Opinions

We need smart solutions to mitigate the coronavirus's impact. Here are 40.

(Ann Kiernan for The Washington Post)

MAY 27, 2020

The coronavirus crisis has upended American life, and fresh ideas are needed for dealing with the problems it's creating. Here is a collection

of smart solutions. We are expanding this list as we receive more ideas. Have an idea? Submit it here.

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Revive the physician-scientist

By Vivian G. Cheung, P.J. Utz and Mukesh K. Jain • PUBLISHED MAY 27

The novel coronavirus pandemic has exposed weaknesses and revealed a medical ecosystem that is more fragile and less prepared to deal with medical crises than anyone could have imagined. Among the exposed weaknesses is the loss of a critical component of the biomedical workforce: the physician-scientist.

Physician-scientists are the all-

too-rare doctors whose careers combine patient care and biomedical research. Anthony S. Fauci of the National Institute of Allergy and Infectious Diseases is a quintessential example. Research by physician-scientists has led to some of the most important medical advances such as penicillin for infection, chemotherapies for cancer and statins for heart disease.

Unfortunately, the physician-scientist workforce has been on the decline for decades. The most recent data shows that less than 1.5 percent of all U.S. doctors do research. We need a well-trained group of readied physician-scientists who can be deployed at any time to meet our nation's medical needs, whether a coronavirus

pandemic or other health emergencies.

A solution to the decline of physician-scientists is the establishment of a national service program supported by public-private partnerships. Specifically, such a program would provide sustained mentorship and financial support to the best and brightest medical students and residents to develop an intense research-based career. In return, these individuals would dedicate themselves to life-long careers as physician-scientists. Like reservists, they will be available to serve in national crises. They will be mobilized in times of need to tackle unmet medical challenges.

We are asking leaders in academia, business and

government to join us to rebuild the physician-scientist workforce. We cannot leave the nation's health care in disrepair. Let us work together to ensure that we have outstanding medical research and patient care to safeguard the healthy living that everyone deserves.

[Sign up for our Coronavirus Updates newsletter to track the outbreak. All stories linked in the newsletter are free to access.]

Vivian G. Cheung is an investigator at the Howard Hughes Medical Institute and a professor of pediatrics at the University of Michigan's Life Sciences Institute. P.J. Utz is professor and associate dean for medical student research at Stanford University School of Medicine. Mukesh K. Jain is

chief academic officer at University Hospitals and professor at Case Western Reserve University. They are all members of the Physician-Scientist Support Foundation.

There's no time for stigma. Donate more menstrual products.

By Emily Aikens • **PUBLISHED MAY 27**

With the ongoing challenges presented by the covid-19 pandemic, one bastion of hope is that people are generously donating supplies and contributing to relief efforts. People have no problem giving away food and masks, but there is one item that people

shy away from donating or even talking about: menstrual products. And right now, they're needed more than ever.

Consider the homeless woman who could have had access to self-care items including menstrual products through a local homeless shelter. Since many homeless shelters are closed due to the pandemic, she now must live without. Or consider the woman who recently became unemployed. She needs to buy food for her family, but her period just started. In all likelihood, menstrual products are what get sacrificed.

These scenarios are not just hypothetical. A 2019 study found that two-thirds of women below the poverty line couldn't afford period products, and almost half of

those women had to choose between buying tampons or food. With as much as 20 percent of Americans unemployed, the number of women in this predicament keeps growing.

If menstrual products are one of the things that women need most right now, why aren't donation bins stacked with them? The simple answer is that periods make people uncomfortable. I know this firsthand; when I lobbied people to sign my petition for free menstrual products in schools last year, I found that many people couldn't even say the word "tampon," much less have an honest conversation about period poverty.

Just because people don't want to address periods doesn't mean that they will go away;

ignoring the problem leads to a greater exigency for a solution. Think about the uproar that would erupt if nobody had access to toilet paper in public bathrooms. People would protest that it's a product necessary for natural bodily functions. Nobody gets squeamish about a pack of Charmin, so why are tampons viewed differently? Regardless of the reason, one thing is clear: Women can't control menstruation, and they shouldn't be punished for that. The stigma surrounding periods needs to end so that women can get access to menstrual products during the pandemic.

Emily Aikens is a high school sophomore in Pennsylvania.

Use local organizations to reach black communities

By Uché Blackstock • **PUBLISHED MAY 27**

Disproportionately black counties account for more than half of all covid-19 cases and almost 60 percent of deaths, even though blacks represent 13.4 percent of the American population. Given a clear lack of federal leadership and guidance, it has become apparent that state and local agencies must intentionally move forward to mitigate ongoing racial disparities.

The problem, however, is that many black Americans distrust the health-care system, due to centuries of neglect, abuse and exploitation of our communities. State and local

agencies will need to engage with black communities through a lens of structural humility, by developing an understanding of and responses to the long-lasting effects of structural racism.

They can do this by strengthening preexisting connections with community-based organizations, such as faith-based organizations and neighborhood coalitions. These organizations already have trusted relationships with community members, which is essential for successful outreach, education and feedback.

Community health workers could also be a vital solution in this pandemic for black communities. These workers are often under supervision of a clinician and can perform

door-to-door assessments. They can be trained to assist with contact tracing by collecting information on symptoms and progression of infection, following up with contacts and testing, as necessary. They can also distribute educational materials, as well as food and other essential items to community members.

Currently, not all states allow the reimbursement of services from community health workers through Medicaid, but advocates are pressing governments to consider doing so as part of a covid-19 resilience strategy. Community health workers can also serve as an opportunity for employment for black communities that have been hardest hit.

Ultimately, in the long term, federal, state and local agencies will need to fully address the social determinants of health, including access to health care, education, employment and housing, of which structural racism is a key driving force. In the meantime, states and localities will need to innovate and collaborate with black communities around solutions to the pandemic. Now is the time for public health officials, by using community engagement, to repair broken bonds and reaffirm black Americans that our lives matter.

Uché Blackstock is an emergency medicine physician and founder and chief executive of Advancing Health Equity.

Bring back the methadone vans

By Laura Stanley • **PUBLISHED MAY 14**

For more than 350,000 people in the United States, one essential activity is a daily visit to a methadone clinic to treat their opioid addictions. This is a staggering logistical feat in regular times, and now it is even more difficult for patients to get their dose of the potentially lifesaving medication.

Before the pandemic, access to methadone clinics was already limited. More than 90 percent of methadone clinics are in urban areas, making it hard for rural patients to get treatment. Now, many clinics have decreased hours, and some

small facilities stopped accepting new patients altogether. Patients must also worry about exposure. There are reports of methadone clinics with crowded waiting rooms as well as clinics that allow people testing positive for the novel coronavirus to pick up medications in person.

Meanwhile, opioid overdoses are rising. One hard-hit county recently reported that overdoses were up 50 percent from last year.

We have an alternative. Methadone vans are clinics on wheels that typically serve patients in rural and underserved urban areas. Evidence suggests operating a methadone van costs roughly $300,000 less than a brick-and-mortar clinic over five years. Deploying methadone

vans is a cost-effective way to replace the reduced treatment capacity created by the pandemic.

Unfortunately, the Drug Enforcement Administration stopped licensing new methadone vans in 2007. Only eight are in operation today.

The DEA recently proposed to lift the ban on new methadone vans. The proposal is a step in the right direction, but it will take significant time to finalize the regulation. The DEA can move faster. Under the Controlled Substances Act, the DEA can approve methadone vans now, just as it did before, with security requirements to ensure methadone does not end up in the wrong hands.

For Americans fighting addiction, the pandemic has

made life exceptionally challenging. They deserve every tool possible to combat the two crises, including these lifesaving clinics on wheels.

Laura Stanley is a senior policy analyst at the George Washington University Regulatory Studies Center.

Let grand juries operate remotely

By Randall D. Eliason • **PUBLISHED MAY 14**

Along with the massive government spending to respond to the novel coronavirus crisis come massive opportunities for fraud. The Justice Department

has announced that pursuing covid-19-related crime will be a top priority. But features of the criminal-justice system that are incompatible with social distancing threaten to grind that system to a halt. As one solution, we should allow federal grand juries to meet remotely.

The Fifth Amendment requires a grand jury indictment for all federal felonies, and grand jury subpoenas are the critical investigative tools for obtaining testimony, documents and other evidence. But a grand jury consists of 20 or so people gathered together in a room for hours each day. Such activity might not be safe for some time — which helps explain why the number of new federal criminal cases has dropped precipitously in

recent months.

Unlike a criminal trial, a grand jury hearing could be readily adapted to a remote format. The proceeding consists only of the grand jurors, prosecutor and witness — no defendant, no defense attorney and no judge. At a trial, the accused has the right to confront witnesses and present evidence, but those rights do not apply in the grand jury. As long as the grand jury hears the government's evidence, deliberates and determines probable cause, no rights of a criminal defendant would be implicated by not having jurors in the same room.

