MMITM Ep 011 – Dr. Suzanne Donovan: The Politics of Outbreaks and Healthcare

Announcer: From Curtco Media, what are you gonna do about.

Bill Curtis: Welcome to a very special edition of Politics. Meet me in the middle. I'm Bill Curtis. Joining me again is the host of Meet Me in the Middle, Pulitzer Prize winning author, historian, Worldwide Lecture Professor Ed Larson. How you doing Ed?

Ed Larson: Hello, Bill. Great to be here.

Bill Curtis: And for this edition of Meet Me in the Middle, we've brought over our host from Medicine. We're Still Practicing the triple board certified physician, Dr. Stephen Taback. Welcome, Steve.

Dr. Steven Taback: Hello. I'm happy to be here.

Bill Curtis: We're so honored to welcome to our studio a true American hero. If you're not inspired by this special guest, then frankly, there's something wrong with you. Dr. Suzanne Donovan, an infectious disease specialist, has spent a career battling outbreaks in some of the world's most dangerous places at the special request of the W.H.O. and the CDC. Welcome, Suzanne.

Dr. Suzanne Donovan: Thank you, Bill. Thank you for inviting me to join you today.

Bill Curtis: When someplace in the world needs truly special medical attention. They call someone here in the U.S. and we have heroes that respond.

Dr. Steven Taback: Suzanne Donovan really embodies those philosophies that actually make this country great. She is a truly gifted and generous human being. She's in a class by herself.

Bill Curtis: Suzanne, let's start by asking you to help our listeners understand the CDC's role when an outbreak occurs in a third world country.

Dr. Suzanne Donovan: Basically, they asked if I could help out with doctors and nurses who are being infected in the hospitals in West Africa. We lost an entire generation of health care providers during that outbreak. I said yes immediately. And the person on the other end of the phone call said, no, I think you should think about it for 24 hours. This is a big decision. We've had to evacuate some of our personnel. So I gave it 24 hours and I called back and said that I would go. That was after I talked to both my kids who were teenagers at the time. And when I arrived, the first thing you do is you get training from the U.N. of how not to be kidnapped, how not to be shot. They gave me a badge with my blood type in big letters. And so I put underneath the blood type, do not transfuse because I thought it would be better for me to exsanguinate then to get a transfusion during an Ebola outbreak. So during that training, I got pulled out because the hospital that I was going to be going to, there was one doctor left, a U.S. doctor, and I was told that doctor just became infected with Ebola. So I jumped in the jeep with my buddy, who is a French physician, a Swiss physician. Fantastic. And we traveled eight to 10 hours to the eastern border of Sierra Leone. He was in the guest house. My first Ebola patient was a U.S. physician. And I knocked on the door. He answered the door and he clearly was sick. And then what ensued as he did not want to be evacuated because it was nighttime, he knew how difficult that was going to be, the evacuation. He wanted me to put him in the hospital, which I said was not a good idea, because, number one, we did not have consistent power in that hospital. And it was a very high risk situation. I had not even been in the hospital and I knew it was a high risk situation.

Bill Curtis: When you went to visit him, were you protected at the time?

Dr. Suzanne Donovan: No. So. So I think what it's really important when you talk about highly fatal diseases that are infectious is my approach is I do a risk assessment. Ebola is a very unforgiving disease. So the infectious dose of Ebola is like six to eight variants. It's tiny. If it landed on your skin, you're not going to get infected. But if you have small abrasions, if you have irritation, if you touch a mucous membrane, that would be enough for you to get infected.

Bill Curtis: So is it transferred by sweat. Could someone that's, that doctor that you went to visit, if he had just opened his door and you touched the doorknob? Is it something that you.

Dr. Suzanne Donovan: No and you can see, we didn't have really any sustained transmission in the U.S. with the cases that we had here. When transmission occurs, it occurs at the very end of the illness, when the the amount of virus or what we call the viral load is very, very high. And so the highest risk are going to be the health care workers, which is why the health care workers are always the canary in the mine for Ebola and other hemorrhagic outbreaks.

Bill Curtis: You got there. You had one fairly disappointing conversation.

