**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. Albert Ko. But first, we’d like to check in on current health and healthcare topics. And I know there’s [an article](https://www.nejm.org/doi/full/10.1056/NEJMoa2300080) that got your attention this week from *The New England Journal of Medicine*. Do you want to tell us about it?

**Harlan Krumholz:** Yeah, sure, I’d love to. So this is a study about leadless pacemakers. So let me just set the stage for this. So a leadless pacemaker is a type of heart rhythm management device for people whose hearts, they’re not beating properly. They may need a device that helps them to trigger the heart to be in a more normal way. And of course, this was a great breakthrough many, many years ago in cardiology that we could help people like this by putting in these pacemakers. But what we’ve been using are threading leads into the heart then. So for anyone who’s seen this, there’s like these long wires that go into the heart and then the wires are connected to a box. There’s a tunnel that’s created under the skin, believe it or not, where these device resides and has the battery and nobody likes it and—

**Howard Forman:** And the box is in the chest, right?

**Harlan Krumholz:** Under the skin, usually in the chest. These pockets can get infected, they can cause problems, the leads themselves can fracture. And so people would start thinking about, is there a better way to do this? So then technology was advancing. There was…advances in miniaturization, development of smaller, more powerful electronic components that could fit entirely inside a device that wouldn’t have to reside in this box that was in people’s chest but actually could be within the pacemaker itself. And then battery technology was advancing, so that very small batteries could last up to maybe 15 years. Again, one of the reasons to have this box burrowed under the skin in your chest was so it could have a big enough battery that could last a long time.

And then if you put it in there not connected to a box and without these leads, the leadless pacemaker, you needed some way to communicate with it if you needed to change the settings and so forth. So wireless communication technology began to advance. And then also, you needed to find a way if you were going to put these things in the heart without leads, how are you going to keep them in the right place so that they could trigger the heart? So this active fixation mechanism, the way to be able to screw it into the wall of the heart so it will stay in the right place. So at the end of the day, miniaturization, battery technology, wireless communication, this fixation has led to the development of these little pacemakers that can be actually, basically, placed in the heart and they can be set in place. And then they can trigger the heart to beat, and they can be communicated with through the wireless communication. And if you look at them on an x-ray, for example, it just seems like there’s something floating in space. It’s obviously not floating in space. It’s connected to the wall, but it’s inside the heart.

Now, initially they came out with this so that they could put one of these in the heart, but for a lot of people they have problems both in the upper and lower chambers, so they need to be able to have a pacemaker at the top and the bottom of the heart that can work in synchrony, that can take the place of the normal sequence of the heart’s depolarization, which is basically the electrical signal to get the heart to squeeze the upper chamber, then the lower chamber. And now, what they’ve just come out with is this: you can actually put in two of these pacemakers, one into the upper chamber, one into the lower chamber. People are always thinking this would open up the possibility that many more people could get it.

In [this study](https://www.nejm.org/doi/full/10.1056/NEJMoa2300080) in *The New England Journal of Medicine*, I know that was a long windup, but this study in *The New England Journal of Medicine* was 300 people who were enrolled in a study to determine whether or not implanting these leadless, that is, these little two devices, in the heart, not connected to wires, not connected to anything in the chest, but leadless ones, how well would it work? And they first found out that when it came to safety, 90% of these people were free from any procedure-related serious adverse effects. This, by the way, is interesting, Howie, because people may say, “Only 90%?” When you put in a regular pacemaker, 10% of people actually have a problem, a major serious adverse event.

But this was no worse than that. It was on par with it. And then when they tested the sensing, because this has to sense whether the heartbeat’s on its own and whether they tested the triggering, whether or not it could actually bring about a heart rate, all these metrics actually turn out to be quite good. So this represents a really major breakthrough. It’s still an experimental device. It needs to go through the FDA process. But this was a really remarkable study that said, “Actually, we may get to a point where we don’t have the leads, we don’t have the pocket in the chest, and we’re just able to put these into the heart, screw them into the right place.” And then people now have a means to overcome the problem of the heart’s not beating normally and that the pacemaker actually is the right way to help them.

**Howard Forman:** Yeah. No, I saw the article. And in radiology we do get to see the technologies roll out pretty early because we see them inside patients, and I’ve seen leadless pacemakers for a while now, but I’ve not seen the dual chamber, and this was a substantial advance. And when you talk to people who have pacemakers in, it’s not inconsequential to have this box under their skin that can sometimes irritate them or you can actually see it on people. So this is an advance. That’s a great thing, and hopefully it continues to work well. And maybe one day we’ll even see that these things can recharge off the energy of the heart, so that they don’t even have to get a new battery.

