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

**Howard Forman:**And I’m Howie Forman. We are physicians and professors at Yale University, and we’re trying to get closer to the truth about health and healthcare. This week we will be speaking with each other. We try to bring you a new speaker most weeks, but we have reserved a few slots during the year to catch up on health and healthcare news. I have a long list of items that I want to talk about today, but let’s start with you, Harlan. What’s got your attention?

**Harlan Krumholz:**Thanks, Howie. And I’m eager to hear what you’ve got to say. I wanted to maybe talk about a couple articles, I thought people might enjoy just hearing about some of the science that’s coming out. And I wanted to start off with this one that many people may have heard about in the news, and that’s about [the effect of colonoscopy screening on the risks of colorectal cancer](https://www.nejm.org/doi/pdf/10.1056/NEJMoa2208375). The reason this study is so important is because we’ve been advocating for colonoscopies for decades, and yet the evidence base for them is, honestly, relatively weak. I mean, it makes sense. It’s sensible that colonoscopies prevent cancer. Makes sense. I mean, it’s early detection, and it should help us find things in ways that can prevent cancer down the line. But really, the evidence base hasn’t been great. So this has been considered a landmark study across many countries where we could say, “Let’s randomize people to an invitation for colonoscopy, recognizing that most people or a lot of people who get invited will have it, and let’s follow them over time and see what happens and try to answer this question more definitively.”

What is actually the benefit of colonoscopy? Because, again, we’ve accepted it as gospel that we should be promoting colonoscopies, but there has been some uncertainty and some debate about it. And the fact you could do this trial recognize that. I mean, the ethical board approved this trial; it suggests that there is a degree of uncertainty about it. So that’s what this study sought to answer. Let me just go through this a little bit and explain a little bit why it’s complex. I don’t want to take too much time, but just to give people a quick summary. So this was about almost 85,000 people from Poland, Norway, and Sweden. And what they did was they took about a third of them and they sent them invitations for colonoscopy. Now, it’s an interesting design because they didn’t consent people at first.

What they did was they just sent out the invitations, and then those people who responded to the invitations, they then consented them in the study, and so that they were part of this. And what happened was that among the people who were invited, a proportion of them decided to go ahead, it was 42%, underwent the actual colonoscopy. So in the invitation, 42% are getting the colonoscopy. In the other group, it turns out not many people actually underwent the colonoscopy. And so they continued to follow people for a decade. And what they found was, of all these people that they were following in the 10 years of follow-up, there were 259 people who developed colorectal cancer in the invited group in the group that was invited to undergo the colonoscopy, and 622 in the usual care group. Now, that may sound pretty impressive. There were a lot more cancers that were found in the group that wasn’t invited to the colonoscopy.

But when you dig into this a little bit further, you see that actually, it’s a pretty small effect. It’s less than 20% lower rate in the not-invited group. And when they looked at death from colorectal cancer, there were no differences. And so many people in the field found this quite disappointing. By the way, one of the things that’s interesting is colorectal cancer, that recommendations largely come from what we call observational studies, cohort studies, just trying to figure out what happens in the population among people who get colonoscopy and people who don’t. It’s not the same quality of evidence that you see in drug trials, where we actually randomize people. So this was a randomized trial for screening, so it actually is higher-quality evidence than we’ve seen before. There has been prior evidence about sigmoidoscopy, which is looking a little bit into just the end of the colon, but not so much on colonoscopy.

And then I’ll just quickly just say to you, the reason that there was a lot of backtracking on the trial was because they also did what’s called a per-protocol analysis. So they looked at the people who underwent colonoscopy and tried to make some sort of conclusions about, well, the invitations are good, but only less than half underwent the colonoscopy. Let’s just look at the colonoscopy group and try to make an estimate of the benefit. And in that case, they come up with a little bit of a bigger benefit when you just look at that group. But actually they’ve converted it to an observational study at that point, because you don’t have the advantage of the randomization anymore. You’re saying, “I’m going to look at a group that decided to have the colonoscopy,” and you’re going to compare that to the control group and try to come up with some sense of an estimate.

