

World of Stories

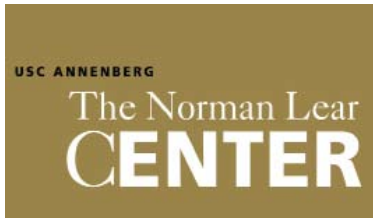


Hollywood, Health & Society

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The Norman Lear
CENTER

An edited transcript of a panel discussion
held at the Writers Guild of America, West
July 20, 2009



THE NORMAN LEAR CENTER

The Norman Lear Center is a nonpartisan research and public policy center that studies the social, political, economic and cultural impact of entertainment on the world. The Lear Center translates its findings into action through testimony, journalism, strategic research and innovative public outreach campaigns. On campus, from its base in the USC Annenberg School for Communication & Journalism, the Lear Center builds bridges between schools and disciplines whose faculty study aspects of entertainment, media and culture. Beyond campus, it bridges the gap between the entertainment industry and academia, and between them and the public. Through scholarship and research; through its conferences, public events and publications; and in its attempts to illuminate and repair the world, the Lear Center works to be at the forefront of discussion and practice in the field.

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HOLLYWOOD, HEALTH & SOCIETY

Hollywood, Health & Society (HH&S), a program of the Norman Lear Center, provides entertainment industry professionals with accurate and timely information for health storylines. Funded by the Centers for Disease Control and Prevention, The Bill and Melinda Gates Foundation, The California Endowment and the National Institutes of Health, HH&S recognizes the profound impact that entertainment media have on individual knowledge and behavior. HH&S supplies writers and producers with accurate health information through individual consultations, tip sheets, group briefings, a technical assistance hotline, panel discussions at the Writers Guild of America, West, a quarterly newsletter and Web links to health information and public service announcements. The program also conducts extensive evaluations on the content and impact of TV health storylines.

For more information, please visit:

www.usc.edu/hhs.

PARTICIPANTS



Sandra de Castro Buffington, MPH, is director of Hollywood, Health & Society, a program of the USC Annenberg Norman Lear Center that leverages the power of the entertainment industry to improve the health and well being of individuals and communities worldwide. She has nearly 30 years of experience working in global health, entertainment education and emergence technologies; 20 years were spent working internationally, and

five of those years were spent in residence overseas. Formerly Vice President of the Centre for Development and Population Activities (CEDPA), Sandra guided the flagship WomenLead program to equip, mobilize and empower women globally and nurtured a network of 5,000 alumni in 140 countries. With USAID, she led the development of a \$250 million strategic framework for global health leadership and management and managed a \$108 million portfolio of strategic communication programs worldwide. With the Johns Hopkins University Center for Communication Programs, Sandra launched an award-winning vasectomy promotion campaign in Brazil, earning seven international advertising awards including a Bronze Lion at the Cannes Film Festival and Gold Medal at the London International Advertising Awards. She is a former associate faculty member at The Johns Hopkins University Bloomberg School of Public Health and a past Board member of the Pan American Health and Education Foundation.



Patric M. Verrone is a television writer, attorney, and President of the Writers Guild of America, West. In 2007-08, he led that union through the 100 day strike that won writers a contract covering the Internet. He graduated magna cum laude from Harvard College where he was an officer of The Harvard Lampoon and earned his J.D. from Boston College Law School after serving as editor of the Boston College Law Review. For ten years he was issue editor of the

Annual Entertainment Law issue of Los Angeles Lawyer magazine. His television writing credits include *The Tonight Show Starring Johnny Carson*, *The Larry Sanders Show*, *The Critic*, *The Simpsons*, *Pinky and the Brain*, *Rugrats*, *Muppets Tonight!*, *Class of 3000*, and *Futurama*. He has been nominated for eight Emmys in four categories and won two. He has also received an Environmental Media Award, an ASIFA Annie Award, a People's Choice Award nomination and the Writers Guild's Lifetime Achievement Award for Animation Writing. He was #75 in last year's Time Magazine poll of the 100 Most Influential People in the World. He has spoken all over the world on media, entertainment, and law.



Neal Baer, MD, is a Harvard-trained physician, practicing pediatrician, and award winning television writer and producer. Since 2000 he has been the Showrunner and Executive Producer of the NBC series *Law and Order: Special Victims Unit*. Before his tenure at Law and Order, he was Executive Producer of *ER*. Recently, his mentorship of a Mozambican HIV/AIDS orphan resulted in the documentary film *Home Is Where You Find It*. He was also an adjunct professor (2001–2005) at the

University of Southern California teaching in the area of health communications, health promotion and disease prevention, and sex education. He is Co-Chair of Hollywood, Health & Society. Dr. Baer's primary medical interests are in adolescent health, and he has written extensively for teens on such topics as teen pregnancy, AIDS, drug and alcohol abuse and nutrition. He also serves on the boards of numerous health care organizations, including the Venice Family Clinic, Advocates for Youth, Children Now, and Physicians for Social Responsibility.



Tadataka (Tachi) Yamada, MD, president of the Bill & Melinda Gates Foundation's Global Health Program, leads the foundation's efforts to help develop and deliver low-cost, life-saving health tools for the developing world. He oversees Global Health's grantmaking, which focuses on four major activities: discovery, development, delivery, and advocacy. Before joining the foundation, Yamada served as chairman of research and development and was a member of the board

of directors at GlaxoSmithKline. Prior to that, he was chairman of the Department of Internal Medicine at the University of Michigan Medical School and physician-in-chief at the University of Michigan Medical Center. Yamada is a past president of the American Gastroenterological Association and the Association of American Physicians, a master of the American College of Physicians, and a member of the Institute of Medicine of the National Academy of Science in the United States and the Academy of Medical Sciences in the United Kingdom. The mission of The Bill & Melinda Gates Global Health Program is to help ensure that advances in health are created and shared with those who need them most. The program works with organizations around the world that are using innovative methods to improve health in developing countries. The program also supports advocacy efforts to build awareness of global health challenges, develop new ways to finance health programs, and improve health data.

PARTICIPANTS



Peter Blake is a Co-Executive Producer on the Fox TV show *House* where he has been on staff for the last five years. Peter attended Harvard Law School and worked as a management consultant and a film development executive before becoming a writer. Before *House*, Peter wrote for ABC's *The Practice* for four years and has written feature film scripts for Universal, Focus Features and Paramount.



David Harden is a former Executive Story Editor for the television series *Numb3rs* (CBS). For his work on the *Numb3rs* episode "Harvest," about global organ trafficking, David was the 2006 recipient of the Sentinel Award from Hollywood, Health & Society, a program of the USC Annenberg Norman Lear Center. He has also developed pilots for Warner Bros Television, including a whimsical adaptation of J.M. Barrie's *Peter Pan* ("Wendy & Peter").

He has published fiction, mostly science-fiction, in *Zyzyva*, *The Exquisite Corpse* and elsewhere. Prior to his time in Hollywood, David worked in private equity, served as the CEO of a software firm, was the Ahmanson Fellow for Renaissance History at UCLA, and worked at the rodeo in Guthrie, Oklahoma. He lives in Los Angeles with his wife and two children.