**Harlan Krumholz:** And people may be wondering like, “Well, so why would people choose this?” I’ll just go tick them off. It’s a less invasive procedure. They don’t have to tunnel anything under the skin; there’s no leads. Reduced risk of complications, presumably because you don’t have that potential pocket infection where you’ve tunneled that thing. It’s not visible. Lots of people do care what it looks like. They don’t like this box under their skin. And it has the potential for fewer long-term complications as well. The leads won’t fracture. Sometimes in current pacemakers, the leads will fracture or they have to be taken out. In this case, you’ve got it in.

So anyway, I think this is going to be interesting to watch and see what happens. It’s a little more expensive I think right now, but some people think long term it may be better off, even cost-effective. And so we’ll just keep an eye on it.

**Howard Forman:** Great.

**Harlan Krumholz:** Good. Let’s get on to our interview.

**Howard Forman:** Dr. Albert Ko is the inaugural Raj and Indra Nooyi Professor of Public Health and Epidemiology at the Yale School of Public Health and a practicing infectious disease specialist at Yale New Haven Hospital and a professor at the Yale School of Medicine. His work centers on the intersection of rapid urbanization and inequity with infectious diseases. Dr. Ko coordinates a research program in Brazil and has implemented community-based interventions for the Zika virus, leptospirosis, and COIVD-19, among other epidemics. Additionally, Dr. Ko is a collaborating researcher at the Oswaldo Cruz Foundation, a leading global public health institution associated with the Brazilian Ministry of Health. During the pandemic, he co-chaired Governor Lamont’s Reopen Connecticut Advisory Group.

Dr. Ko holds a bachelor’s degree from MIT and an MD from Harvard. He completed his internal medicine residency at the Brigham and Women’s Hospital and an infectious disease fellowship at Massachusetts General Hospital. What’s more, he’s the [first returning guest](https://insights.som.yale.edu/podcasts/health-veritas/dr-albert-ko-wider-view-of-covid-19) to the podcast. And I went back and looked at that episode, and it turns out he was our guest in the week leading up to Christmas of 2021, when Omicron was hitting us really hard. Today, our pandemic restrictions have been almost completely relaxed. Our own hospital has a COVID census around 10, a level we haven’t seen since the highly restrictive summer of 2020, and life seems awfully normal to most people.

There’s a lot of ground we can cover today, but our listeners would love to hear some words of wisdom from you on whether COVID is now just another respiratory virus. Do we still have to worry about new variants? Should we just enjoy the beautiful summer and stop asking questions? So Albert, first, again, thank you for coming, and impart your wisdom on us on what we should all be thinking about.

**Albert Ko:** Well, thank you very much, Howie and Harlan. It’s a real pleasure and honor to be invited back, and especially as the first returnee on your podcast.

**Howard Forman:** So tell us, [what should we be thinking about COVID-19?](https://www.nytimes.com/2023/04/24/well/live/covid-cases-deaths-spring.html) Now, I’m not trying to force you to tell us the future, but should we worry about a new variant that could be devastating, or do we start to think of this as like a flu, and there’ll be bad and good flu seasons?

**Albert Ko:** Yeah, so a lot has happened since we last talked. We went through successive waves of different variants and different flavors, the Omicron variant. And I think what’s playing out, at least until now, is that although it’s much more highly transmissible, it’s a lot less virulent. Probably the case infection-to-fatality ratio is probably 10 times less than the variants that we had experienced beforehand. So that obviously has changed how we think about the virus and how we react to it. I think the other important fact is that this virus is much more transmissible, and the transmissibility is probably three or four times that of the original ancestral strain that we experienced.

So thinking about how we deal with this now, things that we relied on early in the pandemic are not going to work as well. These include face masks, but this is because of the aerosol transmission and so forth. And also, some of the nonpharmaceutical interventions. And certainly the vaccines are still holding in terms of their effectiveness against severe disease, but they’re certainly not transmission-blocking. You raise the advent of a new variant, and one that we particularly worry about is not only that it’s more transmissible, it escapes immunity or it promotes immune escape from the vaccination or hybrid immunity, but if it’s going to become more virulent. And at this point, we need to double down on surveillance and really keeping a close eye. So still uncertainties for the future, but what we’ve learned in the last year shows us that this virus is much less virulent than we had encountered previously prior to Omicron.

