Rolf Taylor: Hello, and welcome to The Health Disparities Podcast, the regular exploration of inclusion, diversity, equity, and allyship. A program of Movement is Life Caucus. I'm Rolf Taylor, series producer and today I'm sharing hosting duties with my good friend, author, and fellow Movement is Life contributor, Frank McClellan, JD Professor Emeritus at Temple University Beasley School of Law in Philadelphia. Good to see you, Frank.

Frank McClellan: Thanks so much, Rolf. I'm so happy to be here.

Rolf: And Frank's book, "*Healthcare and Human Dignity*," is a must read. It's been discussed in a previous podcast from this series, actually way back in episode two.

Frank: Yeah, that's quite a way. I want to congratulate you, Rolf, as well as the Movement is Life team for the high-quality podcast that they've presented. And today is going to be one of the highlights, I promise you. I've been looking forward to it because Dr. Johnson is someone I've admired and known for several years, many years, really in professional capacity. And he brings a diverse, fascinating background to us that we want to share his perspectives on medicine and public health with the audience that follows the podcast for Movement is Life and Dr. Johnson, welcome to the podcast.

Dr. Johnson: Thank you, Frank, and way to raise the bar and the pressure, but it's a pleasure to be here with you, thank you.

Frank: Yeah, and I'm going to raise it more because I'm going to quickly run through for our listeners, some of your background. I can't do all of it because it'd take the whole podcast, but it's really a fascinating career that you've had. You started out studying sciences at Morehouse College and then both medicine and public health at Johns Hopkins, practiced as clinician in pediatrics and were associate professor at Temple.

Dr. Johnson: Yeah, I have to slide in there. I trained in pediatrics at The Children's Hospital of Philadelphia, a place that I'm forever, ever grateful to and proud of.

Frank: What was the position you served in, in New York before you became secretary of health in Pennsylvania?

Dr. Johnson: I actually served a couple of positions in New York. Kind of went in a brand-new position just supporting one of the deputy commissioners and left as medical director for what was the division of family health services? At that time, I think they completely reorganized since then, but that covered a lot of ground in terms of the maternal child health and family services there.

Frank: And I know that you served the secretary of health for the Commonwealth of Pennsylvania for five years, between 2003 and 2008. And then after that, return to Temple University Health System as VP and chief medical officer. And actually, I think I knew of you before, but I met you during your years and tenure as secretary of health when you created an advisory committee to deal and addressed some of the issues of health equity and I was lucky that you appointed me to serve on that advisory committee, and I'm going to ask you some more questions about that later. I also understand you later became involved with correctional facilities and health of persons who were incarcerated. And on the side in your spare time, been a radio host for WURD radio program, the only African American owned and operated talk radio in the commonwealth of Pennsylvania.

Dr. Johnson: That was a great time at WURD, started, owned and operated by, a great man, Dr. Walter Lomax, who was instrumental in my own personal and professional development as well, and is still run by his daughter, it stays in the family, yeah.

Frank: And now you've assumed the position and the challenge of being chief medical officer and executive vice president at Royal Caribbean Group. When did you start that position?

Dr. Johnson: A year and just about two months ago, in the midst of this pandemic.

Frank: Oh, that must have been a very peaceful beginning for you then, in terms of your responsibilities.

Dr. Johnson: It's been an amazing journey and there has not been a dull moment.

Frank: So, I would like to go back and let you, in your own words describe how your career first got directed toward both public health and medicine. We have a lot of audience members who try to mentor young folks in high schools, in colleges about careers in health law, and you uniquely have done both, in terms of both the medical degree and the master's degree. Did your parents influence you to start this path in high school? How did the seed get planted to do both?

Dr. Johnson: Well, as usual, that's a great question Frank, and I think absolutely my parents influenced me and directed me. I can't say that they directed me specifically into this, but there's been no greater influence on me than my mother and my father who I'm blessed to still have with me today. I think it really all started for me with just that kind of service. I grew up in a house of family where my parents, who were both kind of first-generation professionals, first generation college, but they both went on to graduate

degrees and both in their professional and personal lives, it was focused on service. And so, I grew up seeing service personified, and so that was just a natural part of what I thought made sense. And so, professionally, I think ways to serve was a part of the beginning, and for me, I learned that I enjoyed science and math and I was pretty good with it. And then, I got to a point where I really wanted to know how to save a life, and I can't remember exactly how that came about, but I knew I wanted to know how to save a life. And so, all that kind of combination of joining the sciences and service and wanting to know certain things pointed me in the direction of medicine.

