**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.

**Harlan Krumholz:** Hey, Howie. We got a great show today. I’m going to jump off with something about the American Diabetes Association. People may think that’s mundane, but heck, there were a lot of headlines out of there—

**Howard Forman:** Huge headlines this week.

**Harlan Krumholz:** ... around obesity, the anti-obesity drugs. Then people should hang on tight because Hil Moss is coming in the interview, and she knocks it out of the park. What an extraordinary individual doing amazing things.

**Howard Forman:** Look, she’s a patient survivor and she’s a CEO and entrepreneur. It’s an awesome interview.

**Harlan Krumholz:** And then people should stay on to the end because you’ll be giving us a little bit of a “one year after *Dobbs*” viewpoint—

**Howard Forman:** Yeah, sadly.

**Harlan Krumholz:** ...will not be missed.

**Howard Forman:** Yeah.

**Harlan Krumholz:** It’s really good.

**Howard Forman:** What do you think? A diabetes meeting is normally not about obesity, but why don’t you tell us what we learned?

**Harlan Krumholz:** Oh, my gosh. For people who celebrate Christmas, it was Christmas this year in San Diego because there was just so many different headlines. Let me just frame this for everyone again, because we’ve had [Ania Jastreboff](https://insights.som.yale.edu/podcasts/health-veritas/dr-ania-jastreboff-the-revolution-in-obesity-medication), a real star. By the way, she leads [another *New England Journal of Medicine* trial](https://www.nejm.org/doi/full/10.1056/NEJMoa2301972) this week. I’m going to talk about that in a second, but again, it’s this movement towards a recognition of obesity as a chronic, treatable, neurometabolic disease. A condition, not a weakness of character, not simply “no willpower,” but that it’s something for people in the right social context, receptible, you know, obesity occurs, just like hypertension occurs in that kind of context. So there are these nutrient-stimulated, hormone-based pharmacotherapeutics. Boy, that’s a mouthful. This is talking about Ozempic and Wegovy, but now on the horizon, there’s Mounjaro from Lilly and much more.

So Howie, at this meeting, what we heard was new science—a lot of these have been injectables—talking about, “Hey, effective oral meds.” Now the first medications, we’re focusing one type of hormone pathway. Mounjaro focuses on two, tirzepatide. It is more effective. Then Ania was doing what’s a phase II study, which means it’s still preliminary, about almost 400 people, was targeting three pathways for this disease and wow, knocked it out of the park. Incredible.

**Howard Forman:** I know. Enormous. Enormous. Can you just tell us about the dose effect and the magnitude of what we’re talking about?

**Harlan Krumholz:** Yeah, sure. By the way, there’s a lot in here. Pfizer’s in the game. Amgen’s in the game. Boehringer is in the—almost all the major pharmas now are tacking toward this area, and there’s a lot of innovation. But the paper that Ania was on, basically, phase II is like, what’s the right dose? Does it work at all? Is it safe? It’s on the way towards what we call phase III definitive pivotal study, which would then lead to its approval by the FDA. In this study, about 400 people, they randomized them, but they’re looking at different doses and trying to figure out what score gets a double-blind, randomized, placebo-controlled trial. It is done really well. It goes about 48 weeks. Actually, I was saying 400. It was a little more than 300, 338 people. What they found was really marked weight reduction. When you look at the Wegovys and the Ozempics, semaglutide, you got about 15% of weight loss. When you got the tirzepatide, which was the one of the two hormones, we got about 21% weight loss.

Now, with three pathways being targeted, we got about 24% at the top dose. But here was the thing, Howie, I don’t know if you notice this, but even at the end of the 48 weeks, it hadn’t plateaued. Some of these people who quite had obesity, quite high levels, they had almost 30% of their weight was lost in the courses. Again, what I’m trying to focus on on these drugs is not the weight loss but the health promotion. In that case, for these individuals, it was really, really remarkable because it seemed like this can reverse diabetes, it can treat hypertension, all of these obesity-related conditions tracked together. In this study, what we’re seeing is that there are really important effects not only on weight but on these other comorbidities. I think you’re going to see readout on studies that are going to look at cardiovascular outcomes later this summer, which I anticipate will show really beneficial effects on overall risk.

**Howard Forman:** And look, we have so many more questions to answer. Often you say there’s more questions than answers now, but right now, we have an enormous number of answers, but there’s still a lot of questions. We still don’t know, can people safely stop these and not have to worry about regaining most of the weight back or even some of the weight back? We have some limited evidence about that. But there’s a lot of questions that we still need to answer, and I think we’ve entered into this generation right now that’s going to go on for probably well over 10 years to help us better understand the disease, had it treated optimally, and also to help people afford and have access to it.

