

## **Center for Strategic and International Studies**

**“A Conversation with U.S. Surgeon General Dr. Vivek H. Murthy”**

**Featuring:**

**Dr. Vivek H. Murthy,  
U.S. Surgeon General**

**Moderated By:**

**J. Stephen Morrison,  
Senior Vice President and Director, Global Health Policy Center,  
CSIS**

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J. STEPHEN MORRISON: I'm Steve Morrison. I'm senior vice president here at CSIS and run our global health program. And we're really excited and honored to be able to host today the United States 19<sup>th</sup> surgeon general, Dr. Vivek Murthy – welcome Vivek, for a conversation on America's evolving response to substance use disorders, specifically the opioid epidemic. We'll touch on a few other related topics that the surgeon general's been so active on.

This is the first time that a surgeon general's come to CSIS. And so we're – you know, this is unprecedented. So thank you so much, you know. And we're a global health program. We're predominantly focused on those issues. This certainly has a very – some very big international dimensions, which we'll talk about, particularly on China, Mexico. But we've taken a special interest over the last few years in the questions around drug policy, illicit drug trafficking, the health implications, public health approaches, and the like. We have a podcast series, "Take as Directed," which my colleagues Sara Allinder, Cathryn Steifel have started up. You may have noticed on that, there's a wonderful podcast by Michael Botticelli. We'll be taking this – the audio version of this today, to convert that into another podcast. So please enjoy that. I want to say welcome to those who have come online. We had over 100 people confirm for that.

Let me do first a few quick words of introduction of our guest of honor, a few words of background on the opioid epidemic. And then we'll move into a series of questions. We'll go on for about 40 minutes – 30-40 minutes, and then we'll open it up to you and bundle up some questions and comments for the surgeon general. We'll have folks just coming around with microphones. Please – when we get to that point, please be very succinct – single intervention, very succinct. We'll need to – we'll need to conclude around 1:20.

So, Dr. Murthy has served in this role of surgeon general since mid-December of 2014, which means that he's roughly halfway through his five-year term. He's a son of immigrants from India. He grew up in the Miami area, received his bachelor's degree from Harvard, his MBA and M.D. from Yale – a very good choice. I happen to have gone there myself. (Laughter.) Delighted to see that you made that choice. He, from early in his career, has been highly activist, highly creative, highly entrepreneurial in the work that he's undertaken, and highly focused on communities. He created a group called VISIONS, focused on HIV/AIDS education of communities in both India and the United States.

He established a group called Swasthya – did I get that right – a community health partnership in rural India, with a special focus on training women to be health providers and educators. He's a widely-published research scientist, with a special focus on vaccine development. He's an entrepreneur, founding a software technology company, TrialNetworks. He's the first president of Doctors of America, a nonprofit organization of doctors and medical students advocating for an affordable and effective health system here in the United States. And these were all things done before I think you were 32 or something. (Laughter.) These are just a remarkable set of achievements.

Before I begin, just a few words of special thanks also. On our staff, a number of people really worked very hard to make this all happen. We've had a dialogue of putting all the details together. Lily Dattilo, Deen Garba, Katey Peck, Joe Jordan, Alex Bush, Travis Hopkins have all been very, very important in pulling this all together. At the back of the room, on our camera – on our cameras are two of our interns, Brian (sp) and Oliver (sp). Thank you. And our wonderful crew here at CSIS that makes these events happen – Guillermo, Carlos, Guzman. From the surgeon general's staff, we're especially grateful to Shavon Arline-Bradley, Rafael Campos and Jessica Scruggs. It's been wonderful

working with you all. And I just want you to know what a wonderful team you have. They're really terrific to work with.

VIVEK H. MURTHY, M.D.: Thank you. I'm very lucky.

MR. MORRISON: This has been a long time in the works. So we're delighted this has all worked out.

The subject before us today, the epidemic, remains a harrowing and complicated threat. There's been some very important recent progress that we'll touch on, and there's continued dangers and uncertainties. It continues to surge. More than 52,000 died of drug overdose in 2015. Roughly two-thirds had used prescription opioid like Oxycontin or Vicodin or illegal drugs like heroin. And these overdoses have jumped 33 percent in the past five years alone, with some states in our country reporting the death toll had doubled or more. Just today there was new data issued, reported in Reuters, on heroin.

There's a few other startling facts, some of which were brought home to us by the surgeon general himself in a letter from August and in a very important study that was published at the end of the year. Since 1999, there's been a full fourfold increase in overdoses of prescription opioids. Even today, after 15 years of struggling with this, over 68 deaths per day here in the United States. CDC and the surgeon general estimating over 12 million Americans who engage in misuse of prescription opioids. Two million addicted, a one million gap in treatment access. It's a – arguably the major challenge that we confront. And it has to be confronted from multiple directions. And it's – and we're so fortunate that the surgeon general has taken this up and made this such a huge piece of the – of his work.

There has been a lot of progress. In 2016, the Comprehensive Addiction and Recovery Act, the 21<sup>st</sup> Century Cures Act, which brought a billion dollars in new money, the Affordable Care Act itself, Medicaid expansions. Many have argued Medicaid expansion was the single most important weapon in the battle against the epidemic, establishing additional treatment on the same level as medical and surgical procedures, and including mental health into that. The FDA has brought forward new treatments – methadone, buprenorphine, naltrexone. These are important gains. We now have the NARCAN, naloxone, used widely by health workers, by police authorities, law enforcement and the like. We have new CDC guidelines on prescription of opioids, and overall a big change of perceptions that the surgeon general and others have pushed hard to treat this problem of additional as a – and substance use disorders as a chronic disease form that requires a public health approach.

Lots of outstanding continued challenges. We know now that the heroin epidemic, the fentanyl epidemic is filling the gap as there's tightened controls over access to prescription opioids. There's still challenges in getting cooperation from doctors, industry law enforcement. There are data gaps and things that need to really happy. And of course, we know that in the grand debate that's ongoing on now in our country around the Affordable Care Act – is it to be repealed and replaced and what form might that take – creates lots of questions around preserving and sustaining the progress that has been made, the protections, the access, the coverage that became – that made it so possible to begin to address this.

So let me turn now to our guest, and ask him if he would – before we get into the substance of your work, why don't we start with a little bit more of personal note, and you can tell us a little bit

about yourself, as to how did you – how did you find yourself in this position two years ago? How did you get here?