Frank: And so, you first enrolled, in terms of your education in Morehouse, one of the greatest institutions we have in the country, in terms of education and training of both undergraduates and medicine. How did you get steered toward, or choose to go to Morehouse and what impact did that educational experience have on you as a professional?

Dr. Johnson: Yeah, Morehouse, I agree with your description of Morehouse, one of the greatest institutions that there is, and it sits in a family of great institutions that have served this country and the broader community so well over the years. The Atlanta University Center with other HBCUs there, all kind of there creating a large family of colleges and universities and it was from there. My father, one of the schools he went to Clark Atlanta University, it

was called Clark College then. And so, I was actually, that I've grown up with knowing everything about Clark College. And so, I was on track to go to Clark College and actually was at a summer program down there between my junior and senior year of high school. And one of my counselors graduated from Morehouse and was on his way to dental school. One day, he took me over across the street, literally, the schools were across the street from each other, and he took me over to Morehouse, and it was one of those experiences where everything just felt right about it, when I walked onto that campus. From meeting some of the professors to some of the students that were around for the summer, to just being there in that kind of environment and aura, it just felt right. And so, ultimately, I had to share with my father that I thought Morehouse was a better place for me than Clark, and true to the man that my father is, he supported me all the way in that. I know it was tough for him not to see that, with my father's legacy there, but, again, it was all in the family. So, that's kind of how I got to Morehouse and then just there, I majored in chemistry there. Again, kind of the love of the sciences and wanting to be kind of pre-med and a pathway to medical school, and just had a tremendous life experience. I say that's where I went into Morehouse a boy and came out a man.

Frank: We have a very diverse audience on this podcast. Can you just give us a quick illustration or naming of some of the illustrious graduates of Morehouse? Just a short list.

Dr. Johnson: Sure! Well, I think probably one of the most well-known is Reverend Dr. Martin Luther King Jr. and actually, he came from a legacy of family going to Morehouse as well. We've had everything from leaders like that former Mayor, Mayor Jackson of Atlanta, who transformed Atlanta in so many ways, a graduate of Morehouse College. We've had athletes, Edwin Moses, the Olympic gold medalist hurdler. We've had arts and entertainment successful icons, Spike Lee. He's a graduate of Morehouse. Samuel L. Jackson and many more from medicine to law, sports entertainment to some of the greatest preachers the world have come from Morehouse. And so, it is a school that has a lot of history, a lot of legacy to it, but also has a very true and real grassroots mission. And my best friends today are folks that I met as an 18-year-old starting Morehouse. In fact, I just saw some this weekend at an event.

Frank: I know I asked you for a short list so I really recognize that there are many more that you could continue with. I'm wondering now in comparison to Morehouse, well, not to compare them, but just to think and reflect on the difference in your experience when you decided to go to Johns Hopkins, which has always been an innovative institution, particularly when it

comes to medicine and public health. How did you choose that and what do you consider to be the unique influence that Johns Hopkins had on you?

Dr. Johnson: Yeah, well, one of the buzzes I've had is that there have been people who have gone before me and paved the way, and so there were actually two at the time, two graduates of Morehouse a couple years ahead of me who were at Johns Hopkins. So, I went to visit and see them and see the school, the university, and it was, again, another one of those feelings that check the boxes for obviously the superior academic institution and for preparation for a medical career, then it just felt right. And so, that kind of led me to say this was where I should go for the next portion of my career training. Again, I was focused on medicine. Public health hadn't really come into view for me then, but that was kind of the familiarity of people that have been there and then going in and seeing it, walking on the campus and meeting people, and then just going with that feeling that says, alright, this is a place where you should be, and could be, and could do well.

Frank: And you subsequently became a clinician practicing, actually providing healthcare directly to patients. So, can you tell us what your specialty was and what period of time you worked as a clinician?

Dr. Johnson: Pediatrics, general pediatrics, my clinical specialty, and I got introduced to pediatric there at Johns Hopkins. Frank Oski was chairman of pediatrics, one of the great leaders in the field of pediatrics and author of one of the textbooks in pediatrics, was there at the time. But it was also at Hopkins where I became familiar with and introduced to public health. The School of Public Health was literally across the street from the School of Medicine, and I went across there one day and kind of opened up a whole new world for me. And suddenly, I understood and realized that this idea of population health, and so that created an interest for me being the clinical practice of medicine. But policy involvement and large-scale change that happens from operating from a public health and policy perspective. And that kind of then really was where my career was shaped and pediatrics as a clinical specialty, fell right in with that. It made sense to me. When you deal with children, so much of it is anticipatory guidance looking forward and preventative, in terms of the care and health. And again, that's kind of foundation in many ways of public health as well, so, the two really fit nicely for me.

