

KHN's 'What the Health?'

Episode Title: A(nother) Very Sad Week

Episode Number: 248

Published: May 26, 2022

Julie Rovner: Hello and welcome back to KHN's "What the Health?" I'm Julie Rovner, chief Washington correspondent at Kaiser Health News. I'm joined by some of the best and smartest health reporters in Washington. We're taping this week on Thursday, May 26, at 10 a.m. As always, news happens fast, and things might have changed by the time you hear this. So here we go. Today we are joined via video conference by Anna Edney of Bloomberg News.

Anna Edney: Good morning.

Rovner: Joanne Kenen of the Johns Hopkins [Bloomberg] School of Public Health and Politico.

Joanne Kenen: Hi, everybody.

Rovner: And my KHN colleague Rachana Pradhan.

Rachana Pradhan: Hi, Julie.

Rovner: Later in this episode, we'll have my interview with Dr. Richard Baron, CEO of the American Board of Internal Medicine, about a piece he co-wrote in the New England Journal of Medicine about how medical boards and accrediting organizations should deal with doctors who spread disinformation. It's a long-standing problem, but one that has taken on new resonance in the age of covid and social media. But, first, this week's news.

I'm going to start by quoting The Onion. Yes, that Onion, whose homepage yesterday was just the same headline over and over again — "‘No Way to Prevent This,’ Says Only Nation Where This Regularly Happens" — on top of a dozen stories with various datelines, we have all, alas, come to recognize, most recently Uvalde, Texas, and Buffalo, New York. I don't imagine that we have that much to add to the ongoing discourse about gun violence, mental health, and public health. But, Joanne, you're our public health person. Is there anything that could break the cycle of moving from one tragic mass shooting to another?

Kenen: I've covered guns as both a public health issue and a political issue, I've covered it on the Hill. So that's going back to Columbine. It's a lot of years of ... not only is it no progress, we've gone backwards, both in terms of gun laws in the states and the amount of violence in this country.

Rovner: Yeah, there used to be an assault weapons ban.

Kenen: Yes. Well, also concealed carry and a lot of state laws are very, very pro-gun. And it's really discouraging. I realize that ... I personally know people who've been involved, not killed, but involved or present at two mass shootings. And my son has friends, also who survived, but had friends at Parkland. And we live in Maryland, but he knows kids everywhere, including Florida. And

I know someone who was at Tree of Life [synagogue in Pittsburgh], as does Julie. And I have several friends who I know the kids who were at the [Edmund] Burke School in Washington, D.C., where no one was killed, but there was an assault a few weeks ago. So it's not abstract. But I also think we have to remember these mass shootings are atrocious and the ones that are racist have other social implications, but there are shootings every single day that don't make the headlines. And those are actually the ones that make up the majority of deaths in our country. I think these mass shootings speak to some other larger social problems. And obviously the ones that are directed at Black Americans, or a synagogue, or a church, or a Latino population have ... there are other issues there as well. And I think we also have to remember, and this is something I keep forgetting and relearning and have vowed not to forget again, more than half — and in some years really around 60% or 65% — of the gun deaths in America are suicide. So it's a really complicated problem. It is a political problem. It is a public health problem. And there are solutions that we're choosing not to tap. No other country has the problems we have because we're awash in guns.

Rovner: Yeah. At least one place where things have moved forward is the [Centers for Disease Control and Prevention] is once again allowed to spend federal money to research gun deaths. But I guess it's too soon to really have a lot of results from those things yet, right?

Kenen: Right. They were banned for close to 20 years, more than 20 years. So there was some private sector academic ...

Rovner: In the mid-'90s, they were banned. I covered that.

Kenen: The Dickey Amendment, right. There is research at a number of public health schools, including Hopkins. One thing ... the Association of Health Care Journalists — for any journalists listening to this today — just posted some resources, and it's open access — you don't have to be a member. I did a panel a few weeks ago. And they reposted the blog post someone wrote about it, and they added some resources. So part of this is changing social norms. Part of this is working on proven, workable things that we know that are community violence reduction programs. And then we all heard Sen. Chris Murphy [of Connecticut] the other day.

Rovner: Basically begging on the Senate floor.

Kenen: It's just heartbreaking.

Rovner: Yeah. So obviously much has been written about this, and much more will be. But I was kind of taken by [a piece in Vox](#) about what it means that we now have an entire generation that's grown up with mass shootings at school and never really been treated for the trauma. As Joanne said, even if you're not shot or killed, you're definitely affected, particularly if you were there when this happened. According to The Washington Post, more than 300,000 K-12 students have been on campuses with mass shootings since Columbine in 1999. That's not counting all the college students at places like Virginia Tech. That's the population of a midsize city. And now they're sending their own kids to school and worried about whether those kids will come home at the end of the school day. I'm just wondering: Is this a stressor that's affecting our ongoing mental health crisis that maybe could use some more research?

