

Cancer and COVID-19: A Conversation with Otis Brawley

April 9, 2020

Presented by the National Coalition for Cancer Survivorship (NCCS)

Full Transcript with Timestamps

Timestamps match webinar video: <https://www.youtube.com/watch?v=rROUG6SYZH4>

Intro and Dr. Brawley's Opening Remarks

NCCS CEO SHELLEY FULD NASSO: Hello everyone, thank you so much for joining us during these difficult times. I'm Shelly Fuld Nasso, CEO of the National Coalition for Cancer Survivorship. We know that this pandemic is unsettling to everyone and we hear from cancer survivors that they feel both uniquely challenged because of concerns about their risk, and also in a strange way uniquely prepared for this time because of what they have endured through their cancer experience. NCCS has been collecting questions from patients and survivors on the coronavirus crisis and we decided to address these questions through a series of webinars and podcasts. We knew exactly who we wanted to be our first guest speaker in this series. Dr. Otis Brawley is a Bloomberg Distinguished Professor at Johns Hopkins University, an oncologist and an epidemiologist. He's also a truth teller, a myth buster, a straight shooter, and an all-around nice guy. When we called him last week to ask for advice on how we can best serve cancer patients during the scary and unpredictable season, his response was simple. "Just be honest with them," he said.

We've had an overwhelming response to this webinar with almost 800 people registering—including survivors, advocates, health care professionals, and public health officials—that tells me that there's a hunger for more information and that Dr. Brawley is just the person to help us. We thank all of you for joining us for this important conversation as we all navigate through these uncertain times and we hope that today's webinar addresses some of your questions and concerns.

Now I'm going to turn it over to dr. Brawley to make some opening comments.

1:34

OTIS BRAWLEY, MD: Hello, thank you, and I really appreciate the invitation, the NCCS has been so good to me and so important to me in my career over the years. It's an honor to be asked to do this. I'd like to talk just for a few minutes to try to bring us all onto the same page about what's going on with the coronavirus and possibly answer a few questions that not a lot of people have out there and then we can open it up perhaps for discussion and more questions.

The COVID-19 disease, that's the name of the disease. COVID-19 is actually caused by the SARS-CoV-2 virus. Occasionally some people will see SARS CoV-2 and think, "are we talking about a separate disease?" No, that is the virus that actually causes the disease. It's an RNA virus--you've heard of DNA and RNA, this is an RNA virus, it comes from animals, called zoonosis in medical literature, there are

actually many coronaviruses out there. Many of us have had coronaviruses and we just thought we had a cold. Indeed, some people who do well with the COVID-19 virus do well with it because they have had previous exposure to coronaviruses and it causes a partial vaccination, so to speak.

3:06

We are currently in a pandemic, which means that there's an epidemic throughout the world. This is not the first pandemic of a virus that we have had. Indeed we've had four pandemics over the last hundred years. This is the first pandemic with a coronavirus previous pandemics have been with influenza many of you are very familiar with the Spanish flu, which occurred from 1917 to 1919 and killed between 50 and a hundred million people worldwide. By the way the Spanish flu started in Kansas it crossed over from horses to some US soldiers who went to Europe and spread it throughout Europe. It was discovered first in Spain but it actually came from Kansas. You're also probably familiar with the several swine flus that we've had over the years--there was one from Hong Kong in 2009, one that actually killed four million people in 1968, and a previous one in 1957.

4:13

The way that you catch this coronavirus, it's been talked about an awful lot. It involves people inoculating their eyes, their mouth, or their nose with the virus, picking it up off of a surface from the hands, or breathing it in from the air. It's become very clear in the last several weeks that people do put the virus out of their mouth through talking, through singing, through coughing. Actually the virus is much more fine particles when it comes out through talking, versus through coughing. Then other people can breathe the virus in.

That brings us to the mask issue. The n95 masks that many people use in hospitals many healthcare providers use, EMS use, for example, those masks actually can protect the individual from breathing in the virus. The normal paper or cloth masks that we use in the operating room, or the people will use out in the public--that actually prevents the wearer from sending more particulates out into the air that other people can breathe in. So the way to think about this recommendation recently for wearing the mask is, the assumption is the person wearing the mask may be spreading the infection and the mask prevents the spreading of the infection. It doesn't protect the person who is wearing the cloth mask.

