I'm Barry Weiss. This is Honestly. And today, we're diving deep into the biggest and maybe the most contentious drug on the market right now, Osempic.
Osempic is proven to lower A1C. Most people who took Osempic reached an A1C under seven and maintained it. And you may lose weight. Adults lost on average up to 12 pounds.
Osempic is the brand name for a medication called semaglutide. And while it was developed and has been used for years to treat type 2 diabetes, we're going to get back in your type 2 diabetes zone. Ask your health care provider today about once weekly Osempic.
The injectable drug has boomed in popularity of late for its off-label use to help people lose weight fast. I just start dropping pounds left and right. Like really fast.
These days, it's the talk of TikTok. The topic Osempic has over 300 million views.
And predictably, Americans across the country are eager to get their hands on it.
Some doctors, like Nancy Ranama, say they've been flooded with inquiries.
It's become something very hot and heavy in Los Angeles, Beverly Hills.
As one doctor said, we haven't seen a prescription drug with this much cocktail and dinner chatter since Viagra came to the market. It's a miracle. It's too good to be true. You can just make people who've struggled with their weight, their entire lives thin. It's a miracle.
Celebrities and public figures ranging from Chelsea Handler. I've injected about four or five of my friends with Osempic. Can you believe the amount of people in L.A. that are using that **** Osempic? My doctor, my anti-aging doctor, just hands it out to anybody.
To Elon Musk, have admitted that they are taking it. Instagram influencers are showing off stunning before-and-after photos. Other women are taking to TikTok in droves, touting their Osempic weight loss stories. This lady says she lost 20 pounds. And look at this woman's remarkable transformation. All of which has caused there to be an actual run on the drug in cities like Los Angeles. Inecrescent demand for a type 2 diabetes drug has made it harder for diabetics to get their hands on it, all thanks to social media, hyping an unintended side effect, weight loss. And there are a lot of questions, both safety questions and bigger ethical questions, that Osempic has brought to the forefront. For one, who should be taking this drug? Osempic has only been approved for diabetes. And while Wigowi, another brand name for the drug that's currently on the market, has been approved to treat obesity, there's a big distinction between people in the 95th percentile of weight using it and celebrities who are 130 pounds and want to get to 110 to fit in their dress for the Met Gala. Which leads us to a second question. Is it safe? And who is it safe for?
The American Academy of Pediatrics has released new guidelines on treating childhood obesity, the first in 15 years. It recommended pediatricians should evaluate and treat obesity. Last month, the American Academy of Pediatrics released new guidelines for treating childhood obesity.
The guidelines also suggest more drastic interventions for the first time, including offering weight loss medications to kids 12 or older and considering bariatric surgery for teens 13 or older.
And among other things, they now recommend anti-obesity medications like Osempic for children as young as 12 years old. But what are the implications and long-term side effects of putting a child on this kind of medication, a medication that really hasn't been studied very much in children at all? And finally, all of these concerns lead to a bigger set of questions, deeper questions that hover over every conversation and cultural debate about obesity. Is this new drug just a band-aid, another quick fix, or is it a permanent solution to this national epidemic? Does Osempic actually address the root causes of obesity, which

begs the really big question? What is the root cause of obesity?
The number one cause of obesity is genetics. That means if you are born to parents that have obesity, you have a 50 to 85% likelihood of having the disease yourself, even with optimal diet, exercise, sleep management. Last month, 60 Minutes ran a story with a Harvard doctor named Fatima Cody-Stanford. She's one of the most highly cited scientists in the field of obesity. And she claimed on 60 Minutes that obesity is a brain disease and that the number one cause of obesity is genetics.
It's a brain disease. It is. It's a brain disease. And the brain tells us how much to eat and how much to store. So will power throw that out the window? My last patient that I saw today was a young woman who's 39, who struggles with severe obesity. She's been working out five to six times a week. Consistently, she's eating very little. Her brain is defending a certain set. Now, mind you, Dr. Stanford is a paid consultant of the drug company that happens to make Osempic and Wagovie. The thing is, it's not just this one doctor. She's one of many medical leaders in America now pushing a new consensus about the underlying cause of obesity. It's not really about willpower. It's not really about personal responsibility. It's not about calorie intake or exercise or healthy lifestyle choices. It's now conceived as an illness. And like other illnesses were afflicted with, the solution is medication. Now, my guests today don't all agree with that. And they're here today to debate these very complicated and important questions. Dr. Chika Anekwe is an obesity medicine physician at Massachusetts General Hospital and an instructor in medicine at Harvard Medical School. Dr. Vinay Prasad is a hematologist, oncologist, and a professor at the University of California, San Francisco. His most recent book is Malignant, How Bad Policy and Bad Evidence Harm People with Cancer. And lastly, Callie Means is a former consultant for food and pharma companies who now works to expose their practices and to incentivize healthy food as the foundation of health policy. As you're about to hear, today's conversation gets really heated at times. And I want to say off the bat, as perhaps is unsurprising, I don't fully agree with any one of my guests. At times, I'm sympathetic to each of their individual arguments. But the reason I brought them here is that I think this debate is really important and I see value in hearing all sides of this conversation. We'll be right back.

words, companies aren't just selling products anymore. They're selling you. To protect your identity and data, check out ExpressVPN. Think about all the websites you visit, Facebook, Twitter, Google, the Daily Mail, Drudge Report, 55 times a day. You probably want to keep that private. That's where ExpressVPN comes in. ExpressVPN makes you anonymous online by camouflaging your IP address and replacing it with the different secure IP of your choice. ExpressVPN also encrypts all of your data so that it's protected from hackers and anyone else trying to spy on you. If you're like me and believe your internet data belongs to you, protect your data with the number one rated VPN provider today. Visit expressvpn.com slash Barry to get three months free on a one-year package. That's ex-p-r-e-s-s-v-p-n dot com slash Barry.

Let's start with the basics here. A lot of people have heard of Ozympic, but they don't know how it works. What is this drug? How does it actually work? How does it help people lose weight? Chika, let's start with you.

Sure. Ozympic, or also known as semaglotide, is what's known as a GLP1 agonist, which stands for glucagon-like peptide 1 agonist. This medication is based off of a hormone that's naturally produced in the GI tract, and it's normally produced after meals. It helps you feel full, but the naturally occurring hormone only lasts on the order of minutes, but the medication version of it is more stable and lasts much longer, and so it keeps you fuller. Basically how it works is it slows down how quickly food exits out of the stomach, making you feel fuller for longer, and decreasing the amount that you're able to eat. People realize they're just not as hungry as they were previously. Their portions are smaller, but they're not having to impose a self-restriction or feel hungry in order to achieve that. It affects our dramatic. People say things like it turns off the brain chatter. It just takes food off of people's minds, and so you can live your life without thinking about food.