Lawrence Barat, MD, MPH, serves as Senior Malaria Advisor at the US Agency for International Development (USAID), working on the \$1.2 billion President's Malaria Initiative. With fifteen years experience, Dr. Barat has become known as one of the foremost authorities on the control of malaria. He received his degree in Medicine in 1986 from SUNY Downstate Medical Center. After completing a fellowship in Infectious Diseases at

Boston University School of Medicine, he joined the faculty and worked with the Boston City Hospital Clinical AIDS Program and the Harvard Hospitals/Boston City Hospital AIDS Clinical Trials Unit. From 1992 to 1993, Dr. Barat served as AIDS Policy Advisor ("AIDS Czar") for the Mayor and Health Commissioner of Boston. After completing the MPH program at the Harvard School of Public Health (1995), Dr. Barat joined the Malaria Branch at the Centers for Disease Control and Prevention (CDC), where he conducted research and published widely on malaria diagnosis and treatment, assisted several countries in the design and implementation of malaria control activities, and co-managed USAID's Blantyre Integrated Malaria Initiative in Malawi. In 2000, Dr. Barat was assigned to the World Bank by CDC, where he led the Bank's Malaria Team and represented the Bank on the Roll Back Malaria Global Partnership Board. He left the Bank in 2004 to work for AED, a Washington-based nonprofit organization, where he provided technical support to several USAID projects, including NetMark, SARA and Africa 2010 and served as Senior Malaria Advisor to the USAID BASICS project (USAID's flagship program on child survival).



George Rutherford, MD, is Director of the Prevention and Public Health Group, Salvatore Pablo Lucia Professor of Preventive Medicine, and Head of the Division of Preventive Medicine and Public Health in the Department of Epidemiology and Biostatistics in the School of Medicine at UCSF. He is also Adjunct Professor of Epidemiology and Health Administration at the School of Public Health at UC Berkeley. Educated at Stanford University and

the Duke University School of Medicine, Dr. Rutherford is board certified in pediatrics and general preventive medicine and public health. Following training in epidemiology in the Centers for Disease Control's Epidemic Intelligence Service, he spent the majority of his professional career in public health practice, with primary emphasis on the epidemiology and control of communicable diseases. Dr. Rutherford is currently Director of the Joint UCSF-University of California, Berkeley Residency Program in Public Health and General Preventive Medicine. He is also Director of the International Program at the Center for AIDS Prevention Studies and Coordinating Editor of the Cochrane Collaborative Review Group on HIV Infection and AIDS.

A World of Stories

Patric Verrone: Good evening. I'm Patrick Verrone, president of the Writers Guild of America, West. Thank you for being here. I'm actually not supposed to be. If anyone asks, I'm at home writing a script about iPhones in the 31st century.

We are so pleased at the Writers Guild, West to partner with Hollywood, Health & Society on this event – the first panel discussion of the HH&S Global Health Initiative. There is a growing trend in entertainment to look not only within, but outside of U.S. borders. Global health issues make for truly compelling storylines. In fact, the script I'm working on about iPhones in the 31st century actually has a health component. Apparently, in the 31st century, "iPhones" are phones actually implanted in your eye. You twitter like this [Batting eyes].

Also, there are these "killer apps" that are actually killer apps.

[Laughter]

And since that joke worked I'm going to put it in.

Tonight we have an extraordinary panel that will speak to you from the global perspective. To introduce our keynote speaker I'd like to present Sandra de Castro Buffington, Director of Hollywood, Health & Society.

Sandra?

Sandra de Castro Buffington: Thank you, Patric. Good evening. I am so glad to welcome you to this event. We have a terrific group of writers, producers,



Patric Verrone



Sandra de Castro Buffington



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Buffington

Hollywood, Health & Society board members, and public health experts. Hollywood, Health & Society works with television writers to help them access accurate medical information from experts for their scripts. It is part of our global health initiative, which supports writers in addressing global health.

I am delighted to introduce our keynote speaker, Dr. Tachi Yamada. Dr. Yamada is president of the Global Health Program at the Bill & Melinda Gates Foundation. In his position, Dr. Yamada leads the foundation's efforts to help develop and deliver low-cost, life-saving, health tools for the developing world. He also oversees the Global Health Program's grant making, focusing on four major areas – discovery, development, delivery and advocacy. In 2008 alone, Dr. Yamada's program granted \$1.8 billion toward global health programs.

Dr. Yamada has worked in many sectors of health – the private sector, clinical medicine and academia. Before joining the Gates Foundation, Dr. Yamada was the chairman of Research and Development at GlaxoSmithKline. He also chaired the Department of Internal Medicine at the University of Michigan Medical School and was the physician-in-chief at the University of Michigan Medical Center. Please welcome Dr. Tachi Yamada.

[Applause]

Tachi Yamada: Thank you very much, Sandra. I'm delighted to be here. And I'm very proud that the Gates Foundation supports Hollywood, Health & Society. I'm here to talk about global health and think we should probably start with a definition: *What is global health?*

Health, like everything else, has become “globalized.” It used to be very local. In fact, in many parts of this world it still is. But things change rapidly the faster people can get from one part of the world to the other, as well as how quickly the Internet allows communication



to take place from one corner of the world to another.

Today, when we think about global health, we think about things like HIV. HIV started in one corner of the world and expanded to have an incredible effect on U.S. society. Then there are people like Andrew Speaker. Anyone remember Andrew Speaker? He was the young lawyer who had drug-resistant TB. He got on an airplane, went on a honeymoon, and was then treated like O.J. Simpson chased by a television camera. They followed Andrew Speaker until he was almost incarcerated in the U.S. Then they found out he didn't have the highly drug-resistant TB.

And then there's the issue of SARS. SARS went from a remote village in China to almost destroying the Singapore economy. It also had a devastating effect on the Canadian economy. But it taught Canada a lesson – a lesson we haven't yet learned in the U.S. – that their public health system was broken and needed to be rebuilt, which they're doing now. But because we escaped SARS, we're now facing another global health problem – H1N1 influenza – and we don't have a public health system to deal with it. I'll talk more about that in a minute.

But global health is really much more than just the globalization of health. I understand you tell stories, so I'd like to start with a story.

It starts back to the time when I was with GlaxoSmithKline, and actually pretty happy there. We had many programs involved in global health at that time. When I met with the Gates Foundation to talk about our programs, I was approached about whether I'd like to run the Global Health Program at the Gates Foundation. I wasn't sure I wanted to. But I interviewed with Bill and Melinda anyway. It was when I was

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talking to Melinda about the problem of global health, something happened to me that really surprised me. A memory came back to me that I had apparently suppressed for 30 years.