DR. MURTHY: Well, the short answer is, quite unexpectedly. But I will first just say how grateful I am for the chance to be here with all of you. How is everyone doing today? Good. I am impressed that you are in here and not out there, given how nice the weather is. But I'm glad that you're here, because we have a lot of important things to talk about. And I'm very excited, in particular, to hear the questions that you have at the end of our – of our conversation.

But the truth is, my story to this position was very unexpected and unlikely. I, as Steve mentioned, am the child of immigrants from India. They came here from humble roots. My father came from a small farming village in rural India. He didn't really have thoughts about leaving the village when he was growing up, because that's not what people did. He thought you would become a farmer, just like his dad, and grew up in, you know, a fair amount of poverty. His mother died when he was very young. They raised six kids on their own. It was tough circumstances. And my mother, while not from as challenging a background, also came from humble roots.

So they came to the United States hoping that their kids – my sister and I – would have the opportunity to get a good education and to get a good job down the line, and hopefully make a contribution to society. And that's what they came with expectations of. That's what we hoped for when we were growing up. But I will say that our experience in America has just been really extraordinary. We found that we were welcomed by the community that we first encountered in Miami. We were given incredible educational opportunities at the public schools down there, which allowed me to not only nourish my fascination and interest in science, but also gave me a lot of exposure to other subjects that I found myself unexpectedly excited about – including English literature, history, and economics.

Coming out of all of that, you know, I decided that I wanted to pursue something in the health field, I wasn't exactly sure what. And I actually stumbled into public health somewhat unexpectedly during my freshman year of college when my sister and I decided to begin an effort to address HIV in India, because at that time HIV was actually on the rise in India and many people weren't paying attention to it, were in denial that it was a problem, we would hear all the time, well, this is a Western disease. It's not a problem in the rest of the world.

And so we thought, well, what if we were to mobilize youth – young people, who are traditionally not tapped for public health reasons – what if we were to mobilize them and actually get them to go out and to educate communities about HIV prevention? And that started out as a fanciful idea one afternoon during our first semester in college, and later became an organization that we worked on for eight years. And it also – more than, you know, how much time we worked on it, is the fact that we developed this excitement and interest and passion for public health as a result of that. So that's what got me started in public health and led to many of the other things that I worked on in public health.

And I eventually went to medical school, thinking that – and really feeling that I wanted to be a part of delivering care directly to patients. I wanted what I saw my mother and father having with their patients when I was growing up, which is these beautiful relationships that were based on trust, relationships that were in fact mutually therapeutic, and which gave my parents these beautiful windows into the lives of other people and a chance to help them during moments of suffering. And I wanted to be able to contribute in that way. So that's why I went to medical school.

But then finally, I'll say, the last twist in that road which was unexpected, is I find myself engaged in public policy and advocacy. You know, at that time, probably about eight, nine, 10 years ago, I was practicing medicine and I was building my technology company. I had a longstanding fascination with technology. This was at the time when social media was actually on the rise. Facebook was just starting. There were other social networks out there. Some of you may remember Friendster – (laughter) – anybody a Friendster member from way back in the day? Yeah, we got somebody back here. And the rest of you, I know, won't admit it, but half of you were on it, I'm sure. (Laughter.) But I remember all of those platforms, and wondering if these platforms could actually be a tool for enhancing our productivity in the workplace, our work in research. And so that's what led to the technology company.

But I will admit that throughout all of that, that I thought that public policy was probably the slowest and least effective and efficient way of creating change. And hence, I stayed far away from it. But that conclusion was not born out of experience. It was actually, I realize in retrospect, more and more out of ignorance and a lack of exposure to public policy and to public servants who were engaged in the good work of crafting effective policy. But over the last eight or nine years, I had a chance to – working hand-in-hand with my now-wife Alice – we had a chance to build an organization that brought clinicians together around the country to think more about what we need in our health care system, to talk to their elected leaders about what that might be, and then to really advocate for their patients, which is what most clinicians came into the profession wanting to do.

So that was the path that I was down. And I had just gotten off a redeye flight on my birthday in 2014 in July, when – and I was picking up my dry cleaning in Brooklyn and my hands were full, and my phone range. And it was a call from folks at the White House asking if I would be interested in serving as surgeon general. And after realizing this wasn't a prank call – (laughter) – I thought more seriously about it. And I realized that, you know, life has a funny way of preparing you for what you should be doing, not necessarily what you want to be doing. And I realized that many of the experiences that I had had, focusing on clinical medicine and education, on public health, on public policy and grassroots advocacy work, that a lot of that had actually given me some of the skills and tools and insights that I felt would go into making me potentially effective, and hopefully able to make a contribution in this role as surgeon general.

So that's how it all came about, unexpectedly. But I will say, finally, that it's just been an extraordinary honor to have the chance to serve in this role. It has given me an even deeper appreciation for the extraordinary public servants that we have in government who have dedicated often decades of their life, not to achieving a name or fame, but to really building systems at a state, local and national level that will ultimately serve people. And each and every day I count myself lucky, because in this job I get to go out and hear also directly from people throughout our country about what's concerning them, what's exciting them, about the innovations that they're working on. And that has given me a great deal of hope during uncertain times.

MR. MORRISON: Let me ask you to just explain to people what the surgeon general job actually is. (Laughter.) And I – and I say that simply because I'm surprised at how many people don't know what the Commissioned Corps is and they don't know what the surgeon general is. They don't know what the rights and – (audio break). You know, people could name, OK, Regina Benjamin was here in that role, earlier David Kessler. Many people remember Dr. Koop. But there's – the position is not that familiar to many Americans. So just tell us quickly about what the position is.

DR. MURTHY: Yeah, it's a great question, because many people – most people have heard about the surgeon general, because they've seen warning labels on a pack of cigarettes. (Laughter.) When people tell me this, they'll never admit it was their pack of cigarettes, by the way. It's usually somebody else's that they read it off of. (Laughter.) But they've seen those warning labels, or on bottles of, you know, alcoholic beverages they see warning labels as well about pregnant women not drinking alcohol. So they recognize the title from the warning labels. But you're absolutely right, Steve, that people often don't have a good sense of what I do. And that's actually reflected sometimes in the letters that we get to the office. There are people who write to me asking me to change laws, people asking me to diagnose a rash they had. (Laughter.) You know, we get all kinds of interesting requests and it's quite fascinating.

