I wanna welcome everyone to our Grand Rapids. I think this is the second or third that I've presided over in my very brief tenure at Yale so far. And today we're doing something a little different, a little different from most of the presentations that I've seen. And today's grand rounds grows out of or comes out of a book that Abby Glock at the law school, and Charlie Fuchs,
who you all know well as my predecessor. And who was here until just a matter of months ago?

A book that they put together called a new deal for cancer lessons from a 50 year war. And this book. Thank you Melinda. There’s this book as described to me when I was first asked to write a chapter. Is a book that isn’t necessarily meant purely for scientists or purely for clinicians, but as a book that’s meant for students and for doctors, and for other health care professionals, and for the lay public, and for really everyone to review where we’ve
come with cancer over the past 50 years?
Not so much where we’ve come scientifically, describing scientific progress
and exquisite detail, but more of a sociocultural.
Look at the evolution of cancer and our approach as a society to cancer and in truth some of the great progress we’ve made.
So there are many chapters in this wonderful book,
and we’ve put together a group of people today who have been involved with the book,
and we’ve asked each of them to come together and to speak for about 5 minutes. And then we’re going to have time for some questions at the end. So without further ado and I’m going to act as moderator and I will introduce each of the speakers. And our first speaker is well known to all of you Doctor Charles Fuchs, who was the former director of the Yale Cancer Center and Physician in Chief of Smilow Cancer Hospital. And is now the head of oncology and hematology.
NOTE Confidence: 0.94754502875
00:02:38.586 --> 00:02:40.104 global product development.
NOTE Confidence: 0.94754502875
00:02:40.110 --> 00:02:43.270 Charlie is an internationally
NOTE Confidence: 0.94754502875
00:02:43.270 --> 00:02:45.586 recognized GI oncologist.
NOTE Confidence: 0.94754502875
00:02:45.586 --> 00:02:48.638 Before coming to Yale,
NOTE Confidence: 0.94754502875
00:02:48.640 --> 00:02:53.545 this is now probably five to six years ago.
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00:02:53.550 --> 00:02:56.616 He was a professor at Harvard Medical
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00:02:56.616 --> 00:02:58.866 School and the chief of the GI
NOTE Confidence: 0.94754502875
00:02:58.866 --> 00:03:00.794 Oncology Division and the Robert E
NOTE Confidence: 0.94754502875
00:03:00.794 --> 00:03:03.442 and Judith B Hill Chair in pancreatic cancer.
NOTE Confidence: 0.94754502875
00:03:03.450 --> 00:03:04.893 At Dana Farber,
NOTE Confidence: 0.94754502875
00:03:04.893 --> 00:03:07.779 where he and I were colleagues
NOTE Confidence: 0.94754502875
00:03:07.779 --> 00:03:10.568 for approximately 19 years.
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00:03:10.570 --> 00:03:12.186 So Charlie,
NOTE Confidence: 0.94754502875
00:03:12.186 --> 00:03:14.610 without further ado,
NOTE Confidence: 0.94754502875
00:03:14.610 --> 00:03:15.925 maybe you could start us
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off with some comments.

Eric, thank you. And it’s so great to see you and everybody,

and I’m really so honored to be back at this wonderful forum and and I guess virtually at this amazing center.

You know, I my years at Yale, were just such a privilege interacting with so many talented people and the experiences were really transformative. For me,

but you know related to today’s forum, I think 1 Red Letter day came in the summer of 2017 when I first met Abby Gluck in my office at Smilow,
00:03:57.976 --> 00:04:01.318 let's do a conference between the law
00:04:01.318 --> 00:04:03.420 school smilow and the Cancer Center.
00:04:03.420 --> 00:04:06.709 And admittedly I it just didn’t
00:04:06.709 --> 00:04:07.756 seem to click.
00:04:07.756 --> 00:04:09.850 It seemed inconceivable that we could
00:04:09.918 --> 00:04:11.851 come up with such a venue, but.
00:04:11.851 --> 00:04:14.588 You know, really all of this is
00:04:14.588 --> 00:04:16.840 the product of Abby’s vision,
00:04:16.840 --> 00:04:18.712 her genius, and really,
00:04:18.712 --> 00:04:21.052 it’s she is the architect
00:04:21.052 --> 00:04:22.974 of this and you know,
00:04:22.974 --> 00:04:25.510 she sort of led me along this path
00:04:25.589 --> 00:04:27.899 to launch this joint conference,
00:04:27.900 --> 00:04:29.196 which, as many of you know,
00:04:29.200 --> 00:04:32.220 was an extraordinary van bringing
together leading figures in cancer care
NOTE Confidence: 0.903583793846154
research regulation policymaking and was,
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as Abby can attest,
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one of the leading cancer conferences.
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In Connecticut, and I think, uh,
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an important event in terms of
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an important event in terms of
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what we know about cancer.
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Following that,
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Abby, the innovator,
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really the the engine of all this
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suggested that we craft a book and
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what I think the end result was a
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constellation of amazing thought leaders,
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innovators many of whom from Yale and Smilow,
NOTE Confidence: 0.903583793846154
some of whom presenting today
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and one thing I think we wanted to do was to plan the book. To launch around the 50th anniversary of the National Cancer Act or as many of you know, the war on Cancer Act that Richard Nixon signed into law in December 1971, which is really where the phrase moon shot as it relates to cancer care and research emanated from with the idea that they would launch a NASA like program and would conquer cancer. By the 200th anniversary of the United States, that is five years later in 1976 and
ambitious perhaps unrealistic goal.

But bottom line is a lot of great things happened, you know?

And at the time the bill was signed, we spent $0.89 per person on Cancer Research in this country.

Now we spend $20 per person, you know we launched the NCI.