Back then, I was an intern in a hospital in Virginia. I remember a 16-year-old African American mother came in with a child who she was gripping so tightly that it took us about 10 minutes to get her to let go. When she let go so we could examine the child, the child was dead. Now, it was a devastating experience for me. As an intern, you see people die, but this touched me so much that I actually suppressed the memory of it. That same night, I went home and cried about it. But since then I hadn't thought about it for 30 years. Not once. But when I was speaking to Melinda, it came back – suddenly, roaringly. It was because I recognized that about 10 million – now closer to 9 million – children under five die each year from treatable or preventable diseases.



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It's hard to understand what that number means until you realize what the death of one child means, and the impact of that one child's death on you personally. Then you think about 9 million. It's unbelievable. In health, there is great inequality. Life expectancy in sub-Saharan Africa is under 50 years; and, in most other parts of the world it's approaching 80 years. Many people cannot live productive, meaningful lives because of this inequality. And this more than anything else contributes to instability in the world.

The Bill & Melinda Gates Foundation believes that all lives have equal value. There are many different things that we could do in this area, but we have a bias – that technology-based health solutions are the most economical way to reach people all over the world. We focus on infectious diseases, maternal/newborn child health and nutrition. Where technology-based health solutions exist, we try to make them widely available. We're one of the largest supporters of the global fund to fight AIDS, TB and malaria. We distribute anti-retroviral



treatments, TB medicines and anti-malarials. We're also one of the initiators and the largest contributor to the Global Alliance for Vaccines and Immunizations, which makes vaccines available to as many people as possible. But where the solutions don't exist, we discover, develop and deliver new solutions.

The question you might ask is, "this is a big problem, but does America care? How does this affect our lives?" You'd be surprised. The Kaiser Family Foundation ran a recent poll that found that two-thirds of Americans favor either maintaining the amount of development assistance we provide for health in the developing world or increasing it. Even in this difficult economic time, two-thirds believe we should maintain or increase our commitment to eradicating disease in the developing world. That's really astonishing. People are willing to take money out of their own pockets to support this cause.



The Global Alliance for
Vaccines and Immunizations

I hate to say it: I don't watch much television. But the Foundation did sponsor two episodes of *American Idol*. These two episodes were focused on issues of health and economic deprivation. And these two episodes – over two nights – raised \$159 million. Americans taking money out of their pockets and doing something about the problem.

Another unbelievable example is the fight against polio. We don't have the problem of polio in the United States. Polio has been beaten back by technology – by a vaccine. Polio is endemic in just four countries in the world: Nigeria, India, Pakistan and Afghanistan. But it's really India and Nigeria where we have to fight the fight. At this point, we're down to the very last stage; but it's the last stage that's more expensive than the first stages put together. For our efforts, we have a partner – Rotary International. In a challenge grant we've created, Rotary International, made up of a group of citizens – people just like you all over the world – are putting up

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\$200 million for this campaign. The Lutherans and the United Methodists each have put up \$100 million to fight malaria. So, yes, America cares. Absolutely, America cares. When people hear the stories, they understand what has to be done and they're willing donate money to address this problem.

We consider ourselves a pretty large foundation. Last year we gave out \$1.8 billion in development money. But relatively speaking, we're actually a small player in this field. There's about \$25 billion going for development assistance, and it's mostly from governments – like the United States – or the Department for International Development in the U.K. or other development assistance agencies. But even \$25 billion is not enough. The World Bank estimates that in order to really address the problems of the developing world, and in order to reach the millennium development goals that were set up in 2000, we need about \$75 billion a year. This is why I'm here. We can't reach everybody, but you can. You can tell the stories that will help commit people to causes, which in turn will make governments listen and make governments contribute.

You are really the master storytellers. So, I hesitate to tell you stories because I'm not all that good at it. But let me tell you a few that might set the stage, and then I'm happy to answer any questions you have.



How did I get here? I had a long academic career in medical research, seeing patients, teaching. I enjoyed that. Then the idea of being able to develop medicines that would have an impact on people's lives was appealing to me – really enticing – so I joined a pharmaceutical company. But what happened to me at that pharmaceutical company changed my life. The company I joined (actually, it was a company formed as a result of a



Tachi Yamada

merger) ended up suing Nelson Mandela over the price of HIV medicines in South Africa.

I thought to myself, “Do I want to be at a place that prevents people who need medicine from receiving medicine?” Fortunately, I was also on the pharmaceutical company’s board of directors. So I was able to convince them that we didn’t want to be the kind of company that would charge South Africans prices they couldn’t afford for medicine they so desperately needed. Instead, we had to change our image – clearly, directly and dramatically.

We created a laboratory for diseases of the developing world, focusing our efforts on malaria and TB. Today this laboratory accounts for production of almost two-thirds of new malaria and TB medicines for the entire world. Understand that over the past 30 years, of the 3,500 registered medicines only 17 were directed at diseases of the developing world. But to be able to have the rich pipeline we have today required a major commitment, not just from our company but from the many others who followed since.

Then I met Bill and Melinda. And their passion has really driven me to where I am today.

So what does the developing world look like? I can tell you horrible stories. I’m not sure how useful those stories are, but I’ll tell you one. Let’s talk about malaria in Africa. On my first trip to Africa as part of the Foundation, I visited the southern part of Mozambique, an area called Manhica. This is a very malaria-rich area, with literally hundreds of thousands of babies dying from the disease

annually. I went to a subdistrict hospital and in the emergency room was a mother and baby. I know what a sick baby looks like and this was a very sick baby, but really no sicker than the many babies I saw in the hospital's intake area. I assumed that the baby would be admitted and eventually be alright. I was given a tour of other parts of the hospital and by the time I returned to the pediatric ward, the baby was desperately sick, breathing at 150 times per minute.

I challenge you to try to breathe at 150 per minute. This is how the baby was breathing. In a very short time, the baby went from sick to desperately ill. And I realized that many babies in Africa live on a very thin line between life and death. They have so many problems to begin with. And in this case the baby probably had parasitic disease and was iron deficient. So when they get malaria, it's that little bit of hemolysis that can mean the baby cannot get enough oxygen to survive. So it tries to compensate for this lack of oxygen by breathing inefficiently at a higher rate.

“Many babies in Africa live on a very thin line between life and death.”

-Tachi Yamada

This is the desperate kind of story we hear so many times. But there are some really hopeful stories too. I'll share one story that began during a trip to Abuja, the capital of Nigeria. There I visited a slum area called Mpape. Mpape is a very typical slum, one of scores of slums in these parts. Their local health clinic had only one nurse, an assistant and two community health workers. Dirt floor, no plumbing, no furniture and no medicine. I asked the staff how they dealt with the patients, and they said "Well, they don't come here." Even though this was the neighborhood health clinic, why would you go somewhere where there are no medicines?

Within 200 yards of this clinic are literally dozens of small pharmacies. In some countries, they're called "chemical sellers," and their shelves are lined with medicines. This is where people actually get medicines. They come in, pay their money and go home.

Often they have a little clinic next door. It's not really a clinic but a consultation area – an

examining area where the diagnosis is made. When I asked them what they give for malaria, they said they gave chloroquine.