Grand jury testimony could be conducted with the prosecutor and witness in one room (a safe distance apart) and the grand jurors watching

remotely from home. Grand jurors could ask questions either directly or by sending them to the prosecutor through a chat function. Exhibits could be shared on the prosecutor's screen. When the presentation of evidence is concluded, the grand jury could deliberate and vote via a remote meeting conducted by the grand jury foreperson.

The greatest concern would be security. The secrecy of these proceedings must be preserved, but this is manageable. The remote connection would have to be closed and secure. Grand jurors may have to keep their cameras on and attest that they are alone and will maintain confidentiality. Breaches of grand jury secrecy would, as always, be

punishable by contempt of court.

Remote grand juries would not solve the more challenging problem of how to conduct criminal trials, but the vast majority of cases are resolved short of trial. It would be a huge step in enabling federal criminal cases — including those related to the virus response — to move forward.

Randall D. Eliason teaches white-collar criminal law at George Washington University Law School. He blogs at Sidebarsblog.com.

Stop monitoring emails between inmates and their lawyers

By Catherine Crump and Ken White • PUBLISHED MAY 14

As the potentially devastating impact of covid-19 on the incarcerated becomes clear, the federal Bureau of Prisons (BOP) reacted by banning visits to inmates. Criminal defense attorneys nationwide are struggling to represent inmates they cannot meet in person. The BOP has needlessly made this harder through its long-standing policy of insisting that inmates "voluntarily" waive all claims to confidentiality in emails they send their lawyers through the BOP-provided email system. If ever there was a time to end this policy, it is now.

Federal prosecutors have argued that alternative methods of communication are

available to inmates. But nothing is as fast and cheap as email. The American Bar Association has found it can take "two weeks or more for an inmate to receive postal mail sent from an attorney." Arranging an unmonitored attorney-client telephone call can take up to a month. And in-person visits, which are likewise time-consuming and difficult to arrange, are no longer an option.

This year Rep. Hakeem Jeffries (D-N.Y.) introduced legislation to prohibit the BOP from monitoring attorney-inmate emails identified as privileged. Even before covid-19, the bill had 23 co-sponsors (11 of them Republicans) and unanimously passed out of the House Judiciary Committee. It now awaits a full vote in the House.

The bill provides a simple and effective solution, requiring the BOP to exclude from its monitoring the contents of any privileged communication. The usual limitations to the attorney-client privilege apply (such as when a person enlists an attorney to perpetuate a crime or fraud), and law enforcement must obtain a warrant when it wishes to access emails sent through the BOP system — just as it would have to do if it sought emails from Google or another email provider.

Changing this email system was important even before covid-19. These days, it is imperative.

Catherine Crump is an assistant clinical professor at University of California-Berkeley Law School and

director of the Samuelson Law, Technology & Public Policy Clinic. She co-represents the National Association of Criminal Defense Lawyers in a lawsuit seeking records about the Bureau of Prisons monitoring policy. Ken White is a former prosecutor and federal criminal defense attorney at Brown White & Osborn in Los Angeles.

Stop taxing unemployment benefits

By Toni L. Kamins • **PUBLISHED MAY 7**

The millions of people receiving unemployment benefits because of the

pandemic will be in for a shock next April. That's when they'll be confronted with the tax bill on that crucial lifeline. Yes, absurd as it may sound, these benefits are taxable both federally and in most states. It's long past time for that policy to end.

Weekly unemployment benefits vary by state, ranging from $190 in Puerto Rico to $823 in Massachusetts. Even the most generous isn't enough to make ends meet anywhere in the country — with or without the pandemic stimulus supplement. When you subtract federal and state withholding taxes, the amount left over to take care of bare minimums — rent, food, health insurance and job-hunting expenses — just doesn't add up. People are forced to

borrow from relatives, friends, credit cards, payday lenders and pawnshops and descend into debt. Take the amount without withholding, and you're left with what could be a hefty tax bill in April.

Unemployment insurance didn't start out as taxable income when it was introduced by President Franklin D. Roosevelt in 1935. It only became fully taxable with the Tax Reform Act of 1986 under President Ronald Reagan. A few studies by conservative economists and think tanks at the time suggested that the benefits encouraged people not to look for new jobs. The idea was sold to the legislators they advised and influenced, and it has driven policy and discussion ever since. In fact, many conservatives still

believe that the program, like the food stamp program, allows recipients to live in comfort.

Other studies show the opposite. Unemployment insurance, as stingy as it is, prevents people from sinking into greater poverty and keeps money circulating within the economy. Taxing these benefits treats the unemployed like slackers out to bilk the American taxpayers. Now is the time to end it.

Toni L. Kamins is a freelance writer who lives in New York City.

Let the robots do their part

By Gary Shapiro • **PUBLISHED MAY 7**

As covid-19 makes human contact more of a concern, the need for self-driving vehicles and automated delivery technologies is clear. Now, we need the policies to match.

“Contactless” deliveries are already limiting the spread of infection and protecting those most at risk, but we have the technology to do more. For example, the United States has not fully realized the potential of drones, technology that is hindered by a patchwork of state laws that create confusion for drone operators. Widespread use depends on the development of new operational rules and the remote identification of drones.

Self-driving cars are similarly facing roadblocks because of conflicting state rules, testing restrictions and federal limitations. As I testified before a House subcommittee in February, these vehicles have the potential to boost the economy, save lives, aid seniors and those with disabilities, and provide critical services. But the effort to advance this technology has been caught up in politics, especially by trial lawyers concerned about fewer car accidents and fewer lawsuits.

This is unfortunate, since the industry is poised to do a lot of good in this crisis. Innovators such as Waymo and Nuro are partnering with retailers and shipping companies to test self-driving delivery. Sidewalk delivery is happening in select

areas by companies including Starship Technologies, and medical supplies and covid-19 tests are being delivered to the Mayo Clinic in Florida by self-driving vehicles, thanks to a partnership among Beep, NAVYA and the Jacksonville Transportation Authority.

While we must be deliberate when safety is involved, adapting outdated laws and rules to fit innovation has to be a top priority in the coming months and years. Congress should pass a self-driving-vehicle bill and enable broader testing and deployment of automated technologies. States should not create different rules that limit these technologies. Especially now, we urgently need national policies that enable the public to access the best technology at

the lowest risk.

Gary Shapiro is president and chief executive of the Consumer Technology Association. He is the author of "Ninja Future: Secrets to Success in the New World of Innovation."

Local governments need more revenue. Try progressive property taxes.

By Andrew Hayashi and Ariel Jurow Kleiman • **PUBLISHED MAY 7**

Local governments are cash-strapped. Even if Congress agrees to give them financial support, it probably won't be enough. Localities must raise revenue using the fiscal tools

available to them — but without overburdening struggling households. The answer is a progressive property tax. The tax could feature rates that increase with property values, income-based tax relief or deferral of payment. Many states provide such deferrals to senior citizens and the disabled, and this could be extended to those eligible for unemployment benefits.

Not only is a progressive property tax fair, but it can help stabilize household finances. Homeowners are far from being universally wealthy; more than 15 percent earn less than half of their area's median income. Since tax rates would fall with home prices during a recession, households would have more

to spend on the goods and services that keep people employed. Our research shows that cutting property taxes in a recession increases spending and reduces mortgage defaults.

Raising property taxes for those who can afford it is better than the alternatives. Increases in sales taxes reduce economy-sustaining consumer spending, and if localities can't raise revenue from taxes they may turn to fines, fees and charges, which raise less revenue and often disparately impact vulnerable populations.

Property tax reform faces legal and political barriers. Most localities need state permission to tax. State legislatures should move quickly to delegate more tax authority to localities. Seventeen states also require

cities and counties to hold public hearings and notify taxpayers in print before taxes increase. To reduce costs and avoid public gatherings, states should allow localities to satisfy these requirements electronically.

In our partisan climate, it may be too much to ask citizens to help those in other states, but they may be willing to help carry their neighbors' burdens. A progressive property tax is the way.

Andrew Hayashi is Class of 1948 professor of scholarly research in law at University of Virginia. Ariel Jurow Kleiman is assistant professor at University of San Diego School of Law.

Use the power of reprieve

By Norman Reimer, Jonathan Smith, Kevin Ring and Steven Salky • PUBLISHED MAY 7

The spread of covid-19 will continue until we address its growth in prisons and jails, where people cannot self-distance or otherwise protect themselves. Thankfully, the Constitution gives the president, and numerous state constitutions grant governors, a mechanism to address this crisis: the power to issue "reprieves."

A reprieve — the temporary suspension of a sentence — would not be a statement that a prisoner is guiltless or rehabilitated. It would simply be a recognition that the prisoner's sentence was one of

imprisonment, not death, and that his or her temporary release during the covid-19 state of emergency avoids further spread of the disease.