**Harlan Krumholz:** I wonder if you could share with folks a little bit about your journey in public health. I mean, what really got you to specifically focus into these areas? I mean, how did you even learn that this was an area that you could spend time in and devote a career to? I’m really curious how it got started and what were some formative experiences for you?

**Albert Ko:** Like many of us in our journeys, both through science but also through medicine and public health, there’s a myriad or a complexity to the motivations. But one of the driving forces is of course, my parents. My father was a refugee from North Korea, lived in an urban slum after the division of the country, fought in the Korean War. Came to the United States to study, spent two years after developing hemoptysis, or coughing up blood for tuberculosis, in a sanitarium in Worcester. He was probably one of the first people... He was institutionalized in 1954, and he was probably one of the first people to get [isoniazid](https://www.tballiance.org/portfolio/compound/isoniazid) and benefit from really the great achievements that we’ve done in medicine and in public health. That was a major factor.

I think the second is, none of us travel alone. Many of us also travel on the backs of giants. And I’ve had great mentors who really showed me how a scientist could be an advocate for social justice. One is [Warren Johnson](https://vivo.weill.cornell.edu/display/cwid-wdjohnso) at Cornell. A real hero during the AIDS pandemic in providing care with his colleagues hand in hand in Haiti, as equals, equal partners. The other was [Lee Riley](https://publichealth.berkeley.edu/people/lee-riley/) at Berkeley, who was the person who actually identified first E. coli 0157: H7, hemorrhagic colitis. And dedicated his life to working on viral diseases, tuberculosis in vulnerable populations.

I think the third factor is just the ability to learn. And I think there’s a real important lesson to this. The best solutions are not going to be coming top down. They’re not going to be coming from places from Brazil. They’re going to be coming throughout the world, and many times from communities. And it was a real privilege for myself to be one of those learners, spending 15 years in Brazil with the Ministry of Health working in communities, taking care of patients, and learning from them. And myself more as a vehicle than a mover. One thing I learned in Brazil with many of the great public health achievements they did before I came and while I was there, but one was poverty reduction through conditional cash transfer programs. The other was a world-class vaccination program that was even resilient to the political pressures of the Bolsonaro government, where more people got vaccinated... 90% of the Brazilian population got vaccinated, much higher than what we experienced here in the United States. Equivalent to what we did here in Connecticut.

So many lessons learned on that journey. And it was just, well, having been mentored by exceptional people and people committed to social justice.

**Harlan Krumholz:** It was a big decision to go to Brazil. That’s not an easy choice. I mean now this is your home, this is where you’ve been, and I don’t know whether you were fluent in Portuguese when you left, but that, that’s a big decision. How did you make that?

**Albert Ko:** Yeah, and it shows the changes in paradigms, that for somebody who was interested in global health and particularly in issues at that intersection of social justice and health. Back then, the paradigm was you went abroad for one or two years, set up your laboratory, came back, set up your laboratory and did translational research. And the big question that came to me, to maybe the discomfort of my wife and my chief, Warren Johnson, was that it was that the people that you trained, it takes about 10 years or more for them to start, whether medical students or master’s or PhD students, and then become established.

And that, for me impressed at the commitment—ever more critical when we think about community. When we’re thinking about embodying the vision of having the community solve their own health problems, it requires a long-term commitment in building up training programs and creating pipelines through high school. Head Start programs, college work-study programs. So you can get cohorts of people from the communities to solve their own health problems. Again, with the theme of, try to build ground-up solutions to problems rather than top-down solutions.

**Howard Forman:** So I want to get back to what you are doing as population health, public health at a particularly Brazil, global level, also applies domestically to the state of Connecticut. But you also have been an active clinician right up until this time. And Dr. Fauci, who just retired, also continued to round, up until he was about 80, at the NIH. And I’m just wondering if you could give our listeners some sense of why you did that and how does it inform the way you think about your field of both infectious disease, as well as public health and epidemiology?

**Albert Ko:** Yeah, so I think, Howie, in that sense, you and Harland are really good examples and role models. Not only of the proverbial physician-scientists but people who care and people who translate that care through their research and in a broader context. And I think we all strive, and both of you are faculty in my institution, which is the Yale School of Public Health, we strive in public health to serve people and communities. We can only do that if we listen and learn. And taking care of patients and their families provides that opportunity and grounded in service and healthcare and in empathy.