But it’s no longer the high-quality evidence of the randomized trial. So whether that backtracking was justified or not is subject to discussion. I will say, in The New England Journal of Medicine, the conclusion to the article is pretty clear. In this randomized trial, the risk of colorectal cancer 10 years was lower in participants who were invited to undergo screening than among those to no screening. But then they didn’t put the rest, but there was no difference in deaths. And so I think we’re left with a landmark study but some uncertain results. I don’t know how you read this study, Howie. But it’s kind of evoked a lot of controversy.

**Howard Forman:**Yeah. No, the only thing I thought about with this is, our understanding of the development of colorectal cancers is premised on the idea of finding polyps really early that will turn into cancers 10, 15 years hence and that a true screening program is not screening for the cancer itself per se but screening for the pre-cancerous adenomatous polyps. And so I did think this is actually a positive study, but the more important thing is going to be to follow these individuals 20 years hence, 25 years hence, because that’s when you should expect to see the real positive effects in those groups.

**Harlan Krumholz:**Yeah. I think that’s a really good point, and they raise it in [the paper](https://www.nejm.org/doi/pdf/10.1056/NEJMoa2208375) and in [the editorial](https://www.nejm.org/doi/full/10.1056/NEJMe2211595), that maybe there is a need for longer follow-up. Another issue, by the way, is it’s not innocuous to have colorectal cancer. So there’s a big hit on your quality of life. Even if you survive it, it’s a lot to go through, so that’s not nothing to avoid. And then I think the other issue is just that the numbers are small, so a lot of people have to undergo the screening in order to find one of these things that you might act on.

It’s a substantial issue if you have colorectal cancer. But I think this is going to raise a lot of concerns. The other issue is that we’ve got new technology coming too, which is you can test stools for evidence of colorectal cancer in ways, not just the blood, but actually the sensitivity has been increased by looking at remnants of the cancer and so forth. And so I think these advanced molecular techniques may actually supersede the need, eventually, for colonoscopy. But important study, lots of discussion. I think we’re not quite decided exactly what it means yet.

**Howard Forman:**And one of the things for our listeners to remember is that we’ve been doing this now for 40 years, and yet we don’t have all the answers about something as simple as does it work and how it works and how effective is it? It’s four decades, at least, of doing screening colonoscopies in a population-based way.

**Harlan Krumholz:**So anyway, Howie, what’s something you want to talk about today?

**Howard Forman:**Yeah, I want to give a couple of quick updates to our listeners. We talked in July and August about monkeypox and polio, so I want to give them very quick update on those. First, in terms of monkeypox, when we first started talking about this, even earlier than that, our concern was that [we could have a real outbreak](https://www.washingtonpost.com/health/2022/07/23/monkeypox-who-global-emergency/?itid=lk_inline_manual_7). The concerns were that it was going to spread to multiple populations, including children. People talked about it spreading in schools and daycare and so on. And it didn’t come to pass. And it didn’t come to pass for a number of reasons. It turns out that it was not that infectious in populations other than those through intimate and sexual contact. And it turned out that we could vaccinate people a lot earlier than we thought we would. And it turned out there is acquired immunity and that behavioral changes can occur at the same time.

There was a lot of good science that came out that led us to that point. And here we are now where the outbreak in [New York City in particular is down](https://www.nytimes.com/2022/08/26/nyregion/monkeypox-cases-nyc-worldwide.html) about 96% from its peak, and it may in fact be completely contained in the next few weeks down to zero. It doesn’t mean we’re going to eradicate it from the population, and this is not to say that it can’t be spread through nonsexual, non-intimate contact, but just that type of spread is going to be very unusual and it will not lead to outbreaks. And so we learned a lot from it. And from my point of view, I hope that some of the lessons that we learned will be that we need to do a better job of explaining this to the public as we go. We need to be able to be honest with the public about what we know at the time that we know it.