Frank: You became secretary of health in Pennsylvania in 2003, as secretary of health, how did you go about setting forth your priorities and goals, and then trying to implement them? And specifically, I want you to talk about the Department of Equity or Health Disparities operated under your supervision while you were secretary of health.

Dr. Johnson: Sure. Well, in a position like that, it's a poignant position, so you serve at the pleasure of the chief executive. In this case it was the governor. So, in the larger sense, the priorities were the governor's priorities and each of the agency heads work to address the governor's priority. Now that said, again, that's the big picture umbrella, there are certain aspects of there that need to be dealt with. The Department of Public Health in Pennsylvania at the time really had a broad purview, both in terms of promotion of health and prevention of disease but also, in terms of regulatory and overseeing of the patient care aspects of managed care organizations and being the regulator and licenser for all acute care hospitals, and nursing homes, and care facilities. And so, I had a very broad purview in that way. and then, at the time that was shortly after 9/11. And so, obviously, your priorities come from both the population that you serve, and we had twelve and a half million Pennsylvanians that we were responsible for protecting the health and promoting the health for. As well as very specific and regulatory roles, and responsibilities as well, and one of the things that is a foundation of public health, and health, again, as I said is prevention and using data to help understand the world in which we live and ways to help make the population healthier and better and raise the quality of both care and life for individuals, and you can't help but see, by looking at data around that, that there were disparities. So, that kind of created the foundation for one of clear priorities is that, when you

look at various groups and there's so many ways to divide populations into groups, whether it's by age, whether it's by gender, whether it's by race, whether it's by socioeconomics, whether it's by geography, there are so many different ways. And when you look and slice the information and data in so many of the ways, they show disparities and when consistent disparities show, that demonstrate that one or another particular group crosses multiple of those categories, and it clearly is affecting their health status and health outcomes. Then, kind of drives your priorities in those directions, so, addressing health disparities, became a very clear and almost easy, kind of point to focus on and set as a clear priority.

Frank: What strategies or programs did you identify and attempted to implement in order to reduce health disparities?

Dr. Johnson: It's almost pretty basic though. The first part we found was really raising awareness and helping to clearly define and articulate what health disparities were and meant, and what they looked like and putting a face, a name, a life, livelihood to it. And you mentioned the Office of Health Equity and that was something that we started during that time. It became one of the governor's initiatives as a part of his overall healthcare reform plan, as well. And that gave a focus and a base for beginning to coordinate the efforts, once we defined and began to raise awareness.

It also began to give a point focus to really programmatically, into address very specific points and issues of disparity, whether they be infant mortality, whether it be heart disease, whether it be violence, and in particular, gun violence. They're all, again, the data tells the story very clearly and points you to where the clear differences and disparities are and how it results in very disparate outcomes for people's health and wellbeing.

Frank: So now, there's always a challenge of once you have set a goal and priority like that of getting the best out of the professional community and the institutions in the community, as well as community leaders and community members. So, did you develop or learn anything with respect to things that worked, for example, funding of certain types of organizations or direct care for certain types of populations? Just probing the outside.

Dr. Johnson: Yeah, I think I learned a lot and I probably can't remember all the lessons that I learned they were just so numerous, but nonetheless, extremely valuable. And one is that there are a lot of organizations and institutions, both grassroots and more traditional and established whose infrastructure actually can lend itself and really benefit the implementation of programs, efforts, initiatives, and help with the sustainability, because that's a piece that is often very elusive, in terms of many of the efforts that are made to

change things or improve aspects of life or address issues, is the sustainability. So, tapping into the infrastructures that exist as well as kind of the foundations of both established and new organizations is, I think I found to be very important, and in fact, vital to both the credibility, establishing the credibility and making progress in terms of efforts. Many organizations that existed long before I became health secretary in Pennsylvania, who were doing all kinds of incredible work, and so, part of the opportunity and success is really just supporting and finding ways to support, encourage, and help those kinds of existing organizations, as well as providing opportunity for new and fresh organizations and ideas to come to the forefront. So, it really comes down to I think respecting what exists, connecting with what exists and creating those relationships that help to take the best of what does exist and infuse it with new information, new ideas, new energy and move it that much further.