It's almost a dozen other FDA-approved anti-obesity medications right now on the market in America.

How is this drug different from what's currently offered?

Its efficacy is just much greater, and so we've been using what we call anti-obesity medications for decades. Some have varying levels of success and varying levels of efficacy, and some cause, well, they all cause side effects of their own, just because each medication has a potential to do that, but the amount of weight loss that you can see with the injectables, semaglotide in particular, is just way beyond what other medications have been able to achieve. The trial results with semaglotide showed the average weight loss was about 15% body weight compared to some of the other oral medications, which showed maybe like three to five. At the most, I'd say maybe 7% body weight reduction.

Okay, real briefly, what are the side effects for this drug? Because we've heard everything from horrible nausea to the New York Times ran a piece about how it makes you look really old. What's real? What isn't real? I think the common sensical approach that I feel is if something is this effective, if you're making this deal with the devil, there's got to be something really bad at the other end of it. What are the side effects that we know about, and what are the side effects that are open questions?

The GI side effects take the cake for sure. Nausea is the most common, and that makes sense when you think about how the medication works. When you feel really full, sometimes that can really just make you feel nauseous in and of itself. That's the number one side

effect. Then it ranges from constipation for some people to diarrhea for others, maybe a sense of dyspepsia or stomach upset, heartburn type of sensation. A lot of these effects are actually also related to what you're eating. If you try to eat above and beyond what your body's telling you, you tend to get worse effects. Similarly, if you eat high fat or high sugar foods, it tends to worsen these side effects.

As for the aging side effect, that's not something I'd actually seen before that New York Times article came out. I suspect it's really just a result of the loss of fat from the face, the sagging skin that you get when you lose weight, no matter what the mechanism. Maybe because it's occurring much more quickly than people are used to it happening, it might be more dramatic.

Beyond nausea and diarrhea and maybe having especially accentuated cheekbones, am I right in my intuition, Callie, that this is too good to be true?

Yeah. Up until this point, I'm in agreement with Dr. Neckway. I just want to back up just to what this drug does. I'm in agreement, as she said, it makes you eat less food and it really has the patient take the mind off of food. As Dr. Neckway and her colleagues at Harvard have recently written, they actually recently wrote, quote, if you have obesity, remember it is a disease, not the result of choice or lifestyle. I agree this is what the drug does. It makes you eat less. What I'm concerned about is the misdiagnosis of obesity as the disease to be treated and not a symptom of underlying metabolic dysfunction. What's happening in society at large is that eight of the 10 leading causes of death are food-related conditions. Obesity is not really the cause or really the disease to be treated. It's a symptom. It's the same branch of the diabetes, cancer, kidney disease, autoimmune conditions, these things we're seeing exploding. I just want you to envision. It's actually being promoted for much more than the 95th percentile. Actually, what the guidance is saying is that for overweight children even, much, much larger percentage that have had failed dietary interventions and everyone would attest to that, that the drug should be prescribed and paid for by taxpayers. It's much, much larger than the upper 5%. I just want you to imagine a child, this is what concerns me about the drug, is that if you have a child and they're eating inflammatory food, they're eating processed food and you go into the Harvard, you go into Dr. Neckwitz Clinic and they say, this is a disease. We're going to treat you. By the way, this is a treatment for life. That child is actually almost being instructed that diet doesn't matter. They're going to lose weight, but they're continuing to feed their cells with processed food. The reason we're getting sick, the reason life expectancy is going down is because we're feeding our cells with processed food. Actually, this is a moral hazard. It's actually not attacking the problem. The weight is a symptom. That child getting ozympic is basically being told to not worry about their diet. It's being told to continue eating inflammatory food. On the side effects, I think we've kind of glossed over that, yes, it's mass gastrointestinal issues. Ozympic essentially is gastrointestinal issues. That's what the drug does. It basically is gastrointestinal metabolic dysfunction, which makes you less hungry. That's what the drug is. I just want to put a quick point about the gastrointestinal dysfunction. 95% of the serotonin in our body, which regulates our contentment, which regulates our outlook on the world, that's not producing the brain, that's producing the gut. You're also seeing an increase in depression on semi-glutide. That's very predictable because any gastrointestinal issue is generally associated with depression

because that's where the serotonin is made. We're absolutely, I think, Dr., you probably agree with this. We're going to see an increase in depression and potentially suicide among teens as we mass prescribe this drug because it's literally acting on the center in ways we I don't think fully understand. Another side effect, you could call this a side effect, is that the instructions, correct me if I'm wrong, that you're not supposed to go off of this drug. There's big metabolic problems. I think that we don't even know what the causes are if someone goes off this drug. The diabetes patients are instructed to be on it for life. If a 12-year-old, which these are being pushed on now, goes on this drug, correct me if I'm wrong, the guidance, the standard of care is that they don't go off of it.

Kelly, there's a tremendous amount in there, including the new AAP guidelines, which you're referencing, which recommend this for 12-year-olds and even gastric bypass for kids 13 years old and over. You mentioned the question, which to me is the most interesting question in this conversation. Is obesity the result of genetics and a kind of disease? Is it the result of personal responsibility and willpower? Then also, it's something that I hadn't really known, which I want to get to now too, which is the question of serotonin and its location in the gut and not the brain, which is news to me. I want to get there. I'd like to stay just for one more second if we could on the drug itself, because I think there's a tremendous amount of noise around it. I just want to get super clear on what it does and what it's actually approved for.

My glutathode was only approved by the FDA about five years ago in 2017. My understanding is that it hasn't actually been tested for the way many people are using it, which is weight loss. It seems like we've seen this movie play out before. You think about Oletstra in the 1990s, this fat-free additive that turned out to cause, among other things, poor absorption of essential vitamins and caused abdominal issues, or even more recently, the FDA had to remove lorcazarin. I hope I'm pronouncing that correctly from the market because of an increase in cancer risk. My point is this. It doesn't seem like there has ever been in American history, in human history, a miracle weight loss drug without unintended or harmful side effects. Do you believe, Chica, Vinay, that this is going to be different?