**Harlan Krumholz:** Lots of questions, but highly effective medications that seems safe. They’ve already been shown in other circumstances to low risk, the semaglutide, for example, in people with diabetes. We’re holding on tight here to see what’s going to happen, but it does seem to be a major change in what’s available to help people. Howie, let’s get on to Hil.

**Howard Forman:** On [our 35th episode](https://insights.som.yale.edu/podcasts/health-veritas/dr-amy-justice-unlocking-the-insights-in-healthcare-data) on May 26 last year, I got to first introduce our listeners to [Hil Moss](http://www.hilmoss.com/), so it is great to have her as a guest today. She has a powerful story to tell our listeners, and I will leave it to her to tell it. But in brief, she’s now the co-founder and CEO of [VivorCare](https://www.vivorcare.com/about), a virtual survivorship clinic that supports cancer survivors posttreatment. She’s also a multiply published and multiply honored individual who has committed her life to the intersection of management on public health, having earned both an MBA and MPH from Yale after five years in marketing after graduating from Princeton with her bachelor’s degree. So first, welcome to the podcast, Hil. You and I have known each other for several years right now. You arrived at Yale, bright-eyed and bushy-tailed, in August of 2018. Am I getting the start to the story right?

**Hil Moss:** That is absolutely right, Howie. First of all, thank you so much for having me. I’m psyched to be here.

**Howard Forman:** Right after arriving here, you’re taking accounting. You’re doing orientation activities. You’re starting the core at the Yale School of Management. It’s a very exciting time. What happens next?

**Hil Moss:** Yeah. I have to say, I think when I first started business school in fall of 2018, I thought that accounting was going to be the scariest thing that I would face, and that ended up not being the case. About two weeks of orientation and four weeks of class into my MBA, I found a lump and I found a lump that would ultimately be diagnosed as breast cancer.

**Howard Forman:** And you’re a very young woman even now and five years ago, younger still. This is very unusual. What did you do next?

**Hil Moss:** You’re absolutely right. I was 28 years old. I also had no family history. As you can probably imagine, I marched into the Yale Health Center with absolutely no concept of a cancer diagnosis. That was not what I thought was in the cards, and quite frankly, nor did the clinicians I was seeing in the earliest days. I began to move through the diagnosis process. I think at every step of the way, we were all shocked to ultimately be diagnosed with Stage II breast cancer.

**Howard Forman:** And at that point, you have to make a decision about how you’re going to manage it and what do you do about school. I realize those two things are hugely divergent. Many people may think it’s crude that I would even put them on the same plane, but you’re still in the middle of life.

**Hil Moss:** Huge, and you haven’t quite shifted your lens yet. So actually at that moment, it was really top of mind for me. I remember after receiving my diagnosis, leaving New Haven the next day, heading back to Boston where I would be treated at [Dana-Farber](https://www.dana-farber.org/) and one of the first calls that I made was to the dean of the business school. I had no concept of what this was going to mean. So in my mind, I thought maybe I’ll back and forth and I’ll still do school. As soon as I received my treatment protocol, which included about 24 infusions and six surgeries, I realized that that was not in the cards.

**Howard Forman:** So now let’s fast-forward. You go through all of that and successfully, although you had complications along the way, and it was a very, very hard road from what I’ve read online, talked to you about, when do you then pivot to returning to campus?

**Hil Moss:** I made the decision to restart school a year later with the new class. So I was actually still navigating the final months of my treatment but returned in fall of 2019.

**Howard Forman:** Fast-forward to the end of business school and now you’re starting a company. Why don’t you just give us a brief overview of what that company does and where you are now, and I’ll let Harlan finally get a word in edgewise.

**Hil Moss:** Absolutely. Thank you for setting this up. I am the co-founder and CEO of a company called [VivorCare](https://www.vivorcare.com/about). We are building a new comprehensive care model for cancer survivorship care. It is really designed to answer the question, what happens when you survive a critical illness and how do we think about the long-term implications and how do we really quarterback for patients more effectively so that they can lead happier, healthier lives after illnesses like cancer?