It’s not the only way. Some of the best people I know are at doing this are non-medical people. For example, our government leaders in Connecticut. Very much impressed by people....Harlan served together on the Reopening Connecticut Advisory Group. People like Indra Nooyi, Governor Lamont, many of the people in the Department of Public Health, who really had a feel or a tie in or a connection with communities and populations. But I think the sine qua non or the requirement is that we have to listen and learn. And I find it so useful, as you do, in order to identify what’s an important problem from a patient. And then whether we’re going back to the laboratory or whether we’re going out to the community, trying to develop solutions or mobilize or train people to develop solutions for that purpose.

**Harlan Krumholz:** One of the things I’m pondering lately is this…where we should be pushing our view about healthcare. Because for so long, we’ve had this paradigm of biology. And we learned in medical school pathophysiology and…we really over-index almost, I believe, on thinking about things only in biological terms, when really it’s these [social determinants](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1) that are so much more dominant for so many people with regard to health. Now they’re mediated, of course, through biology. But I’m just saying that in terms of causal underpinnings. And your work has been so much around social marginalization and how the urban ecology can affect the emergence of diseases, and then how people’s health and health outcomes are affected by the social context of their lives.

And it’s interesting you say, “I go to Brazil, I’m involved. One great public health intervention was actually these transfers of payments, I mean the eradication of poverty.” And I believe that we’re often too myopic as we think about health and aren’t opening our eyes to the kind of various determinants, including poverty, that are driving so much of this health suffering in the country because of our dichotomization, our sequestration of thinking about just the biology as opposed to thinking about the social context. You’ve been in this for a while, what are your thoughts about how we bridge this? And is it really just public health’s over here and medicine’s over here, or can we begin to have a synthesis where we really understand these social determinants and emphasize them just as much as we do basic biological causes of disease? Where do you stand on this now?

**Albert Ko:** Yeah, so I think all we have to do is just look back at the pandemic and look at the lessons learned from the pandemic. And just to list several of many that are out there. The first is that during the pandemic we saw our most vulnerable populations, whether they’re here in Connecticut or in the United States or throughout the world, harbor the burden of the COVID pandemic. The second issue is there are several structural reasons, as you related about our healthcare system. In the United States, opposed to many other countries, such as Brazil, health is not a social right. And we guarantee individual rights, civil rights here in the United States, but we don’t guarantee social rights. And that is a key structural issue in many things downstream, whether it’s the fragmentation of our healthcare system, whether it’s marginalization of population, stems from that key structural issue.

The second is I think the part of ideology and dogma. You and I, Harlan, we went to the same medical school, we learned the same textbooks. When we looked at infectious disease, it was just the interaction between the microbe and the person. And very little of our education was focused on the importance of social determinants of health, and that played out badly for us during the pandemic. We can look towards the great achievements and certainly the biomedical achievements, whether they’re diagnostic tests, whether they were the antivirals, or whether the vaccines that came out. But certainly, one of the biggest failures was the lack of investment in social behavioral sciences, and the emphasis of biomedical sciences. And that wasn’t just in the last several years, this is over decades. And we have to look towards our research bodies who fund us or fund people like us to look at those issues.

So key structural issues, but key ideological issues that really got us in a bad place. And we compare ourselves to other countries, which were much more flexible and much more resilient. Take many of the Asian countries, where on the turn of the dime, could reformat themselves. So there are deep-rooted causes. And we really need a good reflective moment, which we haven’t had. Everyone, myself included, wants to get back to normal, but we haven’t had that reflective—really getting at the structural issues, the structural barriers that were the root causes.

**Howard Forman:** In addition to working at the social determinants level, you’ve also been building the feedstock of talent in Brazil and elsewhere. And one of the concerns I think all of us have is that if you bring people from another country to the United States and train them, they may not go back and you may be actually exacerbating a brain drain. And so I know you’ve actually put some thought into, how do you avoid doing that with the best of intentions when you train physicians, graduate students, and even earlier trainees. Can you tell us a little about your thoughts on how do we help raise the level of technical and professional knowledge in Brazil and elsewhere?