What we have for long-term data so far for the GLP1 agonists is that they have shown a decreased risk in cardiovascular outcomes, including stroke, heart attack, both fatal and nonfatal stroke and heart attacks. In terms of the serotonin piece, yeah, I think there's definitely more work to be done in terms of truly elucidating the long-term effects. There hasn't been so far reported an increased risk of suicidality or suicidal ideation, and it's not something that I've seen in my practice either. There's a difference between the expression of some of these hormones and the actual long-term effects of what they're actually producing or what the outcomes are in terms of behavior. I think counseling goes a long way in terms of giving people the information that there's a potential for these outcomes and monitoring. Just as you would with any treatment option, there's always risks and benefits. As you said, weight loss is a symptom as opposed to as the disease being treated. That can be, I think, something we can address further. We know that there are risks associated with being at an excess body weight, metabolic risks, and risks of other comorbid conditions developing. If you're mitigating one risk and potentially increasing another, it's up to that discussion between the patient and the doctor to decide if it's worth it

to pursue that. That's something that you can discuss with the patient, the parents, if that's the age set that you're looking at in order to really determine what's the best approach for that patient. The idea that the risk of suicidal ideation or depression or anxiety would be worse on this drug than it would be just from being horribly overweight, that is deeply counterintuitive to me. It seems that a person or a patient would tend to be very depressed if they are morbidly obese and that perhaps Kali, you're right about the serotonin being in the gut and we're fucking with that, but that the risks of suicidal ideation, anxiety, and depression would be so much worse remaining morbidly obese.

Barry, the rise in depression, the reason I think you can tie 25% of teenagers now reporting that they contemplated suicide during COVID and the fact that 25% of the American people are now in a mental health condition, this is correlated with not with obesity, but metabolic dysfunction. Metabolic dysfunction is cellular dysfunction and 20% of our energy is created in the brain. I think you're actually really actually going down a dangerous territory here for us to think and for the medical community to tell us that obesity is the reason that we're depressed.

That we're depressed, a huge contributor is that diabetes, metabolic dysfunction, that literally is dysregulation in our brain and that is a key root cause. Just taking a symptom of obesity when there's still metabolic dysfunction happening in that child when 15% of children still have fatty liver disease, where there's depression, huge problem, that's not obesity related, it's metabolic dysfunction related and thinking we're actually solving one of the symptoms and taking it off our plate, that's actually very dangerous. We've got to understand and identify that if you have prediabetes or diabetes, you are much, much more likely, whether you're obese or not, to have depression and suicidal ideation because literally that means that the cells in your brains are malfunctioning. That is the problem in this country right now and we really need to, I think, be clear and we're obfuscating, I think, that point with this pinning obesity as the problem in and of itself.

Vinay, I think you wanted to jump in with something.

I want to talk about the suicidality in a second, but I just want to draw a distinction upfront. I mean, these drugs, semi-glutide and the GLP, one agonist were originally developed as a diabetes drug and they work really well there. They have weight loss, they improve A1C, which is the sugar in the bloodstream, and they even lower cardiovascular events as the doctor was pointing out. I think doctors have a lot of comfort in prescribing these drugs for somebody with type 2 diabetes who may also be overweight. I think the question is, what do we know about these drugs if you take it at the age of 12 and take it 10 years or 20 years? I think we have to acknowledge there's a lot we don't know about what side effects may occur with 10 or 20 years of use.

As for the suicidality, I think we should point out, Wigovie, the FDA package insert, does say to monitor for suicidality, it's based on very thin data. We've just had a few suicidality events. Maybe it looked as if it was slightly worse on the Wigovie arm than placebo arm in the study in adolescence. I think you got to take that with a grain of salt. I wouldn't conclude that it increases suicidality just yet, but I do think providers would have to be vigilant about that. I do think there are lots of things that contribute to teenage depression. I don't think we're going to be able to get to the bottom of that

here. Obesity may be a factor. Changes from pandemic may be a factor. So many things. That's a broad question.
When Wigovie was approved by the FDA in the summer of 2021, there was a flurry of media attention around what seemed to be its almost miraculous results. One doctor declared it in the New York Times a game changer, though he was a paid advisor to Novo Nordics, the drug company that makes the drug. The BBC ran a story saying that this drug marked a new era in treating obesity. My question is this. Is Osempic a long game approach to weight loss, a long-term approach to weight loss, or is it just a short-sighted quick fix that appeals to our Amazon Prime culture that's not going to actually do much ultimately once you get off the drug to keep the weight off and address the root causes of obesity? Kelly, let's start with you.
Well, healthcare is now the largest and the fastest growing industry in the United States. When I come from tech, we're usually innovations, lower costs, and better outcomes. Healthcare is the faster it grows, the worse outcomes we get. And this is another example with the biggest problem in healthcare, which is that everyone's getting sick primarily because of food, and then we have these band-aid cures. Once people get sick, that's how the healthcare system makes money. So I think it is important, as you alluded to, to go into the... Just I think you follow the money and you go into the raw financial conflicts of interest. So this isn't personal, but I think it's very important to put on the table. As you mentioned, the parent company of Ozympic has paid $30 million a year, 420,000 individual payments, almost covering the whole obesity field. Dr. Neckway is one of those doctors has been directly paid by Nova Nordic. Her colleague, Dr. Fatima Stamford recently went on 60 Minutes and said, obesity can't be treated with exercise or food. She's been directly paid and 60 Minutes is heavily paid by pharma. So we really do have these rigged institutions of trust, rec payments to the doctors, direct payments to the medical organizations, huge, it's the number one, pharma is the number one payment of media in this country. And there has been a full-corp press. And that's not even the biggest conflict. The biggest problem is that on the Harvard website, the obesity clinic, Dr. Neckway's office, it says, quote, we're experts in surgical medical treatments for obesity. Nothing about food, nothing about healthy lifestyles. It is a direct solicitation of medical interventions. That is how the medical system, that is how 95% of dollars in the medical system work. It is interventions on people that are already sick, okay? And a patient who comes in the clinic, learns healthy habits, loses weight, leaves, that's not a profitable patient. What we have to understand about Ozympic is that this is a lifetime customer, a 13-year-old, and let's be very clear, this is being recommended for a wide percentage of teenagers, because close to 50% of teenagers are overweight or obese. A teenager comes in and has the patient-doctor conversation as Dr. Neckway alluded to, where that's obviously, it's directly soliciting on the website that there's gonna be a medical intervention. That is a lifetime patient. That patient is required or also suffers severe metabolic issues to have this treatment for life instead of learning healthy habits, when I think we all agree that we're being brought to our knees as a society with health due to metabolic conditions tied to food. So that child is not learning healthy habits, they're getting a lifetime intervention. And these conflicts have led, you know, Dr. Neckway and her colleagues are not talking about soda being the number one item on food stamps. They're not talking about 95% of the nutritional