Frank: The question that I want you to give us your thoughts on, or the role of safety net hospitals, and the impact that the closing or the reduction in services available in urban and rural areas of safety net hospitals and what your thoughts are about what we need to do to address those issues?

Dr. Johnson: Well, when you think about it in some ways, the fact that we even have or need something we call safety net hospitals, speaks to the vast and ongoing disparity that exists, in terms of access and care.

Frank: What is a safety net hospital? Just in case some members of the audience are not familiar with it.

Dr. Johnson: Yeah, the idea of the safety net hospital is just that, think of a tightrope walker in the circus and walking on that thin wire up there, and what's below them is a big, broad, wide net, the length of the wire. So, if they fall, they're caught by the safety net, so, if you're going to fall from the platform, or fall from the wire, or fall from the greater heights, there's something there to catch you. And so, in the safety net hospital around, these are the hospitals where those who wouldn't be able to get care or access to care anywhere else, will get their care. And often, it's late in the stage of illness, and so you see the sickest, those are the hospitals that are there for the sickest of the sick. But if you have the ability, whether it's the income or the wherewithal to do go elsewhere, that the idea of the thought is that you go elsewhere to other hospitals. And, just even in, again, even in that construct, it speaks to, and perpetuates this idea of a disparity. Now that said, some of these hospitals that are deemed safety net hospitals are places where you have some of the most talented and gifted physicians, and nurses, and other healthcare providers. And so, it doesn't speak to always the quality of the individuals who provide care there, but sometimes it does speak to the availability of resources that

they have, those individuals have with which to work and care for individuals.

Frank: I don't know if you follow this in any detail, but Hannaman Hospital, one of the main safety net hospitals in Philadelphia, closed before the pandemic and I'm just wondering if you have any sense of what impact that had on patient population that depended upon those types of services from that kind of an institution.

Dr. Johnson: Yeah, I haven't followed it as closely as I have other closings in Philadelphia earlier and other places, but I suspect that the story is relatively the same, is that there is a population that consists of a relatively high percentage of un or underinsured individuals. And so, the reimbursements for the care that's provided is often the care, again, is being provided to people who are sicker and so coming in higher acuity because for various reasons they haven't had access, and so, whatever condition that they're to be treated for has been unattended for extended periods of time, and so is more advanced stage disease or more complicated disease. And so, the cost of care is higher and yet reimbursements are less, and so, it becomes that kind of vicious cycle.

So, when a place like that closes it's that those individuals then, are once again faced with a barrier to access to care. Philadelphia itself is a

metropolitan area that unlike many others in the country does not have a single safety net hospital, or a kind of public hospital, as it's called. And so, various private hospitals have taken on and receive a significant higher percentage of those kinds of individuals who, again, who have higher burden of disease and more severe, more acute disease. And so, when a hospital like that closes, ultimately, at least some of them seek care and will connect to care in other places. And so, it just increases the percentage of higher acuity on un or underinsured individuals that go to other institutions. And typically, there are two or three institutions in an area like that, that will increase and take on that capacity.

Frank: So then, what should we do about it, Dr. Johnson?

Dr. Johnson: People say that money doesn't solve everything, but money does solve some things. And so, the cost of healthcare, for a lot of reasons is high in our country, your care may have been neglected for an extended period of time, for lack of access, for lack of availability, for other life priorities that have caused you as an individual to make decisions about your health that make it secondary to transportation to get to work so that you can provide for your family, and put food on the table, and things like that. And so, a commitment and a willingness, and then, when I talk about that, I'm talking a lot of ways of the political will and this is where the more things change, the more things stayed the same, in so many ways that politics, which is

one of the aspects that attracted me to health policy, quite frankly is something that is cyclical in so many ways and plays a real role in the daily lives of people, even though sometimes, when it's time to vote we don't always think about that, but many of us do think about that. It is real, and so, political will of when budgets are being made and decided upon, and what are priorities in terms of what needs funding. Those are issues and decisions that really can have a real impact on what ultimately turn into broad disparities or can help eliminate disparities. And the money itself, what does that mean? Well, that means funding that helps train providers who are able, and willing, and desirous to care for complicated conditions in urban areas, for example, or complicated conditions in rural areas because disparities exist, as I said before, there are geographic disparities as well.