We have to put aside political correctness, so to speak, but certainly think about how we give good, consistent messaging and avoid people giving bad messaging. And we also have to acknowledge that we managed this a lot better than people were predicting early on. And let me just say a couple of words about polio, and then I’m curious to hear your thoughts on this. Polio too, and when we first heard about the cases that were announced in late July or early August, we learned about this young man who was unvaccinated being infected by a vaccine-derived polio virus. He had been infected by somebody who had been vaccinated elsewhere through the oral vaccine. And we thought that was going to be the tip of the iceberg because, as you know, somewhere between one in 200 and one in 1,000 infected individuals actually develops poliomyelitis.

And we thought this is tip of the iceberg, and it got even worse over the ensuing months because [we found wastewater sampling](https://www1.nyc.gov/assets/doh/downloads/pdf/han/alert/2022/polio-in-nyc.pdf) in multiple counties in upstate New York and then in New York City as well. And the good news here too is that even though we obviously know a lot of people have been infected by this vaccine-derived polio virus, we are not seeing paralytic polio cases. And we’re in a situation right now where this too seems to be managed reasonably well. We still need everybody who’s unvaccinated to get vaccinated, but this too is not the outbreak people were worried about when we first announced this.

**Harlan Krumholz:**Howie, I wanted to ask you just a couple quick questions. One is, do you think that [the WHO declaration of monkeypox as a global public health emergency](https://www.washingtonpost.com/health/2022/07/23/monkeypox-who-global-emergency/?itid=lk_inline_manual_7) was justified? I mean they pretty quickly moved to that, and that was a pretty unusual declaration. I mean that was reserved for polio, SARS-COV-2, and then monkeypox. That was the third one that they had declared a public health emergency on it. Do you think that declaration was justified?

**Howard Forman:**Yeah. So they have a very specific set of parameters that they use for that, and it means that outbreaks are occurring in multiple countries simultaneously. And I’d have to go back and look at the specific language, but it’s something along those lines. I would rather them have a lower trigger than a higher trigger for this specific issue about a new infectious agent or one that we haven’t dealt withHoward Forman: in a long time cropping up in multiple nations at the same time that are disparate, not Norway and Sweden, but rather multiple countries throughout the world. And in the case of monkeypox, at least at the time, we had cases in Africa, in Europe, in Asia, and in the United States at the very least, as I recall. In the case of polio, we have it also in multiple continents. And if you look at the data on vaccine-derived polio, it’s been even scarier because prior to this period we had almost no cases in the UK or the United States. It was all relegated to Pakistan, Africa. Yeah, Pakistan and Africa, pretty much.

**Harlan Krumholz:**Yeah. But I think the polio declaration was pretty longstanding, and then the SARs-COV-2 was on top of that. The monkeypox was interesting because they did it in July; the leadership went against the WHO emergency committee, which had actually decided and voted against recommending public health emergency of international concern. The justification was more than 70 countries, but most of it was non-endemic and really wasn’t clear about how it was going to spread. I don’t mind that they have a low threshold, but I am concerned about alarm fatigue too, because I felt in a way the public took this as, “Okay, here’s another one and what’s the next one, next one?” And it was being filtered out, in a way. Not that we shouldn’t have had a strong response. And the reason people may wonder like, “Well, why do you care about this declaration?” And it’s because it really galvanizes resources and focuses attention and it brings to bear a lot of action on a particular problem.

Now, we’ve got lots of problems of health throughout the entire world, so no one’s standing still. But it was a big statement to say that that should be that declaration. And then the other thing I wanted to ask you, Howie, was to what extent do you think where we are today with monkeypox is a result of the response versus the thing kind of just has smoldered? And I’m not saying gone away by any means, but have we really done anything that’s caused it? Or is it just the natural evolution of this infection right now through the population?

**Howard Forman:**I mean, I happen to believe it is something that we did, because I think this was so deeply infecting the gay community that the gay community was mostly paralyzed by it for a few months. And I think they did respond. And during that time they got vaccinated, those that were infected developed immunity, and so I do think that we’ve actually seen a significant impact from both behavioral change as well as a vaccination campaign. I think the awareness of it probably helped a little bit, getting doctors just to diagnose it a little bit better at a certain point. But remember: we were diagnosing over 70 cases a day in New York for several weeks, and now we’re down to averaging around three.