No matter how conscientiously prisons follow recommended precautions from the Centers of Disease Control and Prevention, they cannot remain safe places for either staff or prisoners. As of the end of April, eight of the top 10 clusters of coronavirus outbreaks in the United States were in prisons or jails. Though the Justice Department and various state correctional departments have expanded their use of home detention, these administrative efforts are proving insufficient to avoid both unnecessary prisoner deaths and staff exporting the disease back into

their communities.

Reprieves need not be granted indiscriminately, as the suitable candidates can be easily distinguished from unsuitable. Further, conditions can be imposed on those granted reprieves, including that they remain quarantined after release. The president or a governor could even grant modest reductions in sentence terms to assure compliance.

The constitutional authority to issue reprieves is an old constitutional medicine that deserves a new use.

Norman Reimer is executive director of the National Association of Criminal Defense Lawyers. Jonathan Smith is executive director of the Washington Lawyers Committee for Civil Rights

and Urban Affairs. Kevin Ring is president of FAMM. Steven Salky is a lawyer from Washington and a resource counsel for the Compassionate Release Clearinghouse.

Let inmates talk to their families for free

By Uzoma Orchingwa, Gabriel Saruhashi and Lara Schull •

PUBLISHED APRIL 30

As many of us adapt to the cadences of a quarantine world, through Zoom classes or Netflix parties, others are left behind. Throughout the country, prisons have prohibited in-person visitation to stop the spread of covid-19. Unfortunately, they have failed

to enact measures to ensure that the incarcerated and their families can maintain contact.

Prison reform advocates have demanded free prison communications for nearly 20 years. It's time we finally make the investment.

Communication with incarcerated loved ones is more vital now than ever. Inside prisons, fear about heightened risks of infection and limited access to families is raising concerns of possible unrest and riots. Outside, national unemployment rates soar, yet contact remains prohibitively expensive. One study found that the cost of visits and exorbitantly priced calls contributed to 1 in 3 families with incarcerated loved ones falling into debt. It can cost up to $25 to make a

15-minute phone call to an incarcerated person.

Why? Because the $1.2 billionc prison telecommunications industry is controlled by two companies, Securus Technologies and Global Tel Link Corp., which have been granted exclusive contracts in exchange for highly profitable commissions. These companies charge high prices because they can, which is why one Connecticut resident reported spending $500 each month just to talk to her imprisoned husband.

Economic self interest, if not empathy, should spur us to action. Overwhelming research shows that increased contact between loved ones and those in prison reduces recidivism. Our country spends an average of nearly $35,000 each year to

incarcerate a single inmate. About 600,000 people are released from prisons annually; 33 percent are incarcerated again within a year. Free prison communication could reduce re-conviction and boost, not drain, states' balance sheets.

[Full coverage of the coronavirus pandemic]

Families with incarcerated loved ones should not be forced to decide between clinging to financial security and maintaining connection. During a global pandemic, inattention to this predicament is indefensible. Our heightened appreciation of the value of human connection should catalyze a national reckoning.

Uzoma Orchingwa and Gabriel Saruhashi are co-

founders of Ameelio.org, a nonprofit that builds free prison communication tools. Lara Schull is a student at Yale University.

Fight the pandemic of silence. Say hello.

By Kimberlyn Maravet Baig-Ward

• PUBLISHED APRIL 30

While we're united in longing for better times in the midst of the covid-19 pandemic, we couldn't be further apart socially and emotionally — and not just by six feet. Experts warn of a "silent pandemic" affecting those with mental health disorders. However, another pandemic is brewing — one of actual *silence*. In

person, we silently navigate around each other. Not only are we not speaking, we aren't even looking at each other.

Humans are social creatures, and the emotional fallout from a pandemic of silence could be disastrous. I support social distancing in mitigating spread of the virus, but am increasingly concerned by the pandemic of silence. Those with mental health disorders — including depression and anxiety — may lack adequate social interactions even under the best conditions. What about now? What about people with alcohol or other substance-use disorders or who are sheltered in place in unsafe home conditions? How can they reach out in silence? How can we as friends, family, neighbors and health-care

providers help?

Stay six feet apart, use appropriate protective equipment — and say hello. It seems simple, but it works. Look at and acknowledge each other. Wave. Without human interaction, we risk disconnecting from what it means to be human. We need each other. We need to watch out for those most at risk in the pandemic of silence. Use technology, including video chat, to stay connected. Connect with someone you haven't in a while. If you are a provider, offer video "check-in" appointments with your patients or use the time to create an app so your patients can have an alternative way to connect. We're a world at war with a terrible foe, but we cannot let the human

connection be collateral damage.

Kimberlyn Maravet Baig-Ward is a psychiatry resident physician at the University of Texas Southwestern Medical Center in Dallas.

Scale up AmeriCorps

By Michael Tubbs and Emma Vadehra • **PUBLISHED APRIL 30**

America has a long, proud tradition of national service, especially in the wake of tragedies. As we rebuild from covid-19, recommitting to service — and scaling up AmeriCorps, in particular — should play a key role in our recovery. Doing so would not

only help young people who will be disproportionately affected by joblessness, but also serve as a lifeline for communities hardest hit by the virus.

For starters, AmeriCorps members can help supply the "army" of contact tracers needed to slow the spread of covid-19. This labor-intensive work, while critical, does not require public-health expertise, meaning members could be trained as tracers and dispersed across the country, working in partnership with local health departments.

Beyond contact tracing, members could provide direct support to communities in fields such as education, economic well-being and disaster response. Indeed, many AmeriCorps

organizations have already shifted their models because of covid-19. More than half of Stockton Service Corps are now focused on emergency relief efforts, such as powering a telephone hotline connecting seniors with essential services.

Much as in the wake of the Great Recession, AmeriCorps could provide employment opportunities to young people entering into a largely nonexistent job market. Plus, evidence shows that the program is a successful talent pipeline into public service and is cost effective, with each dollar invested returning more than $3.50 to society.

While AmeriCorps is well suited to aid our recovery, we need to first reform the program and greatly increase our investment in it. Congress

should fund 250,000 AmeriCorps positions this year, dedicating new members to areas most in need. It should increase living allowances and temporarily waive the requirement that groups raise a “match” from local or private funds.

Expanding AmeriCorps in the wake of covid-19 is far from a silver bullet. But national service must be a part of our recovery. Doing so can help restore confidence in our public institutions and government. It can hasten our return to society, deliver direct support to communities and provide employment and training pathways for young American. It’s a win-win.

Michael Tubbs is mayor of Stockton, Calif. Emma Vadehra is executive director

of the think tank Next100 and former chief of staff in the Education Department.

Turn baseball into a winter sport

By Ioannis Gatsiounis •

PUBLISHED APRIL 22

The baseball season should now be in its fourth week, and with each passing day the prospect of playing a full schedule looks dimmer. Hence the news last week that Major League Baseball is considering starting play at empty spring training fields in Phoenix and possibly Florida.

You can't blame the league for thinking outside the diamond

to preserve as much of the season as possible, as anything less than a full 162 games— for a game of inches in which individual and team performances demand to be measured against that number — will forever feel tainted. But games in ghostly ballparks to start the season would be a sad reminder of our collective sense of alienation and is no way to connect with fans.

The flaw in MLB's contingency plans is in assuming that the season must wrap up when it traditionally has, in early fall, before the weather turns cold. It doesn't.

The league has 11 stadiums spanning time zones and divisions that are either domed or have average daytime temps in the upper 60s in December — in Phoenix; Anaheim, Calif.;

Los Angeles; San Diego; Seattle; Milwaukee; Houston; Arlington, Tex.; St. Petersburg, Fla.; Miami and Toronto. These cities afford the league an opportunity to commence the season once the country is back on its feet — say, in June, when players can conceivably report for duty in their home ballparks in front of some number of fans. Then, as the season progresses deep into fall, the aforementioned cities would be designated the home of two additional teams (accounting for all 30 teams), and host up to three games per day.

Of course, covid-19 might still be with us by then, but unlike calls to play at spring training facilities, this arrangement buys the league vital time and can accommodate worst- and

best-case scenarios.

Teams (ideally in a revenue-sharing arrangement) would at a minimum generate more returns than playing for zero fans in Arizona and Florida. The sight of players and fans feeding off each other's energy would draw more TV fans, too.

Ioannis Gatsiounis is an author and journalist based in Phoenix.

Short-time work is good long-term policy

By John Delaney • **PUBLISHED APRIL 22**

Small businesses had a hard time accessing the stimulus

package's Paycheck Protection Program. Because the program was launched so quickly, there was a lot of confusion among both small businesses and lenders about eligibility, loan size and documentation. And not enough money was authorized, leaving many small businesses high and dry.

