Chair and Professor, Hubert Department of Global Health, Rollins School of Public Health, Emory University</td>
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<td>John Santelli, Professor, Population and Family Health and Pediatrics, Columbia University</td>
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<tr>
<td>343</td>
<td>Joseph S. Ross, Professor of Medicine and Public Health, Yale University</td>
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</tbody>
</table>
344. Katharine Walter, Postdoctoral Fellow, Stanford University School of Medicine
345. Vidya Eswaran, Chief Resident, McGaw Medical Center of Northwestern University
346. Nina Harawa, Professor-in-Residence, Division of General Internal Medicine and Health Services Research, David Geffen School of Medicine at UCLA (DGSOM), Department of Psychiatry, Charles R. Drew University of Medicine and Science (CDU)
347. James Lloyd-Smith, Professor, Department of Ecology & Evolutionary Biology, University of California, Los Angeles
348. Lance Gable, Associate Professor of Law, Wayne State University Law School.
349. Sherril Gelmon, Professor, Health Systems Management & Policy, Director, PhD in Health Systems & Policy, OHSU & PSU School of Public Health
350. Risha Gidwani-Marszowski, Adjunct Associate Professor, UCLA School of Public Health
351. Carol S. Camlin, Associate Professor, Dept. of Obstetrics, Gynecology & Reproductive Sciences, University of California, San Francisco
352. Nicholas G. Reich, Associate Professor, Department of Biostatistics and Epidemiology, School of Public Health and Health Sciences, University of Massachusetts, Amherst
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357. Traci C. Green, Professor and Director, the Opioid Policy Research Collaborative, The Heller School for Social Policy and Management, Brandeis University
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359. Corey S. Davis, Former Chair, Orange County (NC) Board of Health, Teaching Professor, East Carolina University Brody School of Medicine
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363. Brett Feret, Clinical Professor, Director of Experiential Education, University of Rhode Island College of Pharmacy
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368. Maryana Arvan, Postdoctoral Scholar, Department of Psychology, University of Central Florida
369. Deborah McFarland, Associate Professor, Hubert Department of Global Health, Emory University
<table>
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<td>Lillian Carter Center for Global Health and Social Responsibility, Nell Hodgson Woodruff School of Nursing and Hubert Department of Global Health, Emory University</td>
</tr>
<tr>
<td>371</td>
<td>Rosemary K. Sokas, Professor</td>
<td>Department of Human Science; Georgetown University School of Nursing and Health Studies, Professor, Department of Family Medicine, Georgetown University School of Medicine</td>
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<td>372</td>
<td>Marizen Ramirez, Associate Professor</td>
<td>Director, Midwest Center for Occupational Health and Safety, University of Minnesota School of Public Health</td>
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<td>373</td>
<td>Andrew Goldstein, Assistant Professor</td>
<td>at NYU School of Medicine</td>
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<tr>
<td>374</td>
<td>Sandra A. Springer, Associate Professor</td>
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<td>375</td>
<td>Jim Lavery, Professor and Conrad N. Hilton Chair in Global Health Ethics, Hubert Department of Global Health, Rollins School of Public Health and Faculty, Center for Ethics, Emory University</td>
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<td>376</td>
<td>Ted Cohen, Professor</td>
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<td>Leslie I. Boden, Professor</td>
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<td>Ranit Mishori, Professor of Family Medicine</td>
<td>Georgetown University School of Medicine</td>
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<td>379</td>
<td>Lorna Thorpe, Professor and Director, Division of Epidemiology, Vice Chair, Strategy and Planning, Department of Population Health, NYU Grossman School of Medicine</td>
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<tr>
<td>380</td>
<td>Kay Lovelace, Associate Professor of Public Health Education</td>
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<tr>
<td>381</td>
<td>Isabel Morgan, PhD Student</td>
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<tr>
<td>382</td>
<td>Barak Richman, Bartlett Professor of Law and Business Administration, Duke University, Visiting Scholar, Department of Medicine, Stanford University</td>
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<td>383</td>
<td>Joshua L. Warren, Associate Professor of Biostatistics</td>
<td>Yale University</td>
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<td>Carolyn L. Westhoff, Sarah Billinghurst Solomon Professor of Reproductive Health</td>
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<tr>
<td>385</td>
<td>Maile Phillips, PhD Candidate</td>
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<tr>
<td>386</td>
<td>Betty Kolod, Resident Physician</td>
<td>Mount Sinai Hospital</td>
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<td>387</td>
<td>Michelle Mello, Professor of Medicine and Professor of Law, Stanford University</td>
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<tr>
<td>388</td>
<td>Peter C. Melby, Director, Division of Infectious Diseases; Director, Center for Tropical Diseases; Paul R. Stalnaker Distinguished Professor in Medicine; Professor, Internal Medicine (Infectious Diseases), Microbiology and Immunology, and Pathology, University of Texas Medical Branch (UTMB)</td>
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<td>389</td>
<td>Joseph S. Ross, Professor of Medicine and Public Health</td>
<td>Yale University</td>
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<td>Sangeetha Madhavan, Professor of African American Studies and Sociology, University of Maryland</td>
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<td>391</td>
<td>Anne Davis, OB/GYN, Columbia University Irving Medical Center</td>
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<td>Jennifer S. Hirsch, Professor of Sociomedical Sciences</td>
<td>Mailman School of Public Health, Columbia University</td>
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<td>393</td>
<td>Poonam Daryani, Clinical Fellow, Global Health Justice Partnership of the Yale Law School and the School of Public Health, Yale University</td>
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<td>394</td>
<td>Elizabeth Spradley, BHLI Project Connections in Baltimore City</td>
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</tr>
</tbody>
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Maggie Ornstein, Psychology, Sarah Lawrence College
Maggie Ornstein, Guest Faculty, Psychology, Sarah Lawrence College
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