guideline committee having a conflict with food companies. They're not talking about the fact that Harvard Medical School to this day does not require doctors to take one nutrition course. They're not talking about the fact that we subsidize fructose and grains that go into processed food billions of dollars. No, Dr. Neckway is writing blog posts about how keto gives you bad breath, so you shouldn't follow that diet. She's saying obesity is not due to choice or lifestyle. These incentives, the incentives of Ozympic, which we're all being told is going to be the most profitable and highest selling drug in American history are extremely problematic. And I think they're blinding us from what the real problem is, which is that we're feeding our children horrible food. And that's causing a host of issues.
Okay, Chika, I'd love for you to respond to that. Obviously, before we invited you on, we looked and we saw, I think you have received a several hundred dollars from NOVO, which hardly makes it seem like you were a paid up representative from a drug company. So I would love for you to respond to what Callie just put out there.
Yeah, there's several things I like to respond to. Thank you. So I'm not a paid consultant by any means of NOVO Nordus.
You haven't received money from the drug company?
I have not received a dime from the drug company. I have attended sponsored educational presentations
and the payments that are recorded for those are in the form of a meal provided at the evening events. So as you said, maybe that's a couple of hundred dollars over a year, a couple. I don't even know the numbers because I don't get a paycheck for that. So that's one thing. And actually, we are not allowed to be solicited by the NOVO Nordus representatives at Massachusetts General Hospital. We don't even accept samples of the medications from these drug companies. And so, you know, I don't know what numbers it is that you're saying that you're looking at that are telling you that I'm a paid, any sort of paid consultant or individual.
Your colleague, Dr. Fatima Stanford, who went on 16 minutes, has been paid tens of thousands of dollars.
I'm not Dr. Fatima Cody Stanford. So yes, maybe that is true, but that's not me. So we can maybe leave that to the side. In terms of nutrition education, I am actually a physician nutrition specialized physician certified by the National Board of Physician Nutrition Specialists. So I personally have many hours of nutritional education. My primary specialty is actually preventive medicine and public health. And so when you kind of talk about wanting to take care of sick patients versus prevent disease, this is exactly my field. This is exactly what I went into this field to do.
When you also bring up the point about behavioral and lifestyle interventions, while we might not have an ad for that on our website, we do use it as the foundation of everything we do. There's a specific PowerPoint slide that we showed to every patient, every new patient that comes into the weight center, which outlines the intensity and the escalation of treatment that they're going to be offered at the weight center. And so it's like a pyramid structure. I can kind of describe this visual. So the base of the pyramid are all the lifestyle interventions that we should all be doing, whether you struggle with weight management or not. Dietary intake, increasing your physical activity, stress management, adequate sleep. These are just the baseline of what everyone should be doing to maintain their health.

And then for somebody who that is not sufficient to control the metabolic derangements or the excess body weight, which is physically what you see when you look at a person, whether you're doing additional testing to see these other metabolic issues is another thing, which we do do, obviously. But then you're escalating the care as needed, depending on what's going on with that person. So moving into dietary, special dietary interventions, we do meal replacement programs, we do intermittent fasting. We recommend some of these interventions, not as the one and only solution for everybody, but depending on where a person's coming into you from and where they are, what their preferences are, when they see you, you can kind of tailor the treatment, depending on what that person is most likely to succeed with. And then moving on from there, of course, we have medication options and then bariatric surgical options. So each of these interventions is targeted towards a particular group of people based on their starting weight, BMI, and metabolic conditions in a way that's best to produce the outcomes desired for that person.

I think I fall in between these two in sort of the broader philosophy, but I just wanted to make a couple of points. I mean, one point is that I think acknowledging that obesity may have some genetic component is fine and is probably true. But I don't think anyone finds it plausible to believe that the market uptick in obesity is not linked to some of the things that Kali's pointing to, changes in lifestyle and food and nutrition. And I think we have to acknowledge that that is the case. I just don't see any way around it. Genetics did not change dramatically in 25 years that yet obesity has. So I think that's what...

But Chika, do you agree with that?

Absolutely. Yeah.

So Chika, you do disavow the 60 minutes piece that said that wasn't the case then.

Well, I think the piece was cut in a very specific way to emphasize certain points.

And so...

I didn't see a disavow from your clinic on that. It was very... There was not nuance in that piece.

But Kali, let us get to that. Let's get to it. Vinay, go ahead.

Okay. So then the next thing I think to acknowledge is that even if it is the case that these sorts of factors that Kali is rightly pointing out have read to the rise of obesity, I think we do have to acknowledge that diet and lifestyle has really had a tough path in the biomedical literature. Going back to the 1990s to randomized trials done at obese youth, we haven't had a lot of success. Now, I think there is an important problem of financial conflict and I don't want to disparage individuals. I don't think that's the root of it. I think the root is that because we have a system the way it's constructed, we have tremendous incentive to develop pharmaceutical products rather than really invest in broader studies of different diet and lifestyle interventions, different levels of intensity. I mean, if you think about how much we spend on developing drugs and how much we spend on trying to change our lived environment, change how much we exercise on the way to and from school, the sorts of things we eat, it's not even balanced or fair. And I think the reason why many of us intuitively think that if you could solve it with a pill or you could solve it with diet and exercise perfectly, many of us would lean towards diet and exercise why. And I think it's the point that you made, Barry, which is that the history of medicine

sort of makes us worried that there is no magic bullet and there is some unanticipated side effect you're not aware of with the pill. But to my knowledge, there is no unanticipated side effect of just getting out there, getting healthy, eating better food. So I think that's why we have that intuition that all things being equal. But I think to Chica's point, we've tried very hard and nothing has really worked as well as this drug. Now that said, my last point is I do disagree with the AAP. I don't think you should go to 12. I think the recommendation is premature. I think the evidence is lacking and we can talk more about that.

Yeah, we're going to get there in a second. More than 40% of Americans today are obese. That is an absolutely staggering statistic. I would love just a quick round robin here of how did we get there in a few sentences, each of you? How did we get to a place where more than 40% of people in this country are obese? Vinay, we can start with you.