That's one of the things I learned in Pennsylvania, we had a country that's, a state, I'm sorry, that was 80% rural by geography, and so they're vast areas of state that don't have easy access to healthcare. And so, conditions, people allow conditions to get worse and more complex because they don't have the ability to leave their work, to go travel a far distance to get care. So, their funding and allocation of resources in strategic meaningful ways really can help and begin to address those kinds of issues as a starting point.

Frank: So, you mentioned politics, and we know how deeply it affects allocations of resources and not clearly demonstrated by what's going on now with respect to the vaccines, et cetera. One of our most distinguished members of our steering committee, Dr. Augustus White, who's published a number of books, but is consistently arguing that we, in order to solve this problem, we need to politically characterize healthcare as a human right. Do you see that as something that you would concur with and is it impractical or practical that we would one day achieve that in the United States?

Dr. Johnson: So, you asked a lot of questions there, so let me see if I can answer all of them. So, healthcare as a human right, I think, I do believe that everyone deserves to have the opportunity for health and wholeness, and so if we characterize and instead of stepping more into kind of your realm, Frank and others, and outside of mine. But when you think about what this country is based upon and the pursuit of health, and happiness, and a full life and I know I'm paraphrasing, but, when you lay as a societal foundation, then you essentially are articulating that there are certain rights and one's opportunity to be healthy, is one of those. Now, what one does with the rights that they're given, and the opportunities that they're given is another story, but everyone should have, I believe that opportunity. And the way that our system exists today, everyone doesn't

have that opportunity. And so, if you're one that believes in fairness and an opportunity, then, I think it's hard to argue against that.

Frank: So, from a political and social point of view, one of the challenges that we have, I think is that when we start talking about access and universal access, a lot of times opponents tend to stigmatize the vulnerable populations that we're trying to assist and help. Members of the public and voting public, or people, or political activist, oppose it primarily because they don't see the individuals who are being excluded as worthy of the kind of public resources that will be required to help them.

Dr. Johnson: Stigmatization comes from, my view, a combination of fear and ignorance. And I'm not saying that in a pejorative sense at all, but you don't know someone until you know them. You don't know someone's story until you've heard it and been willing to listen to it. But when one has a fear of things different than oneself, has a fear of what that means or understanding it, and lacks a desire or willingness to learn about it, I mean, there's no harm in learning, because then, you can still form your own opinion and say that's not for me or decision that says that's not for me, or I don't like that. But, without that openness and willingness, that fear and that ignorance really leads to that kind of stigmatization. And so, it blocks progress, it blocks change, it blocks improvement, so, and that's why we keep having these same conversations. Access to care for certain

groups of individuals, was an issue 25 years ago, it's still an issue for those individuals today. And it's not because we aren't smart enough, or innovative enough, creative enough to drive toward solutions, or to do with the ultimate willingness. And again, I think that fear and ignorance are the blockade to that willingness to improve ourselves and improve our condition. I do believe that rising tide raises all boats and ships, and so, me doing better doesn't, or you, doing better doesn't diminish me, it actually helped me. That's been the case with healthcare for oh so long. One of the arguments that I used to make, going back to an earlier question that you asked around disparities, was really the economic argument. You're sure you start, you may start with the altruistic argument, you may start with the compassion argument, you may start with the decency argument, but you shouldn't leave out the economic argument. And the fact of the matter is that the cost of care is paid by all of us, and again, going back to the data, the data shows that, that uncompensated care is ultimately compensated in one way, shape, or form, and it comes from others. So, ultimately, yeah, if I don't want to work towards support solutions that help to move the cost of care for an individual to a lower cost of care, by helping that individual to get in front of care earlier. So that preventative efforts can be put into place that avoid costly illness or that earlier diagnosis that can lead to earlier treatment and less expensive treatment.

Frank: What unique lesson did you learn in your efforts to provide equitable care to prisoners or people who are confined in correctional institutions?