But I'll tell you what I do and what I don't do. So the surgeon general's primary responsibilities are twofold. The first is a public-facing responsibility to share the best-available science about health with the public so people can make good decisions for themselves and for their families. And that's a role that involves thinking about what our major health needs are, thinking about what people know and don't know, and making sure that we think of creative ways to get them that information. The second role of the surgeon general is to oversee the United States Public Health Service Commissioned Corps.

The Commissioned Corps is one of the seven uniformed services in the U.S. government – alongside with the Army, the Navy, the Air Force, et cetera. And the Commissioned Corps is actually the reason why I wear this uniform. This uniform actually bears a lot of resemblance to the Navy uniform. So those of you who have served in the Navy or have friends or family members who have, may recognize that the uniform is similar. And there are very few differences, one being the insignia here.

But our Commissioned Corps comprises 6,600 officers around the country and around the world, in fact, who serve in public health roles. And they may be serving in the CDC, in the FDA. They may be working in the D.C. area or Atlanta, or they may be in rural parts of Alaska or Idaho. But they're all over the country seeking to address critical public health needs. We also, though, deploy the Commissioned Corps during times of public health crisis. So, for example, in recent times many of you will remember a few years ago we had a scare with Ebola in West Africa, but a scare that actually pervaded outside West Africa to other parts of the world. And we sent hundreds of Commission Corps officers to standup the Monrovia Medical Unit in Liberia to help treat people with Ebola.

We have also deployed our officers after hurricanes and tornadoes to help setup clinical operations, to help strengthen the public health infrastructure. We sent officer to Flint after the water crisis was made more public. So whenever there are disasters – whether it's man-made disasters like 9/11 or natural disasters like hurricanes or tornadoes – we send our officers, who are doctors, nurses, public health experts, physical therapists, pharmacists, veterinarians, public health engineers – you may not have even known they existed but they do, and they help strengthen our infrastructure when it comes to water and a host of other things.

So those are the roles of the – of the surgeon general. And what the surgeon general does not do, though, is the surgeon general does not write and pass legislation. The surgeon general does not write and push forward regulation either. And the surgeon general also does not command a massive budget through which he or she deploys grants, you know. So we're not a grant-providing agency either. Our primary powers are actually in communicating to the public, using the pulpit of the office, and convening people as well around critical issues to enhance collaboration, and, third, around calling

the country to action through scientific reports, which is what we did recently in November around substance use and addiction.

MR. MORRISON: Yes. Thank you. I just want to add, my colleague, Cathryn Steifel and I, in early '15 had occasion to visit the Monrovia Medical Unit.

DR. MURTHY: Oh, wonderful.

MR. MORRISON: And we worked very closely with Mitch Wolfe and with some of the other officers who have stood that up. And it was a remarkable achievement, undertaken under some of the worst circumstances imaginable. And it had such a dramatic impact psychologically on the health workers that had to know that they would have this option as they were signing up, in which their ability to exit quickly by air if they became ill had to be known. And it was also put together in a very equitable way – in other words, Liberian health workers were as eligible to come in as American health workers.

And while it didn't – it ultimately didn't treat all that many Ebola patients, about 30 as I recall, that was became the epidemic, to everyone's surprise, miraculously did come down so rapidly. But in that period – in that September, October, November period, it was one of intense dread and fear that this was really on a skyrocketing trajectory, and that that unit was going to play just a pivotal role. And it was – it was a great achievement. So congratulations.

DR. MURTHY: I appreciate you saying that. You remind me of a conversation I had with President Sirleaf when I went to Liberia towards the end of our tenure with the Monrovia Medical Unit. And she said to me – she said, you know, before we set up the MMU, before the Commissioned Corps came, organizations from around the country were reluctant to send in volunteers because they asked the question: If our volunteers get sick, who will care for them? And after that unit was set up, and people had a sense of assurance that their men and women that they would send it would be cared for, then the floodgates opened in terms of volunteers.

And I remember when the president shared that with me, that felt very gratifying because, you know, public – when public health works well, most people don't notice public health, right? It often operates silently and in the background. And that's one of the real challenges, because we live in an age where the things that get the most attention – and by attention, you should also think of funding – are the crises that are the loudest, that are the most, you know, in your face, so to speak.

But ultimately when I go out in the country and I ask people, you know, hey, would you rather get Zika or prevent Zika? Would you rather develop diabetes or prevent it in the first place? Everybody wants to prevent their illness to begin with. But prevention requires a strong public health infrastructure. And we have over time in our country invested predominately in treatment. And for that reason, we have some of the greatest treatments in the world, and some of the greatest hospitals and clinicians in the world. But we have significantly underinvested on the prevention side. And, by extension, in our public health infrastructure. And for that reason, we have a dramatic increase in chronic disease that we're battling including not just addiction but heart disease and diabetes and cancer. And we're paying the price for that, in terms of not just health care costs but lost economic productivity and, most importantly, human suffering.

And so that is why when I came into office I decided that in everything that we do, every issue that we take on, there are two values that have to guide us in our work. Number one is on creating – is

around prevention, making sure that we are helping to build a stronger culture of prevention in America. But the second is around health equity, ensuring that the benefits of prevention and treatment accrue to everyone in our country, not just to those who are fortunate enough, like me and you, to have access to resources in terms of good health care – good health care.

So anyhow, so those are two values that really guide us. But that's why, to me, like, when I came into this job, I wanted to make sure I focused not only on talking to the American public about health issues, but on working with and strengthening our Commissioned Corps, because the Commissioned Corps is one of the greatest and best-kept secrets of the U.S. government. It's an extraordinary asset for public health. And when working in collaboration with our other uniformed services, can just be an extraordinary force at ensuring that our country is healthy and strong going forward.

MR. MORRISON: Thank you. So the position, in a way, as America's doctor, as the surgeon general, you have a special bully pulpit. You have a special ability to win people's trust and confidence and attention. But you also have an ability to listen to people in all walks and in all corners of our society, and to – and to draw from that. So you've been – you're halfway through your tenure, your appointment. Tell us a bit about what have you learned? What has surprised you? What have you, in this period, learned about America, but also learned about the job itself as you came into it?