This is a deep question that speaks to many of the subsidies and way in which American life is constructed. I mean, we have removed walking from our lives. We go from car to car. We go from place to place. We have the availability of low-cost ultra-processed, highly available foods. Those foods taste better. They're more pleasurable than eating an apple. They are marketed heavily to young children. I think Kali's right that sugar-sweetened beverages are a major problem, has not been adequately tackled. And all of the incentives in farming, in agriculture, in nutrition, in school lunches have all favored cheap, empty calories. And combining that with taking us out of a lifestyle where we get any exercise has been catastrophic. And we have, for all those reasons, I think we are in this predicament where obesity is a huge problem. And then the last thing I'd say is the one thing I think we all agree is that obesity is a huge problem. That's a step in the right direction because there are some people who would have us believe obesity is not a problem at all. And we should just be healthy at any weight. And I think that's also a problematic ideology that's entered the fray. Chika, anything you want to add to what Vinay said about how we got here? Just emphasizing all he said and also just the term lifestyle creep was coming into my mind, which is normally used to describe when you spend, according to a higher lifestyle than what you maybe are earning. But in this case, I think it can really apply to just how we live our day-to-day lives. You really don't even have to leave your house anymore to do anything. You can work from home. You can get everything you need delivered to your house. I've had people who, well, actually, one person who actually used the pandemic to his advantage, who started putting in an online order for only exactly what he needed to eat based on the meal plan that he wanted to follow. And he actually lost a significant amount of weight during the pandemic, but it could really go in the opposite direction where you just do whatever you want. Nobody's there to see you. You can place your orders and not have to answer to anyone really in this day and age.

And so I think it's an accumulation of all that plus the added stress that we're dealing with in modern worlds, social media pressures. There's so many things that are altering our realities and our awareness, and really not allowing us to kind of go back to the basics of just those basic lifestyle habits that we discussed earlier, the diet, exercise, stress management, sleep. So it's an accumulation of a lot of things, and it's hard to say what is having the greatest impact on people, but it's obviously a problem. I also want to make an additional comment just referring back to the point about having patients be life-walked

patients and that being kind of a bottom line goal maybe for certain weight management practices. Our weighting list currently at the weight center is 4,000 plus patients. It's not going down. This number is actually growing as time goes on. We're not in need of more people to prescribe medications. Do we have enough? But we need to also emphasize the other things that need to be, which I support. I agree with the terms of what you're saying, all the lifestyle preventive behavioral management items and pieces that need to be in place before you can even really talk about and use medications. They're not the end-all tool. They are a tool, but they're not the ultimate solution.

Kelly, you're someone who in a previous life worked as a consultant for big pharma and for food companies like Coke. So what is your insight about how we got here?

I think we're being gaslit to think that this is complicated. Very it's happening because of food. Early in my career, I consulted for food and pharma companies. What's very clear to me is that there's a devil's bargain between food and pharma that has occurred over the past 50 years. Food companies want food to be cheaper and more addictive. We've totally changed our food supply to three core ingredients, added sugar, highly processed grains, which turn into sugar in the bloodstream and make the food more addictive, and inflammatory seed oils. That's been a total change in the past 100 years, evolutionary and unprecedented. Coke and other processed food companies rigged the system. They spent 11 times more on foundational

and traditional research than NEH, and we've seen absolute devastation, which obesity is just one, I would say, actually small example when you take the rates of diabetes, the fact that 25% of kids now have pre-diabetes. The criminal situation and the problem is that we would expect the medical system. We would accept, frankly, my album out of Harvard to stand shouting an alarm that this is wrong, that there's actually a clear reason we're all becoming metabolic and healthy. But instead, it's just very simple, that the growth of the medical system is based on interventions on sick folks and people have been getting very sick on food. The experiment of medicalizing chronic conditions over the past 50 years has been another failure. The more stands we prescribe, the more heart disease goes up. The more metformin we prescribe, the more diabetes goes up. The more SSRIs we prescribe, the more depression goes up. Ozympic is not going to increase life expectancy or decrease diseases for children that are given it and told that they don't have to worry about what they eat. The problem is that diseases are not in silos. That has been, obviously, obviously, the greatest mistake of the past 50 years. The root is metabolic dysfunction, and this is not a... Let's be very clear. This is not a marginal thing. This isn't going to be given to patients on the margin. There's JPMorgan conferences, and any literature you read say this is going to be the best-selling drug in American history. There is an all-out war.

Kali, I just want to say back to you and make sure that I'm understanding what you're saying. I mean this in the most literal definition of the word. You have a radical perspective, which is the incentives of big healthcare, big pharma, and maybe even big food, are deeply aligned on incentives, which is, in order to make more money, they need to fundamentally not do no harm, but allow Americans to become more harmed. Am I getting it correct?

Well, yeah, and I appreciate that, Barry. I don't see it as... I see it... I'm actually just asking everyone to just... This isn't personal. There's great people. There are great people on this roundtable. There's good, dedicated people. But food companies, and I saw

this, Coca-Cola lobbying to keep kids on food stamps, spending on Coke. That's something I actually worked on and have written about. It's like, that makes sense. I guess a soda executive wants that to happen. Food companies understandably want to make the food cheaper and more addictive. And it's just a fact that 95% of healthcare dollars, which again, is growing at an increasing rate, is tied to interventions on people who are sick. Dr,
I appreciate, and I do, that you... And I'm sure you do want your patients to be healthy and talk to them about preventative. That's not how your clinic makes money, period.
But I just want to make one point about... I think one of the things... I mean,
I agree with a lot of what you're saying, but one of the things you said that I think the right answer is I don't know is, will Ozympic increase the longevity and well-being of these 12-year-olds who take it? And the right answer is, nobody knows. I mean, I don't think we know it doesn't. I don't agree with that. I mean, how could you know it doesn't? I mean...
Because the kid is being instructed that food doesn't matter. And if the child continues to... But it's still an extrapolation, I mean...
No, it's not. No, it's not. We are being told by Harvard that it doesn't matter what you eat, that if you take... I think that's where you lose your argument,
because you go a little too far. Here's where I'm with you on. I'm with you on all of the bad business and the profit incentive of the agricultural and marketing firms.
I also think that one of the challenges that would help your argument a little bit more is to give credit to the fact that actually it's not so easy if we had 4,000 overweight kids and we gave 1,000 to Chica to take care of, 1,000 to Kelly to take care of, 1,000 to me to take care of. We have to acknowledge it. None of us has the perfect diet and lifestyle idea that's been validated that can actually result in tremendous weight loss in those kids.
We still haven't sorted that out. What is the advice you're going to tell them precisely? And the one thing I'd say is, so that's why the company sees an opportunity with Ozempic. And what I would say is that any outcome beyond two or three years with Ozempic in a 12-year-old is simply unknown. I know they lose weight.
Well, then why are we mass prescribing it?
I agree. It shouldn't be. And I actually strongly disagree.
Well, that's where we're at. That's where we're at right now.
Chica, is it being mass prescribed?
Not at all. A lot of insurance companies aren't even covering it yet.
Chica, the way that Kelly is describing the terrible incentives of Big Pharma, the incentives of Big Food, where do you agree and where do you disagree?
Because I actually imagine there's some major points of agreement here, especially on food quality.
Yeah. And so that point about we don't know where this is coming from, that was a bit of an exaggeration.
So there's no one answer for everyone. So people can have a perfect, quote unquote, perfect diet and still struggle with their weight. You can be exercising two hours a day and still struggle with your weight. It's a combination of different factors and how those factors affect each person as an individual.
When it comes to, I think, just the financial aspect of it, and I think this is something that we can go a long time on, just in terms of the health care system in the United States.