Dr. Suzanne Donovan: So I'm very persuasive. It's very hard to say no to me.

Bill Curtis: I get that feeling already.

Dr. Suzanne Donovan: Yes. I convinced him it was in his best interest to be evacuated by me and my buddy. The journey back to Freetown was quite interesting because you can't go in the ambulance with him because it's a highly infected environment. So we followed him and we had a police escort because there's police stops all along the way and our escorts kept on stopping. And so this guy, this physician's critically ill. And we're both wondering, my buddy and me, Fredrick Bosch, why do they keep on on stopping? And so I finally asked, Have you been drinking? And they admitted that they had brought alcohol on the front of their police car because it was cold and was about 75 degrees and they needed to keep warm. So they had to keep stopping so that they could go to use the bathroom. So we finally got to Freetown and we got this very brave U.S. physician into the hospital there where he was evacuated the next morning to the U.S. He was in the ICU at Emory for many months and survived.

Bill Curtis: So what is the treatment that he was given in order to survive?

Dr. Suzanne Donovan: Well, that's such an excellent question, because we talk about the mortality rate. So the mortality rate for health care workers in Africa who get Ebola is 70 percent. The current mortality...

Bill Curtis: Meaning the death rate for those listeners.

Dr. Suzanne Donovan: So seven out of 10 individuals who get Ebola that are health care workers are going to die if they're in Africa. You have no supportive services in Africa. You don't have oxygen. You don't have ventilators. Very difficult to do IV's. So you don't have the support or services. But the death rate, if you are evacuated to Europe or to U.S. or developed country is much less. I'm not minimizing it. Almost everyone who had Ebola was in the intensive care unit. They were critically ill. Many of them developed kidney failure and failure of their other organs. But many of them survived.

Bill Curtis: If they survive, are there ramifications to having had the disease?

Dr. Suzanne Donovan: Absolutely. Absolutely. We're, in much of this we don't even recognize. We're recognizing now that there are reservoirs where this virus may persist. We know that there are long term impacts on your eye. I evacuated or helped evacuate three of my colleagues. So it shows you the number that get infected. These were people I worked with.

Dr. Steven Taback: So let's step back a little bit just from the very beginning. The W.H.O. came to you and you said you didn't even think about it for 24 hours. Have you always had this kind of courageous spirit that you're going to walk into the lion's den and without even much consideration, you say you're going to be there? Because in this permissive society where everybody gets an A and everybody is a hero because they helped an elderly person walk across the street, the fact that somebody would actually put themselves in harm's way, which to me is the definition of a hero for a greater cause. It is truly heroic. And yet it's something you did with almost no thought whatsoever. You knew right away.

Bill Curtis: And over and over again, Steve. She's been back to these kind of outbreaks many times.

Dr. Steven Taback: Indeed.

Dr. Suzanne Donovan: Well, I thank you for those thoughts. But this is what I would say is, you know, this is kind of what I do. I'm an infectious disease physician. I'm a specialist in infection control, how diseases are transmitted. And also,.

Dr. Steven Taback: I'm sorry. I know lots of infectious disease doctors and I love them. They're great physicians. I rely on them every day. But to have the courage, truly the courage and the dedication to walk into such a dangerous environment is truly amazing and inspiring.

Dr. Suzanne Donovan: Thank you.

Bill Curtis: Well, we're going to take a short break. And when we return, we're going to dive into what should be America's role in combating outbreaks and the funding of the CDC. We'll be right back.

Promo -MWSP: On Medicine, We're Still Practicing. Join Dr. Stephen Taback and Bill Curtis for real conversations with the medical professionals who have their finger on the pulse of health care in the modern world available on all your favorite podcasting platforms produced by Curtco Media. What are you gonna do about.

Bill Curtis: We're back with a very special guest. Infectious disease specialist Dr. Suzanne Donovan.