We saw a new opportunities for funding new programs for research, the revolution of therapies, targeted therapies, immuno oncology, new technologies and no less importantly the launching of careers of countless
talented individuals across the spectrum of what we do in cancer. And you know, among the advances were the fact that cancer mortality rates declined 29% really over the past 20 or 30 years. But you know what? We also learned where the gaps? Right that that the war on cancer wasn’t against a single enemy, and I don’t mean just single cancer ’cause we obviously know the cancer, or hundreds potentially thousands of subtypes, but many other things about the complicated way we fund cancer care.
You know how we use the payment on drugs and procedures to cover the costs of payout of care, nutrition, social work, clinical research that are largely under reimbursed?
The pressures of everyday practice in cancer medicine.
The paucity of resources provided to public health and prevention.
The challenges of supporting the next generation of researchers and providers.
The issues of HealthEquity.
The fact that R&D is extremely costly, redundant, and inefficient.
The fact that the landscape of regulate
00:07:46.299 --> 00:07:48.747 regulation is fragmented and costly,
00:07:48.750 --> 00:07:50.975 that our approach in government
00:07:50.975 --> 00:07:52.310 is highly fragmented.
00:07:52.310 --> 00:07:54.278 And our approach to how we
00:07:54.278 --> 00:07:56.578 leverage the vast data we collect
00:07:56.578 --> 00:07:58.410 is fragmented and inefficient.
00:07:58.410 --> 00:07:59.894 And you know, really,
00:07:59.894 --> 00:08:02.579 with Abby’s vision what we did
00:08:02.579 --> 00:08:04.889 with the authors is challenging not
00:08:04.889 --> 00:08:07.588 only to reflect on the past 50 years,
00:08:07.590 --> 00:08:10.326 but to really offer a vision for the future.
00:08:10.330 --> 00:08:12.472 And that was really the idea of
00:08:12.472 --> 00:08:14.956 a new deal for cancer that is
00:08:14.956 --> 00:08:17.188 not only to address the science,
00:08:17.190 --> 00:08:20.058 but a truly comprehensive effort to
tackle the full panoply of challenges.

To eradicate radical cancer and you’ll hear from the coauthors,

my colleagues and of course, Abby.

But you know, among the things that just I wanted to highlight was a really an extraordinary chapter from David Solid and colleagues about the advances in treatment, namely, targeted immune based therapies, but also the need going forward to come up with innovative clinical trial designs, regulatory flexibility, the ability to.
Really understands sensing resistance and also to address diversity and bringing all these innovations to the underserved.

At the same time, Charles Sawyers and colleagues talk about the vast data we now collect in clinical care and tumor sequencing. We’re sitting on a goldmine, but we’re so fragmented in that collection of data that we don’t have the ability to leverage that for true innovation and they offer. A lot of ideas and future reforms of how to reinvent data and privacy protections Tigard patients.
But to leverage these great datasets collectively to generate insights, Rich Shulsky and colleagues talk about. We created a lot of government infrastructure to build cancer care and research by virtue of the Act 50 years ago, but it’s so fragmented we don’t really harness all its power. So really is, as we say in the introduction, what’s needed now is to move to the next level in all hands on deck approach a new deal that reinvests, and last week we saw that is with the Biden moon shot.
and I think the book is so you know

is almost tailor made for what is

needed in the future and what obviously

Biden in the White House are trying to offer,

you know,

before I conclude I want to,

you know, thank you Gene Russon who.

Worked with Abby and me and

in creating the book,

really was tireless in his efforts.

I want to thank Abby,

who’s been an amazing partner and really

the visionary and architect of all this.

And then lastly,

I get the privilege of introducing.

17
I think the next speaker, who is a great friend and colleague and a great leader in cancer care and research who always has made himself available to me in times when I needed support for family members with cancer who was really an amazing mentor during my years at Harvard and who is now a great leader at Yale. I want to introduce the physician in chief of Smilow Cancer Hospital and the director of the Yale Cancer Center, Eric Weiner. Thanks Charlie. Then thanks thanks. Thanks for your comments. There may be a little overlap.
between your comments and mine.

I'm actually not the supposed to be the next speaker, so I'm going to move on.

And introduce our next speaker who is Carrie Gross and Kerry is a professor of medicine, public health and director of the National Clinical Scholars Program at Yale. He's the founding director of Yale’s Cancer Outcome, Public Policy and Effective Research Center, otherwise known as copper, and he has coauthored not one but two chapters in the book, a real hero from.
Like Charlie and Abby’s standpoint? And those chapters are are on pricing and also on the role play by state governments in shaping cancer policy.

I called up Kerry before I took this job because I wanted to know what was going on in terms of healthcare effectiveness research, and he very generously on his sabbatical spend time with me and reviewed all that was taking place. And there were just really rich interactions between copper and the Cancer Center.

So Kerry. All yours. Thank
you and yeah again, thank you Charlie

and Abby for the opportunity to.

Participate in the book and

by writing two chapters I I

get 2 free copies of the book,

so it’s well worth it.

So I’ll yeah try to keep my comments brief,

but I do want to touch on

both chapters briefly first,

the chapter looking at state

policy had the pleasure of

working with Doctor Deb Schrag,

also with Harvard roots on that end.

Well sorry, I’m having

a cat attacked me here.
Basically, if there was ever any doubt about the importance of states in public health, I think the last two years of the COVID epidemic has been raised that there's actually been a fourfold very variation. I just looked it up this morning and COVID mortality rates across states so that really underscores the importance of what states can do in the public health arena and that pertains to cancer as well. There's a 7070% variation across States and cancer mortality rate. So in Debs and my chapter we looked at some of the levers that states can employ to effect. Cancer incidence, cancer mortality and the patient experience,
and we live in a federalist society which really does allow states great.

Variation in how they use these levers to address cancer care,
cancer access, Cancer Research,
but it’s critical of to look at how states are doing this,
so Deb and I call for greater transparency,
greater accountability on the behalf of the federal government to maybe have some more carrots and sticks with to address and improve how states are on our tackling cancer.
The other chapter deals with the cost of cancer care and this I worked on with Zeke,
Emanuel and Stacey Juice had seen a. It was a lot of fun bringing our diverse viewpoints and here we talked about what I think about is a cancer cost trinfecta. You know, it’s a common question, how do we end up with a $200 billion system of cancer care in our country? And basically it’s too many cancers, too many treatments, too many dollars per treatment. Too many cancers.