One of my colleagues actually said, "Not wearing the mask in public is not suicide, it may be homicide."

6:02

Who is at risk for this disease? The immunocompromised, certainly people who have lung disease like COPD and asthma, people with diabetes, people with bad cardiac disease like congestive heart failure. We have some evidence that people who have hematologic diseases--leukemias, and lymphoma are at higher risk than people who have solid tumor diseases.

However there is some data from China that people with GI and lung cancers and people with metastatic disease are at both higher risk getting the disease, and higher risk of not doing well from the disease, compared to the normal population. It is clear that older people are more likely to get the

disease and do badly compared to younger people, but that does not mean that younger people do not get the disease and that does not mean that younger people don't do badly with the disease. Older people are more likely to get the disease and more likely to do badly.

7:15

Now the symptoms of the disease are typically a cough, sore throat, sometimes shortness of breath. There are people who have this and is only an upper respiratory infection, and not a lower respiratory or lung infection. Also interestingly there's a group of people who have been diagnosed purely because they've had diarrhea episodes. There is a GI upset stomach component that involves diarrhea and abdominal pain and no respiratory problems in some people who have been diagnosed with the disease. The most interesting symptom that some people have as an early sign if they have a disease there's a loss of taste and loss of smell.

Many experts are now of the belief that perhaps half of all people who get infected with the coronavirus this COVID-19 have no symptoms whatsoever and they may be totally asymptomatic walking around shedding the virus. One of the reasons why the recommendation for wearing masks nowadays.

The people who get symptoms from this disease typically get symptoms four to six days after exposure. It can be as long as 13 days after, hence the 14-day isolation after an exposure that was very common several weeks ago. I don't hear that talked about as much now but it's still out there and still should be done. The most common worst day for people who get something managed automatic is day 10 to 12. Some symptomatic people are sick for 21 days.

The sickness involves, when it gets into the lungs it's when it becomes really a problematic disease. And it can involve cardiac problems, respiratory problems, a cytokine storm where people start having their immune system just go haywire and go crazy, and an acute respiratory distress syndrome. There can also be secondary pneumonias caused by bacterial infections.

9:36

The initial World Health Organization test, by the way, picked up some coronaviruses that were not COVID-19 and actually identified some people who had had other coronavirus infections. There was a Korean test that was very similar to the WHO test and you might recall that Vice President Pence rejected the WHO test and said that we would establish our own test. The CDC test was ultimately disseminated and was rejected by a number of health departments, local health departments, state and county health departments having a high false positive and high false negative rate. There's a second CDC test that was very labor intensive that required that samples be sent either to Atlanta or Seattle for analysis and that's what led to some people being tested and having a 5 to 10-day wait to figure out if their test was positive or negative. I have much more hope for what's come out recently as a 15-minute test which still needs to be distributed around the country. It uses the same machine that many doctors have in your offices already to test for strep throat, it just uses a different cartridge to test for coronavirus.

10:59

There's been a lot of interest in treatment of this disease. You know we have very few viruses for which we have met treatments. HIV was really the first virus where we started actually having a number of drugs that are useful in treating the disease.

There's been a lot of interest in hydroxychloroquine, which is used to treat malaria and lupus. There was a French trial that involved about 20 patients in an intensive care unit and it said the hydroxychloroquine and the azithromycin, an antibiotic (the z-pak) decreased the viral load. I should point out that trial did not say that the patients did better--that trial said that hydroxychloroquine was correlated with a decrease in viral load. It was not a randomized control trial. It was only about 20 people and those of you who watched Twitter overnight will know that the journal that published that paper retracted it yesterday. The International Society of Antimicrobial Chemotherapy retracted the paper about hydroxychloroquine.

There are about a hundred candidate drugs out there, I would consider hydroxychloroquine to still be one of them. We really do need to do good clinical trials to figure out which drugs work, which drugs do not work, and we need to be careful that we don't waste resources while we try to figure that out.

I can recall when z-mapp was thought to be a really great drug for the treatment of Ebola and when it went in the clinical trials it actually failed. We also by the way have some hope for remdesivir, the Gilead drug that's used to treat HIV, but they all need to be tested.

