**Harlan Krumholz:** Welcome to *Health & Veritas*. I’m Harlan Krumholz.

**Howard Forman:** And I’m Howie Forman. We’re physicians and professors at Yale University. We’re trying to get closer to the truth about health and healthcare. This week we’ll be speaking with Dr. Cary Gross. But first we always like to check in on current health news, and I know there’s a paper that you wanted to talk about today, Harlan. I’m eager to hear about it.

**Harlan Krumholz:** I like talk about papers that get a lot of national attention, and of course when papers are published about weight, they tend to catch people’s eyes. There was [a paper that came out this week](mailto:https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2803643) that was looking at the association of a change in body size, including weight with all-cause and cause-specific mortality, causes of death, among healthy, older adults. And people have seen headlines that was something like, “Losing weight isn’t good for you if you’re older.” And this paper was a little more nuanced than that. I just thought I would take a quick little deeper look, for people can get some perspective on this. This was a group that really was asking this question, “Is change in body size associated with a change in mortality risk among healthy older adults?” And what they did was they made use of a study, we call this a post hoc analysis.

Essentially you do one study, but you end up having a database that you can use for other studies. This study was one about whether aspirin reduced risk in older people, and it was a randomized clinical trial. And they recruited people from 2010 to 2014, and they were particularly recruiting people 65 and older in the U.S. and actually 70 and older in Australia. And then they followed them up for a period of time and they finished that study. But the question then, with this data, they could take advantage of it because it turned out that in this study, body weight and waste circumference were measured at the baseline visit when they first started the study and at a regularly scheduled visit two years later. And then what they were able to do was to say, how about the changes that occurred in body weight and waist circumference—what your belt size was, essentially—and how did that relate to the risk of dying and not just dying from anything or dying from something like cancer.

They had about, I don’t know, 16,500 people that were in this study. The mean age, the average age was 75 years old and about half of them were women. And over the course of about a little more than four years, they had over 1,200 deaths. 1,600 people, 1,200 deaths. And then they started looking at people who had stable weight over those first two visits, those who had a 5 to 10% weight loss, and then those who had more than a 10% weight loss. And they took a look at how it affected mortality. Now, again, these were healthy older adults, but they weren’t looking at them by whether they were trying to lose weight. They were looking at them by whether they did lose weight or they lost belt size, for example. And what they saw was that in men compared to those who had a stable weight over that period, those who had a 5 to 10% weight loss had a 33% higher risk of dying. And those who had more than a 10% decrease in their weight had almost a three times, a 300% higher risk of dying.

Now, women similarly had increased risk with those weight losses, but they weren’t quite as large as the increase in risk that were experienced by men. And when they also looked, for example, at different causes, they saw the weight loss was associated with a higher cancer specific mortality, both in men and in women. And when they looked at non-cancer, also among men who had greater than a 10% decrease, there was also an increase. And by the way, the weight circumference followed what you might have expected from the weight. Now you just need to know something, which is that again, this isn’t about people who are grappling with obesity and whether they lost weight. And we do have a lot of questions about what about people who are older who have obesity, should they be undertaking, particularly with medications now available, how should this fit into our way in which we’re treating obesity?

But this is just about whether people are losing weight. And when you read about this, it’s not that, first of all, people shouldn’t freak out if they’ve lost weight. And it also doesn’t mean that if you purposely follow a plan to get healthier and that involves losing some pounds, that might put you at higher risk. This is about people who showed up two years later. And what you have to take into account is that a lot of people lose weight because they were losing appetite or maybe becoming what we call hypercatabolic. Their body was using calories more, maybe because they had, it was before they developed cancer, something was happening. This is something we’ve known for a long time in medicine, how a patient shows up with unexplained weight loss a lot. We pay attention.

**Howard Forman:** It’s interesting. And also patients that are depressed are prone to that weight loss, and they’re also prone to a lot of other disorders. There’s a lot of correlation, not necessarily causation, but it definitely is something that people should be spending a little more time paying attention to.

**Harlan Krumholz:** I don’t want people to fear taking on a healthy program where they start exercising a little bit more and lose a little bit of weight. That’s not what this test did. This is more about the people that show up and show pretty much unexplained weight loss. And when that happens, we need to pay attention to see if there’s any problem. Again, even though there was an increased risk, I think there were also a lot of people that didn’t bother. It doesn’t mean everyone who had this got into trouble. It just means for some people it was a signal of increase that they had that there was something that then subsequently happened. But anyway, I just wanted to clear it up so people didn’t just all of a sudden think, “Yeah, wow, I shouldn’t be eating healthier because that might hurt me.” That’s not what was in this study. Let’s pivot to get to Cary, what a great guest, and we’ll get to your introduction.