First of all, we’re an aging population. Cancer is largely aging related disease, so we’re going to see more and more cancer as time goes by, but also to many cancers.
You know, tobacco still accounts for about a third of all new cancers. We've made tremendous progress in decreasing tobacco use, but we have a lot of people still developing preventable tumors from the tobacco front. We've also made tremendous progress on developing new modalities. To prevent cancer or detect or prevent cancer death over the past 50 years, I mean HPV vaccine. A variety of screening tests called naskapi, etc.
Those are underutilized, so too many cancers also gets at this issue of we’re not optimally using our screening, but also too many cancers deals with this issue of over screening and overdiagnosis, particularly for the older population. Getting screening tests when. People have very short life expectancy, for example, or overuse of screening that doesn’t have a really solid evidence base can lead to over detection of cancer that may not have caused a problem in the 1st place, so too many cancers, too many treatments.
We’re in a very aggressive society when it comes to treatment, so you know our System of reimbursement and finance at every step of the way is aligned in favor of maximizing the amount and intensity of treatment. So we if we reimburse very heavily on a fee for service basis, and that substantially contributes to some cases over use of a variety of cancer screening and treatment modalities. And if that’s over.
As far as over treatment are too many treatments and as far as too many dollars to how expensive are our treatments? Again, it’s not just our health system reimbursement that. Incentivizes the use of expensive treatments, but also our system of research. We are in our regulatory framework. The FDA has been lowering its bar for approval of new drugs over the past decade. In particular, where now the majority of drugs that are approved for clinical use by the FDA are approved by these alternate pathways such as the accelerated approval process. This doesn’t have as rigorous of a
bar for approval usually does not have things such as overall survival. And the challenges that we in the US increase. For many years have linked reimbursement with FDA approval, so it is usually just a reflex decision. By and by CMS to pay for. I’ll pay for drugs that are FDA approved even when it’s through one of these alternative pathways, so we have a lot of opportunity to make changes to decrease costs by hitting each angle of this trifecta by improving the regulatory process,
improving our screening and cancer
prevention approach,
and redesigning our health care system to decrease overuse in, in,
and improve, patient centeredness and equity.
I look forward to discussing further.
The matter of redesigning the whole healthcare system is of course a simple one.
But you know, we all wish that we could be the individual desire to do it,
but it is really something that we have to tackle it at some point soon.

So our next speaker is someone who I have known for many years collaborating
between my former institution and Yale.

And that is Melinda Irwin, who is the Susan Dwight Bliss professor of epidemiology and associate Dean of research at the Yale School of Public Health. She is also, thankfully, the associate director of Population Sciences in the Yale Cancer Center and in the core Grant and deputy Director for Public Health and the Yale Center for Clinical Investigation. And together with her Co author, she’s written an important chapter on the place of public health and
prevention in addressing cancer and
area that I think our health care system has been somewhat lacking it.
Melinda, please, thank you. Yes, I'd like to share with you a bit about our chapter, and I'd like to acknowledge my Co authors from the Yale School of Public Health, Abby Freedman, Nicole Diesel and Linden Nicolai. So our chapter focuses on four areas with really a focus on policy implication, so tobacco control, obesity, environmental carcinogens, and HPV vaccination. So I'm just going to share
a couple points with you. That we think are critical because many of these issues have been discussed and debated for decades yet how can we make further progress so we know that a third of all cancer cases are preventable and public health approaches to cancer prevention represent the most cost effective long term strategies for reducing the cancer burden. Yet, interestingly, the United States only directs less than 3% of its health care expenditures towards prevention.
Even though the return on investment from public health interventions is incredibly high, about 15 to one. So specifically regarding tobacco. For decades, tobacco use has been the leading cause of preventable mortality worldwide and is associated with 13 cancers and is responsible about a half a million deaths per year and about 50% of all cancer deaths in the US are attributable to smoking 50% of deaths.

What’s concerning? Those at higher burdens and lower socioeconomic status groups are driving substantial health disparities.
The good news? So is that over the past 20 years smoking rates have fallen from about 25% in the 1990s to currently around 14%. In much of this is due to tobacco control policies, so advertising restrictions, anti smoking campaigns, cigarette taxes, smoke free indoor air laws which was critical and then now most recently minimum tobacco sales age of 21. So these policy changes point to substantive reductions in tobacco.
but they have been uneven across populations. Fortunately, the Biden Moon shot initiative addresses cancer inequities and improving access to care including tobacco treatment, so that hopefully we’ll see continued improvements.

Our chapter also focuses on obesity. Recent reports estimate that obesity could overtake smoking as the primary modifiable cause of cancer mortality and what’s most concerning is as cancer mortality rates have dropped to by about 30% since the peak in the 1990s. During that time,
we’ve seen an increase in obesity rates, so there’s concern as whether the decrease in mortality will be attenuated because of the increase in obesity. Rates at present, 40% of US adults are defined as obese, a BMI of 30 or greater, and this is a sixfold increase in obesity prevalence since the 1970s. We know obesity is associated with 13 cancers and the incidence of 13 cancers in mortality from cancer for 14 different cancers and obesity also might be associated with worse adherence to adjuvant treatments.
As well as reduced cancer treatment efficacy, there are a number of lifestyle interventions that have been completed that have shown benefit of these on various cancer outcomes and currently there are a number of large scale trials of lifestyle interventions on disease free survival and when those findings are made public it’s hopeful that this will. Hopefully they’ll be positive and it will cause a shift in how we deliver lifestyle interventions. In the clinic of note though, what is really concerning is
Medicare currently reimburses for weight management services, not specific to cancer, but only 3% of patients who are eligible are referred for these weight management services. So I think the research that we need to do going forward is really the dissemination and implementation of these evidence based findings into the clinic and community so that we can improve referral rates as well as treatment.

I’m switching to environmental carcinogens. These have been identified for more than two centuries over 200 years and...
about 10% of instant cancer cases are caused by occupational chemical exposures.

However, certain racial and ethnic groups in lower socioeconomic populations experience higher exposures to known and suspected carcinogens, so we must improve and expand the monitoring.

Infrastructure for chemicals in our environment and harness the tremendous potential that we have with laboratory and informatics based tools and technologies.

Thankfully, the Buydens infrastructure will help in improving.

Delivering clean water and...
00:25:16.010 --> 00:25:18.630 cleaning up polluted sites.

00:25:18.630 --> 00:25:19.147 Lastly,

00:25:19.147 --> 00:25:22.249 our chapter focuses on HPV vaccination.

00:25:22.250 --> 00:25:24.014 Much of this work done by Linda

00:25:24.014 --> 00:25:25.799 Niccolai here at the School of Public

00:25:25.799 --> 00:25:27.570 Health and as many of you know,

00:25:27.570 --> 00:25:29.688 this vaccine helps to prevent six

00:25:29.688 --> 00:25:32.128 types of cancer in women and men.