Those of you who've known me over the last thirty years remember in my earlier life I was a drug developer and I did a lot of work in anti-cancer drugs and I will tell you we have had drugs that we thought were great and we gave them to the people and they actually died not from the disease, but because they got the drug.

13:24

Now with this disease, 80 percent or so who get infected and get symptomatic do very well. They don't go to the hospital. So only about 20 percent of people who get symptomatic go to the hospital. Since we don't have good screening for the disease around the country, I can only say 20 percent of people who get symptomatic end up going to the hospital and less than half of them end up in near-respiratory arrest, or respiratory arrest requiring a ventilator. And in the United States it seems to be about 2% or less of people are dying from the disease. In China and in Italy, it was about 10 percent. In Germany, it's about 1%.

I should also tell you that of the people afflicted with the disease and doing badly there seems to be a slight preponderance, 60 to 70 percent are men. Also there are some studies--I already mentioned cancer patients already. In China is actually the best studies looking at people who have cancer, and they noted that lung and GI and metastatic patients who get this disease tend not to do well.

14:55

The last thing I'm going to talk about is the rationing of care. Actually I'm going to talk about two things: rationing care, and cancer patients still in treatment. Cancer patients still in treatment first. Many of us,

many hospitals, are not doing adjuvant chemotherapy for breast, colon, and lung cancer right now, because we have done a weighing of what's the odds that this chemotherapy is going to prevent the person from relapsing in the future, versus the odds that it's going to increase their chances of getting coronavirus and having a bad outcome today? Keep in mind, if we lower their white count and they get coronavirus, that is a ticket to not doing well with the disease. So many hospitals are only giving or clinics are only giving chemotherapy to people who truly need chemotherapy right now.

Now one the last note on rationing of care. The governor of New York has actually, I think, been very very good in talking about the fact that our health care system normally runs at 95% capacity. A good, well running hospital in the United States has three to five percent of its beds empty--that's in normal times. We are at a point where we could easily be overrun with people who have coronavirus, people who are really deathly ill, people who need ventilators. And none of us want to be in a situation where someone needs to go on a ventilator and we deprive that individual of the ventilator because we have simply run out. That did happen by the way in Italy, that has also happened in Spain. In parts of Italy, they literally developed protocols where no one over the age of 50 was offered a ventilator no one who has a comorbid disease was offered a ventilator. A thirty-year old with the history of type 2 diabetes was not offered a ventilator.

Those people were treated with supportive care which is usually just an injection with morphine.

Now I will tell you that the best studies today of people who go on ventilators, show that 35 percent actually come off a ventilator alive. In the United States there's one study that says it's 20 percent right now, but there are some German and some Spanish studies that suggest it might be one in three people survived the ventilator.

17:56

This is a really difficult time. My recommendation to anyone who has cancer or anyone who lives with someone who has cancer is to stay indoors, stay away from other people, do all the things that we've been talking about: hand-washing, avoid people by six feet if you have to go out.

Indeed we all need to try to be supportive of each other and try to prevent the spread of this disease until we can come up with some type of a vaccine which would be useful in preventing people from getting sick from it. I do have some hope that we will be able to develop a vaccine and distribute, but I suspect that it's going to be sometime early in 2021.

I'll stop at that point, do you have questions for me?

Q&A Transcript

18:56

Thank you very much Dr. Brawley, yes we have a lot of questions for you. So if you have questions you can use the chat or question box to enter your questions. We also asked people when they registered if they had questions so we've collected a lot of those questions.

19:12

The question that we saw the most in a variety of different ways from many, many registrants is about risk. Are cancer survivors are at greater risk even after treatment? Or suffering worse effects if they get it? And how does the type of cancer, treatment modality, and the length of time from treatment matter in assessing risk?

This disease is so new no one has definitive answers to those questions, those studies have yet to be done. Indeed we need to study those over time and we need to study cancer patients, and non-cancer patients as well, who get COVID and do well but do they have sequelae? For example in the 1917-1919 Spanish flu, people who got that were at a higher risk of Parkinson's disease as they got older.

But the answer to your questions we don't know. The Chinese have told us that people who have hematologic disease that is active don't do well when they get infected. I am personally very concerned about people who got adjuvant chemotherapy for breast cancer or colon cancer a year or two ago and have finished that. We know that their immune systems are still damaged, if not totally recovered, from that adjuvant chemotherapy. So I worry about them but I have no data on them, I don't think anybody has data.