I'm optimistic the House will pass legislation to add more money to the program. But there is a better way for us to keep people on payroll: short-time compensation.

When businesses need to cut costs to survive during a recession, they often look at reducing the size of their workforce. If they need to cut labor costs by 40 percent, they might let go 40 percent of their workforce. But what if instead, they cut everyone's hours by

40 percent without firing anybody?

That's where short-time compensation comes in, as former vice president Joe Biden has proposed. The government can pay for lost hours if a company — because of a recession or national emergency — temporarily moves workers to part time rather than firing them. In the case of covid-19, the government could be paying 100 percent of the lost hours for certain industries, which is what we are trying to do indirectly with the Paycheck Protection Program.

It's a win-win-win. Workers maintain compensation, the dignity of work, their skills and their benefits. Companies benefit by maintaining their workforce and avoiding the

frictional costs of needing to rehire and retrain new workers after the down cycle. And the United States benefits by keeping the labor market intact and stemming surges in use of other social safety net programs.

This idea not only has bipartisan support; it is proven. Germany has had it for years, and during the financial crisis, when U.S. employment fell 5.6 percent, German employment fell a mere 0.5 percent, despite the German economy being more hard-hit. Let's improve our safety net by implementing it federally in the United States.

John Delaney, a Democrat, represented Maryland's 6th Congressional District in the U.S. House of Representatives from 2013 to 2019.

Treat health-care workers like the heroes they are

By Ruth Faden • **PUBLISHED APRIL 22**

Days after the 9/11 attacks, Congress enacted the September 11th Victim Compensation Fund. More than $7 billion was paid to 5,300 victims and their families, including thousands of first responders at the World Trade Center and Pentagon.

Like the first responders who faced death and physical injury after 9/11, today's health-care workers are risking their lives and health to ensure their fellow Americans have the best possible chance to survive covid-19.

Americans express their gratitude by applauding and banging pots, putting up signs and leaving food and flowers. Let's go further and enact a Covid-19 Heroes Fund.

Health-care workers often report that their greatest worry is for their families — that they might bring covid-19 home. But they also fear for their family's financial security if they succumb to this disease. According to the Centers for Disease Control and Prevention, about 9,000 health-care workers have tested positive for the virus, more than 180 were admitted to intensive care units and 27 died. This is almost certainly a significant undercount.

Congress should immediately enact a fund to award the family of health-care workers

who die of covid-19 at least $250,000; serious physical injury from the virus should also be compensated. A similar compensation program for families of law-enforcement officers killed in the line of duty has existed for decades. The families of health-care workers should receive no less.

Health-care workers are not the only essential workers at increased risk for covid-19. We hear daily about workers in meat plants, supermarkets and the transportation sector who contract the disease. A compensation program for these workers will be more complicated, but fairness requires examination of what these workers are owed as well. In the meantime, data systems should track the disease's impact on workers in

all essential sectors.

No amount of money can compensate for the loss of a loved one. But this fund would be tangible evidence of this nation's gratitude to those heroes who sacrifice so much to save our lives.

Ruth Faden is founder of the Johns Hopkins Berman Institute of Bioethics.

Opinion | 'We are not sacrificial lambs': A nurse's message to other nurses

Time for a new national office on private-public partnerships

By Tom Freedman • **PUBLISHED APRIL 22**

The covid-19 crisis has revealed a huge opportunity for improving our government. That's because a wonky policy tool — public-private partnerships — has become much more important during the pandemic. The problem, however, is that these are being deployed in an ad hoc, uncoordinated manner, with too little thought given to how they fit the needs of our democratic society. What's missing is an effective structure for how we could best use the promise of these partnerships in a modern, new government.

To fill this hole, the government should create an office of public-private partnerships that can field a diverse array of potential commitments; share them throughout the federal, state and local governments; and ensure transparency.

What might some of the ground rules of this office be? First, it's not good for a democracy to let decisions of interest to the public be made in secret by privately interested forces. The "public" part of public-private partnerships should be paramount. Public partnerships should have the imprimatur of the whole community and fit within overall national, state and local goals. A good partnership is one that doesn't replace

democratic decision-making but acts under its guidance and is transparent to all.

Second, we can do better than the ad hoc way most states and the federal government put together partnerships. That approach misses opportunities and leads to overlaps of effort when we can least afford it. The staff of a national office should be skilled at building, coordinating and evaluating partnerships.

Right now, if you can help make masks, testing kits or deliver food, you are left to your own devices to find what agency partner to reach out to. And more fundamentally, you must try and figure out what problem you can help solve, and how to best help solve it. Often on your own.

This doesn't have to be the case. A new national office could build relationships with private and nonprofit leaders and set guidelines to avoid self-dealing. That way, government will be ready when a problem arises so partnerships can be quickly discussed and activated.

Tom Freedman was senior adviser to President Bill Clinton. He advises on the creation of public-private partnerships as president of the Washington-based firm Freedman Consulting.

Bring back the Federal Music Project

By Kate Maroney • **PUBLISHED**

APRIL 16

On March 8, I sang my last concert before a live audience with the Folger Consort at St. Mark's, Capitol Hill. It was a program with music from 14th-century Italy, a world ravaged by plague. "Life weighs on me," we sang.

Today, we are living through our own plague, and life truly is weighing on us. Covid-19 has wiped out the livelihoods of freelance musicians and exposed the vulnerability of the arts community. With live performances canceled indefinitely, our field faces a grave threat.

The isolation forced on Americans by this pandemic has made clear the common need to experience music. Live streams are flourishing, as

artists and organizations seek to connect with their audiences. But many featured in these live streams can't afford next month's rent.

The world needs music, and musicians need support. We need to reboot the Federal Music Project for a digital age.

The Works Progress Administration established the Federal Music Project to support musicians during the Great Depression. The FMP sponsored performances, composition and recordings. Similar to live streams today, its subsidized radio broadcasts improved the lives of many Americans during a dark period in our history.

We need similar emergency redistribution of arts funding on the federal, statewide and

local levels to support performing artists who have no sustainability options beyond live streams. Musicians who put content online should be paid.

Big Tech and private donors need to step up to augment public arts funding with fair payment to artists. Companies such as Spotify and YouTube have already set a dangerous precedent for free streaming music, providing nearly nothing to artists in return. That needs to change.

Moving forward, artists and arts organizations must reexamine contractual models that put the burden of risk on artists. For now, with live streams being our only option, a standard subsidized live-stream model needs to be implemented immediately.

Music is essential to ease and make sense of the weightiest moments of human suffering. We all hope to survive covid-19, but we must ensure that musicians' livelihoods do, too.

Kate Maroney is a freelance mezzo-soprano and is on the faculty at the Mannes School of Music in New York City.

Make sure all Americans have access to telehealth

By Lucy McBride and Reed Hundt

• **PUBLISHED APRIL 16**

As the covid-19 pandemic tears through the country, weaknesses in our communications and health-care systems have been laid

bare. Approximately 25 percent of Americans do not have a primary care doctor, in many cases because of geographic, financial, physical or child-care-related obstacles. To alleviate some of these problems, many medical professionals across the country have already been experimenting with managing patients virtually through videoconference, phone or email.

But Congress must do more to assure that every American has access to telemedicine. That will save lives now and in the future.

As covid-19 makes visiting health-care centers more dangerous, doctors are using telehealth to provide not only medical advice but also a vital human connection. Telehealth

also allows for increased access to critical mental-health-care services. When doctors deliver physical and mental health services in tandem, health outcomes improve.

Swift and decisive government action must expedite the shift to telemedicine. Doctors need affordable and secure video conferencing, access to electronic patient records and the ability to collaborate with other doctors remotely. And every American must have at least a smartphone and high-speed broadband at home. On both ends of the doctor-patient virtual relationship, Congress must allocate additional funding. We estimate $75 billion would achieve the goal.

It is imperative that we work to bring affordable high-speed connectivity to every health-

care provider and American in parallel with efforts to invent and administer a vaccine. Yet, no single agency has the mission of simultaneously solving both sides of the shift of the doctor-patient relationship from the real to the virtual sphere. To this end, Congress should establish a nonpartisan commission of health-care and telecom tech experts. The commission would pass the regulations and spend the money necessary to give us a more connected and healthier future.

Lucy McBride is a practicing internal medicine physician in Washington. Reed Hundt is a former chairman of the Federal Communications Commission under President Bill Clinton and author of "A Crisis Wasted: Barack

Obama's Critical Decisions."

Let home be where the hospital is

By Kavita Patel and Shantanu Nundy • PUBLISHED APRIL 16

Because of covid-19, hospitals around the country are either overflowing with patients or bracing themselves for the surge. Caught in the middle are patients who must choose between hospitalization, which risks infection and low-quality care due to lack of staff and space, and forgoing hospital care.