00:25:32.130 --> 00:25:35.610 How and there’s three vaccines available,

00:25:35.610 --> 00:25:38.592 but our HPV vaccination coverage is

00:25:38.592 --> 00:25:41.935 a suboptimal in our population and

00:25:41.935 --> 00:25:45.095 there’s numerous reasons for this.

00:25:45.100 --> 00:25:47.627 The primary one might be vaccine hesitancy,

00:25:47.630 --> 00:25:49.250 which we’re learning a lot about

00:25:49.250 --> 00:25:50.235 now with COVID-19.
A key factor might be related to the lack of middle school entry requirements for HPV vaccination, yet schools have had vaccine requirements in the US since the 1800s and currently, even though this has been made for other vaccines for children, only three jurisdictions in the United States require HPV vaccination for school entry in contrast to 51 jurisdictions for T DAP. So there’s a lot of debate over how to do these school entry requirements as it infringes on individual freedoms and parents’ ability to choose for their children.
But I think there is significant room for improvement here, so the last inclosing the point I want to make is I. I was so incredibly impressed how colleagues, scientists and clinicians here at Yale pivoted. With COVID-19, with their research efforts and whatnot, and I believe that as a scientific community, we need to pivot and double down on efforts towards improving access to cancer care and fixing the structural and systems levels. Factors impeding equitable care. And if every one of us prioritizes
HealthEquity and cancer care, it’s likely I think that we could reach Biden’s goal of seeing a 50% reduction in cancer mortality rates over the next 25 years.

So I’m next and I wrote this chapter with Neil Merola colleague of many years who used to be the chief of hematology oncology at Case Western, and now works at Flatiron. And Neil and I have had some shared interests over the years, and we primarily focused on how cancer has changed for both
the doctor and the patient,
mostly thinking about the patient.
But but since the patient is affected
by the doctor and other clinicians,
that was part of this as well.
When we both started our
careers in the 1990s,
indicating that we are both somewhat old,
cancer was a little
different than it is today.
We still see occasionally patients who
don’t want to talk about having cancer
and who conceal diagnosis or simply can’t come forward with.

Seeking medical treatments, but that was much more common back 30 years ago and not surprisingly, both because of later diagnosis and because of less effective treatment, the outcome was worse.

Today there are 17 million cancer survivors, a pretty impressive number, both in terms of all those people who have survived cancer, but the fact that there’s just been so much cancer, and I think Kerry raised a very important point that there is in many
situations the over diagnosis of cancer, particularly in older individuals, and that has certainly increased that number and is another problem we need to address. But as Charlie pointed out, mortality has clearly decreased. Cancer hasn’t gone away, but I think most of us in the field see a time when it’ll be possible to say to a man or woman with cancer. That if they are able to access medical treatment and if they consent to medical treatment, that death is not something that should be part of a cancer diagnosis.
And the closer we get to making a cancer diagnosis like the diagnosis of a strep throat where you take an antibiotic and it gets better, of course the better it will be, the less it will be so greatly feared. Treatments have changed. They’re more targeted. Sometimes we think targeted means no toxicity. That’s certainly not the case. We still deal with very real toxicities and and immunotherapy, which of course has been the rave for the past five plus years, and which is clearly very effective.
and is very appealing because it harnesses one's own immune system to kill the cancer can also be very toxic, and we have. As we develop, new treatments need to pay close attention to the fact that we want treatments that are both effective and do not require patients to sacrifice a great deal to receive that treatment. The other day I focused a lot on the doctor patient relationship, but I’m going to expand that to talk about the clinician relationship because in
00:30:53.260 --> 00:30:57.159 2022 ruling not talking about just doctors,
NOTE Confidence: 0.851794742857143
00:30:57.160 --> 00:30:59.014 we’re talking about doctors and nurse
NOTE Confidence: 0.851794742857143
00:30:59.014 --> 00:31:00.668 practitioners and nurses and social
NOTE Confidence: 0.851794742857143
00:31:00.668 --> 00:31:03.023 workers and pharmacists, and it’s really
NOTE Confidence: 0.851794742857143
00:31:03.023 --> 00:31:05.549 a team approach that’s so critical.
NOTE Confidence: 0.851794742857143
00:31:05.550 --> 00:31:07.620 I do think that there is
NOTE Confidence: 0.851794742857143
00:31:07.620 --> 00:31:09.639 something very special about the
NOTE Confidence: 0.851794742857143
00:31:09.639 --> 00:31:11.349 clinician patient relationship,
NOTE Confidence: 0.851794742857143
00:31:11.350 --> 00:31:14.276 and I don’t think that that has
NOTE Confidence: 0.851794742857143
00:31:14.276 --> 00:31:16.389 necessarily changed so very much.
NOTE Confidence: 0.851794742857143
00:31:16.390 --> 00:31:18.466 And when a person has cancer,
NOTE Confidence: 0.851794742857143
00:31:18.470 --> 00:31:20.486 there is the opportunity for a
NOTE Confidence: 0.851794742857143
00:31:20.486 --> 00:31:23.150 clinician to walk in through a door into
NOTE Confidence: 0.851794742857143
00:31:23.150 --> 00:31:25.628 someone’s life and their families life.
NOTE Confidence: 0.851794742857143
00:31:25.630 --> 00:31:28.588 And it’s a very special moment,
NOTE Confidence: 0.851794742857143
00:31:28.590 --> 00:31:30.110 and I’ve always been.
I've always been moved by the fact that this is a time when you can have a huge impact, and if you choose to walk through that door, it's a rich experience both for you and for the patient. And I don't think that's changed. Shared decision making is much more common than it once was. I even think about decision making as similar to eating at a restaurant in a country where I don’t speak the language. So imagine that I don’t speak.
a word of French and Frances, like perhaps a particularly good example because they won’t probably try to explain anything to you, but if I go to that restaurant in France. I can just take whatever they give me, which is in my mind the paternalistic approach to cancer care. The doctor makes all the decisions. Alternatively I can say, well, give me whatever you would take yourself, which is perhaps a little bit better than than some other situations. But if I say that it’s not necessarily individualized for me, but what I really need is for the
00:32:48.961 --> 00:32:51.790 for the person serving me to say,

00:32:51.790 --> 00:32:54.350 what do you like to eat at home?