Edney: Research and even acknowledgment. Like you just said, that's a huge number. I saw several people posting things — and which I was sort of appalled by — after the mass shooting in Uvalde that we have to remember for our own mental health that this is a very small number. It's like 1 in however many million kids end up shot in a mass shooting. ... It felt a little bit tone-deaf in the sense that there's so much [of] a bigger effect. And not to mention every life is precious and that — it just seemed not to acknowledge the ripple effects on kids who were there and on everyone else who's watching, scared to send their kids to school, and kids who are old enough to understand what's happening.

Kenen: It's not just the mass shootings. I mean, that's a horrible number. And the mass shootings and the possibility of mass shootings and school shootings has affected every kid. I mean, I can't think of any kid — because they do these drills, and they hear a loud noise or there are false alarms. And there are shutdowns and lockdowns, and it's traumatic. But it's also not just the mass shootings. There are kids in America who have violence around their schools. And they have shut down. And it's not mass shootings. It may be gang violence, it may be criminal activity, it may be whatever, but it's within ... I did a story on gun violence in southeast D.C. right after Parkland. And I was walking with a really extraordinary woman who was working with the community trauma of living in a place where there's a lot of violence. And we were walking by an elementary school, and there was a shooting. We were a block away. I was told that it was the 11th?! These were little kids. The 11th shutdown/lockdown because of a shooting on that block, or adjacent block, in one school year, and we were only in April at that point. So these kids live ... violence is a backdrop to their everyday existence and it's traumatic and frightening. And ... it's so multifaceted. These mass shootings traumatize the nation. But day-to-day violence traumatizes communities.

Pradhan: And I do think — one of the things that I think about with respect to this now, this gets into sort of ... well, I guess everything is a health issue, is how I describe it. But when you think about education, like Joanne and Anna are talking about, these individual incidents that collectively add up to a lot, I do think there's some movement to attempt to change this from people who also study education policy and criminal justice work. But immediately, the instinct, I think, when something really horrific happens at a school is to say, well, we need to boost security. But children don't ... making your school a community institution, like an extension of the criminal justice system, doesn't help children feel safe. It doesn't help process their trauma. There is actually, I think even this morning, there's a story on NBC News about how in Uvalde they had boosted spending considerably over the last few years on security in their school. And it wasn't enough, of course, to stop such a horrific thing from happening. But, you know, fundamentally, if we're talking about trauma from shootings and things that children have to cope with, there is, it seems, a growing recognition that to talk about it, talk about it with your children, how do you process these things, not to just pretend it didn't happen, especially for older children who see it in the news, who hear their parents talking about it and don't know ... clearly are affected by it, but don't know how to handle that sort of stress and anxiety that comes from it. But I think also, you know, just an extension of how we treat our schools — is it really the best thing to say, “Well, we're going to put metal detectors everywhere,” and you basically make them feel like they're in an incarcerated setting. That doesn't make children feel safe in their place where they spend the bulk of their time every day.

Kenen: Plus, there have been guards at a lot of places. There are police at some of these schools, there are security guards.

Rovner: There were people with guns at Uvalde.

Kenen: Right, right. And in the Buffalo [New York] supermarket, there was a retired policeman who, I believe he was killed, who challenged the shooter. These schools, many of these schools and many of these other sites of mass violence do have armed guards and do have security. But they don't have — I mean, these people, these shooters come in with automatic weapons, sometimes more than one, and Kevlar. I mean, it's combat.

Edney: And another issue that's been highlighted in recent years is that Black kids particularly don't feel safe around law enforcement. So you're exacerbating that problem by putting more officers there.

Rovner: Yeah. I think this is something we will definitely talk about more as we go on, alas. OK. Well, in crises affecting those even younger than elementary school children, the federal government is belatedly, as we discussed last week, trying to address the nationwide shortage of infant formula. Anna, you're following this story pretty closely. The head of the FDA was on the hot seat in front of Congress yesterday. What's the latest here?

Edney: He was. Dr. [Robert] Califf went before the House Energy and Commerce Committee's [Subcommittee on Oversight and Investigations]. And the night before, the FDA had approved one infant formula company from another country to be able to sell their product here. And that was going to bring a lot more. And obviously, that's something that the Biden administration has been doing, is flying others over so that they could hit our supermarket shelves. And Abbott itself said that there was some EleCare, which is the very specialty one that was on recall, that they were allowed to release about 300,000 cans. They've been tested more than normal, but it was made at the time that the plant was having issues, where they found Cronobacter in their environmental samples. So, something for people to talk to their pediatricians about if it's a product they really need. But Abbott said that they did think they're going to restart that plant around June 4. They're going to focus on EleCare first, and it might start hitting shelves around June 20 or so. But what lawmakers really wanted to know from the FDA is what took so long. And this has been out there. They took a very long time to get to the plant. The first case of Cronobacter was in September. They didn't get to the plant till the end of January. There was a whistleblower who came forward in October. They didn't interview the whistleblower until December. High-level officials, we found out yesterday, didn't even know about this report until February. So where were all the breakdowns? And Dr. Califf did offer explanations for some of that. I don't think that anything was ... I don't think FDA was then suddenly forgiven for being so slow. They weren't great explanations. They were breakdowns in processes and the way things should work.