There is a third option: hospitalizing patients at home. Years of research have proved

"hospital-at-home" programs to be safe and have lower rates of complications and death for a wide range of conditions — including pneumonia, the most common reason for hospitalization for covid-19.

Here's how it could work: Patients who need hospital-level care for any reason would be evaluated by a home-based hospitalist service to assess whether the patient is appropriate for hospital-at-home and facilitate the necessary staff and equipment. If the patient has covid-19, this may include wireless monitors to measure personal oxygen levels, home oxygen and protective gear for family members. Thereafter, the patient would receive 24/7 nursing care at home and be seen by a doctor daily using a

combination of in-person and virtual visits, until they were ready to be “discharged.”

The benefits of such a model are many. One, during a pandemic, hospitals may carry the greatest risk of spreading the virus. Two, hospital-at-home allows for family members and loved ones to be present, which is impossible in most hospitals today due to infection risks. Three, through advanced technology such as remote monitoring, doctors can manage patients safely and even more efficiently, which is critical given the current shortage of medical staff and resources.

We just might find that moving more patients out of hospitals into the home setting could become part of a new normal that is worth keeping beyond

this crisis.

Kavita Patel is an internal medicine physician in Washington, who served as a policy director in the Obama White House and /a senior staff member to Sen. Edward Kennedy (D-Mass.). Shantanu Nundy is a primary care physician and the chief medical officer of Accolade Inc.

A plea to covid-19 survivors: Donate your plasma

By Diana Berrent • **PUBLISHED APRIL 8**

Right now, the medical community is pursuing a

promising method to treat covid-19: convalescent blood plasma. This technique has been successfully used for viruses in the past, including the SARS and MERS coronaviruses, H1N1 and Ebola. Those who have survived covid-19 to date, myself included, did so because their bodies created the proper antibodies to fight it off. Now, we survivors need to do our part by sharing those antibodies — our own internally created hazmat suit — to help others. By donating plasma to be transferred into patients whose bodies are not naturally creating their own antibodies, we could potentially save lives.

After I was diagnosed with covid-19, I saw that there was no central repository of

information on how to donate plasma, as each scientific institution was doing its own outreach to reach the right individuals. So I created an open Facebook group as a method of quickly connecting survivors with research institutions that are trying to recruit convalescent plasma donors, as well as to the many other research studies focused on the questions that need to be answered about this novel virus.

Today, our group, Survivor Corps, has more than 22,000 members. But why stop there? Those who have contracted covid-19 and recovered should take up the call to become plasma donors. To donate, survivors ideally should be symptom free for 21 to 28 days, with a minimum of 14

days. There's no time to waste to stem the tide of this pandemic. Let's flood research programs with volunteers.

Diana Berrent is founder of Survivor Corps.

Speed up the FDA's vaccine-approval process

By Eric. E Johnson and Theodore C. Bailey • PUBLISHED APRIL 8

With the coronavirus pandemic, our challenge is to move faster than a very fast-moving problem. Changing the law could help.

The estimated 12-to-18-month timeframe for getting a vaccine to market is largely because of

safety and efficacy testing required by the Food and Drug Administration. Legislation could shorten that timeframe without compromising the science — if the testing process tolerates more risk on volunteer study participants.

The FDA's long-standing approval process places a premium on keeping human subjects safe. For most problems, this represents a prudent calibration of risks and benefits. For the coronavirus, however, the tradeoffs are different. The general public faces imminent danger from a virus capable of exponential growth.

Over the years, Congress has repeatedly, and rightly, stepped in with legislation to speed the process. Now, Congress should act to sharpen

the curve of innovation against covid-19 by pushing the FDA to suspend its rules and practices and navigate according to the judgment of its experts.

Regular FDA approval processes begin human testing with a phase-one trial that must run its course with a small number of subjects — studying safety before enrolling subjects for larger phase-two and phase-three trials to assess a vaccine's effectiveness. Yet clinical trial phases that are typically sequential could be combined or overlapped.

Collapsing trial phases without compromising scientific standards will require exposing more individuals to uncertain risk. Yet to do otherwise in a rapidly

expanding pandemic leaves the global population exposed to a bureaucratically protracted period of pandemic risk without medical mitigation.

In the current crisis, it is ethically defensible to expedite clinical research with the cooperation of well-informed and consenting clinical subjects. There is no “safe” choice; it’s a risk-risk tradeoff — a question of more risk for research subjects or a longer wait for an approved vaccine.

We should respect the will of selfless individuals to knowingly take on the risks of investigational vaccines as an act of service for the sake of ending the pandemic.

Eric. E Johnson is an associate professor of law at University of Oklahoma College of Law.

Theodore C. Bailey is chief of the Division of Infectious Disease at Greater Baltimore Medical Center.

Put our veteran medics to work

By Dan Goldenberg • **PUBLISHED APRIL 8**

Governors have put out the call for millions of health-care workers to enter the front lines, with some even waiving licensing and certification requirements for retired medical workers. This is a good start, but we shouldn't overlook another promising source of help: former military medics and hospital corpsmen.

Under current state rules, highly skilled military medical experts — the same people who have patched up severely wounded soldiers and prescribed medication to those overseas — are cast aside upon returning home from service and made to start their training all over again in the civilian world. In fact, former medics are the fourth-most unemployed category among Army veterans. Out of frustration, many have pursued other careers with lower barriers to entry.

As a nation, we are wasting the enormous investment in medical training and experience each one these veterans represents in deference to an obsolete, state-level certification regime. Last I checked, care for the human

body does not change whether you serve in the military or not.

Governors should use the terms of their public-health emergencies to waive or at least streamline state-level requirements for recently separated corpsman and medics, allowing them to immediately serve in health-care roles for which they are already qualified, such as emergency medical technicians or paramedics. While this is an emergency action, in the long-term, this type of change should be made permanent, so our country never again wastes the incredible educational and experiential investment we have already made in some of our nation's finest citizens.

The covid-19 pandemic has brought to the fore our failure

to match medical talent with need. We can solve this problem. Allowing these medics to work in their fields would be good for our veterans and good for America.

Dan Goldenberg is a retired U.S. Navy captain and the executive director of the Call of Duty Endowment.

How to fill a federal leadership vacuum: An interstate covid-19 compact

By Eric W. Orts and Amy J. Sepinwall • **PUBLISHED APRIL 8**

An interstate compact would fill the vacuum of federal leadership. Although comprehensive federal action

would be best, the Trump administration only belatedly encouraged a nationwide shutdown, and it resists efforts to coordinate medical supplies and testing. The result is a "50-state anarchy."

Leaving each state to its own devices imperils us all. When states compete with each other, medical supplies go to the highest bidder or the most influential, rather than to states with the greatest need. Piecemeal policies cannot establish a testing regime to restart the economy after the viral peaks have passed.

The states should recognize the public health of their citizens as a collective good that they have the constitutional power to protect. Rather than banging their heads against the sandstone walls of the White

House, they should form an interstate compact.

The National Center on Interstate Compacts counts 200-plus state agreements on civil defense, transportation, environmental conservation and more. In fact, an Emergency Medical Services Compact already coordinates cross-border licensing and extends to coronavirus responses.

States in a new compact would agree to uniform shutdown, quarantine and testing protocols. Their reward would be an interstate supply network that enhances their bargaining power and thwarts bidding wars and price gouging. The compact would increase access to testing, too.

The bipartisan National

Governors Association could organize the compact. Its chair, Maryland Gov. Larry Hogan (R), could drive the effort with its vice chair, New York Gov. Andrew Cuomo (D), as co-pilot.

The Compact Clause of the Constitution requires Congress to approve some interstate compacts, but not all. The Supreme Court has upheld multistate tax compacts adopted without congressional consent. The clause only forbids state agreements that interfere with the exercise of federal power, which is sorely lacking here.

As President Trump drags his feet, the states can't wait. They must mobilize together — now.

Eric W. Orts is the Guardsmark professor of legal

studies and business ethics and the director of the Initiative for Global Environmental Leadership at the Wharton School of the University of Pennsylvania. Amy J. Sepinwall is an associate professor of legal studies and business ethics at the Wharton School of the University of Pennsylvania.

Borrow from the New Deal: Create a Covid-19 Recovery Corps

By Steven Joffe and Ezekiel J. Emanuel • **PUBLISHED APRIL 2**

As coronavirus spreads across the United States, the number of cases may soon surge into the tens of millions. When

these people recover, most are likely to be immune. Many are unemployed. It need not be so.

America needs a Covid-19 Recovery Corps, now.

Survivors of the 2003 SARS epidemic, caused by a related coronavirus, appear immune to reinfection for a year or more. Although studies are urgently needed, all the experts, including Anthony S. Fauci of the National Institute of Allergy and Infectious Diseases, believe covid-19 immunity is likely similar.