Dr. Johnson: Well, there's a great misconception I think about our criminal justice system, and that is that those people who are in the correctional healthcare system get locked up and go away, and they are those people, and they're different than these people. There's only a small percentage of people that ultimately are kind of locked up forever. And so, most people go in, may serve time, and then they come back out, and so what does that mean? That means that the same people that are in the correctional system, and from my perspective, it was a correctional healthcare perspective, so, receiving care, healthcare in the correctional system, are say people that are going to be, at some point receiving care and needing care in the community as well. And so, when we think about it, literally, these are our new neighbors, these are people that we share in the same community with. To me, that should hopefully kind of open up some eyes and perspectives, understand that there isn't this great distinction, and people are entering into our correctional system, again, that's a whole other conversation for many different reasons, some just, some unjust. But the fact of the matter is, again, that this is a cyclical system and people cycle in out of it. And so, it behooves us to consider for both chronic conditions and acute conditions, helping people to get the healthcare and have access to adequate healthcare that they need because one way or

another, we are going to pay for it, and the “we” is those of us who are taxpayers, the “we” is those of us who contribute to our community, live in our communities and are homeowners, those of us who get ill ourselves, those of us who have employment. So, much of that is cyclical, and so, what happens inside, in terms of oftentimes the healthcare perspective inside and behind the walls in the correctional setting, is in many ways a mirror of what is outside in the community as well. And it's just a matter of the timing of when one is more relevant or in play than the other, and so, us having a different perspective around that and understanding that there's a cost no matter where it's paid. Our drive, collective drive may want to be towards where would that cost be the least and derive the greatest benefit for all of us.

Frank: Well, Rolf, I wanted to give you an opportunity to ask questions. We're getting close to the end of our time, but I know you had a number of I thought really important questions about crisis management, as well as critical thinking. And Rolf is our director of these types of programs and gets to hear the views of a broad view of experts and commentators. So, Rolf, would you offer some of the questions that you have at this point in time?

Rolf: Sure, thanks, Frank, and it's been a really fascinating discussion and I know our friends over at Morehouse College, you're going to want to share this podcast. In fact, Dr. Daniel Dawes who's a professor at Morehouse is

speaking at our caucus, which is just coming up in a few weeks' time, so, that's a timely mention. But, Dr. Johnson, during the course of your career you've been a decision maker in a number of medical emergencies, and I think those include a hepatitis A outbreak, the opioid epidemic, and then more recently safety of passengers during a COVID-19 pandemic. So, I'm really curious to hear what you would say are some of the things that you found in common with those emergencies.

Dr. Johnson: Wow! That's a great question, Rolf. I think one of the first things that comes to mind when you ask that really is information and data. And I think that's critical in any of those situations to really understanding what one is dealing with. I would say another that I found common between is really information kind of on the other side, going the other way, providing information. One of the most important lessons I learned is that, when you're in a position to provide guidance and leadership, and that's what's being sought from you, if you leave a gap there, if you don't provide that in the form of information, in the form of guidance, that gap will be filled. It may not be filled with accurate information, it may not be filled with good information or good guidance, but it will be filled. And so, transparency and willingness to provide information, understanding is critical thinking, being able to manage crises from a number of different points. By and large, I've found that people want to do the right thing and they seek information to help them to be able to do that, and so, providing that

information, but also receiving that information and really letting objective information help inform one's decisions, being data driven in that respect is important because what it does is, it takes, apropos to this conversation, it can help take the bias out of some critical decisions that need to be made in a critical moment. And that applies in the healthcare setting, it applies, in the public health setting, it applies, in kind of the broader and emergency management arena, it applies in the business sector as well. If we really allow ourselves to understand circumstances, situations, people, and we do it in and there's a qualitative way and a quantitative way to do all of that. I think we really do put ourselves in a better position to solve critical issues, so, I think being data driven in how we make decisions and how we assess situations is very important. That doesn't mean devoid of compassion or the emotional equation side of it.

My challenge to myself, which I would share to others, is to always continue to try and be both balanced and transparent in how we look at problems and really drive towards solution. I don't believe that there's ever been a problem made that doesn't have a solution to it, but it is that willingness, that openness to do it from both an intellectual and an emotional perspective, but also, to do it collectively. That really, I think drives us towards real solutions. So, if there's any challenge that I would share with anyone, that's one that I share with myself, to continue to try

and be as good a partner and collaborator as well as good an analyst and operator as I can.

Frank: Well, Dr. Johnson, thank you so much for taking the time to do this. We know it was a significant impingement, undertaking new job as the global head of public health and chief medical officer in Royal Caribbean Group, I'm sure has a lot of problems waiting for you to address with your perspective, and we certainly appreciate you sharing this time with our audience and your insights, and you did not disappoint.

Dr. Johnson: It's been a pleasure and thank you so much and hope we'll get to talk again sometime.

(End of recording)