DR. MURTHY: Well, I have learned so much in the last two years. And that has really been one of the most enriching parts of this job. You know, being surgeon general reminds me a lot of being a doctor practicing medicine in Boston, which is that people often used to tell me when I was working on a few other endeavors, you know, they used to say, why don't you just focus on that and leave clinical medicine for a while? And I would tell them that it's not just that I feel like I can contribute to the lives of other through clinical medicine, but it is so enriching for me, because every time a patient gives you the – you know, the opportunity to learn about their lives and to hear about their challenges and struggles and how they're overcoming them, you learn something, especially if your patients may be different from you in terms of their life experience.

And I feel very similarly about this job. I've had the chance to meet with and speak with and learn from people all across America. And they've taught me a great deal. I'll tell you two things in particular that have stuck out for me. One is that there is a – there is a resilience and a spirit of innovation that exists at grassroots levels in our country that I think we are often unaware of, that don't get attention in the newspaper headlines, that aren't covered a whole lot in the evening news, but which I see when I go out. I see people who don't have a whole lot of resources coming together to try to address pressing problems.

You know, I've seen families come together to support their neighbors who have lost a son or a daughter to an opioid overdose. I have seen mayors get together with their local law enforcement officials to figure out how they can create better mental health services for their incarcerated population – recognizing that they need those services early and not just at the tail end after a terrible problem develops. I've had the chance to sit down with police officers in Seattle, who have decided to carry naloxone with them, not because they were trained as doctors or nurses or pharmacists, but because they realize that they are on the frontlines of the opioid epidemic, and if they have naloxone they can help save lives if they attend to somebody who has acutely overdosed.

All across America, this is what I see. And some of you may know Tom Friedman, the journalist and author. And he once said to me – he said, you know, if you want to feel optimistic about

America stand on your head, because it looks a lot better from the ground up. (Laughter.) And there's a lot of truth there, because when you actually go out and you leave the headlines and you leave sort of the – as we refer to it here in Washington – the Beltway conversation, you start to see that there are reasons to be hopeful all across America. And those reasons for hope are rooted in individuals and communities and in their stories.

The second thing I've learned, which is – which has been concerning to me, is that while we have focused a lot on physical wellbeing and physical illness and on physical pain – especially physical pain, as we have thought about the opioid epidemic and what's driving it – what I've come to realize just more and more and more is something that I started to see even as a clinician up in Boston, which is that people all across our country are also experiencing a great deal of emotional pain, not just physical pain. And that lack of emotional wellbeing is in fact having severe consequences for our health. It is contributing to our opioid epidemic and to our addiction crisis more broadly. But it's also contributing to other chronic illnesses like heart disease and cancer.

And one of the – you know, people used to ask me when I was practicing medicine up in Boston. They would say, what's the most common illness that you see? Is it diabetes? Is it heart disease? Is it cancer? I would tell them, it's none of those. The most common illness I see in America is isolation, and isolation that stems from a lack of meaning, from a lack of self-worth. And isolation is really powerful. You know, the people who are living in states of social isolation actually live shorter lives. They in fact – the impact on mortality of isolation is similar to that of smoking or obesity. And we spend a lot of time thinking about how to get people to quit smoking. How much time do we spend thinking about how to bridge social isolation? And we don't spend nearly as much, because we don't often recognize how important a public health threat that actually is turning out to be.

So emotional pain, it turns out, is a root, root cause. It's driving much of the disease that we see. That doesn't mean it's the only cause of disease, but it's an important factor in driving it. And that's one of the reasons why, you know, one of the – why my office has decided that among the many initiatives that we work on, we also want to develop an initiative around emotional wellbeing and how to improve that in America, recognizing that science has already been telling us that there are tools that we can use to proactively cultivate our emotional wellbeing. And if we do that, that we can have a powerful impact not just on our health but on educational outcomes, on civic engagement, on social cohesion, on workplace productivity, and a host of other outcomes that we care about.

MR. MORRISON: Thank you. You know, in talking to people that are connected in different ways to the opioid epidemic, this isolation theme keeps coming up. And it's usually tied to the thought that you can be surrounded by people and be socially isolated. And it may not be even understood as such by you or by those around you. And it's tied in some respect to a broader despair around economic opportunity or lost opportunities or erosion of those connecting threads – whether they are church or other elements within the community that bind people together. So that – restoring and strengthening that wellbeing is a bigger project, right? It's one that really does bring us to the debate we're having today about why are so many people feeling alienated and marginalized and anxious over that, and what's the solution going to be? And I think it's very positive to sort of make the point that public health a very important role to play in this.

DR. MURTHY: And, Steve, just let me say one thing about this, because this can become a point of confusion for some folks when thinking about what goes into one's emotional wellbeing. We know that there are internal and external factors that contribute to your emotional wellbeing. We know, for example, thinking about external factors, that poverty and economic insecurity are major

drivers. We know that the experience of violence can also have an adverse impact on your emotional wellbeing, the experience of discrimination can also have an adverse impact. We also know that there are internal factors as well.

And as we think about how to address emotional wellbeing in America, we have to think about both sides. We have to think about how do we change those structural factors to decrease the sources of chronic stress in people's lives that lead to adverse health outcomes. And how do we also equip people with scientific, evidence-based tools that can enhance their own resilience, their own ability to withstand hardship when it – when it arrives, their ability to be, essentially, resilient in the face of – you know, of obstacles. And the good news is there are tools that people can actually use to do that. And social connection actually is one of those tools.

So when people ask themselves a question, how can I contribute to help in America? How can I enhance emotional wellbeing in America? Keep in mind, you don't need a medical degree or a nursing degree to do that. Your ability to help foster and build social connection with the people around you can be one of the most powerful tools that's used to actually enhance their wellbeing and ultimately their health. And that's – and that's important, because if we're really going to create a more cohesive, connected America, we need to do it with the participation of each and every person. We need to do it with people in communities recognizing that they have the power to heal based on their power to connect, that the outreach that you make to another – whether it's a stranger or whether it's somebody you know well – that that is a medicine in and of itself.

You know, we often talk – and not just in the context of the opioid epidemic but also other epidemics – that we sometimes have this fascination, in 2017, with new medicines and new technologies. We think that the solution to chronic illness is going to be the next pill that we develop or the next machine that we create. But the truth is that while we need to push forward on innovation and we do need better medicine and better medical technology, we also can't forget that compassion and love are actually the oldest medicines that we have. Their power to heal individuals and communities cannot be overstated.