Covid-19 survivors are a critical resource, both to perform tasks that non-immune individuals cannot safely do and to get the economy moving. To enlist them, the federal government should immediately create a

CRC modeled on New Deal programs such as the Works Progress Administration.

CRC associates could perform essential support roles in hospitals: preparing and delivering meals, transporting patients and samples, helping to clean. They could staff drive-through testing centers so health-care workers wouldn't have to. They could care for, teach and tutor children whose parents must work. They could assist in places where physical distancing is impossible, such as nursing homes. They could deliver food to people who are self-isolating. They could go door-to-door as census workers.

Congress and the president will have to muster the political will and cooperation

needed to establish a major new program. A mechanism will also be needed to certify who is a survivor. Soon, we will have a serological blood test to determine who has antibodies against the coronavirus. Until then, we will have to confirm active infection followed by resolution of symptoms, passage of time or repeat viral testing.

Americans need work, and there's plenty of work to be done by people immune to the virus. By taking advantage of a precious resource — immune covid-19 survivors — a CRC could meet these needs without fanning the flames of the epidemic.

Steven Joffe is a pediatric oncologist and interim chairman of the Department of Medical Ethics and Health

Policy at the University of Pennsylvania Perelman School of Medicine. Ezekiel J. Emanuel is a professor and the vice provost of global initiatives at the University of Pennsylvania.

Donate your stimulus check to someone who needs it more

By Maggie Master • **PUBLISHED APRIL 2**

As a sequestered writer, I remotely submit a radical idea: I plan to sign over my forthcoming stimulus check to someone in need. And if you are able, I think you should, too.

There are an estimated 130 million Americans in the middle class. Consider: If even 20,000 stimulus recipients chose to pool our $1,200 checks, we would create the grass-roots equivalent of a $24 million micro-bank. That's some serious grant-making power.

What could this look like? Pass your payment along to someone whose services you normally utilize — a barber, a nail technician, a house cleaner — whose work has evaporated. Donate to a reputable organization channeling resources to affected households. Buy gift cards to local businesses. Those are just a few ideas. A friend and I have created a website to help people make high-impact donations. It also

shares resources for those in need.

Megan Greene, an economist at the Harvard Kennedy School, has advocated for wide-reaching stimulus checks. But she notes that government is inherently a sledgehammer, not a scalpel. Such bottom-up grant-making, she says, "could be an incredibly powerful way to address the fatal flaw in our policy tools."

In Maryland, tens of thousands of my fellow citizens have filed for unemployment. If even 20,000 people could deliver our checks directly to them or to the organizations scrambling to serve them — and if another 20,000 could promise to "pay it forward" by supporting struggling local businesses through patronage

or donations — we could make a significant impact. All of us at home are wondering what life will look like when this illness has run its course. Together, let's make sure that the places we love survive, and that the people on whom we count in boon times can get through this hardship.

Maggie Master is a writer living in Baltimore.

We need more bankruptcy judges. Congress can help.

By Peter Friedman • **PUBLISHED APRIL 2**

If we are "roaring into a recession," as Goldman Sachs projects, and a wave of covid-

19-related bankruptcies follow, our bankruptcy system will be overwhelmed. To avoid this foreseeable calamity, Congress should immediately authorize a substantial increase in federal bankruptcy judgeships to handle the load and ensure that our economic courts of last resorts can meet their critical obligations.

A company's ability to restructure its debt and obtain a fresh start is a fundamental tenet of U.S. corporate law. Our system has worked in past downturns, allowing businesses of every type to reorganize and save jobs rather than wither and liquidate. In a real sense, U.S. bankruptcy courts and judges are the hospitals and doctors for ailing businesses, and they must be sufficiently staffed and

supported. Without more bankruptcy judges to face what some predict could be as much as a fourfold increase in cases, the system will be hard-pressed to carry out its mission.

In this time of growing crisis, the need for additional bankruptcy judges is especially acute in venues that may face heavier volumes of filings. And Congress should amend current law so that bankruptcy judges can temporarily serve anywhere in the country, not just intheir home districts.

Liberals and conservatives ought to come together on this issue. Bankruptcy courts cannot be packed with ideologues by the president or the Senate; bankruptcy judges do not have life tenure and are selected by other judges, not

politicians. Historically, this has been done with great care and has led to an exceptionally high-quality pool of capable bankruptcy judges with extensive subject-matter expertise. Our judiciary can fill new judgeships in the same way now to meet our needs.

The United States has seen the costs of failing to prepare before a crisis spins out of control. Appointing additional bankruptcy judges before the bankruptcy system is inundated is a low-cost proposition with significant benefits. Failing to prepare leaves systems overwhelmed and lets contagion spread. We can't afford for that to happen.

Peter Friedman is a partner in the restructuring practice at O'Melveny & Myers LLP.

End voter registration

By Ellen Kurz • **PUBLISHED APRIL 2**

As the coronavirus threatens our nation's health and democracy, now is the time to act to ensure a legitimate general election in November. There has been a lot of talk about voting by mail — but we're missing a critical piece of the democracy puzzle. We need to ensure every eligible citizen not only can cast their ballot safely but also obtain a ballot in the first place. The best solution is to skip voter registration altogether and send a ballot to every eligible citizen for the November election — not just to registered voters.

Even in a normal cycle, only about 60 percent of eligible

voters take part in our elections. Civic groups and political parties spend millions of dollars and months on the ground registering voters. But this year, they won't be able to go door-to-door or set up shop outside supermarkets to register voters due to social distancing guidelines. By ending voter registration, we'll not only protect our democracy, but we'll also give it the vital boost it needs.

This is especially critical because registration is already used as a tool to suppress the vote. Before recent elections, we've seen Georgia, Indiana and Ohio purge hundreds of thousands of people from voter rolls. Without bold action, we can expect an election that isn't just unrepresentative but is also delegitimizing of the

next government's response to the multiple crises we will face.

We already have the resources to make sure everyone can vote. The government has records, such as Social Security numbers, that could serve as voter rolls when individuals turn 18. State agencies — such as the Department of Motor Vehicles — have this information as well.

With only a fraction of Americans choosing their leaders, our democracy is already extremely fragile. We can come out of this pandemic with democracy on a lifeline, with a select few choosing our next president, or we can act now and have a healthier democracy when this ends. Wouldn't that be the best silver lining?

Ellen Kurz is founder and chief executive the voting-rights advocacy group, iVote.

Lift restrictions on blood donations from gay men

By Kevin Ballen and Reese Caldwell • **PUBLISHED MARCH 27**

At a White House Coronavirus Task Force news conference on March 19, Surgeon General Jerome M. Adams outlined one action that young people like us can take to help our country during the coronavirus: “We know many of you are home practicing the president’s guidelines for social distancing, but one thing we should all consider, especially our millennials and

Gen Z, is donating blood."

Dr. Adams, we hear you and we want to help. The Red Cross is asking for blood donations, as thousands of drives have been canceled across the country because of coronavirus fears. Our country is facing a dire blood shortage, and yet we, along with millions of other healthy gay men, are being turned away.

At the height of the AIDS epidemic in the 1980s, the Food and Drug Administration barred gay men from donating blood. In 2014, the FDA modified this ban to prevent gay men from giving blood if they have had any sexual contact within the past year, even if they test negative for HIV, practice safe sex and are in a monogamous relationship. Meanwhile, straight men and

women, all of whom are capable of having HIV, face no restrictions on blood donation (even if they engage in risky sexual activity).

It is long past time to lift this discriminatory policy. Other countries, such as Italy and Spain, have moved toward individual risk assessments rather than discriminatory bans on gay men, and have faced no issues with HIV in the blood supply. The United States is in a national crisis: the coronavirus threatens our health-care system, and a blood shortage only adds to the stress. We call on President Trump to sign an executive order revising the blanket restriction to an individual risk assessment, accounting for HIV testing and safe sex practices. This is an

opportunity for the administration to respond quickly and effectively to our current crisis. Millions of gay men want to help. Please let us.

Kevin Ballen and Reese Caldwell are sophomores at Harvard College studying sociology and molecular and cellular biology, respectively.

Let foreign-trained physicians join the fight

By Leslie Omoruyi • **PUBLISHED MARCH 27**

As the coronavirus crisis puts intense pressure on the health-care system, the Veterans Affairs medical system and

some governors are asking doctors and nurses to come out of retirement. And in some hospitals in New York, final-year medical students are already working as clinical observers and note-takers to help manage the spread of covid-19. But there's another resource hospitals should examine: foreign-trained physicians.

There are an estimated 65,000 doctors in the United States who have not done any residency training in the country and therefore cannot be licensed to practice. Many of these doctors have extensive medical schooling and postgraduate training and possess clinical competence in diagnosing and managing infectious diseases. Due to the highly competitive nature of

U.S. residency programs and restrictions from the Balanced Budget Act of 1997, which limits the annual number of residency slots supported by Medicare, many U.S. medical graduates and foreign-trained doctors do not make it into residency programs.