**Howard Forman:** Dr. Cary Gross is a professor of medicine and public health at Yale School of Medicine. He’s the director of the [National Clinician Scholars Program](https://www.nationalcsp.org/about-us), which is dedicated to fostering leadership and providing mentorship for future clinicians. And he’s the founding director of the [Yale Cancer Outcomes Public Policy and Effectiveness Research Center](https://www.yalecancercenter.org/research/copper/), or COPPER. His research focuses on healthcare effectiveness, quality and health equity, concentrating on cancer prevention and treatment. Dr. Gross also serves as an associate editor for [*JAMA Internal Medicine*](https://jamanetwork.com/journals/jamainternalmedicine). He received his bachelor’s degree at Johns Hopkins University and his medical degree from NYU School of Medicine.

He completed his residency in internal medicine at New York Hospital Cornell Medical Center and served as chief medical resident at Memorial Sloan Kettering Cancer Center before moving back to Johns Hopkins to complete the Robert Wood Johnson Clinical Scholars Program. First, thanks very much for joining the podcast. Before you arrived at Yale, you published [a paper](https://www.nejm.org/doi/full/10.1056/nejm199906173402406) on the association or lack thereof of burden of disease with NIH funding. You [followed this up](https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775642) two decades later. Can you tell us what you learned then, what you know now, and what our listeners can take home from that?

**Cary Gross:** First of all, thanks Howie and Harlan for having me on the podcast. I’m a big fan of the podcast and, more importantly, big fans of yours. I really appreciated our friendship and collaboration over the years. When I was a chief resident at Sloan Kettering, I was a primary care doctor, but as a chief resident, I really grew not only as a clinician, but grew as a skeptic of the research process. I really saw—a lot of the focus, naturally, in Sloan Kettering was on curing cancer—but I really began to wonder, “What are we really trying to do with our research studies? What are we trying to accomplish with our research ecosystem?” When I was a fellow in the clinical scholars program, some colleagues and I initiated a study where we looked at how the NIH was allocating funding to specific diseases.

And the question was whether the burden of disease on society, which you could measure burden of disease in a variety of ways, number of deaths, number of years of life loss, costs, et cetera. We looked at the relation between burden of disease through various metrics and how much the NIH was investing in research on these different diseases. So what we found was that there was a weak correlation between burden of disease and how much the NIH is funding, spending on different diseases. But we also found there was gross overspending in relation to disease burdening for some conditions such as breast cancer, AIDS, dementia, diabetes. Again, not against research on those diseases, but by contrast, other diseases with large burdens were very much understudied, perinatal disease and emphysema, et cetera.

Another finding from the same study I mentioned, that we looked at different ways of measuring disease burden. What we found is that the way you define burden, if you pick one metric such as deaths, your disease of interest may come out looking really underfunded and you pick a different metric, maybe it’s cost, then your disease may look overfunded. What we really tried to point out that advocacy groups and scientists could potentially game the system when advocating for their diseases.

**Harlan Krumholz:** I think on Howie’s introduction, what’s good, I want to just add to it a little bit, that you’re really one of the most creative investigators that I know. You think broadly about a wide range of issues and have made contributions across a wide range of medicine and healthcare, and a lot of your work is truly actionable. It has changed practice, it’s influenced guidelines, it’s helped make medicine better. And you’re a terrific mentor. I just want to use this platform to say out loud what a pleasure it’s been for me to be able to work with you. And it’s one of the great privileges of our work in academia that we get to have colleagues like you who help inspire us and push us to do ever better and are such a good example about how good it can be in academia to try to help others.

I want to just talk to you about some of the work that you’ve done and its practical implications. For example, you’ve written a lot about when we should stop screening for cancer, when is the time that we can start telling people, “You no longer have to go through a colonoscopy,” for example? And I know you’ve thought deep about a wide variety of other screening tests, mammography and so forth. What’s the answer here? How old do you need to be that you don’t need to worry about screening? And does that really make sense given the cancer rates increase with age? People listening might wonder, “Gee, I don’t think I should stop.” How do you explain your research to them and its implications?