**Albert Ko:** Yeah, so I think Howie, you touched on an important point that faces us in global health, and that certainly is imbued in the discourse on democratizing and decolonizing global health. It goes much beyond the brain drain. It really goes down to the inequities in our business model, our financing model, in the incentives that we have worldwide. We are setting up, for example—I’ll give a good example. We’re setting up collaborations with various institutions, including the Brazil Ministry of Health. At Yale, we’ve had over 10 years a memorandum of understanding. The worst thing we could do to a Brazilian or a Ugandan or South African or a Cambodian is to take their best and brightest, bring them here to do their PhD or their postdoctoral training and have no place to send them back but also to weaken their educational processes, their PhD programs, their research programs. And so there’s a lot of predatory forces within global health, and that gets to the point where equity and outcome requires equity and process. And that’s what I think many of us are having to grapple with. And fortunately, much of that dialogue is being driven by Brazilians, by Ugandans, by South Africans, and to really call us out on much of the paradigms that we’ve been based on, which our business model has been based on, whether it’s for research or for training in global health.

**Harlan Krumholz:** We’re getting to the end. And I just want to, again, express appreciation for you. Given everything you’ve done, I just wonder if we could—and we have a lot of students who listen to this—and maybe you could convey an anecdote or a little bit of wisdom and advice to people listening to your career and thinking that might be something they would be interested in. And what would you say to them? What you like to convey?

**Albert Ko:** Yeah, so I think the first... and I’ve gotten great advice over the years, and there are two proverbs that were given, one by Pierce Gardner, who was a well-renowned global health educator from SUNY Stony Brook. And he says, “Pick a worthy topic and find a great mentor.” And worthy topics, his list was the UN millennium developmental goals, now they’re the UN sustainable goals. And just picking one of those and dive in. And finding a great mentor. And I was fortunate in my life to find a great mentor and role model in that issue.

I think the second issue, which really, and it gets back to the issue of democratizing and decolonizing global health, is the issue of how to be an equal, whether it is with your collaborators internationally or with the community, and how to work as equals in the discourse. Not a very easy thing to do given the structural constraints. But embedded in that is thinking about, which was the other proverb from my chief, Warren Johnson, who is your successor. So Warren told me one year after I arrived, “Albert, the most important decision you’re going to make is who’s going to be your successor.” And I kind of thought about that and I said, “Warren, I just was there in Brazil for one year and now you already want me to leave.”

But he was right. And in those successors for at least our team were the Brazilians, whether they’re from the community or from the Brazilian Ministry of Health. Many of these people we’ve trained have now become vice ministers or directors of communicable diseases in leadership positions. So I would give those two pieces of advice to people thinking about the future and thinking of doing the right thing.

**Howard Forman:** Yeah, that’s a great way to end, Albert. And I like the idea of having sustainable human capital, and that’s a great way to think about it. But thank you so much for joining us, again. You are, as we say, an *übermensch*, just a great person at Yale, and we’re so lucky to have you here.

**Harlan Krumholz:** Yeah, it’s great to see, Albert. Thanks for joining us.

**Albert Ko:** Thank you very much, Howie. Thank you, Harlan.

**Harlan Krumholz:** Well, that was a terrific interview with Albert, but now I want to get to my other favorite part of the podcast besides our guest, that’s listen to what’s on your mind this week.

**Howard Forman:** Thanks, Harlan. So two items caught my attention this week, and there’s more than just timing in common here. So first, earlier this week, *The Lancet*, a prestigious journal from the UK, released [a longitudinal analysis](https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(23)00169-4/fulltext) from what’s called the Millennium Cohort Study on the role of dieting, happiness with appearance, self-esteem, and bullying in the relationship between mental health and body mass index, or in some ways obesity, in UK adolescents. And this is a mammoth undertaking of collected data on youth from 11 to 17 years of age. And tried to figure out temporally, by time, what was causing what. So it’s still based on associations. We can’t prove causation, but the associations can be tested so that you can see what is present at age 11 might predict what is present at age 14 or 17.

So those are the questions. Does obesity lead to worsening mental health? Is it mediated by dieting or bullying? Other things like that. So here are some of the associations they found. One is happiness with appearance and self-esteem, but not dieting or bullying itself, mediates the relationship between BMI or obesity, really, getting a higher BMI and mental health. So BMI at age 11, mental health at age 17. So put another way, higher BMIs at age 11 were associated with lower self-esteem and greater concerns with appearance at age 14, and then worsening mental health, including externalizing and emotional symptoms at age 17. There are many other findings of note, but self-esteem and concerns with appearance appear to have an impact on future behavior, future mental wellbeing, and even future worsening of obesity. And their concluding line in this was, “Academic institutions, public health researchers and organisations, and the government should encourage positive body image and weight stigma education to facilitate a public narrative about obesity that is based on contemporary scientific evidence. Our findings reinforce calls for greater advertising and social media regulations to reduce weight stigma in adolescence.”