20:51

In the absence of data then how should survivors who are post-treatment, who may be a year post-treatment or ten years post-treatment, think about this? You said we should all be doing the social distancing, staying indoors, is there anything else they should do? I think that a lot of people are really consumed with fear about it and and looking for ways that they can protect themselves.

My greatest concern is I know of one patient who I've counseled--she is a bus driver who has done quite well after breast cancer chemotherapy. A bus driver still is exposed to a lot of people even if they're wearing a mask and I hope the people getting on the bus are wearing a mask. In DC, by the way, they've actually started where people only enter the bus from the back to actually decrease the exposure for the bus driver. I think people like her ought to be indoors and ought to be isolated. Remember I once said "we should tell people what we know, what we don't know, what we believe, and label it accordingly, and question what we know moreso than anything else. I don't know the answer to this, but my belief is that anyone who has been treated for cancer needs to try to avoid exposures as much as possible. And that includes avoid jobs that increase exposure to the public right now.

22:33

As we move to sort of reopen the economy, whenever that happens, and it sounds like there are people pushing to have that happen sooner rather than later, and other people saying that that can't happen for some time. What about your bus driver patient who doesn't have a job where she can stay indoors? Some of us have the luxury of jobs where we can still work from home and we can still be productive and we can still have an income, but not everybody does. So how do we help those people?

This gets directly into the issue of the racial and socioeconomic disparities that we've been hearing about only recently with this disease, but we've been struggling with as a country since time immemorial. I would give that person disability compensation and let them retire from their job as if they were disabled. Unfortunately I don't control the rules in this country. I think people who are immunosuppressed, or they have had their immune system manipulated—that's virtually anyone who's received chemotherapy and most people who received radiation therapy for cancer—those folks are putting themselves at risk when they're exposed to the population right now. I have data that shows that they don't do well once they are infected—I do have that data.

24:10

For cancer survivors who have completed treatment how should they think about regularly scheduled scans, testing, and follow-up appointments? I know there's been a lot of movement toward telehealth, but you can't do a follow-up scan by telehealth. How should they think about that?

People who have non-aggressive tumors—these are the folks who have [something] other than the fast-growing lymphomas, other than the very fast-growing breast cancers—most of those people, who should always talk to their doctor about this, their doctor is going to I think explain to them that they can delay the every-three-month or every-four-month CT scan looking for relapse right now. The risk of them being exposed while they're out and about going to the doctor and the doctor's office and so forth is such that those every-three-months and every-four-month CT scans for surveillance—in most diseases, they can be put off right now. You can miss one, we'll catch up in July or August when things are a little bit better. The folks who have the things that grow fast like the Burkitt's Lymphomas they just went into complete remission in the last couple of months, who are getting CT scans every three months—they need to talk to their doctors. For them, I think it is worth the risk and they ought to be getting those CT scans still. But it's going to depend on the disease. Most people can skip going to the doctor and we have converted at [Johns] Hopkins, most of our outpatient follow-up is being done by videoconferencing right now and that's working out well.

26:09

What are the challenges to using telehealth? What are the things that you feel like you can't accomplish as well using telehealth? I think that it could potentially be a big benefit to the expansion of telehealth but I was talking to a survivor yesterday who told me she had a couple of different telehealth appointments that were really not very useful for what she needed at that time. What are the pluses and minuses of telehealth?

I see a small number of patients but I learn a great deal by looking at their body language. I learned a great deal by looking at mostly prostate cancer patients, by looking at their spouse when we're having the conversation. Tony Fauci says that we should never shake hands again in our society. I'm going to miss that tremendously. I agree with him, but I'm going to miss that tremendously. I learn a lot just by seeing the patient that I don't learn with telehealth. It would be far worse with just a telephone, but the Zoom camera just doesn't do it for me. Especially when you're talking about patients who are less

literate or older patients who are less likely to tell you this hurts or that hurts, you don't get that from telehealth and it's unfortunate. Maybe some of us can learn how to use it better right now, but I'm still struggling to learn how to.