Rovner: But I get to gently interject at this point that how many weeks did we talk on this podcast about the fact that the Biden administration had not nominated anybody to head the FDA? And what it meant to not have a permanent head of the FDA?

Edney: Yeah. And it clearly meant something because Janet Woodcock was acting [commissioner], and a lot of things just did not fall in line. And maybe it would have happened with Califf there, too. But it's an agency that needs everything running in a certain way and needs support behind it. It needs a very strong head and an understanding of who to go to when, especially on the food side. There is just a weird system going on there where they kind of have two food safety heads and nobody knows who reports to what. And Dr. Califf, to answer a lot of questions around those things, said that they're going to do a review ... on the very specific issue of infant formula and their processes around recalls and inspections and things, but also a larger review around the whole food system there.

Rovner: Yep. Yeah, this seems to be sort of renewing calls to split the food safety part out of FDA. FDA is so busy with drugs and medical devices, and now tobacco, that food is always an afterthought at the FDA. And one of the weird quirks of covering Capitol Hill is that FDA isn't even funded through the Department of Health and Human Services appropriation. It's funded through the Agriculture Department appropriation, even though it's part of the Department of Health and Human Services. I mean, could this be sort of a catalyst to renew that conversation about maybe we need actually a separate food safety agency?

Edney: Yeah, I think that's possible. That could be where some of this goes. There's the FDA, like you said, is so busy. And they have ... a lot of user-fee programs for most of the things that they cover. There's some for food, but it's not nearly — doesn't give FDA what it needs. It doesn't allow them to do the level of surveillance and things that they might need to do. Because, in reality, that's really not what the other user fees are for either. Like on the drug side, it's mostly for reviews and approvals.

Rovner: It's to speed up the processes.

Edney: Right, exactly. But there is no ... most of the time — and infant formula is a little different — but there's no approval for food. So FDA just isn't in there in the very beginning. And so it's just a process that doesn't — the oversight is very different. And it's massive. The food part of it, of consumption, is , of what they cover. Compared to USDA, who's got an inspector in every meatpacking plant and things like that. But the other thing to mention on Capitol Hill yesterday was that, mostly virtually, that Abbott ... there were a lot of hard questions for them, too. And the FDA has done their investigation of everything that happened at the plant. And the commissioner just called it egregiously unsanitary there. And that's not something you want to hear about where your infant formula is being made. And he compared it to if you went to somebody's house and their kids were running around outside and tracking mud through the kitchen, and there was standing water on the counters and bacteria and would you want to eat there? And he said, that's kind of what this plant was like. And they really ... Abbott has tried to say again and again there's no conclusive evidence linking us to these illnesses that first sparked everything, that the four babies to unfortunately die who had Cronobacter. FDA has said again and again, and they really hammered it yesterday, the evidence doesn't tell us one way or the other. It doesn't let Abbott off the hook. And it doesn't say definitely it was them, but there were all these things wrong there. And there's a very high likelihood that Cronobacter could have contaminated products there.

Rovner: Yeah. So, more for the FDA to do. All right. Well, let us move to covid. We are currently in what one reporter on Twitter this week called, quote, “the first surge of the endemic era,” where cases are going up fairly fast in most places. And while hospitalizations are rising, they're not at crisis levels yet in most places. This appears to be the point where more and more people are catching these more and more contagious variants. But either due to vaccination or natural immunity from having been infected before, they're not getting sick enough to need hospital care. And if they do need hospital care, they're mostly not sick enough to end up in the ICU. Still, it seems like most of the public just wants to pretend that covid is over. And most policymakers don't seem to want to anger voters in an election year. So are we headed for trouble or is this just the way things are going to be, that everybody eventually is going to get it, and you got to hope for the best?

Kenen: We can't know because there are two really big factors. Right now as a society, we have a pretty good level of protection between vaccination and recent infection. But the key word is “recent,” because ... the natural immunity, you can get it again and again and again and again. So, I mean, we're learning that over the last couple of months, people are getting repeated cases. So we don't really know how long this natural immunity lasts and we don't know what the next variant looks like. Right? I mean, right now the next variants are becoming more and more transmissible. It's almost at measles level right now, which means super infectious, but it's not getting more ...

Rovner: Which means if you walk into a room where somebody infected has been, you could be infected.

Kenen: It hasn't gotten more dangerous. In fact, there's some debate — it might even be a little less lethal. It's hard to sort that out because we have immunity. And we also have medicine now. So doctors are better at treating it. They know how to deal with it better. And there's Paxlovid — I'm not even sure how to pronounce it. Is it PAX-lo-vid or Pax-LO-vid?

Rovner: Pax-LO-vid.

Kenen: Anyway, we've got that, which is not a perfect drug, but a very, very, very, very useful drug.

Rovner: But of course, we're also seeing people who are taking Paxlovid relapsing.