The food environment in the United States is very different from other countries.
And whether or not this is all by design, like the master plan of these health care executives, etc.
Again, another conversation.
Just economics. It's just the financial incentives. It's not a conspiracy.
It's not a conspiracy. I'm just trying to point out how the clinic makes money.
But to be fair, Kelly, there are clinics that only give diet and lifestyle advice.
They also make money. I mean,
95% of medical spending goes to interventions on people who are sick.
That's absolutely true. And the drug company is going to make a tremendous profit margin.
But in the case of her particular clinic, I think whether or not she prescribes ozympic or not,
her clinics are openly soliciting medical and surgical interventions on that.
That's what the clinic does. That's how they make money. This is a statement of fact.
Your point is well taken. The incentives are wrong, but she is not profiting from ozympic.
I'm pretty confident of that.
Ozympic creates a lifetime customer who needs lifetime injections coming back to the obesity clinic. Of course, this is the greatest boondoggle for the profit of the obesity medicine industry.
Your argument would be stronger if you didn't have to go that extra step, I mean.
Chica, go ahead.
When we talk about obesity as a disease, which I know was something from the outset,
you wanted to also throw into debate, but it is. It's a chronic multifactorial disease.
All chronic illnesses require lifelong care. So whether they're coming in for a
reversible or for, I'm sorry.
It's reversible though. You can be cured of obesity, right? Shouldn't that be the goal?
You can be in a mission. That's correct. But like any other long-term illness,
you're still going to need follow-up to maintain that.
So every person is obese and needs lifetime care?
Yes. You know what, guys? Let me actually set up the question about genetics and disease.
Okay? So we've touched on in this conversation about the question of whether or not obesity is the result of genetics, whether or not it's a disease, whether or not it's about willpower.
When I was growing up, the entire idea was simple. You can control your weight with diet and exercise. And now it seems like we've shifted pretty radically to an increasing consensus in the medical field that says obesity is not primarily about willpower. It's a disease. It's an illness. Dr. Fatima Cody Stanford, who's been referenced in this conversation,
one of the most highly cited scientists in this field, called it on 60 minutes recently
a brain disease and said that the number one cause of obesity is genetics.
So Chika, let's go back to you here. How did this new understanding come about
and help us, for those of us who think of a disease as something like cancer,
something that is totally beyond our control, help me understand as just a civilian,
how obesity, which is very clearly connected to how much food you are choosing to eat or how little exercise you are choosing to do, how does that fit into the same bucket of the thing that I typically think of as a disease? So I think the confusion, a lot of it stems from the fact that a lot of the treatments of obesity are lifestyle interventions. And so the common thinking, I think especially historically, was that if that can be the treatment, then it's obviously something that's within our control. But then when you start to look at

the examples of individuals who are actually following those guidances and those treatment options, those lifestyle behavioral interventions, but are not having success in reducing their body weight, that's when you start to understand some of the other underlying contributors. And as more research has come out in regards to the brain gut connection, the hormonal axis, the appetite control regulation processes, we start to understand more of the complexity that goes on behind weight management and understand some of the physiological barriers that prevent people from just eating less or just moving more to solve their problem. So yeah, there are many components. It's multifactorial, as we've discussed. Genetics are one primary component. But even with outside of genetics, like no matter who you are, we're still going to be describing a lot of the same interventions in order to optimize your status. But for some people, it's just not going to be enough. And that's where some of these further more intensive treatment options can come into play, the medications, the bariatric procedures, etc.

But I think this is where Kali's argument becomes really compelling to me, because if obesity is genetic, where was this disease 50 years ago? Like in the 1960s, between five and 7% of American children were obese. Today, it is one in five children. Like did we all magically get afflicted with these new genetics in the past 50 years? And if it is genetic, why are Americans uniquely afflicted by these terrible genes? That's what I'm trying to understand.

Yeah. And so that's where this quote comes into play, which I'm blanking in the moment on who says it. But genetics loads the gun, and then the environment pulls the trigger. So our environment has really capitalized on the underlying genetic susceptibility to excess body weight. It's been there the whole time, but now we're doing more and more things in our day-to-day lives to augment and make the body weight excess increase. Menai, do you want to jump in here? Is obesity genetic? Is it a disease? Or is it more a question of the choices that we make?

I mean, my perspective is between these two, which is that it is clear that the genetic studies do show links. But to your point, I think you just can't get around that central thesis, which is that genetics did not change from 1960 to now, but obesity has changed a lot. And so I think that speaks to that it is very likely our food environment and our lifestyle environment plays a huge role in the surge of obesity. I mean, there will always be somebody who's obese. I mean, that's inevitable. But the question is, should it be this many kids? And the answer is absolutely not. It's catastrophic for their health outcomes. And it is clearly, I think, linked to the built environment and food. And so that I don't dispute. I'll just say one more thing about the nutrition. I think the financial bias does play a role here. And that says, if you think about how big a problem obesity is, how many studies should we have had on this topic? How many studies should we have taken thousands of children who are obese and try different diet and lifestyle interventions? My answer would be thousands or tens of thousands of studies. And how many do we actually have really large, well done randomized studies, a tiny fraction, maybe a few dozen. And that is the bias of the system, which is that we're not even studying this an ounce of what we ought to be because we are so complacent in this agricultural subsidy system.