**Harlan Krumholz:**Yeah. No, that’s great. That’s great. Yeah, it’s always hard to tell exactly even what exactly causes what within a pandemic. We look at different countries. You may have seen [that piece that Topol has written](https://erictopol.substack.com/p/the-marked-contrast-in-pandemic-outcomes) about comparing U.S. and Japan, I mean, very different experiences, and trying to figure out exactly what was it? The host? The virus? The actions? The policies? We’ll spend a lot of time, yeah.

**Howard Forman:**It’s a good question to ask though, right? I mean, we’ve gone through this enough times where people have said, “Are the masks having any effect? Are the vaccines having any effect?” And I think the data does become compelling at a certain point when it comes to COVID. And I think the data, to me at least, seems compelling when it comes to monkeypox, particularly going back... You and I both talked about the paper by, I think one was by Gregg Gonsalves’s team and then another one by another group pointing out that the reproduction rate for monkeypox was actually quite low in an overall population sense. It was probably high among gay men that were very sexually active, and it was probably, definitely was negative in other individuals, and I think that helped us a lot. But we still had to tamp out the outbreak in that high-risk group. And I think we helped do that between the vaccines, acquired immunity, and behavioral change.

**Harlan Krumholz:**Yeah. That’s great. That’s great.

**Howard Forman:**So back to you. What’s your next paper that you want to talk about?

**Harlan Krumholz:**Yeah. So next topic I wanted to talk about was something that’s also I find quite curious, which is a lot of discussions around the importance of circadian rhythms and in our approach to diet and, for example, when we should be taking pills and so forth. I don’t know if you’ve seen this sort of literature that says, I mean, this is the whole thing about [should we be eating in the morning or should we be eating in the night?](https://newatlas.com/medical/mit-harvard-study-push-pull-diet-exercise/) Should we frontload breakfast or should you skip breakfast and be doing heavy on dinner? And I saw a couple of articles that were coming out recently that, again,...it was kind of to and fro. There’ve been some articles that have suggested breakfast is important and some articles that come out and said, no, that’s not really true. We really shouldn’t be eating until late.

And I wanted to go back to a study that was presented in the late summer that I thought was one of actually the most interesting studies I’ve seen around [when should you take your blood pressure pills?](https://www.escardio.org/The-ESC/Press-Office/Press-releases/Evening-dosing-of-blood-pressure-medication-not-better-than-morning-dosing) And I just wanted to unpack it a little bit more, because I thought people might be interested in this. And they may have heard something about saying like, “Hey, really should take your blood pressure pills before you go to sleep at night.” And part of the rationale for that is the recognition that there are many patients with hypertension whose blood pressure doesn’t follow the usual pattern of declining while they sleep. So under normal circumstances, and I hate to use word normal because everyone’s a little bit different, but typically when people go to sleep, your heart rate slows and your blood pressure drops.

But there are some people that don’t, what we call, “dip” at night, and these people, guess what, they’re called “non-dippers.” And some of the thought was, yeah, we could be giving everybody ambulatory blood pressure monitors and measuring their blood pressure all the time. One day, we will actually probably on our wrist have blood pressure monitors that are cuffless. But right now, the idea was just, it’s probably a good idea just to have people take it at night. It’s maybe the best time to control their blood pressure. So [somebody did this study](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2822%2901786-X/fulltext). Guess what, they called it the time study where they randomized just a little over 20,000 people who were being treated with hypertension to either taking their pills in the morning or in the evening. Now, by the way, some people listening may say, but I take pills twice a day, and I’m taking different regimens.

Sure. There are that group of people too. But in this case they were taking people who were taking pills at one time of day, and this group was 65 years old on average, and their blood pressure wasn’t that high at the start. Remember, these are all treated individuals. The blood pressure was about 135 or so, systolic blood pressure. And it was what they call a pragmatic study. They went into primary care clinics, and they basically just brought a bunch of people together and they said, “Hey, we’re not sure when the best time to take the pill is. Would you mind being part of this trial? Take it morning or evening.” So they followed them up for about five years. And guess what? No difference. No difference when they took the pill. So what I like about the study is there was becoming a lot of urban myths about this. And by the way, this study does have some others that counter it, but this was a pretty large, definitive study of typical people in practice who are taking blood pressure pills.