And we see that time and time again in the clinic and in the hospital, when we're caring for patients as doctors, and we realize very quickly that the absence of compassion and love in terms of a healing relationship compromises a patient's ability to get better. You can just – you can give them medicine and that will do a lot, but any patient will tell you that it is the trust, it is the empathy, it is the compassion they feel from their health care provider that makes a big difference in how they feel and ultimately in how they do.

So I mention this because it's important for us to recognize that if love and compassion are our oldest medicines, we have to recognize also that everyone has the ability to prescribe those, to dispense those. And that makes all of us healers. And that is the role that we have to assume, that we have to take on if we ultimately want to overcome the major challenges we face when it comes to health, this tsunami of chronic illness that has been assaulting our country. That's a role that we have to assume if we want to create a healthier and a stronger America, and a stronger world.

MR. MORRISON: Thank you.

Let's turn to the opioid epidemic. We know – and this has been building now for 20 years – over 20 years. I think it gained much greater visibility in the late naught decade and into this decade. And over the last five or six years, there's just been an enormous amount of effort invested in trying to

understand what's driving it and just trying to understand what measures need to be taken to arrest it, reverse it, and be rid of this scourge in our society, which has become such a colossal challenge for us. Looking back over the last several years, there have been several important things that have happened in that regard. Maybe you could offer us your reflections. You've been on this post now for a little over two years, but you've been watching this as a – as a medical professional well-before that too and dealing with communities. But what do you think has happened in the last few years that gives you the greatest promise?

DR. MURTHY: Well, there's been a lot of movement that's been very positive on the opioid front in the last few years. But I'll tell you, this is a tragedy, just going through the opioid epidemic, because this is not like Zika or Ebola, a virus that came upon us somehow. This was something that was created by people through various means. And the truth is, though, that we in part got here on a path that was paved with good intentions, right? So about 20 to 30 years ago, doctors and nurses were urged to be more aggressive about treating pain. They were told that they were undertreating pain and allowing patients to suffer while they had the means to address that, and that wasn't right.

And, you know, any clinician who goes into the healing professions goes in because they want to relieve suffering. And so clinicians responded to that call to action and said, absolutely then. Let's get on it. Let's be more aggressive about treating pain. But here was the challenge, they weren't given the training or the tools in how to really do so safely and effectively. And so what we saw was a dramatic increase in the quantity of opioids prescribed – a near quadrupling, in fact, from 1999 to close to now. And we didn't actually see any significant change in the amount of pain that was being reported by Americans. That's really striking, if you think about that. A near quadrupling in the quantity of opioids without a significant change in pain reported. But what we did see is a significant increase in the misuse of opioid medications. And that has, in part, led and fed into a growing heroin epidemic, into the spread of HIV and Hep C, and a host of other challenges for individuals, families, and communities.

Now, there are some key things I think we need to do going forward, some of which you've already made progress on, which I want to highlight. But number one, we have to – we have to tighten up our prescribing practices, so that we are treating pain safely and effectively. That does not mean not prescribing opioids ever again. I want to be very clear about that, because we let the pendulum swing to the extreme, where we were overprescribing opioids over the last 20 to 25 years. We cannot swing to the other extreme, where we deny people who actually need opioids those medications. We have to find that middle ground. And that middle ground is in part going to come through education, through training, and through technology.

So prescribing is one area that we have to work on. The second is we have to increase access to treatment. We know that there are over a million people with opioid use disorders who cannot – who are not getting treatment right now. We know that when we think about substance use more broadly, that only one out of 10 people with substance use disorders in America are actually getting treatment. And I want you to imagine for a moment if only one in 10 people with diabetes was actually getting treatment, only one in 10 people with cancer was able to get treatment. How would we react as a society? We would say it's absolutely unacceptable in a country like ours, where we have the resources and the science and the trained professionals, that we're not providing more people with care. But that is, unfortunately, the reality when it comes to substance use. So expansion of treatment is important.

The third thing that we have to do is we have to get naloxone in the hands of first responders more effectively. Fourth, we have to do a lot more in terms of public education. There are still people I encounter when I travel who don't realize that opioid medications that are prescribed are in fact addictive. And their rationale is often – they say, well, if the doctor prescribed it, it must be safe. Why would a doctor give me something that's harmful, right? And I understand that logic. But as we know, every medication has a risk and a benefit, has a potential side effect. And they are prescribed weighing those harms and benefits. There's nothing that's absolutely 100 percent safe. And when it comes to opioids, what we have realized is that we far underestimated the risks. And that, unfortunately, has had bad consequences for us.

And then the final thing that we have to do is we have to address the stigma around addiction more broadly, and around opioid addiction in particular. You know, I was visiting a family some months ago who had lost a son due to an opioid overdose. And they told me, they said: Whenever they've had a tragedy in their family – whether it's a pet dying, whether it's a parent passing away from a chronic illness – that people would flock to their home with meals, with words of comfort, with condolence cards. They said, after their son died from an overdose, nobody came. They didn't come – they didn't avoid them because they were callous. They avoided them because they just didn't know what to say. They felt that this was an illness that was enshrouded in stigma and judgement, and they weren't sure if the family felt embarrassed about the fact that their son died from an overdose. They just weren't sure how to talk about addiction, period.

And that simple example shows you that we treat addiction differently than other illnesses. You know, a gentleman in my office said the other day that if he sprained his ankle over the weekend and had to go to PT, physical therapy, twice or thrice a week, he would have no problem telling people that he needed to be out for physical therapy. But if he actually needed to see a substance use provider or mental health specialist, that he would not feel comfortable sharing that with people, despite the fact that our building is fairly openminded. So we have to overcome that stigma.

Now, we've made a lot of progress in some of these areas. As you mentioned earlier, Steve, through the cures bill in particular, we added a significant amount of funding to expanding treatment. During the last administration, under President Obama, there was also a lot of additional funding that was brought in to expand treatment, you know, through his work together with Congress. So that is good. But we still have a major treatment gap that we have to close. We also did make progress on getting naloxone more into the hands of first responders. The police officers I mentioned earlier in Seattle, who had begun to carry naloxone with them, they were in part funded through programs, you know, that we have seen develop over the last several years. So there has been progress there.