Dr. Suzanne Donovan: The CDC traditionally has a branch called the EIS which is the kind of like the medical detectives for outbreaks. And they have had a long term commitment to assisting other countries in outbreaks because they recognize, like all of us in public health, that outbreaks don't respect borders particularly nowadays, where you can jump on a plane and be in another country in an 8 to 12 hours. For as long as I've known the CDC have offered their services to developing countries and the services fall into two main categories. One is laboratory support. So rapid diagnostics at just as important if not more important is they provide the public health and epidemiologic support, both their expertise and just the bodies to go out there and help with contact tracing and partner with the local government. So when this occurred four years ago under a different administration, there was very, very strong support from the CDC and they did an amazing job during that. I mean, it was the largest Ebola outbreak. But they were critical to working both with the W.H.O. and with the governments on this.

Ed Larson: Just to catch everybody up. You've been throwing around a couple of initials quite often, and I don't know if anybody knows, but the World Health Organization is WHO, and that's based, I believe, in Geneva.

Dr. Suzanne Donovan: That's correct.

Ed Larson: And it's an international organization. But you also keep mentioning the CDC, which is an American governmental organization, the Centers for Disease Control, which is based in Atlanta.

Dr. Suzanne Donovan: Let me tell you what happened under our current administration. They have basically told the CDC that they cannot assist during this outbreak so that the current outbreak has not had this critical assistance that has occurred in all previous outbreaks. And that is at the direction of our federal government, which is a huge shame because the foundation of stopping an outbreak is having public health workers on the ground, going out to the villages, doing contact tracing and tracking down every single exposed individual. CDC did this with the eradication of smallpox. And it's an incredible shame that this resource is not being made available during this current outbreak.

Bill Curtis: What can our listeners do to try to goose our federal government into changing their minds about that situation?

Dr. Suzanne Donovan: I think the American public, unless Ebola is an imminent threat to the U.S., it seems very, very far away. I would tell the listeners that Ebola is just one of many outbreaks that could potentially impact our country or countries that you may be visiting. The other thing that our current government has done, our current president has done, has pulled the funding from having centers of excellence for emerging infections in multiple countries. I think it's at least 50 percent internationally, and that is a direct threat to the security of our country, because whatever is happening in Bangladesh or Pakistan is one area which I believe that...

Bill Curtis: Eventually it gets itself here, right?.

Dr. Suzanne Donovan: Yeah. Well, we've already seen that with chikungunya and Zika. Right. These are diseases that were only in Africa and now they're in our hemisphere.

Dr. Steven Taback: What could doctors do living in this country that could actually help curb this epidemic as well as any other emerging viruses that might be coming from third world countries? What can we do? What should we be doing? How can we help?

Dr. Suzanne Donovan: If you look at the major physician organizations where are they in all this? Where's the AMA? Where is, you know, IDSA lobbying the federal government to expand funding? Now, I will say IDSA, which is the infectious disease organization, has lobbied to maintain funding. We talked about the WHO. not have enough resources. Our current president cut the funding to the CDC.

Dr. Steven Taback: But short of full politics, which I think we should definitely talk about, because it's because that's where the power is. But in terms of the individual physicians, is there something that we can be doing in our cloistered world here in the United States that will actually make an impact? You know, thousands of miles away?

Dr. Suzanne Donovan: Well I think number one you know, physicians are amazing educators. And there were many physicians during the Ebola outbreak that chose not to be educated. I was at an institution that physicians signed a petition to exclude me from returning.

Dr. Steven Taback: Wow.

Dr. Suzanne Donovan: I think the critical thing is how can we support our experts, which is really the CDC in doing the work that they're really great at and that's going out and voting.

Bill Curtis: There are a few philanthropists that are putting some serious money into good causes, kind of like Bill Gates and Gates Foundation. Could they be asked to fill in where our government is dropping the ball?

Dr. Suzanne Donovan: That sounds like a question for Ed.

Ed Larson: Well, they can't replace what the CDC does.

Dr. Suzanne Donovan: Yes,.

Ed Larson: Because the CDC is an institution and that institution has institutional expertise. I think that these groups, like the Gates Foundation do remarkable work overseas. But the background work, the sort of thing that has to come from an institutional support. There we have it.