And it just shows that we can start to create stories about how all this stuff gets much more complicated. But in this case, what the important thing was that you are taking your pills. And if somebody finds it more convenient to take it in the morning or at night, that’s more important than telling them you have to do it this way and then having them forget or have it being inconvenient for them. And, again, I think the central theme here is, yeah, maybe we will learn one day how to personalize to each individual the exact time and nature of the meds, but largely, at least on average, it doesn’t seem like there’s a dominant benefit to pick one or the other. So anyway, I like this study because they took the time to answer a question that has been bugging people and to really provide good evidence to help people. And so when I see patients now, I say it doesn’t matter. Most important thing is if you’re on blood pressure pills and you need them, take them.

**Howard Forman:**Yeah. And it gets to a, you raise a point. Just again, in my own class, I continue to quote Mark Polley from 30 years ago saying that only about a third—

**Harlan Krumholz:**Your professor at UPenn, right? It was your professor at UPenn, Mark Polley.

**Howard Forman:**Mark Polley. Yeah, Mark Polley, who’s really a health economics professor there. But he used to love this quote of about one-third of healthcare is strongly evidence-based. And I still use that quote, and I always say, I don’t know if it’s changed, but my feeling is that it’s not like that we grow, we do so much more over time that we’re still missing a lot of evidence. And what I mean by “strong evidence base” is like, we don’t even have answers to questions about whether seven days is better than nine days is better than 12 days for antibiotic therapy. We run the trial at seven days, it works, and we stop there. And the questions that you are asking about timing of dosing are the same types of questions. We don’t have all the answers that we should have at this point, and we don’t have the financing mechanism in place to incentivize people to do the types of studies all the time.

**Harlan Krumholz:**So, what’s your next topic?

**Howard Forman:**Yeah. So [the October issue of Health Affairs](https://www.healthaffairs.org/toc/hlthaff/41/10) is focused on disability and health. This is a topic that’s near and dear to my heart, partly because my sister is profoundly deaf due to congenital rubella syndrome. I sit on [the disabilities committee for Yale University](https://provost.yale.edu/committees/advisory-committee-accessibility-resources). I’m interested in the topic more generally. And in this issue, there were three sort of quick hits that I’ll just mention, give you a sense of the challenge of disability medicine basically. One is that people with disabilities are frequently, frequently, more than the majority, not appropriately accommodated in healthcare settings, often receiving substandard care, and in some cases they’re refused care by their physicians. And that came from [a focus group study](https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00475) done by a former student or colleague who’s now a professor at Northwestern, Tara Lagu. And we’ll try to get her on the podcast sometime in the next few months.

The [second study](https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00408?utm_medium=press&utm_source=mediaadvisory&utm_campaign=october2022issue&utm_content=james) was about sign language services, and they found that they were unavailable in almost 60% of substance use facilities and more than 40% of mental health facilities. And again, if you think about that, when you’re dealing with a deaf population and you’re not able to communicate with them appropriately and you’re counting on family members in many cases to be their translator in the most sensitive situations, this can run into a serious problem as well. And then the third hit from that issue was [a study that looked at disabled physicians](https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00502), which are only 3% of the total, which is to say that they’re underrepresented compared with the general population. They were substantially more likely to experience mistreatment or abuse from their colleagues and their patients when compared with physicians without disabilities. And they raised the issue, in that issue, they actually raise the possibility, how do we fix this?