**Cary Gross:** That’s a great question. One way I think about screening older patients for cancer is to first of all think about this issue of overdiagnosis, that if you have a small tumor that you’re not feeling symptoms from, not showing up on routine tests and you find it on cancer screening, whether it’s colonoscopy or mammogram. If you find this small tumor, the real question is, would that tumor have caused you any problems in the rest of your life or would you have died of something else and been none the wiser about the fact that there was a smoldering small cancer in there? The real question is almost like it’s a race between if there is a small cancer there, would it cause any problems or are you better off not knowing about it?

**Harlan Krumholz:** Is it a problem with that word *cancer*? Because anybody who knows that I’ve actually got a cancer doesn’t naturally want to feel like, “I think I’ll just ignore it.” Is it part of our terminology also?

**Cary Gross:** No, this is cancer exceptionalism, I think in our research and ecosystem and also in our healthcare ecosystem. Cancer is a condition. People were afraid to even say the word in the fifties, sixties, seventies. It was a horrifying word. That’s why we have the National Cancer Act. We don’t have the National Gout Act**.** It’s the National Cancer Act. People are scared, it has a tremendous disease burden, they want to screen for it. People want to treat a cancer if they haven’t and they want to know whether it’s there. But for the older patients, if you have a short life expectancy—short life expectancy, meaning less than 10 years—it’s highly unlikely that screening for cancer is going to do more benefit than it is harm. Most likely, if there is a cancer there, it wouldn’t cause you any problem.

**Harlan Krumholz:** And just to finish this, then, who do you recommend not getting screened for this cancer? Because the truth is, Cary, you say who less than 10 years, I think if you’re 95, you still think you’re going to live more than 10 years. Nobody thinks, “I’ve only got 10 years left.” Most people, if you’ve got a terminal disease, but aside from that, people don’t want to think about that in those terms.

**Cary Gross:** There’s this tension between thinking quantitatively and thinking quantitatively. Quantitatively you could say, I don’t know numbers off the top of my head, but you could say if you’re 90 years old, you only have a 5% chance of living 10 years. But people think qualitatively and they think, “I’ll roll the dice. I want to be in that 5%.” I think at the end of the day, we have to give people the information to let them make an informed choice. But in some instances, the harms are really going to outweigh the benefits, and we have to make sure people know that.

**Harlan Krumholz:** I know, Howie, I’m taking up—I’m going to hand it off to you in a second. I just want to pin you down on this. What do the guidelines say, a lot of it based on some of the research you’ve done, when do they say people should stop?

**Cary Gross:** It differs by cancer type—for instance, prostate cancer, I don’t know that we should be screening anyone, to be honest. That’s a different topic of conversation. Things like breast cancer screening, colorectal cancer screening. Generally speaking, if you’re over the age of 75, [you should not be screening](https://www.nytimes.com/2017/12/19/well/live/cancer-screening-tests-seniors-older-patients-harms-overdiagnosis-overtreatment.html). However, if your life expectancy is greater than 10 years and you really are making an informed decision, it’s not unreasonable to be screened. But we purport to be practicing evidence-based medicine, these tests have never been shown to improve survival in this age group at all. We have to start off by telling people that over the age of 75, we have no idea whether this is going to help you. But that being said, I think you could make a strong argument that the vast majority of patients are not going to be helped by screening over that age.

**Howard Forman:** You talked about screening for cancer, and that’s an area that naturally fits into the typical domain of a primary care physician and a primary care research scholar. But you’ve spent a huge chunk of your career doing research more broadly in the oncology space, including topics of technology diffusion, meaning whether new technologies get out into certain populations or certain communities earlier or later. And you did your chief residency, I think you said, at Memorial Sloan Kettering. Can you tell us a little more about how you’ve built a career in oncology as a primary care physician and what you’ve learned? What are the big lessons?

**Cary Gross:** First of all, I’ve learned the importance of collaboration. Not being an oncologist I feel has always been an advantage for me working in the oncology space because luckily at a place like Yale, there are a multitude of really talented clinician investigators who treat breast cancer, lung cancer, prostate cancer. I can help to actually suggest the most important, most clinically-relevant and policy-relevant questions because I have a different type of training than most of my colleagues who we are able to work together to craft these questions into something that’s answerable. But what I really enjoyed, frankly, I’ve always had the perspective of being an outsider, outsider in medicine, outsider in the role of oncology. And I think that has helped me to be able to ask questions that maybe people who are embedded within the cancer field all day every day are maybe not willing to ask, I think is an advantage.