Mind you, about 50% of the malaria in that region is chloroquine-resistant. But chloroquine also only costs 15 cents. The right treatment – artemisinin and combination treatments – are about \$7. That’s when we at the Gates Foundation started to think about what we needed to bring the price down. We created an initiative called the “Affordable Medicines Facility – Malaria,” where we have negotiated with pharmaceutical companies to bring the price down to \$1. We then have a subsidy of 85 cents that goes directly to the wholesaler. The wholesaler then trickles that incentive down to the retailer. This way, the costs of the proper treatment equal the costs for the wrong treatment.

These pharmacists know what the right treatment is. They also have problems with counterfeit medicines. I asked one of the pharmacists how he knew when a medicine was counterfeit. He said that his patients tell him. The treatment doesn’t work, so they come back and they tell him.

Another place with a big malaria problem is outside the city of Lusaka in Zambia. Here, in a place called the Chelstone Clinic – in a catchment area of around 100,000 people – I met a rotund and wonderful nurse. She wasn’t really a nurse, not a registered nurse, more the equivalent of a nurse’s assistant in the U.S. But here she was the nurse for this community and she knew every single one of her patients by name. I was curious about the malaria problem and asked her how many bed nets they had in their catchment area. She thought it was probably around 2,000 nets for about 100,000 people. I asked her how many were using their bed nets. She said probably about 20% or so. In addition, there was mosquito spraying in only some areas, especially in those areas where there were very close quarters.




...imperfect tools, even when imperfectly applied, work.



-Tachi Yamada

But according to her, within the last six months, not a single child had died of malaria. She used to see dozens of children with the disease. This showed me that imperfect tools, even when imperfectly applied, work. When you looked at the statistics, child mortality in Mozambique had fallen by almost a third in just a couple of years.

So you can see that it's not all hopeless out there. Things do work. People are fighting the difficult fight to address the problem of child mortality. The problem is not at all hopeless when people get involved and attempt to look for solutions in creative ways. As an example of this, I want to talk about the problem of the poor in South Asia, a slightly different scenario than in Africa.



In India, the Gates Foundation has a big AIDS prevention program called Avaham. It's focused on the three populations most at risk: IV drug abuse (which is relatively modest in India); men who have sex with men (again, a relatively modest cause in India); and female sex workers – a big problem.

For female sex workers in India, the Avaham program focuses on empowerment. It empowers a woman to ask for safe sex – to demand it. This kind of empowerment has tremendous impact. At one site I visited, a woman told me that she used to be harassed all of the time. But now she has a whistle. When someone harasses her, she blows the whistle or uses her cell phone and can get 15 to 20 of her colleagues to come and make enough noise that he becomes intimidated and backs off.

Another interesting story comes from one of the community health workers in Bangladesh. Bangladesh is one of those countries that has pioneered community health work. It was mostly in the rural settings where people volunteer to help mothers deliver babies, to help with prenatal care, etcetera. We wanted to move this program from the rural to the urban



areas. In the rural areas, it was easier to get people to volunteer, and all they needed was a loan that allowed them to get a sewing machine. Then they can make saris and develop a small business out of it. A microfinance loan was enough to motivate them to become volunteers.

But I worried that moving from the rural areas to the city would be much too difficult for them and might not work. Well, the solution was for them to get two loans – that way the husband could get a rickshaw. With the rickshaw, there would be two incomes. It was enough of an incentive for people to come to the urban areas and become part of the army of health workers that was needed to make a difference in the developing world.

Uttar Pradesh is also one of the last outposts for polio. This is a huge problem for India.

-Tachi Yamada

Another very interesting story took place in Uttar Pradesh, which is one of the poorest parts in all of Indian, if not all the world. I've personally witnessed more destitution there than just about anywhere else. Uttar Pradesh is also one of the last outposts for polio. This is a huge problem for India. The state of Uttar Pradesh has 300 million people. It's more like a country that way. The state also has 2,000 physicians. So this is not a good ratio. And yet, this state has something in the order of 40,000 to 60,000 "quacks." When you think of a "quack," you think of a faulty doctor. But in India, a "quack" is more of a tradition.

While I was in Uttar Pradesh, I saw a young child with polio. I asked who had diagnosed the baby, and was told it was done by one of these "quack" doctors. So I went to see the quack, and this quack came from a very long line of quacks. He specialized in neurological disorders. He knew the difference between Guillain-Barre Syndrome and polio. He was also one of the savviest neurologists I've met. He wasn't paid for his services. He did it because this was the profession that was handed down to him. He actually had a farm and that was how he made his living.

But there are people out there – not the traditional physician or nurse – but people who nevertheless know what they’re doing. How we capitalize on that is one of the biggest challenges for us in global health.



I also want to point out the importance of American policy. Just because it’s “out there” doesn’t mean what we do here has no affect on what happens. I have three stories that illustrate this point.

One is the story of rotavirus. Diarrhea kills about 3 million babies a year and a third of those cases are caused by rotavirus. So one million babies die from rotavirus infection. A dozen years ago, a vaccine was developed in the U.S., but of the 100,000 or so children vaccinated, about 10,000 children got a condition called intussusception – which causes the intestine to telescope upon itself. It’s a big problem that can require surgery.

In the U.S., the risk/benefit was a problem. Even if three children get this disorder, the U.S. cannot approve the vaccine. But if the U.S. rejects a vaccine, then do you think Bangladesh will reject that vaccine? Absolutely. But from the standpoint of risk/benefit, this vaccine had huge benefit in Bangladesh. But this was colored by a regulatory decision in the U.S.



President's Emergency Plan for
AIDS Relief

Another story to illustrate this point: In the fall of 2007, I took a trip to Kenya. I was meeting with the Health Minister there who had just come from speaking to the U.S. Ambassador in Nairobi. She was white as a sheet because she had to tell me that due to budget cuts, I should expect a 25% reduction in my PEPFAR allocation. PEPFAR stands for the President's Emergency Plan for AIDS Relief and it pays for a lot of the HIV medicines in the developing world. She said, “tell me, which 25% should I write a death sentence for?” So we think of it as a political battle, but it’s a battle that eventually translates into life and death.



I'll end my stories with what's happening right now with pandemic flu. You've all heard of H1N1. It could be pretty bad this fall or next year. Right now, the case-fatality rate is relatively low. The case fatality rate is relatively low right now because we're putting people on respirators when they need respirators. But in the history of pandemic flu, the second season is much worse than the first.

Chris Murray, an economist and health service researcher at the University of Washington, did a study on what pandemic flu would look like today if it had the characteristics of the 1918 pandemic. According to his research, 62 million people would die. But 96% of the deaths would occur in the poorest countries in the world.

We have a solution to this problem: we can make a vaccine. However, the amount of vaccine we can make doesn't equate to the number of people in the world who will need it. The richest countries in the world tie up all the manufacturing capacity. The U.S. is putting in orders for hundreds of millions of doses. The British, the French, the Swiss, the Germans, the Japanese – they're all putting in orders. The poorest people in the world will have no access to this vaccine. We should all stand in line, right? They're the ones who are going to die and they're the ones who need it more than us. But our policy is focused on saving Americans. This is something to think about. And something we'll eventually have to address.