27:46

You know we've heard about treatments being delayed or cancelled and you talked about the decisions in some cases to forgo the adjuvant chemotherapy and that patients are skipping appointments that are not absolutely necessary. How are patients supposed to think about what is absolutely necessary? And what is your advice to someone who learns that their adjuvant chemotherapy is now not recommended, which gives them a higher risk of recurrence, so how do you how do you advise them?

I'm hoping that you have a good relationship with your doc and you can talk to him or her. There are some people whose adjuvant chemotherapy is going to reduce your risk of relapse by 10% and maybe your risk of getting COVID-19 is high, and the risk of not doing well is high, and so a 10% reduction is not worth it. There are other people where adjuvant therapies is going to reduce their risk of relapse by 40 or 50 percent. And there are some doctors who are really trying to talk to the patient over Zoom or WebEx and trying to figure out what the patient's values are. There are certain patients who should get the adjuvant chemotherapy right now and we are giving them the adjuvant chemotherapy, but there's a bunch of patients who can forego it.

29:20

Great that's helpful. I think making sure that it's still an individual decision and not a blanket recommendation.

Yes, for colon cancer we actually a really good computer programs where we can put a person's age and some things about their pathology into the program and we can say, "if we give you full fox, your chance of cancer coming back is X, if we don't give it to you, your chance of cancer coming back is Y. Is X lower enough that you're interested in the chemotherapy?"

30:00

Can you talk a little bit about patients who are in treatment for metastatic cancers and how is this affecting their treatment? I'll let you answer that first and then I have follow-up questions.

Many of the metastatic patients are still getting their chemotherapy and still getting treatment because the feeling is that if we were to let the disease grow during this period of time, it would be inappropriate. When it looked like the shutdown in the economy would only be 2 or 3 weeks, some of us were delaying that next cycle of chemotherapy. Now, quite honestly we need to have our economy shut down into June 1 at least, probably further. Now that it looks like we're going to be going a much longer period of time, most oncologists are electing to give chemotherapy to people who have metastatic disease, unless there's an occasional person—you see this sometimes with breast cancer especially—

who has metastatic disease but their disease is quiescent. Yes it is metastatic, but it's not growing. That person might benefit from observation right now as opposed to continuing some type of chemotherapy.

31:20

Should those in treatment or recent treatment be wearing N95 masks, especially if they're going to their treatments? Would it help protect them?

The problem with an N95 mask—actually I saw a whole bunch of people in the area where I live, walking around wearing them today—when I was fitted with an n95 mask, they put the mask on you, figure out what size you need to wear for face, and then they spray this sweet-smelling stuff and they ask you can you smell or taste the sweetness?" And if the answer is yes, the mask is not fitting correctly. You're not allowed to wear beards with an n95 mask, for example. And so my concern is—I like the idea of cancer patients wearing n95 mask—this is Otis speaking, this is not CDC policy. I like the idea of cancer patients wearing N95 masks, but on the other hand I'm worried they're not going to have them fitted correctly, and number two, I'm worried when we start saying wear masks, that that's going to cause people to—I hate masks and I'm always fiddling with them and moving my hands up around my face actually puts me at greater risk than wearing a mask. So I like the idea of an N95 mask if the person's wearing it correctly, and if it doesn't cause that individual will start fiddling with their face.

33:09

There's been a lot of talk about in-home infusions for some cancer patients, and anecdotally we've heard some mixed views from patients. Some were in favor of it because it would help them manage their risk, and others had concerns about safety. We also heard mixed views from providers from a safety perspective. What are your thoughts?

Certain drugs I think can be administered at home, by usually a visiting nurse or someone who is skilled at doing that sort of thing. Certain drugs I think ought not be administered at home. For example the taxanes, Taxol and Taxotere, we have a good 3 to 5 percent of people who get those drugs have an allergic reaction to them. I want them to be in a medical environment that was able to give them more than just a shot of epinephrine for wheezing and shortness of breath. So there's certain drugs where I think home infusion is fine, and there's certain drugs where I would rather not see home infusion. I think that person ought to come to the hospital, or to the doctor's office if they truly need that drug. Also, by the way, one other thing to keep in mind many of these chemo therapies are themselves carcinogens. I'm going to be concerned about exposure of people in the house to the leftover drug and that sort of thing. We have to be very mindful of that too.