Bill Curtis: I'm not suggesting that the Gates Foundation figure out a way to operationally go into these areas and affect disease. I'm suggesting that they fund the CDC.

Dr. Suzanne Donovan: You want the CDC to really operate autonomously. Would that happen if they're getting, you know, five billion dollars from cigarette manufacturers? I mean, obviously wouldn't be from Gates, but why don't we just use other organizations? There might be a misalliance in goals.

Ed Larson: Foundations have, in the past, tackled particular illnesses early in the 20th century of the Rockefeller Foundation, did remarkable work with hookworm. And the Gates Foundation is trying to do some of that work with malaria. Something like the Centers for Disease Control, we have a governmental institution that has a particular mandate. And the issue I think our guest has raised rightly is since these infectious diseases travel, can we really protect the American population from these diseases if we don't do outreach and stop them where they begin, we're perfectly willing as a country to try to stop, go into Afghanistan and try to stop terrorism before they blow up buildings in New York. And it's really the same thing. Don't we need to go in and stop what's happening with some of these incredibly infectious diseases in Liberia or in the Congo? Because they're going to end up here if we don't do it. And therefore, the CDC has a mandate to keep us safe. And isn't doing it?

Dr. Steven Taback: I mean, very short sighted, right? Is what you're saying to say this is not an American problem. So let's stop poking our nose in when in reality, if somebody winds up coming to this country and is spreading the disease, who are we

gonna get that has the expertise? I would, I would dare say that you probably, as educated as you are, probably learned an awful lot about Ebola and the management of Ebola in your three deployments to Africa. Who am I going to get to take care of myself? My family, God forbid they come down with Ebola. Am I going to get a physician from Africa to come over here and help me? No. I would rather have you who've had the experience. But to say that this is something that will not affect us or will or could not affect us. I think is obviously, as you were saying, it is very foolish. The threat, I think, of Ebola and emerging viruses probably a lot higher than somebody from Afghanistan coming over here to do damage to us.

Bill Curtis: Ed, I'd like to ask you a bit about early United States experiences handling infectious diseases.

Ed Larson: The first infectious disease was smallpox, and smallpox was a truly dreadful killing disease during the American Revolution. Smallpox was ravaging the U.S. troops, especially those engaged in siege operations around British forts like Quebec or New York City. To deal with that George Washington ordered the inoculation of the American troops. And it really broke the back of that infection. When public schools started in the mid eighteen hundreds, passing laws requiring all students attending those schools to be inoculated from smallpox.

That's in the 1850s. It begins in the late eighteen hundreds where you had the public school movement really from nineteen hundred we've had a, every state has had some form of mandatory vaccinations. Actually, in the 1880s and 1890s, Pasture came up with the first vaccinations for rabies and anthrax. And then in the mid nineteen hundreds, we ended up with dealing with diseases that aren't as fatal as smallpox or rabies, like mumps, measles, those sorts of vaccinations. Polio was a real killer and it truly frightened people because of how it could be spread in the water, in different ways. It kept people from sending their kids outside in the summer. And then in the 1950s, a U.S. government funded a program where everyone and I remember it as one of my first memories as a child. Everybody lining up outside our local high school. We were one high school town and the whole town would go in for three consecutive weeks to get our little dose of polio vaccination. So. America has a long term commitment to this sort of vaccinations, because we all know, any of you have had kids in public schools,

There's no easier place to get a disease. Maybe a cruise ship's easier, but other than a cruise ship, I think a public school is where they spread.

Bill Curtis: On that note, we're going to take a quick break. We'll be right back.

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Theme: What are you gonna do about.

Bill Curtis: Welcome back with Dr. Donovan, Dr. Taback. And of course, Ed Larson. Now, Suzanne, I know that you don't watch television, but you've probably heard about the Democratic debates and you've probably heard about the promises of free health care for all, free college tuition, forgiveness of tuition loans and what have you. Let's just focus on the free health care for all right now and the idea of how this country is handling the health care debate. And I'd like to know how you feel about it.