00:32:54.350 --> 00:32:58.178 And I’ll fix your menu appropriately

00:33:00.100 --> 00:33:01.772 And in my mind,

00:33:01.772 --> 00:33:03.862 that’s where that’s shared decision

00:33:03.862 --> 00:33:06.171 making and it’s matching my

00:33:06.171 --> 00:33:07.987 preferences with what’s available

00:33:07.987 --> 00:33:10.986 and that has become ever more common.

00:33:10.990 --> 00:33:14.826 But that takes more time for clinicians

00:33:14.830 --> 00:33:18.270 and it in many ways can add more

00:33:18.270 --> 00:33:21.278 stress to the clinicians life.

00:33:21.280 --> 00:33:22.628 Patients are more knowledgeable

00:33:22.628 --> 00:33:23.639 than ever before.

00:33:23.640 --> 00:33:26.342 The Internet is both a wonderful and
a hopelessly dangerous place to go.

When you have cancer, particularly if you have a little knowledge and physicians and other clinicians. Have these new stresses in dealing with patients coming in with many, sometimes with questions that they don’t feel that they can answer, and this I think is one of the factors that has led to the concern about burnout burnout with doctors and nurses and others.

But I think it’s something that we’ve seen particularly in the oncology space,
and it’s worrisome. And we have to think about how we’re going to get past this. I think one way is to make sure that we’re working with teams of people and not trying to do everything ourselves. And then I just want to touch on very quickly on 2 themes that have been brought up and one is cost and one is health care, disparities. And of course, they’re related. The cost issue is huge and it is just crazy what some of these new therapies and new procedures cost.
it makes no sense to maximize reimbursement from a drug so that you can provide palliative care. There needs to be appropriate reimbursement for each and every one of these therapies. And finally, I think health care disparities is going to become the biggest challenge we face because as our therapies get better and better, it becomes more and more of a travesty that people can’t get those therapies. And that’s true around the world and it’s true in New Haven, CT and it’s something that
desperately needs to be addressed.

So I think there’s a lot that needs to change in the future,

but I think that we can make progress if we keep remembering that the patient needs to be the center of clinical care the patient needs to be the center of research questions and at the same time we have to pay attention to the well being of those who are taking care of this patients.

So with that I’ll end.

Alright,

thank you and fine.

We have two more speakers and next is
Abby, who has been briefly introduced, but I’m going to do a somewhat longer introduction because unlike the rest of us, you don’t know her as well.

Professor Glock is the Alfred M. Rankin professor of law and founding faculty director of the Solomon Center for Health Law and Policy at Yale Law School. From November of 2020 to 2021, she served in the Biden administration.
as the lead lawyer for the White House.

COVID-19 response.

I would have been loved, loved to be there, watching her, that must have been incredible.

But first for the Biden Harris transition and then in the White House, special counsel for the White House.

COVID-19 response and that capacity.

Professor Gwac also served as a member of the White House Counsel’s office, where she was additionally responsible for health care issues and across the administration, including the Affordable Care Act.
She’s a member of the affiliated faculty of the Yale Program on Addiction Medicine, Executive Committee member of Yale’s ISP S Health program and founded and directs the Yale Law School Medical Legal Partnership Program. She joined Yale Law School in 2020 if I remember from looking her up on Google. She also went to Yale College and and was educated at Yale Law School. And before coming here was on the faculty at Columbia, so I’m going to ask Abby to just sort of fill in some of the gaps in the in terms of the chapters that we don’t have representation for.
And Abby, it’s really a pleasure to meet you and to have you on the panel. Doctor Weiner, thank you and it’s my pleasure, Richard, welcome you back and I look forward to many more collaborations. I joined the law school in 2012 at Doctor Weiner is, I think juxtaposed the numbers. So I’m sorry. What did I say? I want everybody to think I was hanging around for the last year as an interloper when I wasn’t actually part of the faculty. So I’ve been around for a decade.
But I did just come back last month, and where I had the privilege of working with my wonderful friend and colleague Marcelo Nunez. Smith worked with all of you.

As well and so thank you for the generous introduction. It’s wonderful to be here. It is wonderful to be part of this project and to work with all of you. You might have heard me saying in the beginning that the Cancer Center and ysm in general is my favorite client. My favorite partner.