Kenen: Rebounding. Right, right. But they're not getting seriously, seriously ill. I mean, there's something going on there and they don't know what it is. It might be as simple as instead of five days, maybe you need 10 or maybe you need a lower dose for longer. It may be a dosing issue rather than a drug failure issue, but we're not seeing deaths. We are seeing relapses, and a fairly high number. But ... could this be the transition to an endemic period? Not if the next variant is really different and really dangerous. If we're on ... so the trajectory we're on of people getting sick but not dying, then we're transitioning to a different reality. But there's no way to have confidence in that.

Edney: Well, I think ...

Rovner: Meanwhile ... oh, go ahead.

Edney: Sorry. I was just going to mention that the CDC came out the other day with their preliminary look at long covid and saying ...

Rovner: That was my next question! [laughter] Go ahead. Just talk ...

Edney: ... saying 1 in 5 have had covid and can experience these longer-term symptoms. It's a battery of symptoms, I think it was 26. But that's what it does. It just affects so many organs in your body and all different kinds of neurological issues. And so I think that's something we haven't quite reckoned with when we talk about endemic.

Rovner: Yeah. And ... the question that I was going to ask about the long covid report was, are we looking at a huge expansion of our disability population that we just haven't begun to deal with yet? I mean, all these people, we don't know how long long covid lasts, but it certainly ... many people certainly are not functioning anywhere near the level they were functioning at before they got sick. And what does that mean long term for the productivity of society? And I feel that question is being brushed under the rug.

Edney: Yeah ... I think you're absolutely right that it is. And ... economically I saw, I think it was maybe a month ago, maybe a little less, the Bank of England talking about how they were looking at unemployment numbers and just saying the job market, the pool of employees, the people that want to work, is not large enough. And they said part of that was because of long covid and they were afraid that what was going on there. And I'm sure we're likely to see that here, too, is that people aren't able to get back to work. And those people are going to largely need, or be able to seek, medical treatment. But those are going to be large bills that are ... they're chronic conditions, there's more diabetes, things you can't cure that are going to be ongoing issues for more people now.

Rovner: Yeah, there's all kinds of circulatory issues with heart conditions.

Kenen: Yeah. I mean, one of the problems with that study is it didn't distinguish between ... it didn't tell us who got it post-vaccination versus non-vaccinated, either prior to the availability of vaccines or people who chose not to get a vaccine. So that's something murky. We do know there are long covid cases post-vaccination. We don't have a good handle on how many or how severe. And the other thing is it lumped together people who had symptoms for a month and symptoms for a year. Now, if I had symptoms for a month, I would not be happy, and I would be terrified because I would have no way of knowing whether it's a month or the rest of my life. But still, there's a difference between — and I really don't want to minimize the illness — I actually have a friend with severe long covid who can't work. But I mean, there is a difference between someone who is tired for a month and someone who's permanently disabled or indeterminate. We don't know. We only know two years, 2½ years out. We don't know how long they're disabled. So the research and discussion base, without knowing the length of the disability and without knowing the vaccination status, I mean, it's still a great big ...

Rovner: Question mark.

Kenen: Right. It's like we know it's a big problem. We don't know how big, and we don't know how long, and we don't know anything. ... I know people [who have] lingering stuff for a month or two and then it goes away. And I know ... I have one friend who's disabled, period. Can't work.

Pradhan: Yeah, those are hugely important ...

Kenen: Can't do anything, really disabled.

Pradhan: There are really, really hugely important questions to answer. And I do feel like over time, even though it feels like an eternity we've been in this, part of the reason is because this is also new. Hopefully in time we will get answers. I do think also, if you think about the long covid report, just the headline alone when you saw it ... talk about what a shocking statistic ...

Rovner: And it's not just 1 in 5 adults, it's 1 in 4 adults over 65 who have symptoms of long covid.

Pradhan: Over 65. Right. ... If they are, hopefully relatively soon, able to determine the difference between risk for vaccinated adults versus unvaccinated, you could use it again as a push to get people to get vaccinated. Look how our vaccination numbers have stagnated over the last several months, even for the — and I'm sure we will talk about the young kids, Julie, in a minute ...

Rovner: That's next.

Pradhan: ... pediatric vaccinations, even for 5- to 11-year-olds are. It's just anemic, the rates. And I imagine that there is a probably small but extremely vocal contingent of parents of children under 5 who are waiting to vaccinate their children. But I don't expect that even those numbers are going to be particularly high over time for a lot of reasons.

Rovner: I was just going to say, it appears that vaccines for our youngest — and we have two toddler moms at the table today ...

Pradhan: Don't get our hopes up, Julie.

Rovner: ... are finally getting closer. So what is the latest timeline for getting those vaccines to kids under 5? Pfizer said this week that they seem to have finally settled on a dosing schedule that they think is going to work.