How do we get this better? And I would just say one of the issues is about financing of medicine. We mandate some things through the ADA to tell people they have to do things, but we don’t actually compensate them for them. So physicians are actually disadvantaged when they’re having to deal with somebody who requires some accommodations. I’m not excusing when they refuse it, but you can understand why it works against them. And then people are very afraid to lodge ADA complaints or lodge complaints using the American with Disabilities Act, a complaint against the practice, I think partly because a lot of people fear doctors. A lot of people know they may have to go back to a doctor, and they don’t want to lodge a complaint, so it doesn’t happen. We need to do a better job. I think some of it goes back to medical education, what we can do in our own medical schools, in our own residencies, and some of it has to be from a policy point of view, perhaps compensating people appropriately for it.

**Harlan Krumholz:**Yeah, I think those are really good points, Howie. I’ve often thought that we should have medical students and all of us throughout our training go to an appointment with some sort of prosthesis that restricts our ability to hear or blinds us so we can’t see or are sitting in a wheelchair so we can’t walk. Because I think that it’s important to see through the eyes and to live through the experience of people who are encountering these kind of challenges and understand what it’s like. When you aren’t of that world, then you tend to do things or arrange things and arrange the clinic in ways that can be wholly insensitive at best and really damaging and inhibiting at worst. And so I’m really glad that you’re ringing this bell. It’s something that needs to be addressed, and we are seeing people who are ill, and there’s all sorts of ways that they have limitations as a result of their illness.

Brain fog is another one, by the way. I mean, you’re talking about sensory... but there are people and you sit there and think like, “Well, can’t you read the sign or can’t you follow directions?” Well, some people can’t do that very well because of the way they feel. And so I think it takes a whole redesign of the way that we approach this in order to be much more, not just accommodating, but welcoming of people regardless of the situation that they’re in. And the challenges... I don’t want to say “challenges.” I mean, it’s just the lives they lead, right? It’s just the lives they lead. So are we attuned to be able to provide the best care for each person given who they are?

**Howard Forman:**Yeah. Look, all I can tell you is that I’ve listened to my sister tell me what situations have been like for her when she gets care, and it is very frustrating. She has lived this life her entire life where people will talk to her children at the table at a restaurant and also talk to her children at a medical visit if they’re there, and that is not the way healthcare should be delivered. It’s a humorous theme in the movie CODA, for those who haven’t seen CODA or might want to see CODA, an Apple TV production, a humorous scene where the patient is being seen for a sexually transmitted disease or something like that, if I recall correctly. And the child is brought in, it’s an adult child, but the child is brought in for translation purposes, and it leads to some hilarity.

**Harlan Krumholz:**That’s a really, really good movie. And I think it does. That kind of movie, I think, increases sensitivity to what people face. But again, one of the problems we have, and from the physician point of view and nurse point of view, it’s hard. If you get 15 minutes in a visit and you’ve got no tools or support, that’s also, I mean, it’s an impossibility to provide the kind of care that that kind of person might need. So anyway, a person who’s facing, a person who has, like I said, it should be not about facing challenges, it’s about that’s who that person is. Can we deliver the best care to each individual, given who they are? And that requires some flexibility in the system that is increasingly inflexible.

**Howard Forman:**Agreed.

**Harlan Krumholz:**So, Howie, I know you’ve got one more topic that’s on your mind that you’d like to share. And I know we’re getting close to the end of this podcast, but go ahead. What’s your last one?

**Howard Forman:**Yeah, so this is a more controversial topic, and it’s something that we see day to day on social media and beyond. We’re living through a time right now where being transgender is increasingly socially acceptable. I wish it was completely socially acceptable. It turns out when you look at surveys, it varies considerably by political party, by age, by education level. But it is increasingly socially acceptable, but at the same time, it is being used as a political opportunity for those who prey on fear, thrive on anger. The outrage machine has been shifting into high gear by a Twitter account called Libs of TikTok run by a woman named Chaya Raichik in Brooklyn, which is the city of my birth. So I want to say a few words about this, because they are feeding misinformation all around and trying to get outrage.