I hope we have many more opportunities to collaborate,
so please come find me if you ever need a lawyer for anything. We are here for you. Working with Charlie has been just a dream come true and I count my lucky stars every day to have made a friend in Charlie to have learn from Charlie. And part of this project. So thank you, Charlie for everything. So, as Eric noted, I am the cleanup batter before Greg and I am just gonna fill in from some of the chapters that we wanted to mention to you.
that haven’t been talked about,
but actually my wonderful Co authors
did an incredible job hitting on a
lot of the high points of the book,
so I think I’ll be able to be very
brief ’cause I don’t want to bore you.
You know Charlie,
The scientific advances in the last 50 years,
so giving us the luxury of
being able to think more broadly
about these kinds of issues,
like equity like financing,
structure or like insurance
and now is the time.
And that is a role for lawyers and non
scientists to play in this cancer space.
Once you take a 360 degree approach,
there’s room for more people to
be involved in the progress.
So that’s where our book comes in.
And as I noted, a lot of you have
already talked about this broader land,
so I’ll just head on a few.
One thing I did when I hit
health insurance.
We have a great chapter from Robin.
Yeah, brown at ASCO and the. Her chapter is about the fact that health insurance is a significant predictor of cancer outcomes, while the Affordable Care Act did a great job on this front, including eliminating copays for many kinds of preventative screenings, and getting more than 20 million people newly insured, including on eliminating discrimination for more than 100 million Americans. We still have 12 states that haven’t expanded Medicaid, right?
And that is incredibly low hanging fruit for cancer progress that we have to do better on. The Biden plan has a plan to try to close that Medicaid gap, but it has to get through Congress and we really need to focus on that when we’re thinking about disparities and things that we can do quickly in the name of progress. Second equity. I’m so glad my colleagues have already talked about equity. It’s obviously incredibly important, just as universal health insurance wasn’t
00:40:47.355 --> 00:40:49.416 front and center on the radar in 1971,
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00:40:49.416 --> 00:40:50.696 and those conversations you know,
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00:40:50.700 --> 00:40:51.093 surprisingly,
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00:40:51.093 --> 00:40:53.451 equity wasn’t either a well known
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00:40:53.451 --> 00:40:55.816 report came out six months after
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00:40:55.816 --> 00:40:57.686 the National Cancer Act passed.
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00:40:57.690 --> 00:40:59.169 Highlighting egregious health
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00:40:59.169 --> 00:41:00.648 disparities and obviously,
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00:41:02.258 --> 00:41:03.948 healthcare equity in a way it
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00:41:03.948 --> 00:41:05.634 wasn’t has ever been shined before,
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00:41:05.640 --> 00:41:07.280 but that doesn’t mean that it wasn’t there.
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00:41:07.280 --> 00:41:08.736 And of course it has been there
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00:41:08.736 --> 00:41:10.150 in the cancer space all along,
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00:41:10.150 --> 00:41:10.831 and I’m very,
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00:41:10.831 --> 00:41:12.193 very proud that you know this
00:41:12.193 --> 00:41:13.833 project with the six years in the
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00:41:13.833 --> 00:41:15.011 making was thinking about equity
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00:41:15.011 --> 00:41:16.537 from the beginning and we have a
NOTE Confidence: 0.942884811428572
00:41:16.537 --> 00:41:18.324 couple of just fantastic chapters.
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00:41:18.324 --> 00:41:21.006 2 I want to highlight Otis Brawley,
NOTE Confidence: 0.942884811428572
00:41:21.006 --> 00:41:23.090 who had hoped to be here with us today,
NOTE Confidence: 0.942884811428572
00:41:23.090 --> 00:41:24.466 but it could not.
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00:41:24.466 --> 00:41:26.186 What a wonderful chapter detailing
NOTE Confidence: 0.942884811428572
00:41:26.186 --> 00:41:27.918 disparity is not just across race.
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00:41:27.920 --> 00:41:29.780 Put across genders, geography,
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00:41:29.780 --> 00:41:31.175 and socioeconomics centers,
NOTE Confidence: 0.942884811428572
00:41:31.180 --> 00:41:33.483 he cites a statistic that 30% of
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00:41:33.483 --> 00:41:34.775 Americans with college education
NOTE Confidence: 0.942884811428572
00:41:34.775 --> 00:41:37.147 have a lower death rate for cancer
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00:41:37.147 --> 00:41:38.897 than those without an interesting
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The fact that cancer outcomes he knows connections to Melinda’s chapter. The fact that cancers that we can prevent often hit low income populations and professions more than other professions, and he also points out a tragic irony of our progress, which is that in 1975, Black and white Americans had relatively equal death rates from breast and colorectal cancer, and why disparities have emerged and not been remedy.
And he points out that this is almost a failure of our progress because advances in screening diagnostics and treatment haven’t been made available to everybody equally. In a companion chapter by Blaise Polite and Lindsey Wiley, they talk about efforts in certain governments to actually address those very kinds of disparities. NYC and Delaware both had experiments and colorectal cancer aimed at increasing access to screening in a very aggressive way. Both of those cities states were able to close the gap in screening.
across race and in Delaware.

They were actually able to close the gap and incidents,

which is quite remarkable and shows what governments can do when they put their mind to it.

My own chapter with Rosa De Lauro, our own congresswoman here in Connecticut.

I’ve great supporter of the cancer space, so Doctor Reiner will no doubt get a lot of time with on his role details.

We detail the role that Congress has in this space.

Funding is obviously huge as a weapon, but also as a signifier of what’s important.
So I’m obsessed with the statistic that the entire budget of the CDC is basically the same as NCIS budget for cancer therapeutics, but that includes everything the CDC does, COVID prevention, non-cancer stuff. The cancer pieces $300 million of the $7 billion budget right? So that’s a signal of how unimportant Congress thinks prevention is. It’s also a signal how hard it is in the matter of budget scoring to enact prevention bills. I can talk about that more if people are interested.
but it’s the way Congress scores bills or the matter of the budget. D incentivizes investments in prevention in ways that are very unhelpful. Congress also has a role to play in speeding innovation in areas of R&D where there are many market failures like rare cancers, pediatric cancers. We have several chapters on that, and just as Charlie mentioned, as cancers become more individualized as we start to think of more cancers, the population for each of those cancers is going to get to be fewer and fewer, we’re going to have to find a way to
NOTE Confidence: 0.845357034666667
00:44:07.295 --> 00:44:09.220 compensate for market failures or in drugs,
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00:44:09.220 --> 00:44:11.515 or only go to effect a small amount of
NOTE Confidence: 0.845357034666667
00:44:11.515 --> 00:44:13.969 the population and not be as lucrative.
NOTE Confidence: 0.6204315
00:44:16.150 --> 00:44:18.180 Charles Sawyer chapter as Charlie mentioned,
NOTE Confidence: 0.6204315
00:44:18.180 --> 00:44:20.644 talks about need for hippo reform and the
NOTE Confidence: 0.6204315
00:44:20.644 --> 00:44:22.537 data privacy space to facilitate sharing
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00:44:22.537 --> 00:44:25.061 of genomic data so we can actually make
NOTE Confidence: 0.6204315
00:44:25.061 --> 00:44:27.329 progress in the data that we collect.
NOTE Confidence: 0.6204315
00:44:27.330 --> 00:44:28.188 And finally economics.
NOTE Confidence: 0.6204315
00:44:28.188 --> 00:44:30.190 My colleagues have already talked about this,
NOTE Confidence: 0.6204315
00:44:30.190 --> 00:44:31.910 so I’ll just briefly wind up with it
NOTE Confidence: 0.6204315
00:44:31.910 --> 00:44:33.894 to say that you know, the book talks
NOTE Confidence: 0.6204315
00:44:33.894 --> 00:44:35.502 about the landscape of cancer care,
NOTE Confidence: 0.6204315
00:44:35.510 --> 00:44:37.590 the shuttering of individual practices,
NOTE Confidence: 0.6204315
00:44:37.590 --> 00:44:39.075 the role that community hospitals
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75
play as both a local Cancer Center, but a network to a larger big cancer hospital like Yale. Some extra interventions are needed and Ed Vance is absolutely terrific. Chapter on cross subsidization in cancer care as both Doctor Weiner and Charlie both mentioned this idea that we subsidized research second opinions. Palliative care social supports with high priced therapeutics and diagnostics. If Congress is going to insist on cutting drug prices, as it must, it absolutely has to be aware of these connections across the whole cancer space. We're going to have unintended
ripple effects.
That are going to hurt those least fortunate and connecting all the dots this way is exactly what we hope to do with the book, and it’s been just a privilege to be part of it. So with that, let me just say thanks to Charlie. Again, express my enduring affection and 2nd his thanks to Eugene Rusyn, who’s just been a phenomenal support on the book. OK,
all right back to you. Thanks thanks thanks that was great.