Vinay, as a consultant in DC for food and pharma companies, I helped steer what ended up being billions of dollars from food companies and pharma companies to places like Harvard, Tufts, many other elite institutions. I do have to disagree with you there. There should be zero nutrition studies. Nutrition studies or PR documents from food companies in order to office skate and make this much more complicated than it is. Harvard Medical School should not be trying to profit billions of dollars off of Ozympic. They should be standing on a pillar

screaming that the nutritional guidelines from the FDA for children should be no sugar to limit seed oils and to limit highly processed grains. Instead, the American Academy of Pediatrics will talk about Ozympic but is also paid off by food companies and recommends highly processed grains as the first thing a child eats. The American Diabetes Association is paid off by Coke and until a couple years ago recommended small cans of Coke for diabetics. We are not in a situation where Americans are trial and they're just failing. This system, the four trillion dollar healthcare system and the six trillion dollar food system is slanted against patients. If you were an alien and came down today and saw what was happening in this country, you'd see 80% of American adults would be overweight and you'd see us being crippled both from a budget and a human capital by almost predominantly metabolic conditions. Okay? Never in a million years would that third party say that our solution should be that 95% of costs to address that problem should be wait for everybody to get sick and give them marginal drugs and we all agree Ozympic is a marginal drug. Okay? Nobody would agree with that. That's the problem, right? We're all just accepting this system. We should not be conducting thousands of nutrition studies. We should not be spending on marginal drugs for metabolic conditions like obesity and Alzheimer's that's going to bankrupt the company, not do anything, which is the history of all chronic disease treatments. Okay? We should be saying that kids should need sugar. Okay. So, Kali, here's my question about the sugar and the seed oil. Where would you intervene on it, you know, in your perfect world? There's two, I mean, at least two possibilities I see. One is, we subsidize these products. So, is that the place we intervene at? Second, a place we intervene on it. Do we intervene on it in the grocery store? Do we make it very hard to get or maybe even, you know, have to high tax on it? The third thing that you intervene on it, do we advise people not to do it? And when I say we need more studies, what I mean is, I don't know which one of those three is the right answer. Maybe all three are needed. So, I guess my question to you is, you know, what do you think?

This is what my answer would be, Vinay. People listen to public health officials. When the public health officials said late in the 1980s that cigarettes were bad, smoking went down. When the public health officials through rigged studies from Harvard, from the Sugar Research Foundation in the 1990s, you know, totally rigged food pyramid saying that we should eat more sugar and carbs, Americans did that. Our diet shifted 20% over the 90s to carbs. Okay? When we're told to take certain vaccines, we generally listen. If the American medical system said that we are our budget and our human capital is being brought to its knees and instead of the FDA, and I'm curious what your thoughts on are this, Dr. Nekwa, saying that a two-year-old, it's okay for 10% of their calories to be added sugar, we should say that's absolutely ridiculous. We should say it's absolutely ridiculous. Harvard should be speaking very clearly that it is ridiculous that school nutrition programs, federally funded for school lunches, don't have a sugar cap. It's unlimited sugar. The medical community should be speaking plainly, not with thousands of studies, we should be absolutely working from our guidelines. And yes, as you alluded to before even talk about bans or any type of taxes, we subsidize these ingredients that are crushing our human capital and are costing trillions of dollars of downstream health impacts. We subsidize these over $100 billion when you look at food stamps, which 70% of that goes to processed food, grain and subsidies. Only 0.4% of federal subsidies go to fruits and vegetables. It's all highly processed grains and corn, school lunch programs, which are federally subsidized. We

are funding the decimation of our human capital and it's resulting in trillions of dollars of downstream health impacts. I would just really push back on what the doctor's saying about this being complicated. This isn't complicated. If you do those things about subsidies and you change some of the FDA regulation about what percent of sugars can be added to beverages, et cetera, I have some optimism that those might be useful strategies. But if the strategy is merely to tell people, don't eat sugar, don't eat seed oil, I don't think you can get very far because I think a lot of people have already heard that advice for the last seven years or eight years. That's when the advice changed and they didn't change anything. Kelly, I want to just push back a bit on the claim that this isn't complicated because here's what does seem complicated to me. Dieters and diets don't usually, it doesn't usually work out, right? 65% of people that diet return to their pre-diet weight within just a few years. I am one of those people as a yo-yo diet or my entire life as a lifelong weight watchers girl, as someone that has noom. I mean, I've tried it all, right? And only 5% of people who lose the weight on restrictive diets keep the weight off. So I guess I'm wondering how is just telling people, don't do these things a solution when even those who try to not do those things gain the weight back?
Well, sugar consumption has gone up 100x in 100 years and our food has literally been weaponized by a highly, highly addictive drug. So this is really, really hard, right?
Sugar is a highly addictive drug that has been exponentially added to our food. And our food, it's not hunger we feel, it's addiction. And I feel it too, right? And it's very hard to get off these drugs. So Barry, I just think it is an important first step for the medical community to bond together and say that as a public policy matter, we should be working to make food less addictive and not, for instance, paying for school lunches that have unlimited amounts of sugar. Get this addictive chemicals out of our food.
There's some famous photographs and obviously you're just like a hilarious cultural stereotype of 50 or 60 years ago. You're a pregnant woman, you're in with your OBGYN, and the guy is smoking cigarettes as he's checking you out. Do you think, Callie, that like our attitude towards sugar, seed oils, carbs is going to be remembered in exactly the way we remember that smoking doctor 50 years down the line? Absolutely. The only difference between an image of a bunch of kids looking like a bunch of meth heads around a birthday party or on a cake and smoking is that what's happening with sugar in our food is an order of magnitude worse. It is decimating our country. Like healthcare is 20% of GDP growing at an increasing rate. Our eyes gloss over, but that's going to be 40% of GDP in 15 years. It's not slowing down. It's all tied to food. So Chica, given that this is what you do day in and day out, do you actually see any evidence about what Callie is saying that sugar, seed oils, processed foods are at the root cause of all this? And when you see an image of a one-year-old, as I'm seeing on my Instagram of so many friends, I have a five-month-old giving them sort of a cupcake on their first birthday, that that's the equivalent of handing them whatever Callie's analogy would be, fentanyl or heroin.
Well, yeah, I think that the whole morphing of the food pyramid over the decades is just evidence of how unserious the government is about actually providing useful recommendations. So I think at this point, we look at these images, we look at the cover of Time Magazine over the decades and how it changes. Our bodies haven't changed that much over this time to have such disparities in what we're recommending, but those basic guidelines that we're talking about, the limiting processed foods, the Kevin Hall study that came out about ultra-processed food in the past couple of years, that was a big highlight, I think that emphasized all of this

that we're discussing right now, limiting added sugars. These are things that I'm saying day in and day out to people. So I think most people, I hear this also, everybody knows what they should be doing, but it's a matter of can you do it and how can you continue to try to do it when you're faced with the addiction side of it that we've been talking about in terms of how this food supply has really changed what we want and how we crave what we want and the ability to really avoid those types of things. So yeah, I do agree that we do need more serious recommendations and focus on getting a healthy food supply into people's bodies and having it be the default of what's available as opposed to having to go out of your way and really inconvenience yourself to get a healthy food intake. But when it comes to how to actually implement that and how we can do that in a way that's effective for people, that's the question. With the current environment that we're in, it's a difficult thing.