The battle against death and misery is stark and real. It's not fiction and it's not exciting. It's miserable. There's no bigger test for society today than the challenge of global health. How we address it will decide what kind of world we'll live in. There's a convergence of science and money and interest into this problem. We just need



Tachi Yamada

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you to tell the story so that it stays top of mind and becomes a key element of American and global policy.

Thank you very much.

[Applause]



Peter Blake, David Harden,
Lawrence Barat and George Rutherford

Sandra de Castro Buffington: Thank you, Dr. Yamada, for that excellent talk. Next, I'd like to introduce our distinguished panelists. First there's Dr. Neal Baer. Dr. Baer is a physician, a pediatrician, and was the former executive producer of the show *ER*. He is now executive producer of *Law & Order: Special Victims Unit*. In addition to his work in television, Neal closely mentored Alcides Soares – one of the 500,000 Mozambiquan children who have lost their parents to AIDS. Neal worked with Alcides to help him make a documentary about his life, called *Home Is Where You Find It*. Happily for Hollywood, Health & Society, Neal is also the co-chair of our Advisory Board. We'll show you a clip of a recent global health related episode of *Law & Order: SVU* tonight.

Next, we have Peter Blake, who is co-executive producer of *House* on the Fox Network. Peter has written for ABC's *The Practice* and has also written feature film scripts for Universal, Focus Features and Paramount. He is currently working on a *House* episode that features an infectious disease normally found in Africa. Peter was also consulting producer on an episode about tuberculosis, called "TB or Not TB" and we'll show you a clip of that tonight too.

Next is J. David Harden, who is a former executive story editor and writer for *Numb3rs* on CBS. While there, he wrote an episode called "Harvest," about the global trafficking of human organs. For that episode, David won the Sentinel for Health Award from Hollywood,



Health & Society. You'll see a clip of that show tonight. David has also developed pilots for Warner Brothers Television and has published fiction with a specialty in science fiction.

We look forward to hearing from these amazing storytellers and watching some short clips of their work.

Additionally, we have some top global health experts here this evening. I'd like to introduce first, Dr. Larry Barat. Dr. Barat is a senior malaria advisor at the United States Agency for International Development and is one of the world's foremost authorities on malaria control. He's a physician in internal medicine with a master's degree in public health. Formerly with the World Bank, he now works on the \$1.2 billion President's Malaria Initiative.



The President's Malaria Initiative

We're also very fortunate to welcome Dr. George Rutherford. Dr. Rutherford is an expert on global HIV and AIDS. At the UCSF School of Medicine, he is director of the Prevention and Public Health Group. He is also the Salvatore Pablo Lucia Professor of Preventive Medicine, and head of the Division of Preventive Medicine and Public Health. He was formerly the state epidemiologist for California, director of the AIDS Office for San Francisco, and director of immunization for New York City. Please join me in welcoming all of our distinguished panelists.

And now, let's hear from our moderator, Dr. Neal Baer.

Neal Baer: Thank you, Sandra. As Dr. Yamada said, the challenges are vast. Certainly as writers we find it difficult to do a show about something happening outside our own purview. But that's a pretty parochial attitude because with a little cleverness one can tie into these issues. It takes some thinking – and some

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”
-Neal Baer

partnering, too. There are also a lot of organizations that can give support. Certainly Sandra and Hollywood, Health & Society are there to provide all the background information one needs – be it on malaria or the guinea worm or schistosomiasis.

There’s an attitude on the part of the networks too, unfortunately, that the audience isn’t interested in those sorts of things. But as long as it’s a good story – and Dr. Yamada certainly gave us a lot of grist for good stories. In Mozambique there are 25 million people, but there are only 350 doctors. So how do you tell these stories? It’s a challenge, but it’s a good challenge for the creative mind.

I’d like to show you a clip from *Law & Order:SVU*, and then we’ll move on to Peter.

This clip was inspired by an unfortunate case of a child diagnosed with PCP pneumonia. The child had an advanced case of AIDS, which – fortunately – is extremely rare in the U.S. because of anti-retrovirals. But it’s not so uncommon in other parts of the world, particularly in Africa and in parts of China and India.

As a pediatrician, it was an interesting topic. I was also interested in the work of some very renowned scientists who claimed that AIDS doesn’t really exist and that the HIV virus is really not the cause of AIDS. So, here you go.

[Video Clip]

So one can certainly bring these stories to people’s attention. But first you need the correct background and knowledge. You have to be informed about these issues first. Then, as Dr. Yamada said, you can start to think about, act and work to effect social change.

Peter is a writer/producer on *House*. We’re going to see a clip from *House*, and then we’ll

hear from Peter.

[Video Clip]

Peter Blake: That clip was from an episode written by David Foster, who is one of our writers, but he's also a doctor. We chose it because it's an episode of our show that most clearly addresses global health issues. For those of you who haven't seen *House*, it's basically a medical mystery show. Every week, someone comes in with a strange disease that the doctors initially can't diagnose. But by the end they solve it. Most of the time we use diseases to make the mystery more interesting. But this episode, David really wanted to talk about public health.

This episode is about a global public health expert who gets sick. It's also about the contrast in public health: one man with TB versus the 3 million kids in the developing world who are going to die from tuberculosis. It's really a question of treatment – what do we do about it? How do we get the medicines to them?

That's the basic contrast David wanted to show. But in general, when we use global diseases we're using them for a very specific dramatic purpose. I'll give you another example. There was an episode written by two of our writers – Russ Friend and Garrett Lerner – about a doctor who accidentally causes the death of a patient. They had heard of an actual case where a doctor forgot to supervise a patient's treatment. The patient dropped his pills on the floor instead of taking them and because the medication had no effect on the disease, the doctor figured the patient had been misdiagnosed. So the patient is treated for a number of other diseases, eventually dies and it was all because he hadn't taken his pills.



Peter Blake and David Harden

“We wouldn’t do anything that would give misinformation about a public health topic.”

—Peter Blake

The writers were looking for a disease that was easy to diagnose and treat, and they found this infection called strongyloides that you can get from walking on the beach in Thailand. So we used that. It was easy to diagnose, easy to treat, but if the patient didn’t take the pills the patient dies. That’s how we generally use global health topics on the show.

Neal Baer: Yours is one of the only medical series, with *Grey’s Anatomy* and *Private Practice*, that is disease-oriented. Do you think that it’s a responsibility of a series – medical series or not – to grapple with these issues?

Peter Blake: We wouldn’t do anything that would give misinformation about a public health topic. In fact, our show writer, David Shore, heard a speech about malaria and wants us to write an episode about it. We also feel we have a lot of responsibility to tell a good story. That’s what we’re really focused on. There’s no downside to using some sort of global disease. The only downside for our show is that we’re a medical mystery drama, so once you know a patient has traveled to, say, a specific area in Africa, it’s easy to narrow down what the diseases are.