And, you know, we've also made a lot of progress when it comes to working with prescribers. So we – in our office, for example, last summer, we launched our – the turn the tide tour, which was our effort to combat the opioid epidemic, targeted primarily at prescribers. For the first time, our office actually issued a letter to 2.3 million prescribers and clinicians, urging them to join the national movement we were building to turn the tide on the opioid epidemic. We also went on a national tour where we met with clinicians all around the country – from Alaska to Tennessee to Massachusetts to Oklahoma. Because we wanted to talk to clinicians directly and understand what some of their challenges were. We sent all 2.3 million health care professionals that we messaged a pocket card as well, recognizing that most doctors and nurses wear white coats when they practice. And we wanted them to have a simple card that would guide them in how to prescribe safely and effectively that they could keep in their pocket.

So there were steps like that that we took, including an online pledge that we asked the clinicians to sign onto. And that, together with a lot of efforts – many at the national medical organizations and local state medical societies, efforts from the CDC, FDA and other parts of government, have helped us actually to make progress in sharpening our prescribing of opioids. But this is – the opioid epidemic is a multifactorial problem. And that means that we can't just turn one lever or press one lever and expect that the outcome is going to change entirely. We have to work on all fronts simultaneously.

Now, we're seeing increasingly reports about fentanyl use in cities across the country. Fentanyl's a very powerful substance that's even more powerful than morphine and some of the other traditional opioids that we see prescribed. And its introduction into communities across the country has been absolutely devastating. And so that's another issue that we have to contend with. But we have to both work on the prevention side and we have to work on the treatment side simultaneously.

And we have to eradicate the stigma around addiction, because if we don't do that, if we don't address what is really a cultural challenge – which is how people look at addiction – then people aren't going to feel comfortable coming forward and asking for help. People are not – in communities are not going to feel comfortable having treatment centers in their neighborhoods. Policymakers at local levels may or may not feel that they have the support of their community when it comes to investing more in addressing the epidemic. This is why it's so important for us to make sure that everyone recognizes that addiction is not a moral failing. It is a chronic illness that deserves the same compassion, care and attention that any other chronic illness does, like diabetes or heart disease.

MR. MORRISON: Thank you.

This has been a – this last phase of our electoral process in 2016 in particular – a very bitter, hyper-partisan, polarized period. And yet, we were able to get two major pieces of legislation through with overwhelming bipartisan support last year. So there's something about this epidemic that makes – that offers a bit of a refuge from the bitterness that we've seen in other places, offers an ability for bipartisanship versus hyper-partisanship. And why is that? How do you – how do you understand and explain that? And what does that mean in terms of hope for being able to continue in that vein?

DR. MURTHY: Well, I do feel very encouraged by the fact that the response to the opioid epidemic has been very much a bipartisan response. I think especially, you know, during, you know, recent decades where people have felt that the divides in our country have grown, it is heartening to see people coming together to address the opioid epidemic. Now, with that said, you know, you can argue that we should have gotten there on addiction several decades ago.

But we, you know, several decades ago declared a war on drugs that became a war on the people who use drugs. We treated a public health problem as primarily a criminal justice problem. And that is a shift that we have had to make, recognizing that often the people that we locked up needed treatment more than anything else, and they weren't able to get that. So while we are somewhat late to the game in terms of addressing addiction as effectively as we could, it is encouraging to see in recent years this bipartisan support to funding treatment expansion and funding prevention measures when it comes to reducing opioid misuse and overdoses.

When I think more broadly about health, though, this is the approach we should be taking to all dimensions of health, because the truth is epidemics like the opioid epidemic, they don't discriminate between conservatives and liberals and independents. Zika-carrying mosquitoes don't decide who to

bite depending on their political persuasions. And we know that illnesses really have no bounds, that they can affect anyone and everyone. And so the pursuit of health should be a cause that actually unites us, not something that divides us. And if we don't pursue better health – both prevention and treatment – as a unified country, then the fallout is counted in lives lost, in human suffering. And that's unfortunately what we have seen for far too long.

You know, I had the privilege of practicing in Massachusetts both before and after Governor Romney and the legislature enacted health reform there. And one of the signature elements of the Massachusetts health reform law was actually an expansion of coverage. And I saw patients who we had struggled to get care for or to get coverage suddenly able to access care. I remember one night that has haunted me ever since, of a woman who was brought in the middle of the night to the emergency room. And she came from a rural part of the state. And she was brought in because she had a breast mass that the other hospital was very concerned about. And so they had sent her to our hospital for further attention.

And when we came down to examine her, what we quickly realized is that she had noticed a lump in her breast a while ago – more than a year ago. But she didn't have health insurance coverage. And she did what so many women do all across our country, which is she put the health needs of her partner and her kids first, and she said if we only have a little bit of money let me make sure that my son or daughter can go and see the doctor. Let me make sure that my partner can go and see the doctor. And all the while, she just tried to manage on her own, ignoring it initially. Then when it broke through the skin, became infected and started oozing pus, she just tried to put bandages on it until it became unbearable. And then finally she was forced to come in.

When we saw her, after talking to her, examining her and doing a series of studies, we realized that she had metastatic breast cancer. And what was most painful about that, as I sat at her bedside talking to her and looking into her eyes and looking at the expressions on the face of her family members, is that this could have been prevented if she had had coverage, if she had had the opportunity to see a good health-care provider, if she had had the opportunity to get the care that she needed, that everyone should be able to have if they're sick.

And that's the – the fact that that was able to be accomplished, though, like in Massachusetts, the expansion of health-care coverage meant that many, many more people had access to the care they needed. That means that lives were saved, that human suffering was reduced. And that's the power of what can happen when we come together to address pressing health issues.

We have a lot of pressing health issues right now. You know, we just dealt with, you know, a scare around Zika. And that scare is not over, by the way. Zika is not gone entirely and will remain a challenge here for a long time. But we struggled to get the funding support in time for Zika, and ultimately we did.

But this all points to the fact that when it comes to health, we need to be unified in how we address health as a country. We also need to be proactive in investing early in the infrastructure and prevention measures and public-health structures that will allow us to be ahead of the game and not wait until something has become a full-blown epidemic.

And while we are used to expecting that unity should come from our most prominent public officials at the top, one thing that I have learned during my last two years as surgeon general is that the capacity to lead our country in the right direction is tremendous at a grassroots level and that the

leadership that I'm starting to see more and more of from mayors, from local community-organization leaders, from faith leaders, from doctors and nurses, from patient advocates and communities, that leadership is real. It's powerful. And we need a lot more of it.