**Harlan Krumholz:** Well, I’ve known about you, and Howie’s talked about you, and you and I have spoken before. It’s just extraordinary to hear the path you’re on. There’s so many things I want to ask you about. I want to ask you about this issue about the survivorship gap and what people really know and how they’re doing it. But I wanted to start with a piece that you wrote because I think folks might be interested in hearing it because you’re hearing “breast cancer” and there’s lots of publicity around breast cancer, but you wrote [a piece](https://www.statnews.com/2021/10/03/enough-pink-lets-do-breast-cancer-awareness-month-right/) that borrowed a term that others have used called “pinkwashing,” in which you said there’s this commercialization of breast cancer and it doesn’t really necessarily address what people need. I wonder if you could just amplify on that a little bit. I thought it was a fascinating piece that you published in *STAT News*. Maybe you could tell us a little more about that.

**Hil Moss:** It’s funny. I was diagnosed on September 25th of 2018, so it was about five days before the start of October, which is breast cancer awareness month. I don’t think I ever quite realized until I was in active breast cancer treatment just how pink the world turns during that month. The truth is, and we could spend a whole episode talking about this, there is [a fascinating history](https://www.psychologytoday.com/sites/default/files/attachments/92349/powerofpink.pdf) here of the branding of a disease. In certain ways, the development of the pink ribbon, the movement towards “thinking pink” and raising awareness about breast cancer, don’t get me wrong, we’ve made incredible strides and incredible amounts of capital have been forwarded towards really thinking about cracking the breast cancer challenge, but the truth is it comes with challenges. I would always urge anyone as they approach the month of October to really think about where these dollars are going, particularly when they’re labeled with a pink ribbon.

We often see that if there are campaigns being done or brand awareness campaigns, often those dollars are not actually landing in the hands of research organizations or patients that could really, really benefit from the support. So it’s a very interesting double-edged sword.

**Harlan Krumholz:** What do you think is the best example of that? We watch football games, people have pink. People are in pink socks. It’s like this whole thing. As someone who’s gone through it and is going through it and as a survivor, what’s the thing that tickled you to write that piece in the first place and what most offends you about it?

**Hil Moss:** I will tell you, having sat in the chemo chair and the surgery table in the OR, breast cancer is not pink and pretty. I think that there has been this push. Brands are things that need to be enticing and appealing and even somewhat delightful. When you see the world turn pink, in some cases, it’s wonderful to feel like there’s momentum, but also as a patient facing the real realities of an extremely ugly disease, I think it can actually, in many cases, backfire and make our community feel a little bit more isolated, a little bit more called out facing the realities of the hardship. Obviously, where there are campaigns that are directing funds specifically towards areas like metastatic breast cancer research, triple negative disparities, awesome. We love to see it, but we’ve got to start really putting our money where our mouth is when we think about breast cancer awareness.

**Howard Forman:** Mm-hmm. That’s a good point. I have a family member who’s a 40-year survivor of cancer and it is striking to me how much of a gap in care exists for people who, years and years, decades out from surviving, really surviving, cured of cancer. They have special needs, challenges that are not really met by almost anybody in the healthcare system. There are survivorship clinics at specialized medical centers, including Yale, including cancer hospitals, but can you tell us about maybe even some personal anecdotes, not necessarily about you, but of other people you’ve talked to through your company about what are the gaps in care, what are the needs of this community.

**Hil Moss:** It’s fascinating. The reason that this company even came to be was that I was noticing this pattern in the incoming that I was getting from fellow cancer survivors. They were echoing exactly what I experienced, which was that they were literally or figuratively ringing the bell. They were exiting active cancer treatment and they were immediately grappling with what we call the short and late effects of cancer treatment. We can talk in more depth about this, but these are the physical and mental side effects that stem from cancer treatment. In all cases, these folks were reporting that they felt thrown out to the wolves. They really no longer had a place at the cancer center, but they also couldn’t find a clinician who really felt empowered to manage their care. I’ll say, I just became obsessed with this as a problem, really trying to understand what at the systems level is going on that all of these people are feeling this way.

Started to chat with the experts in this area and discovered what I think is a fascinating seismic shift in cancer care today. This is going to echo a lot of what we think about in various areas of healthcare related to supply and demand, workforce challenges. We basically have three parallel trends at play. The first is on the demand side, which is that we have an exploding population of cancer survivors. It’s a population that’s going to double between 2008 and 2030. This is the good, the bad, and the ugly. It’s more cancer. It’s more cancer diagnosed younger, and it is the miraculous improvement of therapeutics that is keeping folks living with and beyond this illness. So that’s the demand side. What that’s doing is, it’s putting unprecedented pressure on our oncology ecosystem in real time. Many folks don’t realize this, but we are seeing the demand for oncology services right now outstrip the growth in the number of oncologists.