So gender-affirming care for minors, for those below the age of 19, mostly involves counseling and may involve medical treatment. And in relatively rare circumstances and for older teenagers, may in fact involve breast surgery. It’s in tiny numbers, but it does happen. The specialty societies have weighed in on this and feel really strongly about the recommendations they can make, and they actually clearly do not recommend genital surgery for children. But this hasn’t stopped these accounts from trying to enrage people about the possibility that this may be going on. The state of Arkansas has recently outlawed gender-affirming care for adolescents. That includes just behavioral therapy. And I was truly grateful to see [Jon Stewart tearing apart](https://www.motherjones.com/politics/2022/10/jon-stewart-arkansas-law-anti-trans-medical-care-gender-affirming/) Arkansas’s law meticulously at an interview with their attorney general.

And going back to what we’ve talked about several times on this episode and prior episodes, I have no doubt that we will look back in 50 or 100 years and see that we could have treated these populations better, we could have managed these better. But these are also populations that have high suicide rates, and we don’t have 50 or 100 years to make the best decisions we can make, so we have to make them based on the best evidence we have at the time. And that is the direction that we’re heading in right now. And I just think it’s very important that we need to leave these decisions to the parents, to the adolescents, and their physicians using the best available evidence and the guidelines of specialists and specialty societies that is available at this time.

**Harlan Krumholz:**So what do you think tangibly, I mean, the nation’s being torn apart, and these are major issues. I think the question is, can we get consensus from the medical community about what the right thing to do is? And can we depoliticize this and talk about this from a point of view of healthcare and medicine? Or is it intrinsically going to be politicized no matter what we do?

**Howard Forman:**Look, I think that what we’ve learned over the last few years is that all of evidence-based medicine can be politicized, and people will use good and bad scientific studies to advance their own agenda. We just saw that last week in the state of Florida where [the surgeon general used a non-peer reviewed study](https://www.washingtonpost.com/health/2022/10/11/florida-surgeon-general-ladapo-covid-vaccines/) to recommend that adolescents and young male adults not get vaccinated. It doesn’t mean that his ultimate conclusion couldn’t be correct, but we have no real evidence to support that at this time. And I think this is a good example of a time where we as scientists need to present data, we need to be able to explain things to people, and we need to continue to have humility about what we know and what we don’t know.

**Harlan Krumholz:**So maybe this gets to the point that you’ve made a lot of times, which is we need to have a voice on social media and in the public press and other places in order to try to help combat misinformation and help people make informed choices. Again, we’re not trying to tell each individual what they should do, but we’re concerned that when the state weighs in on health, personal health decisions, it gets complicated. And—

**Howard Forman:**Yeah. Look, I think the idea that the government should be stepping in to prevent physicians, the adolescents, and the parents of those adolescents, from doing what is seen to be in the best interest of that adolescent, were getting to a very, very dangerous zone, and we should be wary about that.

**Harlan Krumholz:**Yeah. Challenging. 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 find us on Twitter.

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

**Howard Forman:**And I’m [@thehowie](https://twitter.com/thehowie/). That’s @thehowie. You can also email us at 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). So one last thing I forgot to mention on the top, but I learned this right before we went on the podcast, your colleague and mine and our podcast guest of March of this year, Emily Wang, just [won a MacArthur Genius Grant](https://news.yale.edu/2022/10/12/yales-emily-wang-and-two-alumni-win-macarthur-genius-awards)—

**Harlan Krumholz:**Oh my God.

**Howard Forman:**... for work on incarcerated populations and chronic health and management. And so that is an incredible accomplishment, and I strongly recommend that our listeners go back and listen to that episode. And I am grateful to have learned from her, and congratulations to her.

**Harlan Krumholz:**Yeah. And rather than say an accomplishment, because I think that really, actually it’s a great decision by the MacArthur Foundation to invest in someone who’s doing such consequential work in such a challenging area and is doing so effectively. I mean, Emily inspires me. I love what she’s doing, and I’m so excited to hear that news. I didn’t know it. Thank you for sharing that.

**Howard Forman:**Yeah. Well, that was great. And well said, Harlan.

**Harlan Krumholz:**Yeah. Health & Veritas was produced with the Yale School of Management. Thanks to our researcher, Jenny Tan, and to our producer, Miranda Shafer. They’re terrific. Talk to you soon, Howie.

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