Pradhan: Right. So the latest, of course, is that ... Pfizer issued some preliminary data showing — and I would say preliminary with a big asterisk — showing that the three-shot regimen of vaccines for kids under 5 produced an initial efficacy estimate of about 80% against symptomatic infection, which is promising, for sure. But of course, I am very eager to see more detail, especially ahead of the FDA advisory committee meeting, which now has been scheduled for June 15. So it is conceivable and, of course, they are discussing the Moderna vaccine for relatively the same age group at that time, which is two doses.

Rovner: Your kid could be 5 by the time this is available.

Pradhan: You know, I made that joke and I really thought it would be a joke. I think maybe that won't happen. But ... I think the thing that is on my mind, especially with respect to the Pfizer — I

guess with both, the two questions I have, predominantly Pfizer's data, of course, is promising, but they even said that the efficacy analysis initially was based on 10 cases of symptomatic covid. And in their trial itself, they needed 21 children, essentially, to develop symptomatic covid. So these efficacy numbers are not final. It seems like people anticipate that there will be a final reading by the time ... by mid-June. So I expect those numbers might change. Maybe not a lot, but they're certainly not set in stone. And then I think the bigger question with respect to Moderna, we, of course, have their efficacy statistics for that age group, and they are lower than what the Pfizer one shows, at least preliminarily. And does the FDA go back and say to Moderna, or do they recommend authorization, or do they essentially say what they said to Pfizer in December, which is that two shots is not sufficient and you need to go and add a booster, which is why we are still waiting at this point, because that's what they said ... toward the tail end of 2021. So I'm looking out for those issues.

Rovner: And I guess you, too, Anna, you're our other toddler mom here.

Edney: Yeah. ... Like Rachana said ... very preliminary numbers, but encouraging nonetheless to finally see something hopefully nearing the finish line. I wish it was a little bit faster. I mean, we saw advisory committee meetings within two weeks when the first vaccines for adults and things came out. So it just feels like things just keep ... the timeline is just longer and longer, and I understand Pfizer ... is hoping to get their 21 cases before the advisory committee meets. But I'll be extremely interested in the discussion and comparing what we know with Moderna with two doses and Pfizer with three and where the FDA comes down on that and where the advisers, where their discussion goes on that.

Rovner: Well, meanwhile, we're still dealing with covid and now we have monkeypox to deal with. I confess I did not have monkeypox on my 2022 bingo card.

Kenen: You just don't have a big enough bingo card, Julie, we just need to get you a much larger bingo card.

Rovner: Unlike covid, monkeypox is not novel. We have treatments and preventions, and it's not generally fatal in most cases. But should we be freaked out anyway that it seems to be spreading around the world, this disease that's normally confined to its own endemic areas in Africa?

Edney: I guess I'm taking solace so far in the fact that we are told there is a supply, that the U.S. has a supply of vaccine if needed and that we have treatments and things for it, versus a brand-new virus like covid. It is a known factor. So that's where I'm looking at it right now, not being not capable of freaking out about anything else maybe at the moment.

Rovner: I think we're lacking the bandwidth to worry about yet another possibly spreading disease.

Kenen: Right. But I also think that, as Congress has to take up the legislation about public health and rebuilding public health and emergency preparedness, the [Sen. Richard] Burr-[Sen. Patty] Murray legislation, whatever ends up taking shape. You know, and I'm not saying monkeypox is a good thing. Obviously, it's not. But just sort of a reminder that a pandemic is not a once-a-century

threat. Right? This is the biggest one we've had in a century. We have had public health emergencies. And we will have more public health emergencies, and in a changing planet, both because of human population settlement, where people are moving to, and climate change, zoonotic — which is animal-to-people infections — are going to occur. They already do occur more than a lot of people realize. They don't necessarily take off and create a crisis. And I'm not pro-monkeypox. But I am pro- being realistic about public health threats.

Rovner: Yeah. And actually Helen Branswell over at Stat [has a piece](#) that came out too late yesterday to send to you guys, but that I will post a link to about how part of this also may be that human behavior having changed so much during the pandemic may ... it's going to change the way diseases are going to spread, other diseases, because we're not having our usual amount of human-human interaction because of covid — that it could expose us to other things. She had some experts who said just expect diseases to be wonky for a while while we get back to some kind of new normal.

OK. Let us turn to abortion. Oklahoma has now become the first state to ban abortion from fertilization. The governor signed the bill last night. It takes effect immediately, although it is being challenged in state court rather than in federal court because abortion rights organizations are already waiting for the Supreme Court to strike down *Roe [v. Wade]*. And I think they don't want to give them an earlier possibility to do it. So we will see if this gets blocked. But in the meantime, as the political and medical world are bracing themselves for this likely overturn of *Roe* in the coming weeks, apparently so are the nation's employers. As we've discussed here previously, a number of companies, starting with those in Texas, where abortion has been effectively banned since last September, companies are vowing to help employees who seek abortions pay to travel to other states if the states they are in bans the procedure. And lawmakers in some states — looking at you, Missouri — have talked about trying to make it illegal for people to leave their home state for an abortion. Now, some legislators in Texas say they'll introduce legislation to punish those companies that want to help their employees get out-of-state abortions. This includes some pretty big important firms: Amazon, Lyft, Uber, Starbucks. Now, this feels pretty implausible to me. It's basically an invitation for companies with more progressive-leaning workforces to leave the state. But then again, overturning *Roe* felt pretty implausible to me a year ago. So do we expect lawmakers to follow up on some of these threats or is ... maybe going after businesses themselves a bridge too far for state legislators?