Neal Baer: Thanks. Now, we’ll move on to David Harden and we’ll show a clip from *Numb3rs*.

[Video Clip]

David, please?

David Harden: First, I’d like to thank Dr. Yamada, not only for a really interesting presentation, but also, if I may borrow it: “Imperfect Tools, Imperfectly Applied...My Career in Hollywood.” That’s the right title for my new forthcoming autobiography. Thanks to Sandra, too, for calling me “distinguished.” That almost never happens.



David Harden

So the story behind “Harvest.” I’d come across an article in *The Christian Science Monitor* about transplant tourism – a global trade in black market organs. For a variety of reasons and to anticipate being asked the same question that Neal asked Peter, it has to be entertaining first. There was something about it that seemed exciting and interesting to me. We also had an Indian actor on the show who we’d badly underutilized and she was very good and very pretty. The Scott Brothers, who are the executive producers of the show, said, “Why don’t you use the Indian girl more?” So I saw it as an opportunity to do that in addition to a number of other things.

I went in to pitch it to the show runner. I assume it’s a Hollywood crowd, but you guys may not know that the show runner is the guy who runs the show. Because we’re writers, we come up with clever titles for things. So I went in to pitch the idea to the show runner and he was immediately interested...immediately excited...the air in my balloon is inflating. Then he said, “But would this happen in L.A.?” There was pregnant pause while all the air rushed out of my balloon, because the show is about an FBI agent and his little brother who is a math genius.

So to serve the stories on this show, you had to have a good, interesting, cool crime that you could solve with math – which is harder than it looks. And I said, “No, I don’t think that it would happen in Los Angeles. I think it’s very unlikely. But it does happen, and people from Los Angeles might go to Eastern Europe or they might go to South Africa to do this. So it doesn’t seem like a big poetic license to move it here.” And he said, “Okay, fine, under one condition. By the time we air this episode, you and I will know how to do one.”

Now, I don’t know if you listened to my introduction before, but I’m not a doctor, and the last biology I had was probably in ninth grade. So I made an immediate and panicked call to the Hollywood, Health & Society folks, who’d been by the show to

present a couple of times. And I said, "I need to know how to do a kidney transplant in a hotel room in downtown Los Angeles. And I need to know now."



Not only did they arrange for me to speak to a number of nephrologists who walked me through the process – so that we actually did represent an organ transplant as it might have actually happened. But they also found a statistician at Johns Hopkins who had developed an algorithm (and anytime you can say algorithm on *Numb3rs*, it's a win) for matching patients and organs through a histamine compatibility complex.

The show was done and *TV Guide* put the little blurb in and members of the medical community saw that there was going to be an organ transplant black market storyline. These are never good for the organ transplant community, because donors typically go away. They actually have done stats that if you do an organ show on television, less people get the pink stickers.

Now, Hollywood, Health & Society had read this script. They knew how we were going to end it and they headed off the backlash before it even started. They started a calling campaign – that they knew what the show was about and that there should be no question it should air. It will be a positive.

And then somewhere along the way I decided I wanted to crash in the ambulance, which we didn't see in the clip. But that was another highlight for me.

Neal Baer: Thanks, David. I'm sure that in the end, it had a profound effect that you'll never know unless Sandra did a study on it.

Sandra de Castro Buffington: It increased donors signing by 10%.

Neal Baer: There you go. So it does have an effect. If you were a show runner – I don't know if you've given much thought to this – but what story about global health would you

do? Or had you thought of any in the past that you just couldn't put on *Numb3rs*?



David Harden: That's an impossible question to answer, not only because the chance of me being a show runner is so miniscule. I'm kind of a medical junkie. I like this stuff. That's why I was the guy who was writing all of the medical storylines at *Numb3rs*. I should've taken more biology after ninth grade. It really depends on the context of the show. It's what you can get away with. To answer the question you asked Peter, do you have a responsibility? I don't think you do. I think you have a responsibility to be entertaining because that's how you keep your job.

If through honoring that responsibility you find an opportunity to do something bigger, I think that you do have a responsibility to take advantage of it. It doesn't happen very often.

I think you have a responsibility to be entertaining because that's how you keep your job.

-David Harden

Neal Baer: But you answered it. You found an article in *The Christian Science Monitor* that you thought was cool. It was universal and you used that to tell the story. Of course, I disagree with you because I do think we have a responsibility to tell things accurately on television. And since I'm the moderator, I get to say it.

But you can do it responsibly and that's why I don't think about entertaining ever. Maybe because I've been really lucky to do *ER* and *Law & Order:SVU*, I never think about entertaining. I never think about the audience. I only think about the story. I think that if the story was compelling, then it would be entertaining. But those are the two sides. I'm also a doctor, so that influences me. It's a very interesting conundrum that we find in Hollywood.

I'm going to move on and we can debate later.

David Harden: I don't take exception. Your shows are more highly rated than mine. So what do I know about entertainment?

Neal Baer: Oh right, you're on Friday. [Laughter]

So, Dr. Barat, tell us about malaria?

Lawrence Barat: I had offered to bring a video of my own, but they didn't want to see pictures from my vacation. So I don't have a video to show you. Fortunately, Dr. Yamada stole most of my thunder. So let me fill in a few gaps and then I'm going to talk to Peter and tell him a few real life stories that I think are fairly compelling.

Malaria causes anywhere from a quarter- to a half-billion infections a year. It kills about 1 million people or more annually, mostly in Africa and mostly children under five.

That's the bad news. The good news is support for malaria has increased. When I started malaria research in 1995, the U.S. Government was investing about \$10 million a year. Now it invests \$500 million a year. Initially, there was no global fund. There is one now. The World Bank wasn't investing in malaria. They are now. Five years ago, a bed net cost between \$12 and \$25, and no one had them except the very rich. Today, bed nets cost \$5 and half the population of some countries are sleeping in them, or at least have one in their house. Sometimes it's not hung up, but that's the challenge we face.

That's the background. Now I'll discuss malaria in this country, because that's what both the previous speakers were alluding to.

There are about 1,000 to 2,000 cases of malaria diagnosed each year in this country. That



The World Bank





may seem like a lot; but most U.S. physicians will never see a case of malaria in their whole career. Most of those 2,000 cases are taken care of by less than 100 physicians – mostly infectious disease experts. Because of that, these cases are often bizarrely diagnosed. For example, you see cases of malaria diagnosed with a bone marrow biopsy – a rather invasive procedure where they drill into the hip or sternum and remove bone marrow. It’s a frequently done test when someone has a fever of unknown origin.

Malaria can be diagnosed with a simple finger stick, a blood slide. Look under a microscope, see the parasites. But they don’t often ask if the patient has traveled. And because of that they don’t do the simple blood test. They do the million-dollar workup instead, including the bone marrow biopsy. There was one case in particular that always stuck with me. It was a case I was involved in, in New York when I was at the CDC. A mother brought her two children – six and eight years old – into a private medical doctor’s office. She told the doctor very specifically that the children had been running fevers. “We’ve just come back from Nigeria,” she said. “And I’m worried they have malaria.” The private medical doctor told her it was the flu, not malaria, and not to worry about it. He gave them some cough medicine and a few other things and sent them home. Two days later, the children were in the emergency room at one of the city hospitals in New York and they were both comatose. This is one of the signs of severe malaria. Even in this country, about 40% of people diagnosed with the disease will die.