34:56

Even as we're talking about risk we're getting a lot of questions from from patients about their specific care and how it may be altered or interrupted due to the coronavirus and about their specific risk. Can you give some advice to cancer survivors about how to communicate with their doctors during this time?

Yeah, I actually think—I am heavily into being open and honest. "Doc this is what's on my mind." The first thing that's going to be on a lot of people's mind, "is my cancer growing while I'm not getting treated? Am I going to be worse off because I'm not getting treated?" I'm really into open, honest communications. If you can't have a good, open conversation with your oncologist, perhaps he or she should not be your oncologist. Unfortunately, this is a fine time to change doctors!

35:55

I'm gonna turn to rationing of care, you already talked a little bit about it but I want to address some additional questions about it. We're hearing from some metastatic patients who are hearing about rationing ventilators, and that if they need care they shouldn't admit that they're that they have metastatic cancer. Are these types of decisions happening anywhere yet in the United States or are they just a grim possibility that we're preparing for?

I am not aware that rationing of ventilators is happening in the United States at this time. I am aware of some emergent transportation of ventilators from one hospital to another, happening in New York—New York City, so there was not a shortage of ventilators. I really do encourage people to be very honest with their healthcare providers about their past medical issues. Some elements of their past medical history are going to be incredibly important. Certain drugs I would not use, for example, in people who have been treated for metastatic cancer. Even people who've been treated to complete remission from metastatic cancer, so please be open and honest about that. I hope nobody ever has to go onto a ventilator, but I am not aware in the United States at this time of anyone being deprived of a ventilator because of—they wanted to go on to the ventilator and they had a past medical history of something, or they wanted to go on a ventilator and they were of a certain age.

37:43

A follow up to that is—we talked about this last week with you when we were asking you for some guidances that we know that, in planning for the potential of these shortages of ventilators, some institutions have may have had guidelines that include terminal cancer in the group of people who would be offered supportive care. But as we all know, many people live with stage 4 cancer for many years and and can be very stable with that, but yet it would still consider that to be a terminal cancer. You told us a different definition of terminal cancer, so can you talk a little bit about that and then should we be advocating for more specific guidelines rather than this broad brush of terminal cancer?

Terminal cancer, in the mind of an emergency room doc, I believe, is someone who has cancer and is going to die of that disease over the next six to eight weeks or sooner. It's distinctly different from stage 4 disease. I say that because one of my dear friends is a patient that I took care of in 2002 and 2003, and we diagnosed her with metastatic breast cancer to brain back then, and I still talk to her. She's living with metastatic disease now for 18, 19 years. There is a difference between stage IV and terminal. Now there are some people who have stage 4 disease who are terminal. There are some people who have congestive heart failure who are terminal as well. By the way, we have really good data to show that people who are very sick who go on to the ventilator—going on to the ventilator, by the way, is not a pleasant experience at all. Many people who have come off of it have described it as being waterboarded. I've actually had patients who said I never want that experience again—don't put me on

the ventilator again. Keep in mind, the people who they are saying don't put on the ventilator are the people who are very likely never going to come off of a ventilator alive.

40:13

I still have a lot of questions, we have some great questions coming in. I'm going to turn now to a few kind of epidemiological questions and public health questions. Do you recommend cancer registries collect data for delays in cancer treatment, or data about cancer patients with COVID-19 that might help us then later assess that what the impact is down the road?

By the way, the only advantage to this whole mess with COVID-19 is people now know that epidemiologists are not skin doctors. I would love for registries to collect data on has the patient been infected with COVID. I would love for them to collect data on has there been a delay in treatment? The reality is that the way these registries collect data, it's going to take them six months to a year for those questions to get into the database of questions that are currently being asked. I don't anticipate that's going to happen. Most of the registries right now, by the way, collect treatment plans over the next year after diagnosis, and they don't necessarily collect the treatment received. We can go into some of these electronic databases like Epic and retrieve some of the data that you just talked about—it doesn't have to go into a registry per se.

41:47

How will we then be able to measure long-term the impact of COVID-19 on the cancer population? And will there be a measurable shift in this stage at cancer diagnosis, or in recurrence rates?