Pradhan: I don't think it is necessarily. I think — and this isn't exactly the same — but I think you do see, in general, with shifts in the Republican Party, the populist wing is really not aligned with corporations in the way that the country club-era Republicans of earlier decades, several decades ago, were. And so ...

Rovner: Most of the history of the Republican Party!

Pradhan: Right. So, I do think if, depending on who's driving the legislation, they don't feel like they need to cater to corporations' demands, especially if they are wading into these cultural and social issues. That's not unique to abortion, but it certainly is one of them. So ... it doesn't seem like anything is really off the table if the Supreme Court rules the way that people are anticipating

now that they will. Now, legally, how they can do that, I don't really know, but I don't think that is going to stop them.

Kenen: There are things they could do with tax codes and punishments. ... I don't know that they would close any of them down, but I think there are ways. Who thought that they would do the bounty hunting and have it be held up? So I think that the creativity on the anti-abortion side is pretty high in terms of what they're reaching for legally and what they're obtaining.

Rovner: Yeah, it's pretty impressive. Although Texas is one of those states where, on the one hand, it's very, very welcoming to guns, very unwelcoming to abortion, but very welcoming to businesses. And a lot of businesses have moved to Texas because they have low taxes. And I just wonder if this is going to cause a rift in what's left of the Republican Party unity. There does seem to be a general consensus among most legislators, not just Republicans, that enticing business to your state is a good thing. And this seems to be a way to tell businesses, yeah, maybe we don't want you.

Kenen: The amount of business going into Texas is really atypically high and both ...

Rovner: Yeah, if you've been to Austin in the last five years, it's exploding.

Kenen: As California has gotten, rents have gotten unacceptable for businesses, a lot of tech and financial services are moving at least some of their businesses to Austin is booming. And other places in Texas, it's not only Austin. So it's changed the economic makeup of, and some of the demographics of, parts of Texas. But yeah, Julie, that was a really smart point. Yes, they want the businesses there. They've given them incentives. But there are also weird privacy issues with your employer paying for you to travel for an abortion. This whole world of abortion travel is a new world. I'm not quite sure how that plays out in the real world.

Pradhan: Right. I mean, I think people have rightfully pointed out that even if it's a gesture that, OK, these companies are making, it puts the onus on the employee to tell their employer that they need this very controversial ...

Rovner: Hey, I want to go get an abortion!

Pradhan: ... procedure that has a lot of stigma around it. And I imagine a lot of people are not going to be comfortable doing that.

Kenen: And then states are big purchasers of insurance. And there's also ways of using that leverage of what insurers cover, although it also conflicts with federal law. ... I think we all think that [this is] going to be an attack on emergency contraception, because the anti-abortion groups, many of them, regard that as a form of very early abortion, which the ACOG [American College of Obstetricians and Gynecologists] and other professional scientific organizations, medical organizations say it's not; it prevents pregnancy, it doesn't abort a pregnancy. But that's not the way it's perceived. And that's ... a separate topic for another week, but I think we all expect that to be a battleground fairly soon.

Rovner: All right. Well, we will come back to this, clearly, next week and in the weeks that follow. That's as much time as we have for the news this week. Now we will play my interview with Dr. Richard Baron of the American Board of Internal Medicine. Then we will come back and do our extra credits.

Rovner: We are pleased to welcome to the podcast Dr. Richard Baron, CEO of the American Board of Internal Medicine, which is the largest specialty organization for physicians in the U.S., certifying 1 in 4 American doctors who pass special exams and take continuing education in internal medicine and its more than 20 subspecialties. Dr. Baron is the co-author of a piece in the May 18 New England Journal of Medicine called "Physicians Spreading Misinformation on Social Media — Do Right and Wrong Answers Still Exist in Medicine?" Richard Baron, thank you so much for joining us on "What the Health?"

Richard Baron: Julie, it's great to be with you.

Rovner: So I want to get into this discussion of misinformation, but first, for our students and our lay listeners, can you briefly explain how specialty boards certify doctors and how that's different from state medical licensing?

Baron: Great question and very relevant. To practice medicine in the country, you have to get a license. And that's anchored in an old system where everybody was a GP [general practitioner] with one year of training. During the 20th century, people started to specialize and created very recognizable forms of doctors: surgeons, OB-GYNs, internists, pediatricians. Each one of those disciplines has a specialty certifying board. You have to be licensed, but you do additional training in that discipline. And the specialty certifying board administers an exam when training is finished and certifies a doctor as being ready for independent practice in the field. And then, over the course of career, it recertifies doctors by having them continue to demonstrate that they've stayed current in the field.