**Harlan Krumholz:** [One paper that you’ve recently written](https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2801748) was really provocative. It was about whether we should be holding professional society scientific meetings only in states that protect abortion rights. And we’ve seen this in major league sports and of course Major League Baseball moved the All-Star Game from Atlanta at a time when there was some question about whether there was agreement with political policies in Georgia. Want to just talk a little bit, I’m just curious, what are you thinking about this and is this really something that we should be doing?

**Cary Gross:** Let’s take a step back. Back in the fifties, sixties, seventies, where was the American Medical Association that were trying to push for uniform national healthcare? Where was the medical profession as a whole, when we’re dealing with or not dealing with systemic racism and understanding the profound barriers to care and profound barriers to education that institutionalized medicine was putting up? We’re thinking about professional societies. Let’s really own it and say we, collectively, have dropped the ball many times over the past century.

All of a sudden, several states are prohibiting abortion or directly harming women or people who could be pregnant or directly harming the physician-patient relationship. I would ask, where do medical professional societies who are supposed to be upholding the standards of our profession, what are we doing now aside from issuing statements or not issuing statements? One of the ways that these professional societies cultivate their norms and disseminate new information is by having their professional meetings and annual big meetings, thousands of people come. It’s a big economic boon for the host of city or host state. But most importantly—

**Harlan Krumholz:** Some people will argue that the natural extension can go into so many different areas, and the people that you’re harming are the hourly workers who are supported by these large conventions who may largely have had nothing to do with that policy, may even disagree with that policy. And you’re in a place like Atlanta, which by the way would probably, as a city, favor more towards those rights than not or in a state where other regions are against it. How do you balance that?

**Cary Gross:** There’s two arguments you’re bringing up. There’s the “slippery slope” argument and there’s the “what about people in those states?” argument. Let’s pick the latter one. First, I would say when you pick one place to hold a conference wherever, Atlanta, by definition 49 other states are losing out. When you make a choice, you’re going to Atlanta. The people from New Orleans are like, “I’m not getting that business.” And 48 other states are all saying the same thing. Whichever state you pick, 49 others are left out. I don’t find that other states being harmed.

**Harlan Krumholz:** No, that’s good. I like that. That’s good argument.

**Cary Gross:** As the slippery slope argument, it’s always a tenuous argument. It is hard to argue with because someone could say, “What about the variety of state policies that are harmful?” Like not expanding Medicaid. Somebody might say, “We shouldn’t go to states that didn’t expand Medicaid because that’s harmful.” But my challenge with the slippery slope argument is you could use that to therefore never do anything. Because no matter how onerous a state policy is, you could say, “I can’t ever act,” because somebody could then say the other policy that we should be acting on. My thought is this one, the Dobbs decision taking away this constitutional right is onerous enough and specifically is harming patients and the physician-patient relationship that we have to have. And are there other things that we should be acting on as a profession?

Are there ways we should be acting? For sure. This is not that be-all and end-all, but our thought when we wrote this piece was that this is just one way for us to show some support for pregnant people and for potentially pregnant people in our own profession who don’t want to go to these states, and what if you have a ectopic pregnancy and you’re in Texas and you can’t get medical care? It’s both an issue of upholding rights in the states that we’re holding these conferences in, but also if you’re sending people off to these states and you want to make sure they’re going to a safe environment from a healthcare perspective. But I agree, it’s a challenging question.

**Howard Forman:** I want to pivot to a different topic. I’m sitting here with the two of you, and both of you have this extraordinary track record of mentoring medical students and even undergraduates. And you, much like Harlan, have a lot of papers with a first author, some of your most cited papers in fact, first author is a medical student and some of them have gone on to become full professors by now. Just for our audience who does not know how this process typically works, can you talk briefly about what it takes to lead somebody who may have never written a paper before through a process of writing a highly cited contribution to the literature? And maybe give an example or two if you want.

**Cary Gross:** Sure. First of all, being in a place like Yale, the trainees are so smart. I didn’t get into Yale, I can’t believe I’m here now. But these are people who are all just so incredibly bright and motivated and are coming with such fantastic ideas. Yes, certainly mentorship takes work because they have the ideas that may not have the research methods or the writing skills or experience, but the energy and the passion that the students bring to the table and the creativity really makes it, frankly, a very, very easy and joyful process. But what I find is that it’s incredibly helpful to have iterative meetings to understand what people are really excited about. Frankly, sometimes to push them a little bit, push them both conceptually to hone down on what is the research question and what are we trying to do, and push them a little bit to make sure they’re leading the charge to make sure that they are the ones who are providing momentum as opposed to being reactive.