In the old-school model, it used to be that an oncologist might hang on to their few survivors and help give them their shots, serve as their PCP over time. That model’s no longer tenable because of the workforce constraints and so we get pushed out of the active cancer care ecosystem and the question is, where do we land? Now in an ideal world, we land in primary care, but that’s trend three, which is that in addition to the primary care crisis, we’re actually seeing, in some cases, 75% of PCPs reporting that they don’t feel comfortable managing a cancer survivor because they weren’t trained in the guidelines. So that’s the survivorship gap. That’s what we’re seeing at a systems level. As I mentioned, because this is a high-risk population dealing with a slew of cancer-related toxicities, we see greater health challenges in this population as well as overutilization of hospitalizations, ER visits, urgent care visits, outpatient visits. So that’s really where the care model innovation is required. It’s a problem that’s happening in real time.

**Harlan Krumholz:** This reminds me, by the way, of my own field of children being cared for with specialists in congenital heart disease and then becoming adults, and then where do they land? They land with adult cardiologists who treat adults who may not be as familiar with this. It’s like, yeah, you’re within this ecosystem that knows exactly what you need and can help support you and then you’re left with people who are well-intentioned and want to do well but aren’t in just the same position. So what is VivorCare going to do about this? How do you see this and how do you get traction on a business model where people are willing to actually integrate it into the system so that it can help?

**Hil Moss:** That’s a great question. I do want to give a shout-out. I have a co-founder. His name is [Dr. Justin Grischkan](https://ldi.upenn.edu/fellows/fellows-directory/justin-grischkan-md/). When we met, he was actually a clinician out of University of Pennsylvania building a cancer rehabilitation model. The two of us teamed up to really build what is a virtual-first transitional care model that’s purpose-built for cancer survivorship. We find transitional care very interesting. It’s something that we’ve seen leveraged effectively in other areas of the healthcare system. We have not really thought about it in cancer, but what we see in our population is that it’s really that moment when folks transition out of acute care and fall off that we see the challenges arise. What we are doing is, we are really trying to become the quarterback in that acute phase of survivorship.

So as someone exits active treatment, we capture them. We wrap them in a virtual-first care team of what we believe to be the right survivorship workforce. This is a survivorship nurse practitioner, survivorship-trained therapist, and a peer guide. We really guide them through a transitional care intervention that is designed to drive specific survivorship outcomes related to mental health and symptom burden and also to more effectively provide that off-ramp that you were just talking about.

**Howard Forman:** Can you tell us specifically how much do you use technology? Because you’re talking about a virtual system. How much are you using technology versus actually integrating existing guidelines into care that can be used on the ground?

**Hil Moss:** Absolutely. This is where I’ll give one disclaimer upfront, which is that I have absolutely zero interest in creating a separate lane of healthcare here. What we know is that cancer patients have many different players in the ecosystem. We want to maintain that tight connection with the oncologist. The reason for a virtual-first approach is multifaceted here. The first, access. We know that 85% of survivors are seen in community cancer centers. There’s often extremely little access to survivorship care, and we can help to bridge that gap. But the other reason for leveraging particularly telemedicine is one that is often a little bit unexpected. But survivors as a population, for us, the physical site of healthcare is the site of trauma. I’ll say, I love Dana-Farber more than any other organization on the planet. When I walk in, if I smell the Dana-Farber air, it is like a Pavlovian response, I am nauseous. It doesn’t matter what I’m doing, what I’m going in for.

So the more that we can really meet survivors where they are, the better. That’s really technology on the care delivery side. When we think about technology in terms of the workforce challenge that I mentioned, that really comes into play too. I hinted at this previously, but if you look at an executive summary of the [NCCN](https://www.nccn.org/guidelines/guidelines-detail?category=3&id=1466) and [ASCO](https://old-prod.asco.org/news-initiatives/current-initiatives/cancer-care-initiatives/survivorship-compendium/care) guidelines that you need to know to manage a survivor, particularly those dealing with short and late toxicities, it’s too much for one person to do, particularly in a 20-minute appointment. So one of the areas that we’re really excited about is actually building survivorship pathways, leveraging data, really thinking about how we can augment the workforce to efficiently and appropriately care for this really complex population.

**Harlan Krumholz:** I know that you’re very deeply committed to this idea of eliminating disparities. While you’re trying to improve the care for individual patients, you’re also thinking broadly about how do we increase access and make sure people can take advantage of best practices. Maybe could you just tell us a little bit about what’s the strategy here, because obviously, this could exacerbate disparities if it’s a highly effective system that isn’t ultimately available to populations that are often excluded.