And I think increasingly we should be looking to the shining stars, like in our local communities, as examples of how to come together around difficult issues, of how to place people above politics, and ultimately how to ensure that we value every life and that we create the environment and the system to support good health that everyone in our country really needs.

MR. MORRISON: I think we should open things up now. Everybody's been very patient. Thank you all. We could keep going, but I think that in fairness let's offer an opportunity for you all to come in.

As I said, we'll do a round of four or five very succinct questions. We'll start with right here. Please identify yourself and just offer a single quick intervention please.

Q: Sure. Jasmine Tyler from the Open Society Foundation. Thank you so much for your remarks today.

In the past I've heard you condemn the war on drugs as a war on black and brown communities. So I encourage you to continue to do that more forcefully. You mentioned, though, that we got here because of the overprescribing of prescriptions, but only a little bit talked about the 30 years of failed drug-war policies that really were directed at black and brown communities.

And can you talk a little bit more about this current posture in the public-health approach to drug treatment vis-à-vis the opiate crisis and sort of white rural America, how that will affect African-Americans and Latinos moving forward, whether or not all boats will rise, whether or not people are actually in those boats to benefit from the rising tides? We need to know a little bit more about that. And if you could tell us what's sort of coming down the pike, because maybe you've had conversations with your new boss or staff that we are not privy to, because we're really, really worried about the rhetoric around the return to law and order, quite honestly.

MR. MORRISON: Thank you.

Right here, sir, and then right here, and then right behind you, and then we'll pass the microphone to you. We're going to go one, two, three here.

Q: Me and then her?

MR. MORRISON: Yes. You start, please.

Q: Thank you. My name is John Stanard. I'm with the Church of Scientology's national office.

We have a 40-year drug rehab, residential rehab program that's secular. It's all over the world, and it is based on a drug-free model. And so I've been concerned with the rising rhetoric and the expansion of medication-assisted treatment because it has appeared to me and some people in the drug-free-model community that the improvements and the advantages there are being promoted in a way that marginalizes and potentially eliminates drug-free approaches. We're seeing this in the state of

Maryland right now, where last year they basically have canceled all funding for programs that don't use MAT.

So my question to you is, where do you see drug-free-model residential-treatment programs in the future? How do you see them fitting into the ecosystem of treatment, if they do at all, in your view?

MR. MORRISON: And could you pass – just the woman right in front, please.

Q: Good afternoon. My name is Dawn Lee-Carty from Speak Life.

I have a 9-year-old daughter who was born with epilepsy. She's been on opiates almost all of her life, up and down; no recourse for seizures. They've never stopped. They've never ceased. Last year I was forced to seek refuge in Colorado for cannabis. And she's been on CBD oil for one year now, and she's 91 percent seizure-free. So thank you. (Applause.)

So I ask this question to you today, that if – has cannabis been – has cannabis been put on the table and considered and also used as an alternative for opiates? I think with the pain with cancer it's been proven and shown that it does remarkably work. My 9-year-old daughter is proof. And now we're grassrootsing and speaking life all over about cannabis. So I just wanted to know your position on cannabis and moving forward.

MR. MORRISON: Let's take one more question here – right here.

Excuse me. We'll come back to you.

Q: Hi. I first want to say thank you for coming today. And I kind of had a similar question, that being that your job includes projecting the best available science for the public, I was wondering today if it is medically and scientifically sound, based on the science available today, to classify marijuana as a Schedule 1 drug, especially how approximately 28 states have recognized the medical advantages.

MR. MORRISON: Thank you.

Shall we come back to you? We're running out of time. OK, we're running out of time here.

DR. MURTHY: Do you want to add one more, or do you want to do these?

MR. MORRISON: Let's add one more. This gentleman right here is waiting very patiently. And I apologize to others here that we are running low on time.

Yes, please identify yourself.

Q: Hi. My name is Saul Garcia (sp).

Have you had any recent conversations with the Trump administration in regards with the opioid epidemic?

DR. MURTHY: Great. Any more, or are we good? Yeah? OK.

MR. MORRISON: Right here. Since this is – we're only able to do one round.

Q: Yeah. Thank you very much for giving your very valuable talks about the role of society for prevention and all. I'm Dr. Krishna Banaudha from George Washington University, and just started a Indo-U.S. brain trust organization, which connect the Indian researcher and the doctors to our teams.

My question is like our west border of Pakistan or India is very much affected nowadays with the drug or the opioids thing. Is there any more that you can prefer to control that? Because Dr. (Harsh Vardhan ?) was here in September, and we organized a gathering to discuss this issue. And he's very much interested to adopt any model or strategy to control that epidemic of drugs. Thank you.

MR. MORRISON: OK, so back to you.

DR. MURTHY: OK. (Laughs.) All right, so let me try to keep all these questions in mind here. But I'll jump around a little bit.

So, sir, to your question about drug-free policy, so when it comes to thinking about how we treat substance-abuse disorders, my philosophy there, which is similar to my philosophy on marijuana or anything else, is that we have to let science guide us in what we do. And what we recognize is that there's no one single approach that's going to work for everyone when it comes to addiction.

For some people – you know, and I think about this with smoking as well – for some – for those of you who either were smokers or have friends who were smokers, you know, you recognize that some people quit cold turkey and that works really well for them, and they never go back again. And then there are others who try and quit, but it just doesn't work out. And they end up having to use nicotine replacement gum or the patch or another aid. And some people will use it for three weeks. Other people will use it for a year. So people will use it for different periods of time. And I think that we – what's important is that we recognize that the care has to be really individualized, but it should also be evidence-based and guided by science.

So in the case of addiction treatment, you know, there are some people, I think, who are going to benefit from an approach that ultimately takes them off of all substances entirely, including replacement substances. There are others who will benefit more from a medication-assisted treatment approach with something like Methadone or Buprenorphine. And they may be on Methadone or Buprenorphine for varying amounts of time.

But here's part of the challenge is that there are a lot of misconceptions around Methadone and Buprenorphine. And I've actually heard these first-hand as I've traveled around the country. I had a very well-respected community leader in one city that I traveled to who told me that he thought that Methadone made people not only use drugs more, but that it made people increase their desire to get pregnant and led to more kids who have neonatal abstinence syndrome.