There’s a couple of graduating students this year. Ryan Chow, is a MD PhD student who just graduated. We looked at the expenditures for cancer care in the U.S. versus in other countries. We’re working with [Betsy Bradley](https://insights.som.yale.edu/podcasts/health-veritas/elizabeth-bradley-leading-vassar-through-covid-19), which is a friend of all of ours. And we found under Ryan’s leadership, we found that the U.S. has spent twice as much on cancer care as in other countries, but we’re getting subpar outcomes. That’s the kind of study that may not be surprising, but it’s important to document and the hope is that will help the lead to future work in this area by others, but hopefully by Ryan. One other topic about mentorship, trying to lure people into our area and focus on big-picture policy questions and big-picture clinical questions.

**Harlan Krumholz:** Some people bemoan the state of academia these days. What’s your view? Are you thinking half-full or half-empty, or how are you feeling about the pressures and the opportunities that exist for people who are trying to do what you’re doing?

**Cary Gross:** I think it’s half-full. I think it’s funny, Harlan, dating back 20 years, you were such an optimist. You always were, “We are on the cusp of a new era. We’re on the cusp of a new era.” We always are. I think now we’re on the cusp of a new era. I think there’s widespread appreciation—unfortunately, thanks to COVID—of the importance of public health and thinking about the broader ramifications of how our research is helping people. There’s after the awakening post–George Floyd’s murder, there’s a widespread understanding that we need to do something to address systemic racism. At the same time, we’re making these technological advancements, I think we’re also making philosophical and conceptual advancements that are really helping to engage a broader swath of potential researchers helping to engage community-based stakeholders to help to hold us accountable. I think there are pressures financially, other docs are also burned out time-wise, hospitals are facing pressures. But I think the opportunities are so great that I think we’ll figure it out.

**Howard Forman:** Look, Cary, I just want to just echo what Harlan said at the beginning. You are a jewel at Yale, and I remember when you arrived here almost 24 years ago, you have delivered on every bit of promise when you came and you continue to be one of the most productive scholars that we have. Thanks very much for joining us and being such a great friend and mentor to so many.

**Harlan Krumholz:** Thanks so much. Really enjoyed having you and appreciate you taking the time.

**Cary Gross:** Thank you both. I really enjoyed it as well.

**Harlan Krumholz:** That was a terrific interview, and I really enjoyed having Cary on. But Howie, this is actually my favorite part of the show, which I get to learn something from you and hear your perspective on something this week.

**Howard Forman:** It’s not my favorite part of the show, and I’m so frustrated to even be coming back to this because it’s hard to believe. But for the second week in a row, I’m going to talk about a legal case that has come out of the northern district of Texas. This past week, Judge Matthew Kacsmaryk of Amarillo in a 67-page ruling [stayed or, to put it a different way, undid](https://www.nytimes.com/2023/04/07/health/abortion-pills-ruling-texas.html) the FDA approval of mifepristone, a drug that has been used in the United States for almost 23 years. This is the most widely used drug for medication abortion. It’s 99.6% effective when used within 70 days of conception, has a very favorable safety profile. And by the way, 54% of all abortions occur with medication. The judge seemed to accept on face value many what I would call specious claims made by the anti-abortion groups that brought the case, including that mifepristone was approved in an overly speedy way, that it is not safe, and that its ongoing approval impacts them personally as plaintiffs.

Few points that our listeners may be interested in. First, mifepristone was first approved in France in 1988, and it’s been used worldwide for over 35 years now. President Clinton in 1993 first asked the FDA to study the drug, but it was actually difficult to get a manufacturer to pursue commercialization in the U.S. due to the risks of boycotts by anti-abortion groups and others. The year 2000, our colleague Jane Henney, who was then the commissioner of the FDA, oversaw the approval of that, of mifepristone. And since that time, it has been subject to a higher degree of ongoing monitoring and scrutiny because the FDA put that in place at that time. Dr. Henney in fact [weighed in this week](https://time.com/6271082/jane-henney-interview/) to dispute some of the statements of fact in this case, particularly that which says that this was somehow an accelerated approval. The risk of death from mifepristone is 0.35 to 0.65 per 100,000 patients.