**Hil Moss:** Absolutely. I think what we see in the survivorship landscape in particular is the very particular case of disparities that even Howie started to mention, which is that we really only see some of these very specialized survivorship clinics pop up in top academic medical centers. So one of the areas we’re really thinking about, we are actually now live with our care in Pennsylvania, for example, and a significant chunk of our patients live two, three hours away from a cancer center. So really thinking about how can you leverage virtual care, how can you leverage access, how can you leverage peer support to really mitigate disparities. The other thing we want to think about, particularly in our model, is really reflecting the needs of different populations. We are a virtual clinic; at the same time, we are laser-focused on building locally because we believe that particularly when it comes to employing survivorship therapists, thinking about our peer guides who are fellow survivors, we want to really be ingrained in the local community and the needs. That really becomes part of the state-by-state go-to-market.

**Harlan Krumholz:** I know that in VivorCare, you’re looking at how to help people strengthen relationships, how to get back to work. You’re also thinking about the financial toxicity, how you can manage cost, how the system can manage cost. Just to dig down into the individual experience, can you tell us about, without disclosing anything that would be related to confidentiality, the experience of someone that you’ve encountered who’s working with you guys and what it’s meant for them to have this opportunity to participate?

**Hil Moss:** Absolutely. I’ll give you an example, de-identified. I’ll change a few details here, but a little bit about what happens in the status quo because I shared a little bit about some of these complications after treatment. We have worked with individuals who have an intersection of two types of post-cancer challenges. One is on the mental health side. Now on the mental health side in cancer survivorship, we actually have a very unique metric. It’s called [FCR](https://pubmed.ncbi.nlm.nih.gov/29447419/). There’s a validated survey for it. It’s “fear of cancer recurrence.” What we see about fear of cancer recurrence is actually that it drives overutilization and engagement with the healthcare system because you go through a life-threatening illness, you don’t receive the mental health support that you require, and all of a sudden, every ache, every pain, we’re engaging in the healthcare system. I’ve done it myself because of the fear. So that’s one very specific bucket that’s very common in survivors. We’re talking minimum 50% of folks experiencing moderate to severe FCR.

The other challenges, though, and these are the ones that are less commonly spoken about, are actually physical. I’ll give one example of a patient who was suffering from severe chemotherapy-induced peripheral neuropathy in her feet, and it was something she’d struggled with for a while. What she found is that she kept falling, breaking her ankle and ending up in an ER, and that’s extremely, extremely difficult. It was a cycle that she felt she couldn’t break. So really what we are trying to do is say, let us be the bucket that captures folks that runs through these very targeted interventions around things like mental health. We have a proprietary therapy protocol that is really designed for this and also provide the support at all hours of the day when people are navigating some of these treatment-induced side effects, which we know often can land in an ER, which I’ll tell you as a cancer survivor, starts a whole cycle of events that are both distressing and also financially toxic for the patient as well.

**Harlan Krumholz:** When you go out like this, what kind of evidence are you having to generate about the effects of your intervention?

**Hil Moss:** It really falls in two distinct buckets here. The first is really around, of course, our clinical outcomes and how are we thinking about survivorship-specific metrics, things like, as I mentioned, FCR, fear of cancer recurrence, quality of life, symptom burden. But the other area that we are super interested in is also on the impact and the outcomes on the systems level. I hinted at this earlier, but we have this really unique phenomenon happening in cancer care around the overburdening of oncologists. So what we also want to prove out is that we can help to reduce that burden. It’s something that’s important to all different players across the healthcare ecosystem. That’s one area, and of course, thinking about how we can reduce excess utilization of areas like the ER.

**Howard Forman:** As we get to the end, I just want to give you a moment to just reflect on perhaps what specific skills you got out of either the MBA or the MPH or both that helped inform you having this very successful startup. You’ve been able to pull off a lot. We don’t have to go into the way I’m judging success, but you’ve done a lot in a very short amount of time. Can you give us a sense of the types of things that your education informed here?

**Hil Moss:** It was huge. I think one of the more interesting dynamics, I’d be curious how you feel about this, Howie, running the program, but it is such a fascinating experience to go across the Yale campus from the business school to the public health school and back and to see the different types of conversations that are happening and the different ways that you use your brain. I think that has come to fruition every day for me in this company. Obviously, we are a business. There are all kinds of questions around how we think about go-to-market strategy and financing and incentives and all of those things, but the truth is we only find our solutions. We only build what we build by really doing systems-level analysis and actually building for a problem and I think that my public health education was so critical in that. I will also just give a hat tip here and say that one of the extraordinary things about education as well is mentorship. To have the ability to connect with folks like you, Howie, and to really have leadership in that world has just been absolutely invaluable.