Now, I, you know, had to inform him that Methadone doesn't actually work that way. But my point is that there are many misconceptions out there from well-intentioned people about what Methadone does and about what it doesn't do. But what's important is that we recognize that, when used in the right way, medication-assisted treatment can work. And it's not just about the medication. That's the other problem is people have focused solely on Methadone or Buprenorphine and said, OK, that's it. But medication-assisted treatment involves not just the medication but the counseling and the

other social-support services you need to bring that all together. As you well know in running a treatment center, those other elements are critical to recovery.

And so that's how I think about this is we've got to take an evidence-based approach. It's not a one-size-fits-all model. And there are going to be people who, you know, are able to come off right away, and others who need a protracted course of treatment. And we have to allow for that kind of variability.

When it comes to marijuana, marijuana's been discussed a lot, and especially in recent years, because many states have moved forward with laws that have allowed the use of marijuana for medical or for recreational purposes. And my feeling about marijuana similarly is that science should guide us in how we approach marijuana policy.

Here's my concern. We actually have – we do have anecdotes of people feeling better or that their symptoms are improved when they have used marijuana. And ma'am, I just want to say how happy I am to hear that your daughter is doing better. I have a young boy myself, and, you know, I would do anything for him, for his health. And if he was sick, that would drive me absolutely, you know, to – it would drive me crazy, you know, and sick with worry. And so I can just imagine how much relief you have about the fact that your daughter is now nearly seizure-free, and I'm really happy to hear that.

Q: Because her quality of life has really changed because of the – (off mic).

DR. MURTHY: Yeah, and I can only imagine. And I imagine yours has too, you know, as a parent who's less now worried and anxious.

So I think that that's – for that reason, I think it's actually very important for us to pursue more research when it comes to marijuana so that we know what conditions it's helpful for, how to dose it properly, what side effects to look out for, et cetera.

Here's the challenge, though. Right now, like, if we ask ourselves, do we have the same level of evidence for marijuana that we do for other medications that we approve for use, data that would allow us to determine how to dose it safely and effectively, the answer is actually no right now. And the reasons for that are complicated. And some of it has to do with the fact that there have been barriers to doing research on marijuana, some of those actually related to government barriers.

In recent years, though, I'm encouraged by the fact that the federal government has actually taken some steps to make that research easier. There have been some administrative review processes that they've gotten rid of. There's also been an increase in the amount of research-grade marijuana that has been provided, so now it makes it a little bit easier to actually go out there and do research. There's been funding also provided from the NIH and from other bodies to do some of this research on marijuana. And that's what we need.

But the question – and we need more of that research, because right now, because that evidence threshold hasn't been met, the FDA has not approved marijuana in terms of, like, marijuana that you might smoke or consume as whole plant as an effective medication. Now, there are components of marijuana which, when – you know, when isolated and when sort of carefully tested, have been shown to have a positive impact, one of those medications being dronabinol, for example. But that's different. You know, taking a purified, isolated component of marijuana that's been tested and using that as a

medication is very different from saying smoking marijuana will help cure illness “x,” whatever that might be.

So this is why – if our goal is to treat marijuana the way we would any other medication, which is to make sure we’ve got the research that shows us it’s both safe and effective for the right medical problem, then we have a bit of a ways to go when it comes to getting there.

And then, ma’am, to your question earlier, you know, about how minority communities are impacted by the efforts to address opioids and such, you know, as I mentioned earlier, we did have a war on drugs, you know, decades ago that ended up primarily affecting minority communities and communities that were poor. And it was primarily a law-enforcement approach that we had, and so we ended up jailing a lot of folks who ultimately needed treatment, and –

Q: But they need treatment, and the war continues. And I love you, but I just have to push back a little bit.

DR. MURTHY: I’m not done yet, so – but I hear you. So what we need and what we actually have been moving toward, but not fast enough, is a much more balanced approach that’s primarily driven by the public-health needs, right. And that doesn’t mean that there isn’t a role for law enforcement and public safety from time to time. There absolutely is.

But it all comes down to how we look at addiction, right. If we look at addiction as a disease of choice, then it’s easy to blame the person or the communities that are suffering from addiction, right. But if we look – start to understand addiction in a more complex way, that it’s, one, a chronic disease, that it also can be a consequence of poverty and structural inequities, if we start to look at it in a more complex sense, then we start to realize that we – that actually incarceration may not be the primary answer. In fact, it is getting people treatment. It’s focusing on prevention programs. It’s focusing on economic security, et cetera.

Now I want to come back to health equity, which I mentioned earlier, which is getting at the real point of how do we make sure that people aren’t left behind, that communities aren’t left behind. And in our work, health equity is a key value that drives what we do when we’re thinking about the opioid epidemic. So when we think about where we go and who we talk to, when we think about what views we represent when we come back and talk to our federal partners, whether it’s folks in the White House or people in the Department of Health and Human Services, we think about that angle, recognizing that many minority communities are disproportionately impacted by addiction, right. We also know that many are incarcerated at levels that are much higher than other parts of the population.

So to us, like, the measure of how well we’re doing as a country in dealing with opioids can’t just be measured by our overall overdoses decreasing or the number of people who are addicted decreasing. It also has to be measured by looking at how individual communities are doing. Are minority communities also benefiting to the extent that they need to? Are rural communities also benefiting? Because the overall – the problem that we’ve had is that the overall numbers, they hide inequities that sometimes we don’t want to face, right.

And the thing is, when you start to talk about the fact that some communities are disproportionately affected, the truth is that makes some people uncomfortable. But that is part of the price that we have to pay if we want to address that. The fact that we have avoided talking about

inequities for a long time is part of what has allowed inequities to persist, not just with addiction, but we see it with a whole bunch of other chronic illnesses. And we see it with violence as well.

And so to me this is partly about how we measure success. It's partly about forcing the conversation, about ensuring that in our discussions in the communities that we visit, in the communities that we highlight, that we're giving attention to communities that are often disproportionately affected. And it's about just making sure that health equity is, in fact, not just a slogan but a value that's reflected in our approach to illnesses across the board, not just addiction but chronic disease more broadly.

MR. MORRISON: Dr. Murthy, this has been tremendously valuable and rich. And thank you so much. I wish we had more time, but I apologize we don't. And I think we're giving some of your staff a bit of a nervous breakdown. (Laughter.) So I don't want to continue down that path. You said we need to be focused on well-being here, so we are.

DR. MURTHY: (Laughs.) That's OK.

MR. MORRISON: But please join me in thanking – (applause). (End of available audio.)

(END)