It was the mid-1990s, and there was a lot of talk about ebola. An overzealous hospital administrator heard about these comatose kids with fever who were bleeding a little. She proceeded to lock the emergency room from the outside, and locking in everybody who was in the emergency room. The hospital went through the whole process of eradicating the blood. But no one bothered to listen to the mother and no one bothered to look at the blood smear. One of these kids, unfortunately, died. The other one, fortunately, survived. Just for lack of simply



Lawrence Barat

asking a couple of questions and doing a test that costs about \$1, both of these kids would have been fine.

We have had cases of malaria that were transmitted by blood transfusion, even organ transplantation. Malaria does pop up. Diseases that are very common in other parts of the world often appear in very uncommon situations when they appear here.

Neal Baer: Thank you.

Unidentified Audience Participant: Talk about Chicago.

Lawrence Barat: Chicago?



Unidentified Audience Participant: Wasn't there a terrible hotbed of malaria there not that long ago?

Lawrence Barat: Malaria is still transmitted in the United States. We've seen it transmitted every year until the 1950s when transmission was interrupted. We do see it in the summer months – not every year, but every couple of years. We see cases of malaria in people who have never traveled outside, never gotten a blood transfusion, never had any of the risk factors associated with malaria and often live in areas with high concentrations of migrant workers. I've personally investigated cases in southern Michigan and in Florida. There were two large outbreaks in North County, San Diego back in the early 1990s when more than 20 people over two successive summers were diagnosed with malaria.

The mosquitoes are here and so is the capacity of malaria being transmitted here. We think it's not a problem, but it can be a problem. It's why I can't give blood – because I travel to



Mozambique. I probably will never be able to give blood, especially if I continue to do this work. You have to wait three years after you get back before you can be a blood donor.

Neal Baer: Thank you.

In the interest of time we'll move on. But I did see Peter light up when you said that the E.R. was in lockdown.

Peter Blake: I am intrigued by this idea that you can get malaria from an organ transplant. If we wrote that story then more people would die because fewer people would give their organs.

Neal Baer: Yes, probably. It's a conundrum. But the salient point is that there are lots of ways to tell a story about malaria from these few real stores. So now, Dr. Rutherford, please?

George Rutherford: When you said "lockdown," I heard Lucknow, which is the capital of Uttar Pradesh. It shows what kind of world I live in.

I was in Namibia last week where the prevalence of HIV in 15- to 24-year-old women has fallen precipitously from 25-30% to 8% in a single year coincident with the massive rollout of anti-retrovirals. We may actually be seeing a suppression of viral levels at a community level. AIDS is a disease probably of chimpanzees that was transmitted into humans in the 1920s or early 1930s from people capturing chimpanzees and butchering them. So it's a blood-to-blood transfusion.

It's basically from bush meat, yes. You can still get it in the markets in Bangui in the Central African Republic. The situation was probably hugely amplified by a French



George Rutherford

campaign to eradicate sleeping sickness through injections in the 1930s when the country was building a railroad in the Congo. They were using dirty needles. So there are human hands in all of this.

Today the stories of HIV are the stories of Lazarus – people rising from the grave. As Dr. Yamada was talking, I was reminded of the time I was a chief resident in Pediatrics at the San Diego Children's Hospital. We had eight beds, six of them were filled at any given time with children with severe complications of haemophilus influenzae type B meningitis. We have a vaccine for that now.



If you go to Oakland Children's Hospital, where my wife is the chief of the E.R., none of the infectious disease fellows – let alone any of the residents – have ever seen a single case. The disease has vanished off the face of the earth, but only off the face of the developed world. It's a rampant epidemic in the developing world and a very fixable one.

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–George Rutherford

There's a wonderful little vignette in the *CDC's Morbidity and Mortality Weekly Report* about the first person treated with penicillin in the United States in 1942 or 1943. Penicillin was so rare in those days that they re-crystallized it from urine so they could reuse it on the next patient. This was real Jesus-in-a-bottle stuff. This is the story of HIV now. Thirty-three million infected, maybe 2.7 million newly infected each year. Counterbalance that with the 2.9 million deaths and the huge epidemics in Southern Africa, where an excess of 30% of adults in countries like Swaziland and Botswana are infected.

Botswana is a very affluent country. Same gross domestic product as Slovenia. HIV is a real problem there and not getting any better. But lately, with the rollout of anti-retrovirals and little change in prevention, they're beginning to see changes in survival rates. We're starting to see true therapeutic effects. It really is a Lazarus story.



I have a story about a woman in a town called Tororo. It's in rural Uganda as you drive out of Kampala and across the White Nile and Jinja, which is a harrowing and crummy little trek. Tororo is on the other side of Jinja, up about two hours to the northeast by Mount Elgon. And Tororo is also where all the cement in Uganda comes from.

The U.S. Centers for Disease Control set up a big demonstration project there where they delivered medicine to homes to see if they could really get serious therapeutic benefit. There was one woman, probably about 40 years old, with a husband and several children dead of AIDS, weighing about 80 pounds, who started anti-retrovirals. Within six months, she was 120 pounds and working in the garden. Everybody there has a garden behind their house. It was truly amazing. Also, in this large cohort of about 1,000 people, 800 were women. In Africa, this is largely a disease of women. Within the first year, there were also 80 new pregnancies, because women had gotten well enough to ovulate again. Yes, that's a potential problem. They shouldn't be getting pregnant, or at least shouldn't be having unplanned pregnancies. But it gives you an idea of physiologically how quickly they can recover.

That's all good news. The bad news is when the anti-retrovirals begin to wear off. As you can imagine, there's a huge problem in the supply chain. People can't go on and off the drugs because that breeds resistance. It becomes a real mess very quickly, which is in fact what's happened with tuberculosis in Africa and other parts of the world.

Lest you think that all the stories about HIV are in Africa or in San Francisco, we do a ton of work in Iran. There they have a very serious HIV epidemic concentrated among drug users. Twenty-five percent of drug users are infected in Iran. Iran also has surprisingly liberal policies around HIV and drugs. It's to the left of the

In Africa, [AIDS] is largely a disease of women.

-George Rutherford

Netherlands. They have needle exchanges, which is something we don't even have in this country – at least officially. They have treatment-on-demand. They have opiate substitution therapy, with methadone and buprenorphine. They have needle exchange programs in prisons. It's a wild story and one that's interesting to tell.



Tachi Yamada

Neal Baer: Thank you. We have a few minutes. Any questions?

Unidentified Audience Participant: Thank you for the great presentation. I've read stories about food aid to third world countries and how the food falls victim to corrupt regimes where it's stolen and sold on the black market. So it never gets to the people who need it. As you deliver your medical services, do you run into political resistance or local politics? Does that make it more difficult? It seems like there's the potential for a political intrigue storyline on this.