This contributes significantly to the increasing deficit in the physician workforce. The Association of American Medical Colleges predicts that over the next decade, the United States will see a shortage of more than 120,000 physicians. Addressing the health-care labor shortage by asking retired nurses and doctors to come back to work may temporarily boost the health workforce, but certainly doesn't address future outbreaks. Also, these retired

professionals are mostly seniors with a higher mortality risk for covid-19 in any clinic setting.

Tapping into the massive pool of foreign-trained physicians could ameliorate gaps in health-care quality resulting from a high patient-to-physician ratio, especially during health crises such as the covid-19 pandemic. The system should decide how to use these doctors, perhaps by engaging them in community preventive medicine and population health planning or offering easy paths to restricted licenses in infection prevention and control. Given the emergency before us, why would we turn away their expertise?

Leslie Omoruyi is a foreign-trained physician and

independent health-care consultant in Lynchburg, Va.

Emergency responders can help besieged hospitals. Here's how.

By Aarron Reinert • **PUBLISHED MARCH 27**

Covid-19 is straining the capacity of America's hospitals, so why not consider alternate models?

Right now, reimbursement for emergency ambulance service is tied almost exclusively to the transportation of a patient to a hospital emergency room. But it doesn't have to be that way.

The Centers for Medicare and

Medicaid Services and the Department of Health and Human Services have the authority to grant waivers that would compensate first responders for providing care for some patients in their homes.

Waivers could also be issued to reimburse ambulance providers who transport patients that need less intensive care to alternate destinations, such as urgent-care facilities. If a patient requires ongoing monitoring, emergency first responders can assist with ensuring regular telemedicine visits are scheduled to allow them to maintain contact with their medical teams without having to leave home — minimizing potential community spread.

This approach would reduce

crowding in hospitals, allow them to preserve scarce beds for those patients who need them and ensure doctors and nurses can devote more time and resources to the patients most in need of the highest level of care.

Giving paramedics, EMTs and other front-line health-care providers priority access to personal protective equipment would also help ensure there is manpower to fuel this alternate delivery model. The national shortage of gloves, masks and other equipment put America's paramedics, EMTs and fellow first responders at an unacceptable heightened risk. It is imperative that lawmakers include a provision in the next phase of the stimulus requiring the health and human services

secretary to issue guidance ensuring that ambulance providers and suppliers are given priority access to such equipment.

First responders and those we serve need government leadership and dedicated funding to support new, innovative approaches during this crisis.

Aarron Reinert is president of the American Ambulance Association.

It's time for emergency physicians to put away our stethoscopes

By Jeremy Samuel Faust •

PUBLISHED MARCH 27

Since 1986, federal law has mandated that any patient requesting emergency medical care must be evaluated by a physician to assess for any threatening conditions. The law, often referred to as the "anti-dumping law," requires that physicians perform a medical screening evaluation, including a physical examination.

Over time, the interpretation of this mandate has slowly expanded, not by law so much as by custom. This is why emergency rooms have become our nation's safety net for care. Despite increasing popularity of urgent-care clinics and telehealth, many patients who could have safely been cared for elsewhere still end up in emergency rooms.

While many of us embrace that

mission with pride, it is dangerous and wasteful in the coronavirus pandemic. We need to course-correct to keep everyone safe. Exposing patients to emergency rooms is now far riskier than it was before. In turn, health-care workers must assume that all patients are infected. This forces us to blow through personal protective equipment that we desperately need so that we do not become infected ourselves.

Over the past few decades, we have learned that many, if not most, of our physical examination maneuvers provide little reliable information. In most cases, the information we need can be obtained simply by interviewing patients. But old habits die hard, and patients

seem to love our stethoscopes. In our current situation, that simply won't do.

We need the federal government to allow us to perform medical screening exams via video or through glass doors, even for patients entering emergency rooms. The removal of the requirement that we evaluate every patient by hand will save resources and keep everyone safer.

In recent meetings and phone calls with stakeholders, the Centers for Medicare and Medicaid Services has signaled that it is seriously considering making this change. But it has not materialized, and time is of the essence. The moment to act is now.

Jeremy Samuel Faust is an

emergency physician at Brigham and Women's Hospital in the Division of Health Policy and Public Health, and an instructor at Harvard Medical School.

Include local media in the stimulus package

By Suzanne Nossel and Viktorya Vilk • **PUBLISHED MARCH 23**

Local news outlets across the country are providing essential, up-to-the minute information aimed at keeping communities safe. Even in cities under virtual lockdown, the news media has been recognized as an "essential service" for public health and safety, alongside hospitals and

grocery stores. Local media outlets have been rising to the occasion, breaking stories, guiding the public on do's and don'ts, and holding leaders accountable for life and death decisions. Many have dropped paywalls on their covid-19 coverage, recognizing that it represents an essential public service.

But while they may seem to be thriving, local media outlets still suffer from the disintegration of longstanding, advertising-based business models. That, coupled with the mass migration of consumers to social media platforms, has stripped local news outlets of their prime source of revenue, leading to the closure of one out of every five local newspapers and the slashing of newsroom staffs in half over

the past 15 years. The spread of covid-19 has made this chronic illness acute: The closure of local businesses and slowdown in economic activity are depriving local news outlets of essential revenue to keep operations going. In recent weeks, several publications have dropped print editions, or made plaintive appeals to readers for the financial support necessary to sustain operations.

As Congress and state legislatures contemplate massive stimulus bills aimed to keep our economy and society afloat, local media outlets should be part of the package. Funds to replace lost revenue and ensure that local news outlets continue to provide essential coverage of the pandemic and other topics will

enable communities to stay informed, healthy and connected through this crisis. The monies need to be carefully safeguarded to ensure that the infusion of public funds does not compromise editorial integrity or deter hard-hitting coverage. Local media is among the vital organs of our democracy and must not be allowed to fail.

Suzanne Nossel is chief executive of PEN America. Viktorya Vilk is the director of digital safety and free expression programs at PEN America.

Lift tariffs on Chinese medical equipment

By Susan Shirk and Yanzhong Huang • **PUBLISHED MARCH 23**

China, where the coronavirus epidemic seems to have peaked and life is slowly returning to normal, currently has a surplus of protective medical gear, including masks, gloves and gowns. The country mobilized resources to manufacture the equipment and is now ready to export it to countries in need. On March 9, China announced it would export five million masks to South Korea. China has also provided testing kits, masks and protection suits to more than 80 countries, including Italy, France, Pakistan, Japan and Iran.

Why, then, isn't the United States buying the equipment it needs from China? Because President Trump's tariffs are

standing in the way.

Since 2018, the Trump administration has imposed more than $400 billion dollars of tariffs on imports from China; $360 billion dollars of duties remain in place. Critical medical products, including face masks, gloves, protective goggles and thermometers, have been subject to Section 301 import tariffs.

The administration has offered to grant exclusions from import tariffs for certain medical products imported from China. But on March 5, the office of the U.S. Trade Representative (USTR) approved just 200 specific requests from individual companies to have their purchase of items needed to handle the epidemic excluded from the tariff; some of the

requests from health-care companies were denied. On March 10 and 12, the administration said it would temporarily reduce some tariffs on Chinese products to address the pandemic, yet the list covers only a handful of urgently needed products.

On March 20, USTR announced that it was considering "possible further modifications to remove duties from additional medical care products" related to the COVID-19 virus and would collect comments from interested parties until at least June 25. Yes, that's three long months away, a period in which thousands of doctors, nurses and patients could die because they lack protective gear.

Public health and safety

demand that President Trump immediately lift all tariffs on the medical products we need. American lives are at stake.

Susan Shirk is research professor and chair of the 21st Century China Center School of Global Policy and Strategy at University of California, San Diego. Yanzhong Huang is a senior fellow of global health at the Council on Foreign Relations and a professor at Seton Hall University's School of Diplomacy and International Relations.

Let foreign-born health-care workers live in peace

By Christopher Richardson •

PUBLISHED MARCH 23

While, as a nation, we are praising and proud of the herculean job being done by health-care workers, what we don't realize is that more than 1 in 6 of U.S. health-care workers are immigrants. For U.S. doctors, the statistic is even more pronounced, at 1 in 4. In the states hardest hit by coronavirus, California and New York, more than a third of all health-care workers are immigrants.

These individuals, who are being forced to work night and day as our doctors, nurses and pharmacists during our national crisis, must also confront unfair immigration provisions such as the administration's travel ban, administrative processing roadblocks, arbitrary green

card caps and the new public charge rule. President Trump's policies are adding undue stress to an already stressful existence to these workers. Close to 30,000 DACA recipients are health-care workers, including 200 who are slated to be doctors, yet they will probably lose their status come June, as the Supreme Court will likely allow Trump to eliminate the program. And there are rumors that the Department of Homeland Security may be planning raids and deportations against these DACA recipients who are saving the lives of Americans.