**Howard Forman:** Well, you make teaching a joy. I think for all of us at Yale, what we’re here for are the students, and you are a joy to have and we’re very fortunate to have you.

**Harlan Krumholz:** You are amazing, Hil, and it is true, Howie’s one of a kind and there are so many people that he had such a positive influence on. It’s an honor to be on the podcast with him every week.

**Howard Forman:** Thank you.

**Harlan Krumholz:** All right. Hey, really great interview. Gosh, she’s just such a spark of energy, so many ideas. I’m so hoping that the work that she does ends up helping people, but I’m really excited to get to this part of the program. It’s a year past *Dobbs*. Lots of people still talking about issues around abortion, policy, healthcare, access. Tell us, what’s on your mind?

**Howard Forman:** Yeah, so we’re a year out. *Dobbs* is the Supreme Court ruling overturning *Roe v. Wade*, declaring there is no federal right to an abortion. In the last year, many states have codified *Roe* or strengthened the protections to the right to abortion, but many others are in the process of restricting the right to abortion, including, [as we’ve previously discussed](https://insights.som.yale.edu/podcasts/health-veritas/cary-gross-effective-cancer-screening), trying to undo the approval of mifepristone, the medical abortion treatment that’s used in over half of all abortions right now. The Kaiser Family Foundation [released a survey](https://www.kff.org/womens-health-policy/report/a-national-survey-of-obgyns-experiences-after-dobbs/) of 569 OB-GYNs—obstetricians and gynecologists—across the country with findings that suggest that the Supreme Court ruling has had far-reaching effects, more than one might ordinarily assume. So here’s some quick highlights from that. Over one third of OB-GYNs nationally and half practicing in states where abortion is banned or where there are gestational limits say that their ability to practice within the standard of care has become worse. Forty-two percent of OB-GYNs report that they are very or somewhat concerned about their own legal risk when making decisions about patient care and the necessity of abortion. This rises to roughly 60% for those who are practicing in states with gestational limits or abortion bans. Thirty percent of OB-GYNs practicing in states where abortion is now banned do not even offer their patients referrals to another clinician or any information about abortion. Most OB-GYNs say the ruling has worsened their ability to manage pregnancy-related emergencies. The Supreme Court term ends this week, and we don’t expect major rulings from the court on these issues, but we do expect the court to take up several abortion-related cases in the coming year. We’re living in a very precarious time where some states are showing an increased predilection for stepping between patient and physicians and dictating how care can or cannot be provided. Repercussions occur for patients, their families, but also for the physicians who care for them and feel threatened by the onslaught of these efforts.

Our listeners may recall, for instance, [the Indiana physician who was reprimanded](https://www.nbcnews.com/health/health-news/indiana-doctor-gave-10-year-old-girl-abortion-disciplinary-hearing-rcna86214) for talking about abortion with the press after her 10-year-old patient had an abortion. There is a role for states in overseeing the public’s health, but usually, it’s dictated by science and evidence and not by political positioning. The intrusion of government into the private health affairs of patients without a public health concern should really trouble everybody.

**Harlan Krumholz:** Yeah, this remains a political hot potato with such strong feelings on all sides. I’m really going to be interested to see what the impact is on health outcomes too.

**Howard Forman:** Yeah.

**Harlan Krumholz:** As you suggest, people feel ill prepared to deal with emergencies now, and there’s a real fear in the community among healthcare professionals and among patients and—

**Howard Forman:** And the trainees who have to get trained.

**Harlan Krumholz:** Yeah. You just wish that we could all come together with a common understanding, but people just see the world so differently.

**Howard Forman:** Yeah.

**Harlan Krumholz:** Thanks for doing that, Howie. Such an important topic. You’ve been listening to *Health & Veritas* with Harlan Krumholz and Howie Forman.

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

**Harlan Krumholz:** I’m still at [@hmkyale](https://twitter.com/hmkyale/). That’s hmkyale.

**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’m 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 or 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 the Yale School of Public Health. Thanks to our researchers, Ines Gilles and Sophia Stumpf, and to our producer, Miranda Shafer. They are absolutely amazing, Howie, amazing, week in, week out. Talk to you soon, Howie.

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