The risk of death from all abortions is approximately 0.7 per 100,000, suggesting that surgical abortions are actually higher risk than medication abortions. And the risk of death from live births, which we call maternal mortality, is 20 to 30 per 100,000, or 30 to 50 times the rate for medication abortion and much higher than that if you’re looking at select subpopulations such as those that are poorer or among people of color. Let’s put that aside for a second. In a separate legal case brought in Washington state, a group of Democratic attorneys-general were granted their motion to pause further restrictions imposed by the FDA on mifepristone use.

This case seeks to undo recently reimposed monitoring and restrictions on mifepristone after the pandemic emergency passed. This case effectively maintains the status quo, but it’s also in direct conflict with the Texas case. Both cases will likely be decided by the Supreme Court in the future, but my best guess is that the Supreme Court will issue a further stay of both rulings pending a hearing next year and then ruling on it at the earliest, I think 15 months from now or final ruling on it at the earliest 15 months from now.

The only risk, which I hope is low, is that the Supreme Court is unwilling to stay the Texas ruling until they have their own final ruling. But let me put that aside for a minute and just remind our listeners. Both cases should raise concerns in that they involve the courts in dabbling in FDA approvals. The FDA process, which is under our executive branch, has been a highly legislated area of policy. It is respected worldwide, and we need the FDA to maintain that respect.

In the former case, there is egregious overreach in my opinion, in that there’s a clear failure to abide by precedents and legal reasoning and a misuse of facts and abject misrepresentations about a drug that has been widely and successfully studied for decades. I didn’t want to mention it last week. We touched on it, but I didn’t want to mention it, but I have to. This week, Judge Kacsmaryk of Amarillo was confirmed by a purely partisan vote of GOP senators while Judge Rice of Spokane received nearly unanimous bipartisan approval. And it does raise the concern that this is mostly a partisan and ideological argument that’s being fought here.

**Harlan Krumholz:** Thanks for addressing this, Howard. It may seem like there’s a lot of inside baseball in these court cases, but it does break down to being very clearly about partisan courts intervening in medical care and abrogating some of the general standards from regulatory decision-making that have stood for years and years and years. And if the court starts stepping into this, the question again, when will it end? I also think it’s about politics playing a bigger role in medicine than they have ever had before, and the courts getting involved as well as the legislatures. Look at all the stuff going on around trans health and so forth.

It’s beginning to put a chill on what doctors and patients can talk about and to put constraints on the ability of patients to decide for themselves about paths that they want to choose. And the real question will be how will we mediate this in this country? Because it’s just become just another battlefield between Democrats and Republicans in ways that I think are going to end up making the public the losers in this. And we really need to figure out how we’re going to extricate this from just one more front on a war taking place between two parties and very different views in America about what represents the life and culture that we should have.

**Howard Forman:** I will just add it if it’s comforting to our listeners to know the majority of GOP House members who are physicians and a majority of GOP senators who are physicians, have not signed on to an amicus brief in support of Judge Kacsmaryk’s ruling, which gives me a little bit of comfort that at least our elected leaders recognize that this is not the right course for law.

**Harlan Krumholz:** And I think many Republicans realize that actually this is a poor path for winning elections because there are many Americans who don’t agree with this, and it becomes, actually, I’m hopeful that it’ll be self-correcting as the elections show that that’s not a winning strategy.

**Howard Forman:** Let’s hope.

**Harlan Krumholz:** But thanks for raising that. You’ve been listening to *Health & Veritas* with Harlan Krumholz and Howie Forman.

**Howard Forman:** How did we do? To give us your feedback or to keep the conversation going, you can find us on Twitter.

**Harlan Krumholz:** I’m [@hmkyale](https://twitter.com/hmkyale/), that’s H-M-K Yale.

**Howard Forman:** And I’m [@thehowie](https://twitter.com/thehowie/), that’s @T-H-E-H-O-W-I-E. You can also email us at [health.veritas@yale.edu](mailto:health.veritas@yale.edu). Aside from Twitter and our podcast, I am fortunate to be the faculty director of the healthcare track and founder of the MBA for Executives program at the Yale School of Management. Feel free to reach out via email for more information on our innovative programs where you can check out our website at [som.yale.edu/emba](http://som.yale.edu/emba).

**Harlan Krumholz:** *Health & Veritas* is produced with the Yale School of Management and now also with the Yale School of Public Health. Thanks to our researcher, Jenny Tan, and to our producer, Miranda Shafer, they are out-of-this-world great. Talk to you soon, Howie.

**Howard Forman:** Thanks very much Harlan. Talk to you soon.