So our last speaker is Greg Simon and he has held senior positions in both Chambers of Congress served in 2 presidential administrations was a senior strategy consultant to a variety of international technology CEOs co-founded with Michael Milliken and LED Fastercures co-founded and LED the Melanoma Melanoma Research Alliance and was the senior vice president, advisor for worldwide policy and patient engagement and the CEO Holy Wauka Financial Services company. Creating unique capital market
opportunities and indices in healthcare and life sciences, he’s developed a reputation as a visionary strategist. A dynamic public speaker and writer, and as an expert analyst of emerging trends in healthcare, information technology, innovative drug research and development and patient advocacy. Most recently and importantly, Greg was the President of the Biden Cancer Initiative and served as the executive director. Of the White House cancer Munshaw taskforce,
Greg Black, glad to have you here. Thanks for joining us.

Thank you so much, Eric. And thank you Abby for asking me to do this many years ago now.

It’s a real pleasure. I want to talk briefly about the chapter in the book, and I’ve been asked to talk more about what’s coming potentially in the cancer moonshots recently announced. The take away from what we did in the cancer Moon shot may surprise you, but I think we got more done in nine months than many people expected because we weren’t doing...
it all inside the government.

The reason we were able to get so much done, in my opinion, is because of the patient communities engagement.

If you I don’t know if I can share my screen. Am I able to share my screen? Let me try if you wonder why it’s difficult to track in the government. Let me give you an example. Nope, didn’t come up. Never mind, I’ll do it later if you want to have a good time go to the NCI website, look on the implementation of the Moon shot link and you will find the most overwhelming chart.
Of dots and arrows and squiggly lines that you will ever see.

I have no idea how well the NCI did in implementing the original cancer. Mention it is a little hard to tell if this is new or if this is just moving the boxes from traditional R 01 grants and relabeling them. That is the first challenge for the current moon shot is what did the government actually get done in a number of these technical programs? Overseen by literally 100 subcommittees, that’s the first challenge. How well did we actually do in
Because I can tell you from the standpoint of the patient community whether it’s financial toxicity, caregiver support, transportation, and help with the day-to-day expenses of being treated for cancer. All of those things were bubbled up from the patient community. Those efforts, including the first Cancer Center on an Indian Reservation and make the Navajo Nation Cancer Center staffed by an oncologist couple from here in Maryland, those efforts that were that
were engaged in cooperation,

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collaboration with the local

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communities where the greatest success

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stories of the Cancer Moon shot.

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And yes, we got $1.8 billion.

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And yes,

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there were 100 subcommittees at the NCI.

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And yes,

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the VA and the DOE all had wonderful

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programs that they did implement.

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But progress is never over and

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progress is never permanent.

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There is a real challenge today

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to move all of this forward.

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So where is the next moon shot going?

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Well,
I have to say if you’re talking to the patient communities, you get a very different story than if you’re talking to the cancer community. The traditional institutional cancer community asks one question, where’s the money? That’s the least important question in the future of cancer. Where’s the money, it’s where’s the ideas. And where are the people? I’d like to make a bold prediction about this. I have been working for the last year,
focused on AI based drug discovery

companies in the economy, and trying to bring some of them public.

I think we will have more progress in cancer treatment and outcomes from private entrepreneurial startups then we will from NCI investment over the next 10 years.

You can come back in 10 years if I'm still here. God willing and tell me I was wrong, but from what I see the questions that need to be asked the barriers that need to be broken, the inequities that need to be destroyed are happening faster in
the private sector and the public.

And as a public servant for many of my years on this planet,

and someone who believes deeply in public service that is troubling to me.

So what should we do?

Well, Biden starting off on the right foot, we can reduce age adjusted death rate.

That’s the critical phrase I have leukemia since I was 64.

If I’d had leukemia 20 years earlier, I wouldn’t be here.

So I’ve had a whole decade almost of

bonus years from what I would have had

if we hadn’t developed the first FDA
00:51:19.210 --> 00:51:21.260 breakthrough accelerated drug in Brewton,  
NOTE Confidence: 0.9666827925  
00:51:21.260 --> 00:51:23.115 which I’ve been on for two years,  
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00:51:23.120 --> 00:51:24.480 and I I picked it.  
NOTE Confidence: 0.9666827925  
00:51:24.480 --> 00:51:25.998 And I say this with great  
NOTE Confidence: 0.9666827925  
00:51:25.998 --> 00:51:27.460 humor because he’s a friend.  
NOTE Confidence: 0.9666827925  
00:51:27.460 --> 00:51:29.119 I’d made a decision a long time  
NOTE Confidence: 0.9666827925  
00:51:29.119 --> 00:51:30.700 ago to always take the other  
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00:51:30.700 --> 00:51:32.320 side of the argument from Zeke.  
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00:51:32.320 --> 00:51:34.889 Emanuel, I don’t think we need to  
NOTE Confidence: 0.9666827925  
00:51:34.889 --> 00:51:37.038 put 75 year olds on an ice floe,  
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00:51:37.040 --> 00:51:38.748 and I don’t think that just the  
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00:51:38.748 --> 00:51:40.699 price of the drugs is the problem.  
NOTE Confidence: 0.9666827925  
00:51:40.700 --> 00:51:43.028 The problem is who pays it,  
NOTE Confidence: 0.9666827925  
00:51:43.030 --> 00:51:45.289 and I was very happy to see in several  
NOTE Confidence: 0.9666827925  
00:51:45.289 --> 00:51:47.323 chapters we need to take Co pay burdens  
NOTE Confidence: 0.9666827925  
00:51:47.323 --> 00:51:49.115 off of patients for cancer treatments