We shouldn't ask these immigrants to risk their lives in labor for us but spend their waking hours under threat of losing their status or

deportation. Trump should suspend his byzantine immigration policies for these health-care workers immediately, work with Congress to exempt health-care workers from any immigration caps and set up task forces within DHS and the State Department to expedite their current cases — whether those cases be non-immigrant visa renewals, Green card applications or naturalization. We, as a nation, cannot afford to lose them. This is the least we can do for them after all they have done for us.

Christopher Richardson is a former U.S. diplomat and immigration attorney.

Unleash fourth-year medical students

By Donald W. Landry • **PUBLISHED MARCH 20**

On March 20, around 20,000 fourth-year U.S. medical students learned which hospital they are assigned for their residency during the annual National Resident Matching Program. Normally, they would begin serving patients in July, but there's a way to do it now.

If medical schools instead confer MD degrees immediately, instead of waiting until the end of the semester, these hospitals could hire, train and deploy an extra 20,000 physicians at a time when we are straining to "flatten the curve" of the covid-

19 coronavirus. This proposal is a few weeks old and has already passed from Columbia University to New York State. But others should take up the idea of accelerating fourth-year medical students into their chosen life of service.

At Columbia, most of our medical students — representative of similar medical students throughout the country — want to help, even if it is not their time. But the fourth-year students are fully prepared. They have completed all the clinical rotations required for the MD degree. Under normal circumstances they would now be taking electives or conducting research, perhaps not even seeing a patient during the final few months of medical school. They would in

the normal order receive their MDs in May and begin as interns (first-year residents) by July.

I propose instead that medical students be graduated now and given the opportunity to serve in this time of great need. I imagine most would jump at the opportunity. If they were not caring for covid-19 patients directly, they could free more experienced physicians to undertake that necessary work.

Donald W. Landry is physician-in-chief, chair of the Department of Medicine and director of the Division of Experimental Therapeutics at New York-Presbyterian Hospital/Columbia University Medical Center.

House mild cases in hotels

By Jeremy Samuel Faust and Cass Sunstein • PUBLISHED MARCH 20

One of the toughest decisions facing physicians and public health officials is where to send patients who test positive for the covid-19 coronavirus. For the small but significant proportion with severe or critical illness, the decision to hospitalize is trivial. But where to send the apparently large majority of cases that are mild or even symptom-free?

These patients, often young, need to be isolated to reduce spread. But using a hospital bed for isolation alone takes up capacity, puts others at risk and chews through protective equipment that doctors, nurses

and other staff desperately need.

A natural alternative is to send people home, with clear instructions to self-isolate. But in some cases that is not feasible, and it poses evident risks. The World Health Organization recommends placing mildly ill patients in dedicated covid-19 facilities as the gold standard for isolation. While countries such as China have the logistical capability to erect new hospitals for this purpose in a matter of days, most places cannot achieve that.

Fortunately, there is a potential answer: America's prodigious hotel industry. And in case you haven't noticed, there is plenty of room at the inn.

The federal government should use its financial and legal resources to temporarily convert some large hotels, reeling from the current economic situation, into covid-19 isolation facilities. Under recently issued federal guidance, these spaces are not required to provide medical attention.

Under ordinary circumstances, the suggestion that the federal government might seek to take over a hotel would run into serious legal objections. But under current conditions, we suspect that many hotel executives would line up to draft temporary and renewable lease agreements with the government. This could also help stave off unemployment in the travel industry.

Yes, all of this needs to be paid

for, and strong steps would have to be taken to reduce health risks to housekeepers and staff. But whatever the upfront costs and risks may be, the downstream benefits — in terms of health, economics and more — are likely to exceed them.

Jeremy Samuel Faust is an emergency physician at Brigham and Women's Hospital in the Division of Health Policy and Public Health and an instructor at Harvard Medical School. Cass Sunstein is Robert Walmsley University Professor at Harvard and a former administrator of the White House Office of Information and Regulatory Affairs.

Forget stimulus checks. Send prepaid cards instead.

By Herbert Lin • **PUBLISHED MARCH 20**

The administration and members of Congress have proposed giving Americans a significant amount of cash to stimulate the economy, such as a check for $1,000 or more to every American adult.

Stimulating the economy by providing spendable cash is a good idea, but what would prevent those in the financially well-off categories from simply investing that money instead of stimulating the economy by spending it?

One way is to provide immediate cash to all adult Americans, but in the form of

prepaid Mastercard or Visa cards that expire in a certain time — such as three months — rather than in the form of paper checks.

This approach has several advantages. First, it virtually guarantees that recipients will spend the cash. Facing the possibility that their stimulus cash will expire, recipients in all financial brackets will be anxious to use the money. Even the well-off will hate the idea of losing free money that they could have spent.

Second, recipients of prepaid cards can use them immediately, whereas a check needs to be deposited first. Although electronic banking with online check deposit is increasingly common, many people do not have access to such a service. And going to

the bank violates infection-control guidelines.

Third, amounts on prepaid cards that are not injected into the economy can revert to the U.S. Treasury and perhaps be recycled for later use. With paper checks, the Treasury recovers only those that are not deposited, whether or not they are spent.

The fundamental principle is to increase the likelihood that spendable cash sent to consumers will be spent immediately. Regardless of the details of such stimulus program, that principle should be observed.

Herbert Lin is a senior research scholar and the Hank J. Holland Fellow at Stanford University.

Provide health care at the neighborhood level

By Stephen Grill • **PUBLISHED MARCH 20**

As a neurologist living in a Washington, D.C., suburb, I want to propose a strategy to help reduce the burden on hospitals as this pandemic plays out.

Many doctors have begun practicing telehealth from our home offices. But I wonder if clinicians might be able to organize, in concert with their local hospitals, to help their communities in some way.

Once organized, and if given some medical supplies, we might help with screenings at our neighbors' houses. Perhaps we could monitor neighbors

recently discharged from hospitals. Or, in my own field, I might visit a person concerned that their facial weakness might be a stroke. A simple examination or an online consult might determine it to be a less serious Bell's palsy, potentially avoiding an emergency-room visit.

I don't know if this is practical, and I know hospitals do not have the resources to set up such a system or offer supplies right now. But with the help of social-networking services for neighborhoods, clinicians could self-organize. They could indicate their expertise, their availability and what they would be willing to do. It is not a lot of work to do it now and perhaps it may pay off.

The writer is a neurologist at

the Parkinson's & Movement Disorders Center of Maryland.

Let patients test themselves at home

By Shantanu Nundy and Marty Makary • PUBLISHED MARCH 20

Missing from the current discussion about rapidly ramping up testing for covid-19: doing it at home. Testing for the coronavirus can be performed using a nasal swab (the equivalent of putting a Q-Tip in your nostril). There is little scientific reason as to why this can't be done by people at home under the direction of a doctor. Research on seasonal flu comparing the accuracy of

self-collected swabs vs. professionally collected swabs shows that they are nearly equivalent.

Here is how at-home testing could work:

Step 1: Individuals with symptoms call in to their doctor's office or use a telemedicine service to be assessed by a qualified health-care professional who can order tests, often billing a patient's insurance company directly.

Step 2: Those who meet CDC guidelines for testing and are able to test themselves and be safely managed at home are sent a testing kit by overnight mail or direct delivery from a nearby facility (which could include labs, pharmacies or specially set-up public-health

depots).

Step 3: Individuals would then self-swab, guided by an instructional video or a virtual health-care professional, and then mail the sample to a testing facility or drop it off. All three steps could be done completely from home — not only convenient for those who are already feeling ill but also ensuring social distancing.

Governments and private organizations should issue guidance on at-home testing for clinicians, laboratories and public health professionals. Also needed: removing state and local regulatory barriers that slow down and sometimes prevent labs from processing samples collected by patients. And government and private organizations should provide funding to laboratories and

researchers to invest in validating and improving the effectiveness of at-home testing.

With swift action, at-home testing could ensure widespread, equitable availability of care and slow the spread of covid-19.

Shantanu Nundy is a primary-care physician and chief medical officer at Accolade Inc. Marty Makary is a professor at the Johns Hopkins School of Public Health, editor in chief of MedPage Today and author of "The Price We Pay."

Read stories from people affected by the coronavirus crisis:

Leana S. Wen: The one thing about giving birth during the

covid-19 pandemic that I didn't anticipate

David Lat: I spent six days on a ventilator with covid-19. It saved me, but my life is not the same.

Tamal Ray: I spend my day working in the hospital. Then I come home and bake.

Cathy Merrill: This is more than a 'hiatus' for my small business

The Opinions section is looking for stories of how the coronavirus has affected people of all walks of life. Write to us.

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