Rovner: So doctors spreading bad information about medicine is nothing new. It's basically what led to the establishment of medical boards in the first place, right?

Baron: Exactly. And medical boards were established to differentiate and distinguish doctors using an independent, third-party validation process. That's the key. It's not self-proclaimed expertise. It's not somebody saying, "I got this." It's a community creating an institution to validate and verify that the people have the skills they claim they have.

Rovner: And I was fascinated in reading the piece to talk about how these board exams come out, because it's really relevant to what's good information, what's true, and what's backed by science, and what's maybe just something somebody believes. I mean, that's key to this entire discussion, right?

Baron: It's absolutely key. And we all know that testing itself has been under major attack. And whether it's No Child Left Behind or any number of standardized testing, your listeners may know that MIT [the Massachusetts Institute of Technology], for instance, which abandoned standardized testing a couple of years ago, brought it back because they found their class was less diverse

without it. Standardized tests are a way — they definitely can have biases in them — but they're way to determine fairly what people know and don't know.

Rovner: And in determining ... what goes on your exams. I mean ... obviously there's a right answer, but it's hard to figure out what which ones should *not* be the right answers. Right? That's peculiar, I think, to medical knowledge, where it just keeps expanding.

Baron: That's so true. What we find in putting the exam together — and all of us have taken multiple-choice exams where we know we could pass them knowing nothing about the subject at all. You know, you take your driver's test and it says “If you see a school bus, you should a) accelerate b) run over a child c) go in reverse d) stop. And you don't need to know anything to know what the answer to that is. It turns out when you're crafting these questions, right answers isn't the hard part. The hard part is wrong answers. If it's going to be a single-choice, multiple-choice question, then the other answers have to be wrong, but they have to be plausible. And what we do at ABIM is gather experts in the field, both people who do research and people who do practice, and people who teach. And they sit around a table and somebody drafts a question and says, “Option C is wrong.” And somebody else says, “Well, I don't think so. I can bring out a credible, well-designed paper in a peer-reviewed journal where somebody could say, ‘That's a good choice.’” And we realized that that process of deciding that there were things that were really wrong could be used in the disciplinary process that we've had for a decade. Because for a decade we have and do revoke certification from doctors who behave in unprofessional and unethical ways. We've evolved policy over the last year that providing false information *is* unprofessional and unethical, and we have a process to determine when the information is really false. Not when it's on a spectrum, not when some people agree and some people don't, but when it's really false. And that's the process we're using.

Rovner: And ... is that being used now in disciplinary activities? What are you doing about doctors who are spreading what is demonstrably false information? Particularly about covid, because that's really what we're talking about right now.

Baron: Well, the process is ongoing. So, doctors get reported to ABIM all the time, and [the] staff does some investigation when we think we can learn something more that might be relevant. And then we have a process that gathers information and invites the doctor to tell their side of the story. It's a confidential process. The doctor gets a letter that says, “We've discovered X, this is what we found.” We have a policy that says why. And we really have evolved policy to be very clear now that providing false information is unprofessional and unethical. And the doctor is told the committee is going to meet, you have an opportunity to tell your side of the story. The doctor is also told if the committee recommends a sanction, the doctor has a right of appeal, including representation by counsel to a three-panel doctor — a panel of three doctors, including one director at ABIM. That decision is final as far as ABIM is concerned, but people can and do sue us. We've never lost a case. We still have one pending. But the courts in general have supported our right and indeed our obligation to defend our standards.

Rovner: Have you seen more cases, obviously, during the pandemic? Are we seeing a flood of things or is this just the typical number of cases you would see in general?

Baron: Well, as you said earlier, Julie, misinformation is not new with covid. We've seen it in cancer treatment. We've seen it in heart disease treatment. But there has certainly been more awareness in the profession that this is an issue. And as you said, this is what certifying boards were created for, but they were created 100 years ago. And I think many people, even in the profession, have lost sight of their reason for being. And there's been some groundswell in the profession over the last decade: Do we need these? Like, what good do they do? We can tell who the good doctors are. And in fact, some people have characterized what the boards do as it's just a money grab. It adds no value. But the reality is that it adds a ton of value by differentiating doctors, and institutions around the country rely on it. But also, as you said earlier, it's different from licensure. Give or take, 90% of licensed doctors in the country are certified in something, but 10% are not. And individual institutions make the decision about how they're going to use the certification credential. When I first went into practice, I was in the National Health Service Corps. The federal government paid for medical school for me. I was in rural Tennessee. There were no doctors more trained than internists. I had the full range of the ICU, CCU [critical care unit and] took care of critically ill patients. When I moved to Philadelphia to an academic health system, admitted my first patient with a heart attack, the nurses said, "You don't have admitting privileges in the CCU because you're not a board-certified cardiologist." So that credential gets used differently depending on the environment. But in general, where people can engage board-certified doctors, that's what they prefer to do.