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and other treatments that require you to be on a drug to save your life. We need to take the price of the drug outside of the people who can afford to pay and charging more for the people who can’t afford to pay and reverse that scenario. And in terms of how we’re going to do that and how the cancer Moon shot can do that. This is not necessarily a government solution I think, and I have been working on for many years, but private solution, you know, we spend $21 billion a year on migraines.
That's the same amount we spend on wheat. There is a massive futures market and derivative market for wheat that stabilizes prices that keeps bread from costing $10. A loaf that keeps farmers from going out of business when there's a bad year or too good of a year. We don't have that in healthcare, but we will soon and I'm hoping we'll see an immediate change in the problems that drive prices higher and higher and higher. Now the RPH program, which has been much ballyhooed by people like me for 10 years.
Is in grave danger because we have nobody who is currently leading the charge. The tragic resignation of Eric Lander after a series of bad incidents has left the movement in the White House somewhat leaderless, and I'm hoping that the Congress will take the reins, put it independently of the United H, and give it the mandate we all want it to have. Do wonderful hard things, and if you fail, it’s OK. Don’t do anything anybody else would do. That’s the mission for a DARPA like agency.
And as far as the moon shot goes, although everybody thought Eric Lander was going to run it, it's really always going to have been run by Daniel Carnival.

My deputy in the first man shot and the challenge for the current moon shot is how do we get people to stop talking about money and what's going to go into the cancer centers and the NCI and start talking about how are we going to engage with the innovators in the private sector and the patient groups who are being very innovative today to build a new Institution for Cancer Research.
that encompasses all of society, not just the campus here in Bethesda, that to me is the biggest challenge. It is time to rethink our institutions. We have had them the same way since Vannevar Bush’s contract, and that is not right. It is time to rejuvenate to redecorate and to bring younger people in. And it might as well say it. I wish we would give it an early out to everybody at NIH and NCI. Who’s over the age of 70. It is time to bring the next generation into the building,
but they can't get there for all the seats are taken so I know I've sort of expanded my time and maybe expanded my license, but I've work with this everyday.

One last point I found out yesterday two different people I know have cancer. One of them found out from a text. That was sent by an AI engine because his medical report showed he had metastatic colon cancer. He's a cancer doctor. He was shocked that he could get a text without a human being attached to it to tell him that. Another young woman in her 30s was diagnosed

00:55:13.470 --> 00:55:15.285 They didn’t give her any


00:55:17.054 --> 00:55:19.680 She called me and I had to do.

00:55:19.680 --> 00:55:21.220 Both of these are wrong.

00:55:21.220 --> 00:55:22.935 Both of these have to be fixed.

00:55:22.940 --> 00:55:25.028 We have got to provide people

00:55:25.028 --> 00:55:27.160 and environment to deal with the

00:55:27.160 --> 00:55:29.170 cancer diagnosis that does not put

00:55:29.170 --> 00:55:31.918 them on the on the on the spot

00:55:31.918 --> 00:55:33.258 to do everything themselves.

00:55:33.260 --> 00:55:35.320 Whether you’re a cancer doctor

00:55:35.320 --> 00:55:37.040 or a mother in their 30s,

00:55:37.040 --> 00:55:38.936 we must do a better job.

00:55:38.940 --> 00:55:40.949 And in 2022 I would have hoped
we would have done it by now.

But with your help and all the people who wrote chapters in the book, we can get there. But we have to be very honest about what the problems are today.

Thank you.

I think we might have time for one or two questions Max, so I guess I'm supposed to look in the chat, but I don't know that I see any Renee.

There was one question Eric, about their fear about moving too fast on cancer progress because it will feel politicized like the COVID vaccine.
I don’t know if Greg you want to take that or somebody else.

I already responded to that text in the chat and said no and no.

I don’t think the public is generally aware of the time it takes to develop new cancer cures.

And when things happen fast in cancer,

it’s still slow in the real world.

in terms of politicizing cancer,
I have never in all my speeches where I’m pretty obviously my politics are pretty clear. I have never had anybody accused me of having a democratic view of cancer, so I think this is 1 Safe Harbor that we can all work on together. Yeah, I don’t think people would accuse you of not being clear about your thoughts. We appreciate it. You know, I think that the the theme of disparities has come up over and over again. I think it’s really an important take away from this and I’m just going to reiterate what I said before. I think that both in terms of clinical
care and in terms of research, if you put the patient in the center and and reformulate everything around that concept, I think we would. We would do ever so much better. In terms of clinical care, Greg, you brought that up and you did. In terms of research as well, I devoted the epilogue of my chapter in the book to exactly this point, and. it’s it’s really key. I devoted the epilogue of my chapter I devoted the epilogue of my chapter I devoted the epilogue of my chapter I devoted the epilogue of my chapter. I thought we had made a lot more progress than we had in racial and equity and as a cancer patient,
and I realize how fortunate I have been. 
I really understand now how little progress we've made. 
It is the most important thing we can do. 
One small example, the head of the national Minority Quality Forum, was told by CMS that he could not have access to all the Medicare data like other people can. Only 20% of it and he told them I can’t do a study of racial inequities on 20% of Medicare. It won’t show up because it’s so small in that sample. So my friends and I raced into action to give him access to all
00:58:45.596 --> 00:58:47.498 of the Medicare data other ways,

NOTE Confidence: 0.858143807142857

00:58:47.500 --> 00:58:50.685 but this is an example of unthinking discrimination of unintended discrimination that has the effect of discrimination.

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00:58:50.685 --> 00:58:52.656 Thanks Charlie, I just wanna give you a chance to sort of wrap up.

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00:58:52.656 --> 00:58:55.836 Thanks Charlie, I just wanna give you a chance to sort of wrap up.

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00:59:02.120 --> 00:59:04.550 Eric, I really appreciate you giving us the opportunity to share the book and thanks to the authors.

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00:59:04.550 --> 00:59:06.960 or have been texting me during the session.

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I’ve been paying close attention, by the way, but it’s still great to connect and Eric, I just want to say how fortunate.
Yeah, and smile OR to have you as a leader. So looking forward to great things from you and all the amazing people at the institutions.
We all just do our best well listen, thank you all.
It was really great today. I think this was again as I said in the beginning, something a little different and I hope people enjoyed it.
And thanks to the audience for spending the time with us.
00:59:58.630 --> 00:59:59.100 Bye bye.

01:00:04.780 --> 01:00:04.999 Eric, thanks so.