Dr. Suzanne Donovan: So you're talking to a county physician, and I 100 percent support universal health care. In fact, I don't support the Obamacare, I think it was very fragmented. I think it was very challenging for people. I think as a community, as a society that we don't provide preventive care to all of our citizens is very upsetting and disappointing.

Ed Larson: And I don't see why people, even conservatives, aren't supporting the idea of universal, at least universal Medicaid.

Dr. Suzanne Donovan: I think one of the issues with the expansion of Medicaid, hand in hand that we don't really talk about it both with Medicaid and Medicare, is the decreased reimbursement to providers, to physicians and other providers. And I think

while I support universal health care, I also support that our health care providers, nurses, doctors, nurse practitioners, P.A.s receive adequate reimbursement for the work they're doing right now. And also you would have probably more of these individuals willing to work in underserved areas if they weren't going into their practice with hundreds and hundreds of thousands of dollars of debt, which doesn't exist in any other country, that you will have a nurse or a doctor or a dentist leave owing one hundred thousand, two hundred thousand. I had one doctor who owed a million dollars, an infectious disease, one of my infectious disease follows. I mean, she will never dig herself out of that hole.

Ed Larson: But when you look at a lot of countries that have effective so-called universal health care, it's not the program as in England. It's not the program was in Canada, but it's a program such as in Switzerland or Australia, where what you have is a bare bones, federal or state program and that everyone can be covered. If you're over a certain income, you have to pay in. But if you're below a certain income, you don't have to pay. And it's graduated in between. It's a bare bones program. People still, if they can afford it, want to buy insurance. No Cadillac. We're talking about very more like a Honda at best. But that has worked in countries like Switzerland or Australia to provide a safety net. So the sort of problems that you're talking about don't happen. But the rest of us, if we could get it, would want to get insurance and you get it through your employer a variety of different ways. So you still have choice.

Bill Curtis: So, Suzanne, how do you feel about the way that it is proposed we handle health care going forward.

Dr. Suzanne Donovan: The proposals by the Democrats, which which support a national health care, a universal health care safety net, I support. I support. It's not popular with with everyone in health care, but I believe everyone in this country should have have access to basic, basic health care.

Bill Curtis: But doesn't that become more of a broad based but highly limited type of care?

Dr. Suzanne Donovan: Well, I don't know that everyone should have access to, you know, their ACL being repaired within two weeks, which I could get my ACL repaired

within two weeks. But I have very good insurance. But I believe that everyone should have access to care for their cancer, to have access to screening tests, to have access to immunizations, to have access to diagnostic testing, to keep them healthy so they can stay in their job. The single most important predictor of financial catastrophe in most families in the US is to have a medical illness that drains their finances.

Bill Curtis: Of course. But just for a second, when they talk about a type of universal health care and some are discussing the idea of eliminating private insurance in order to facilitate their perspective on universal health care, that leaves us with government programs like Medicaid and Medicare that are remitting much lower amounts to doctors, that are limiting, already, procedures. And you know, Dr. Steve, I'd like you to talk a little about what it's like to order some procedures and get it through the process you need in order to get someone to have an MRI, for example.

Dr. Steven Taback: So, I mean, there are two separate issues here in terms of Medicare or medical care for everybody to have some sort of provided health care. I think philosophically, I can't imagine anybody not getting behind that. The devil is always in the details. I do know that if we had a Medicaid system for the bare bones, that individual could only go to a county hospital anyway, most likely, because most private practitioners are not going to be taking Medicaid. I know if I had Medicaid patients in my office who I would love to take care of. We get reimbursed about $10 per visit. With my overhead. There is no way that I could fill my office up with Medicaid patients and keep my doors open, which ultimately is probably what the government wants anyway. And when it comes to efficiency of care, everybody is looking to try to transition to a Kaiser model. And what that is, is a form of managed care where somebody says this is what you should have. This is what you can't have. And we're doing this all because of cost. Under the auspices, mind you, of quality that you know better to use this medication because it's been tried and tested. And the new medication, which is not been so well tested, may be dangerous. But really what they're saying is the new medication is too expensive and we're not going to give you the newer medications. So there's a lot of rationing that's going on in the community even now. One prime example that Bill was alluding to, which is definitely something that that irritates me to no end, is that whenever you want to get a CAT scan as a pulmonologist, we have patients who have nodules and some that have actual tumors in their lungs. And you want to get a scan. It is automatically denied by an insurance company to force