Rovner: So one last question. Do we need to change how we educate medical professionals? I mean, most of today's doctors didn't grow up with viral social media and many of them [not] even with email. I mean, we've seen a difficulty in how doctors communicate with patients. It's no longer just when you're sitting across the desk or across the bed from someone.

Baron: Unquestionably, Julie, and my colleague Vinny [Vineet] Arora, who's at University of Chicago, and some of her colleagues wrote a piece in the New England Journal [of Medicine] a few weeks ago about the need to create an educational curriculum for medical students so that they are prepared to deal with misinformation, prepared to support each other as they deal with it. But you're absolutely right. The whole question of: Does it even count as medical practice if people are putting it on social media? Well, maybe, but certainly many patients seem to rely on it. And our view is that it's unprofessional to disseminate false information. And we're going to draw a line there.

Rovner: Well, we will obviously continue with this, Dr. Richard Baron — much more to think about here. Thank you so much for joining us.

Baron: A pleasure, Julie. Thanks for inviting me and thanks for creating such an excellent educational podcast.

Rovner: Thank you.

OK. We're back. And it's time for our extra-credit segment, where we each recommend a story we read this week we think you should read, too. Don't worry if you miss it; we will post the links on

the podcast page at khn.org and in our show notes on your phone or other mobile device. Anna, why don't you go first this week?

Edney: Sure. So mine is from ProPublica: "[The Plot to Keep Meatpacking Plants Open During COVID-19](#)." This is by Michael Grabell. So ProPublica has done an amazing job tracking this issue in general. And what these new documents show is just how Tyson [Foods] and Smithfield and major meat companies were able to influence the Trump administration to get an executive order to keep their plants open despite the health of their workers being at risk, clearly. And meatpacking plants being an early reason for spread in a lot of communities. Some of these documents are from a court case that was just filed, so I think there's been some discovery there. But some of the emails between the CEOs ... talking about wanting to stay open and then saying, well, maybe we should go to [President Donald] Trump or something. And then that actually unfolding. And I think it's really enlightening and enraging to read some of the comments from lobbyists and things and emails that they got about how if they could just get these pesky health officials out of the way, they could stay open and things like that. So ... it's really a great read. A lot of reminders in there about the work ProPublica has already done. Just something to think about.

Rovner: Yes. Thank you. Thank you to ProPublica for being out there doing this. Rachana.

Pradhan: So my extra credit is an [opinion piece in The Washington Post](#) about teens' mental health crisis, and the authors are writing that a major culprit is lack of sleep, and this is something that is immediately fixable, unlike many other things that might be causing mental health issues among teens. But yeah, sleep more. I couldn't believe some of the statistics they cite in here, as someone who loves sleep myself and needed quite a lot of it growing up. It's a great read. And again, it seems like it's a pretty easy solution to it.

Rovner: Yes. I mean, one of the obvious things, and we've talked about this so many times, it's like don't start high school at 7 o'clock in the morning!

Pradhan: Right. It's brutal.

Rovner: I mean, that is certainly not helping teenagers' mental health.

Kenen: You should have probably started at 4 o'clock in the afternoon!

Rovner: Probably should! That would probably be better. Joanne.

Kenen: I wanted to use a podcast, a five-part podcast by Brandy Zadrozny, who covers the misinformation-disinformation beat for NBC. And she did a podcast series called "[Needle In/Tiffany Dover Is Dead*](#)." Tiffany Dover is a nurse who is not dead. She did faint for completely ... she has a medical issue that she apparently faints a lot. She fainted after her coronavirus shot, on camera, and listen to the podcast to find out what happened next. Because it is an extraordinary saga, not only about misinformation, but how people are victimized by it and how you just can't shake ... I mean, this woman is alive, and people don't believe it. And yet ... it's really good.

Rovner: Yes. Just because you read it on the internet doesn't mean it's true. My extra credit this week is also a podcast. It's [an episode of a storytelling podcast called "Strangerville"](#). The story this

month is about a couple who paid thousands of dollars of their own money to get pregnant, only to have something go terribly wrong late in the pregnancy and be forced to make the sort of awful decision that no one wants to, and basically be thwarted at every step, rather than being given compassion and help. The story is told in excruciating detail. It's very hard to listen to, but it's a really important reminder that everyone's personal situation is different. People whose pregnancies end sadly and early deserve consideration and understanding. Whatever your view on abortion might be, it is definitely worth an hour of your time.

OK, that is our show for this week. As always, if you enjoy the podcast, you can subscribe wherever you get your podcasts. We'd appreciate it if you left us a review — that helps other people find us, too. Special thanks this week to our producer, Lydia Zuraw, filling in for Francis [Ying], who's taking some well-deserved time off. As always, you can email us your comments or questions. We're at whatthehealth — all one word — at kff.org. Or you can tweet me. I'm @jrovner. Joanne?

Kenen: @JoanneKenen

Rovner: Anna.

Edney: @annaedney

Rovner: Rachana.

Pradhan: @rachanadixit

Rovner: We will be back in your feed next week. Until then, be healthy.