Tachi Yamada: Every country has a different story. I'll take the two largest drug programs in the world – anti-retrovirals for HIV and the DOTS program (which stands for Directly Observed Treatment Short Course) for TB. By and large, the medicines get to the people who are supposed to get to them. These were very successful programs that were also built the right way. The U.N. was very involved. Vaccine programs have also been very successful. Africa now has a 75% vaccination rate for the standard vaccines. That's a huge increase from what it was a few years ago.

Yes, there may well be corruption in some areas. But in the areas that really count, such as in HIV, TB and childhood vaccinations, the story is better than you might expect. I can't comment on food because I really don't know what happens with food. I'm also not a Pollyanna. I know there's corruption. In Nigeria, for example, the government gives money to the states, but the state money never gets to the communities. No one knows where it goes.

Oh, it goes somewhere, but it doesn't go to the patients. There's corruption. But for our big programs in medicines and vaccines, they seem to be working.

Unidentified Audience Participant: Speaking of medications, how good is compliance? There's a lot of stereotyping about compliance outside the U.S. What do you see in terms of compliance for anti-retroviral?

Tachi Yamada: The best compliance study took place in Uganda and followed the country's HIV patients. Compliance turned out to be in the 75% range or so, which is better than comparable programs in the U.S. Given the medicines, patients in the developing world take it as compliantly as the patients would in the United States.

George Rutherford: I have a slightly different perspective. Malaria is a different disease than AIDS and TB. With AIDS and TB, the drugs are delivered from international donors to government-run facilities. They are pretty well maintained. But the vast majority of malaria is treated in the private sector. When Cambodia releasing the latest new drug to treat malaria a few years ago, within a few weeks there was a counterfeit medication that also hit the market. It wasn't a drug at all and it looked identical, even with the same packaging. One story in particular from Africa. I was in a meeting where we were trying very hard to get a country – I won't say which one it was – to switch their policy from chloroquine (the old drug) to newer ones. The Deputy Minister of Health stood up in an international meeting and explained that he didn't want to switch treatment, explaining "Even though you have a mistress, you keep your wife because you know her."

His argument was, "we know chloroquine." But the reality was, his brother-in-law owned the company that manufactured chloroquine. We also see leakage of anti-malarials and bed nets into the private sector from the public sector and we are taking measures to deal with that. But the reality is, someone is getting those drugs and someone is getting those bed nets. So I don't lose sleep over that.

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-George Rutherford



Neal Baer: Thank you. Next question?

Unidentified Audience Participant: I have a question about global health authority. I heard about sex workers in the porn industry here in L.A., and two new HIV cases. The local public health department – Cal OSHA – couldn’t get their names. Now, there’s flu coming across the border and questions about whether we should have a quarantine. Who is our global public health authority?

George Rutherford: I do worry about the public health system in the U.S. There was a time back in the ‘40s and ‘50s during the mass campaigns for polio, when the threat of a public health hazard was very real in the minds of citizens all over the United States. Given what’s happening now with pandemic flu I think we’ve been lulled into a sense of complacency. Even if we have the vaccines in the U.S., the sheer logistical challenge of vaccinating a couple hundred million Americans not once, but maybe twice, is something that the public health system hasn’t really thought through.

I recently talked to Tom Friedman, the new Head of the CDC, who views this as a very substantial challenge. People who need to be vaccinated for H1N1 flu are largely the people in this room. It’s not the very young and the very old who are dying. It’s actually people in the middle and those are the people who are hardest to vaccinate. If you look at the developing world, they’re used to mass campaigns. Countries conduct mass polio and measles campaigns, or hepatitis B campaigns. They have the infrastructure to do large-scale public health interventions, especially in vaccinations. But the U.S. lacks that infrastructure. It’s a paradoxical situation. We’re less prepared for a huge public health hazard than perhaps some of the developing countries.



Unidentified Audience Participant: You've talked a lot about the treatment of disease, but what about the preventive, educational approach? Preventative medicine has been left out of the conversation. I started a health center in a refugee camp in Zambia. The UNHCR brought in a simple thing like malaria bed nets, but no one was taught how to use them. So no one used them. There were about 18,000 people who were then diagnosed with malaria in the local medical center.

After we set up our health center, we taught people very precisely how to use bed nets. The next year there were only 7,000 cases diagnosed. Lots of times we throw medicine at the problem instead of educating people and giving them the resources to empower them. It's the "teach a man to fish or give a man a fish" approach. Why isn't education more widely spoken about in panels like this?

...prevention is something that we have to pay more attention to and figure out how to do dramatically.

-Neal Baer

Neal Baer: You see prevention and education in all three shows represented on this panel. As writers we take it for granted. But studies have shown that people learn from what they see on television. We did a study on *ER* – the first pre-test and post-test, non-retrospective study – and discovered that 9% of viewers knew that HPV caused cervical cancer before watching an episode of *ER*. After the show aired, a random sample was queried by Princeton Survey Research and the Kaiser Family Foundation, and close to 30% knew that HPV caused cervical cancer. We could have talked more about prevention on this panel, but this panel was focusing more on what kinds of stories one can do.

Certainly it's a challenge to tell a prevention story and make it dramatic. But you can. You certainly got that from the *Numb3rs* episode. You saw a public health message at the end of that show. It said, "Here's how you donate your organs, you have to have a pink dot on your driver's license, etcetera." That's basic public education. Prevention is something that Sandra can talk about, too, because they've done the studies. But prevention is something that we have to pay more attention to and figure out how to do dramatically.

David Harden: That's also when dealing with the networks becomes an issue – and we don't have to get deep into the politics. Sometimes the networks are for it – like in the "Harvest" episode. CBS was really excited about it. But there were other times when we got significant pushback from the network because they didn't think that was our job. We're not educators, we're television writers.

George Rutherford: There are opportunities to build in that prevention message – to close the loop, if you will. After someone has been diagnosed and treated for malaria, for example, to build in a teachable moment. The physician hands the person a bed net and says use it next time you go to Africa.

Neal Baer: We can also extend the message online. You're going to start to see a lot more partnerships. There's one between Hollywood Health & Society and *House* where they list every episode including what the disease was and where you can get more information. As the networks look for ways to bring in more viewers, they're finding the natural affinity between creating the show and providing useful information. Dr. Yamada, we're going to close and I wanted to end with you. What do you hope writers get out of this?

Tachi Yamada: The moral of the story is that this isn't an exotic story. This is about all the things that happen to all of us. The aspiration is that people who don't have resources, who live without means, have the same benefit of science and technology and medicine that we all have. It's an issue of equality. It's also a common story, but one that can make a huge difference for so many people.

Sandra de Castro Buffington: Thank you all for coming tonight. For the writers out there, please know that you can call on Hollywood Health & Society any time you're doing a health storyline, be it domestic or global. I'd like to extend a warm thank you to all of tonight's speakers, and particularly Dr. Yamada. Thank you.