the physician to then call a reviewer who then is performing a peer to peer review, even though they're not really one of your peers. Because I have had obstetric gynecologists review my requests for scans. I've had cardiologists review my requests for scans and it forces the doctor to get on the phone, be on-line for 20 minutes. Eventually you speak to a member of your peers. You may have to yell and scream and make your case, 90 percent of the time it will be approved. But many doctors will say, I don't have the time to do this. And it also helps force an impediment for doctors next time they try to order a scan. They know that if I'm going to order the scan, I'm going to have to be on the phone for 20 minutes. Do I really need the scan?

Ed Larson: Well, there's also the fear that some doctors have if they're on some sort of preferred provider list, which is what most insurance companies have, that if they do that too often, they might just be knocked off that list.

Dr. Steven Taback: At the end of the day, health care is very expensive. It probably is inflated in this country because if you look at the markup of pharmaceuticals that, you know, it costs $200 in the United States, which will cost you one hundred dollars in Canada. And the same medication is going to cost you $10 in Mexico. And nobody can explain why that is, other than because we have the money and we're willing to pay. So there's a lot of abuse that goes on in the system, but I'm not sure having a government run system guarantees that we're going to have less abuse. I'm not sure that the government bureaucracy necessarily does it right. A long-winded answer to philosophy of care for everybody, I'm all for. It is such a complicated process that I wouldn't even begin to assert that I know even the slightest bit what the correct answer would be.

Ed Larson: Most other developed countries, every other developed country, in fact, has gone to some form of universal care, some all government provided, some where it's a mix of insurance and a government option, some with a, like Australia with a government safety net, and then you buy better insurance on top of that. Those seem to be the three main options. And the United States is the only country with, a developed country without one of those options. Those have happened over time and they have failed in America, given for a variety of reasons, partly lobbying by medical groups and hospitals, partly by lobbying by insurance companies, partly lobbying by lawyers. They all have their voices in Congress. And the result is, despite there were two times where there was a real push toward universal health care, once under Truman and once under

President Truman and once under President Johnson, they always failed in America. And so even if Bernie Sanders becomes president, I wouldn't count on universal health care.

Dr. Steven Taback: I agree with you. I think there's always going to be at least a two, maybe three tier system. I think having to do with what the public wants. I think there's a certain segment of the population that would love to have mandate, would love to have mandated health care so that the citizens are paying for everyone to have the basics. And then there's those, the element of the of the population that can afford private insurance, that want to have all the perks and benefits of having their ACL repaired in two weeks and they're willing to pay for it. And I don't think that's necessarily a bad thing to have multiple options for our community, because, you know, our community is very diverse.

Ed Larson: And one, you raise an important point with that diversity. One reason where these universal systems tend to work best, a place like Sweden or Canada, you have a very homogeneous population and where you don't, where everybody, where at least most people through their families at least have a stake in the whole and are going to be necessarily responsible and people want to support the whole. And you get a country that's as much diversity as the United States has and it's a lot tougher to have that sort of faith and trust in the system or willingness to commit to it.

Dr. Steven Taback: The formula doesn't fit, right. I mean, it is too complicated a formula to just roll out a blanket program because it doesn't apply to all.

Dr. Suzanne Donovan: We do have a national health care system for veterans. And so it has some pluses and some negatives. But a lot of the vets have private insurance. They choose to go to our V.A. hospitals, which are across the country.

Dr. Steven Taback: Some things and some things they do very well and some things obviously, you know, are somewhat flawed.

Bill Curtis: Haven't we found that all forms of universal care is usually an exercise in lowest common denominator health care?

Ed Larson: Oh, no, I don't think that's true in Canada. I don't think that's true in Sweden. It may,.

Bill Curtis: In Canada if you're over 55...