We're going to see that from the registries for sure, and we'll see that from the registries within the next year or two, I suspect. The other thing I'm very interested in is to get a cohort of patients—both those with cancer, with various types of cancer and those without—who do well after being infected with this disease, and follow them over the next 10, 20, 30 years. As I noted earlier there's been a correlation between having the influenza from 1917 to 1919 as a child, and then having Parkinson's disease in one's 50s or 60s. That was from long-term cohort studies. We didn't even call them long-term cohort studies back when they were started in the 1920s, but that's the sort of thing that we'll do.

42:54

I want to turn now to talk a little bit more about disparities. You did talk about some of the disparities and outcomes and there's been a lot of reporting in recent days about higher death rates for African Americans diagnosed with COVID-19. Dr. Fauci acknowledged these disparities in the daily White House briefing earlier this week, and also there's been reporting that the death rate has been higher for Latinos in New York. What do we know about the reasons behind this? Is this just a function of the disparities we already see in cancer care that are now coming to light in a much more public way with this? What can be done in the short term? I know some of these are factors systemic to the healthcare system, but are there any things in the short-term that could be done to make a difference to stop this crisis in African American communities?

I think Dr. Fauci was incredibly appropriate in talking about those disparities. I think the only thing we can do right now is try to make sure that every human being, no matter what their race or ethnicity or credit score is, has adequate care—for all things. One of the problems I have is the president said well we're going to pay for everybody's COVID care. Well, what about their diabetes and congestive heart failure underneath that that's actually going to increase their risk of 1) getting COVID and 2) not doing well with COVID as well? I'm really into giving adequate care to everybody. I'm very concerned— By the way, the incidence rate in poor people is probably lower than the incidence rate in middle class people, because poor people don't have a doctor who can—I ran into this just yesterday somebody called me and asked would I write them an order for them to get tested for COVID-19, you have to have a doctor's permission to get tests—poor people don't have relationships with doctors. They may have a relationship with a clinic that's giving them their diabetes medicine but that's not same as having a relationship with a doctor. Right now I think the most important thing to do is to try to give everybody the care that they need.

I'm going to look into my crystal ball and predict that—we're talking about disparities in Blacks and Hispanics and in the big cities right now—two months from now, I think we're still gonna have this problem out there, but we're going to be talking about the disparities in poor whites in the southern United States. Because we've had a couple of states, Georgia being one of them, where the governors made some absolutely stupid decisions in delaying closing things down and we're going to see spread into the white poor rural population in Georgia and in Arkansas and in a couple of other states.

46:00

It sounds like a lot of it—it's hard to break down kind of what percentage of the disparities has to do with access to care, versus underlying health conditions, versus jobs that require you to not be socially distant. It kind of sounds like it's a mix of all of those.

It's a mix of all of those and that last part you just said is so important. The people who are having to work right now are the folks in the grocery store, the folks who are driving the busses, the folks who are driving the cabs, the folks who would have to make a living with Uber and Lyft. There's a lot of jobs that are out there where they can't sit in their home and Zoom all day. And those are poor folks who are more likely to get exposed, and then of course those are the same poor folks that we're talking about who are more likely to have comorbid diseases already. We're not going to be able to put a patch on the whole health disparities problem right now just because of COVID, but my one effort to deal with it is just try to get every human being the care everyone being needs.

47:17

I'd like to turn to clinical trials. We know that clinical trials have halted enrollment, some clinical trials have. Some research labs have been closed, some cancer researchers are being pulled into COVID-19 research. Tell us a little bit about the current state of cancer research and then what is it going to take to recover after COVID-19 is no longer an emergency?

Almost all the cooperative groups have shut down accrual to most of their trials. People who are going on the trials for very aggressive cancers like the aggressive lymphomas and leukemias are still being

enrolled, but the adjunct therapy trials and so forth have been shut down. At the major universities, the laboratories have all been shut down. At Hopkins we're allowed to go keep our cell cultures alive, keep our lab animals alive, but we're not doing any cancer experiments at least for the time being. So we're all on ice, that's gonna set us back for at least three to four months after the reopening. If we're shut down for three months, this is a six-month shutdown, this is going to set us back six months. This is a huge problem for all of cancer, there's just no way of getting around it. I have no better answers. We do need to be in a position where we can start it up as quickly as possible afterwards. I have yet to see nurses and clinical trial specialists being laid off or anything by any of the major hospitals. But I'm worried about the hit that the major hospitals are going to take over time, and that could even causing more harm to what's going on. This is—this is bad. It's just bad.