So fast-forward basically one day, and our nation surgeon general and our alum, the School of Management and the School of Medicine, issued [a new advisory](https://www.hhs.gov/about/news/2023/05/23/surgeon-general-issues-new-advisory-about-effects-social-media-use-has-youth-mental-health.html) on social media and youth mental health. And one quote from his advisory caught my attention. Children and adolescents on social media are commonly exposed to “extreme, inappropriate, and harmful content.” And those who spend “more than three hours a day on social media faced double the risk of … poor mental health … including [experiencing] symptoms of depression and anxiety.” And then he specifically calls out: “Social media may … perpetuate body dissatisfaction, disordered eating behaviors, social comparison, and low self-esteem, especially among adolescent girls.” And he had no knowledge about the timing of *The Lancet* study. That was pure coincidence.

So you have this convergence of the scientific study and this advisory based on hundreds of papers over time that basically point out that we need to destigmatize obesity and help better understand the role of social media in reducing self-esteem and impairing one’s sense of self-image. So my takeaways on this, and then I’m curious to hear your opinion—social media is everywhere. We can’t take it away. We can’t undo its influence, but we can ask much more of social media companies and how they market and curate for children and adolescents. And if they can’t, we can and should regulate them for this key and vulnerable group. It isn’t social media alone, by the way. You and I both know that body image has been glorified and vilified for much of our lives, well before the advent of social media. More work needs to be done to destigmatize obesity. We invested a lot of time and money in my childhood in public school fitness challenges and similar activities. We need to be doing the same thing about physical wellbeing and doing it with intentionality.

**Harlan Krumholz:** Oh, my God, Howie, there’s so much in what you just said. I don’t even know where to start, and I know we’re getting to the end of the podcast. I mean, look on the social media side, I do think that the government and society could have thought from the very beginning that this had the potential for great benefit but also harm. And when companies were pursuing profit motives, they may not have been investing adequately in thinking about how they can mitigate the potential harms.

I saw [another study](https://sapienlabs.org/whats_new/study-out-from-sapien-labs-links-age-of-first-smartphone-to-mental-wellbeing/) that suggested that the earlier the age that a child gets a cell phone, the more likely it is that they’re going to have mental health issues. And again, association studies. I’m not talking about causation. But it’s raising the question about whether these powerful interventions in society are having untoward effects, especially when they’re being used early. Early access to the internet and all the things that anybody can see that.... How do we begin to think about this side? That’s a whole set of issues. I’m glad our friend, Vivek [Murthy], our surgeon general, is taking on these issues. I’m glad people are studying it. We need to know more. We have to respect freedom, but we have to also understand that, especially for kids, this may have untoward effects. So this is such an important area. Go ahead.

**Howard Forman:** No, I think parents want guidance also, and I think that they’re begging for some advice.

**Harlan Krumholz:** Yeah, and maybe that’ll make it easier if there is some global advice around it, rather than being, litigating this in each family without evidence. And then the thing about obesity is we on one hand need to destigmatize. On the other hand, there are going to be new treatments, highly effective treatments that can really help people. And as we start thinking about obesity, like we do hypertension, maybe we shouldn’t be thinking about it in a way to say, how do we help people live with it? But rather, how do we address it? And yet, this issue in the kids is really complicated because some people grow out of it, some people don’t. It’s a marker. When do we start treating? How do we manage it? These are going to be big questions for society to grapple with. I’m so glad you brought this up in this short time. I don’t have any answers just to say that they’re worth our consideration.

**Howard Forman:** Yep.

**Harlan Krumholz:** 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 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:som.yale.edu/emba). 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 on our website at [som.yale.edu/emba](http://som.yale.edu/emba).

**Harlan Krumholz:** *Health & Veritas* is produced with Yale School of Management and the Yale School of Public Health. Thanks to our researcher, Ines Gilles and Sophia Stump, and to our producer, Miranda Shafer. They are extraordinary, and they help us so much every week.

**Howard Forman:** They do.

**Harlan Krumholz:** Talk to you soon, Howie.

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