Ed Larson: People love their health care in Canada. You look at the polls out of Canada. You go to Sweden. People love their universal care. It works places. It really does. It's just not, I just don't think they would fit in America. America is not Sweden.

Dr. Steven Taback: A totally different environment, totally different level of diversity and stratification.

Bill Curtis: My last question, I have to touch on the refugee crisis around the world and how it's affecting your field and how you look at what the United States should do with the concept of a refugee crisis, given communicable diseases that you deal with.

Dr. Suzanne Donovan: Anytime we have a refugee crisis, that is a time that's ripe for outbreaks, whether they're waterborne outbreaks, a direct transmission, you end up having a large number of individuals who haven't had access to health care. They are frequently malnourished and they're in crowded situations. And in those situations, you're going to see outbreaks of cholera. That's one of the most common other causes of gastroenteritis. Who has filled the gap in this is a lot of international organizations like the Red Cross. I haven't seen as big of a role for the CDC or or any governments addressing the refugee crisis. We're just five steps away from having an outbreak in our camps that we are having along the border. Once the flu season really gets into swing, I'm not going to be surprised if we see outbreaks of flu in these camps, see outbreaks of measles and other diseases. And I don't believe at this point that anyone is going into these camps other than from NGOs, non-governmental organizations, and ensuring these individuals are being screened, immunized and being provided adequate medical care.

Ed Larson: Quite to the contrary, the government has made a decision not to immunize them.

Bill Curtis: Boy, I don't want to end on that, Suzanne. Tell us about something good that's happening in this world when it comes to communicable diseases, infectious diseases.

Dr. Suzanne Donovan: So I you know, I saw my first AIDS patients in 1985 in Tanzania, Dar es Salaam. And, you know, it was wards and in Muhimbili, which was the hospital there, filled with people dying with HIV, most of them also with tuberculosis. And I'm old enough that I was there when AZT was introduced. And then we had two drugs and then we introduced in 96, 97 the cocktail, which totally changed the face of HIV. All of a sudden we had a disease that progressed in one direction, which is really into the hospital. And then people would die, where people were getting their lives back. They were going back to work. Having children, really have a normal life spans. It's incredibly gratifying to see the advances of what really our country has done with a lot of the expedited medication approval through the FDA to get these new drugs out there and to people with or without insurance, because remember, HIV has been carved out by the federal government. And so if you don't have insurance, you will in most states have access. You have no insurance, you're documented/undocumented, you will get treatment for your HIV. And that is a very important thing to do irrespective of the insurance coverage, because treating someone with HIV means it's not going to spread to their partners. So it's a public health intervention. It's not only going to keep them healthy, it's going to break the chain of transmission. I've been taking care of women who are pregnant for the last 20 years. Hundreds of women. I've had no infected babies. Zero. in my institution. This is huge. From an infectious disease standpoint. And this is something that can occur in resource limited countries. The Gates Foundation and other foundations have been incredibly supportive. In addition to the U.S. and providing access to care in countries like Africa, that has, have a very high rate of infected women and infected pregnant women are providing therapy to prevent transmission.

Bill Curtis: Well, Doctor Suzanne Donovan, I have to say that the way you have dedicated your life to making our planet a better place and helping the rest of us and being so selfless and diving into some of the most dangerous areas in the world. Well, there's a special place in heaven waiting for you. And we want to thank you very much. You are a hero.

Dr. Suzanne Donovan: Thank you.

Bill Curtis: Ed Larson, Suzanne Donovan, Dr. Steven Taback, thank you for being in our special episode of Meet Me in the Middle. Come back again with us, will you, Suzanne?

Dr. Suzanne Donovan: Yeah, definitely. Thank you.

Bill Curtis: Thanks so much. Bye bye, everybody. If you like what you hear, please tell your friends. And let us know how we're doing by leaving a comment. It really helps if you give us a five star rating and we really appreciate it. You can also subscribe to the show on Apple podcast, Stitcher or wherever you listen to your favorite podcast. This episode was produced and edited by Mike Thomas. Audio Engineering by Michael Kennedy. And the theme music was composed and performed by Celeste and Eric Dick. Thanks for listening.

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