49:15

Is there anything that we as patient advocates can be doing to advocate for that when the time comes that we can reopen? Sometimes we feel a little bit helpless here--we know it's bad but what can we do to help?

I think that—try to make sure that your congressmen and Senators have in their mind that they need to support the hospitals, they need to support the research infrastructures—it's not just cancer, it's HIV, it's cardiac, it's a number of other diseases as well. You make sure that the congressmen and Senators have that in mind. I've heard a lot more about bailing out the restaurants than I've heard about bailing out medical infrastructure—I support both by the way, I support bailing out both.

50:09

I'm going to ask you to get your crystal ball out again how long do you think the shelter at home and social distancing will last and what do we do when we do reopen the economy? I know you talked about potentially cancer survivors that are at high risk going on disability, but what else can we do when we get back to these—when we reopen the economy and have different policies and procedures about who can go back to work and what they need to do to protect themselves and others when they go back?

I don't know how it's going to come down. My belief is that we should start opening up the economy again in phases starting around June 1st. That's what I believe we should be doing. Unfortunately, if we if we had shut down the economy better, we could have opened it up earlier. But assuming that we keep it shut down now, I think we can open it back up around June 1st, but it's going to be in phases, and I don't think we're ever going to be the way we were three months ago ever again. I honestly do believe that we're going to have some social distancing in June and July. I honestly believe that we're never going to be shaking hands again.

51:45

I know we have a lot of people on from state cancer coalitions, and they have asked what could they be doing to help in their states?

Again, making sure that local legislators understand this problem that cancer patients are going through, that cancer research is going through. We talked about the health disparities. Please try to make sure that your local legislators understand that the most pressing issue in the United States in my mind is how do we give adequate care to every human being, and that adequate health care is a human right, and it's not it's not a right of the rich, it is a human right, is it basic human right. Some of the work I've done recently talks about how we've had a 65 percent decline in colon cancer death rates in certain states and a 15 to 20 percent decline in other states. The states that had had the 15 to 20 percent declines are the states that don't appreciate health, they've not expanded Medicaid so that everybody can have some access to care. Keep in mind they didn't appreciate health before the Affordable Care Act. Those are the states that have the lowest taxes on tobacco and the highest smoking rates as well. So the local and state cancer coalitions, please try to make your politicians appreciate not just cancer health, but global overall health.

53:35

I have one last question for you and this is the one I keep coming back to in our staff meetings, and in my own life with my kids: Do you see any silver linings here? And how when we come through this emergency, any silver linings that will help the cancer care, cancer research, the cancer experience for cancer patients?

The medical community has come together and been united in a way that I haven't seen. We didn't have this one—I was a young doc when we had HIV come forth in the 1980s. We were not united the way we are today for HIV. I think a whole bunch of doctors went back and read what they put in their essays that they wrote when they were applying to medical school, and a whole bunch of us actually realized why we really should have gone into medicine. I think we've got a much greater respect for nurses and the laboratory personnel, even the folks who clean the floors in the hospital. I was very moved the other day, I heard that the chair of ENT at the Cleveland Clinic found that he couldn't be helpful in patient care, and so he went and got a mop and bucket and was mopping the floor with the folks from housekeeping. I think the human aspect has come out of a lot of us, so that's perhaps the the one big positive.

55:34

I think along with that, how much the American public has really rallied behind and supported and honored the healthcare providers who are on the front lines of taking care of COVID-19 patients. Thank you so much Dr. Brawley for joining us and for shedding light on these important and difficult topics. As we promised, you tell it like it is, and it's not always easy to hear, but it's important to arm survivors with knowledge and truth and we're really grateful to you.

Thank you for all that you do.

56:07

Thank you. And I'm really pleased to announce that that our next webinar will be next Tuesday April 16th at Noon. Dr. Imani Price will join us to talk about how cancer survivors can navigate stress and anxiety in these uncertain times. Dr. Price is a licensed psychologist at Women's InnerFitness and Wellness Center, and serves as Vice Chair of the Board of Directors at BreastCare for Washington, DC, so look out for more information about that webinar, the next in our series. Thank you again, Dr. Brawley and thank you to everyone for joining us today and for your wonderful questions. We really appreciate you participating today. Thank you.