When we return, should children as young as 12 years old be on Osempic? Stay with us.

 The American Academy of Pediatrics recently released guidelines for treating children that are obese. Among other things, lots of things in those new guidelines, it says that for children that are older than 12, providers are encouraged to prescribe medications like Osempic for children over 13 years old, could be a surgery, could be gastric bypass for a 13-year-old, which seems pretty extreme, I think, to a lot of parents reading that.

I want to hear from each of you. What do you think of these new guidelines? Chika, I think you did your residency in pediatrics, so maybe let's start with you.

I did my internship in pediatrics, and then I transitioned to Preventive Medicine Public Health. I think the one thing that we haven't really addressed is the fact that lifestyle and behavioral intervention by themselves don't always work. Yes, we want people to do all the things that

they should be doing for their lifestyle and their behavioral and their day-to-day lives to improve their health and maintain a healthy weight, maintain a healthy metabolic status, but they don't always work on their own, and that's why these other options are available, and that's why we should use these other options when they're indicated in order to improve a person's outcomes. Yes, I understand that weight might not be the end all and be all, weight is just a number. There are other aspects of health that are more important to consider, metabolic dysfunction, knee pain, psychosocial health, all these other things that go into a person's quality of life, but at the end of the day, what we want is for people to live the best, optimal, healthiest way that they can, and so whatever that means for a person with that discussion with their provider, what interventions they're willing to accept the risks of and potentially gain the benefits of is what we should be doing.

Vinay, what are your concerns with the idea of putting a 12-year-old on a weight loss drug, presumably in perpetuity? Yeah, so I think the gastric bypass, it has a natural psychological barrier, which is that it's a big surgery, and I think you're absolutely right. Parents and children and their doctors are going to agonize about that, and they're going to have thoughtful discussions, and they're going to think about it. So that has a natural built-in barrier.

The prescription drug does not. I think this is to Kali's point. It's tempting, it's easy, it's seductive, it will be widely prescribed. I think the AAP got a little bit ahead of the evidence, which they often do. They often do. They have a 68-week study of 200 kids who are 12 and up, who are the 95th percentile, and they showed me that if they take this product for 68 weeks, they're going to have lower weight than if they don't take this product.

But what I have no idea is what happens when you extrapolate this to kids in the community who may not take it with the religious fervor of on a clinical study. They may take it, forget to take it. It's an injectable product. They have to inject themselves.

They may not take it. Their weight may rebound. They may have yo-yo gains on this product because they're not taking it exactly like the people on the trial. I don't know what happens if you take it for five years, 10 years, 20 years, 40 years, 60 years. What are we going to have them do? Take it until they're 72? I think there's so many uncertainties. And so I would not extrapolate the cardiovascular data from diabetics to young children. I think we don't know. I think there are safety concerns that could emerge that we don't know. If they get even one safety concern, every one of these things that happen will further undermine whatever credibility institutions have, which is diminished, I think, because of the pandemic, but it'll go even lower.

And so I do worry that it's going to be a lot of money, and we don't know what we're doing, and we're going to create a society of medicated children.

When you step back and you do the sort of alien experiment that Callie was mentioning before, it seems like a very strange reality that we're living in, where we medicate children by the tens of millions so they can spend all day in classes sitting still, especially boys. And now, because they're getting fat from sitting still, we're going to inject them with a different medication because they become so overweight. When did this become normal to make children dependent on drugs and big pharma forever? It just seems to me like we're living a bit in the upside down. It became normal when more than 50% of Harvard Medical School's funding somehow comes from pharma and pharma is the predominant funder of the American Academy of Pediatrics.

And you say dietary interventions don't work. Let's look at the incentives.

The American Academy of Pediatrics is telling them to eat processed grains.

You know, a lower income chile and food stamps, 70% of that through a rig system is going to process food. Their school lunch through heavy lobbying by processed food companies and deafening
silence from Harvard Med School is serving them absolute garbage. Of course, dietary interventions aren't working. The system's totally rigged against them. And now, parents who are desperate, it's not obesity. These kids are metabolically dysfunctional. Their cells are absolutely being destroyed. That's not just obesity. They're dealing with fatty liver disease. They're dealing with depression. They're dealing with a host of other issues. And let's be very, very clear. The Ozympic parent company isn't funding you and your colleagues. I find this argument that a little bit of corruption is okay, but they funded you and they funded your colleagues. No, she went to a dinner. I'm sorry. I think you can make the argument without making it obsessively
about Harvard or a number of doctors there. It's much broader and bigger than that.
Yeah. I hear you. And this is not personal to anyone. I do think it is a big societal factor that this company is able to, in small and large ways, pay $420,000 payments to $30 million to doctors. And I don't think that's right. And I think there's big societal and financial conflicts of interest with obesity clinics, which fundamentally make money when there's interventions to do and that this is a lifetime drug. I just want to refine it a little bit.
Oh, please, yeah. Okay. I actually do agree that the company shouldn't even be paying for the dinners. I think those should be blocked and prohibited. And I actually astidiously avoid even accidentally eating a meal at some of these companies because I do think it's a problem and that kind of conflict is pervasive. In terms of the centers, if the centers are administering an intravenous product, they have an immense financial conflict of interest because they receive a markup on that product. The moment they give you a product that you take at home, the incentive to the center is tremendously diminished. They don't actually get a percent markup of the drug. That's not to say he doesn't have a point. He has a point that they have grants, continued grant support and funding from that company. So I just think it's a little bit more complex than this direct one-to-one sort of conflict of interest. It is a huge problem. The pharmaceutical industry is trying to influence Harvard Medical School and providers, but I disagree with a little bit some of the rhetoric.
I also think that you're maybe misspeaking when you say that we don't care what people are eating or we're not telling people to eat well, reduce added sugars. We are, at least I am. I think all my colleagues are in our clinics. That's the baseline of what we want people to be doing. That's always the first intervention. Many people are trying to do that on their own, but are not having success. All these kind of steps of these added interventions are again, tools that we use to help to allow them to follow the baseline guidance, which is all the improvements on the behavioral and lifestyle front. I think there's maybe a bit of a confusion in terms of where these can fit for different people, but we do want health for everybody. And when they come back to our clinics, we're not making money just by prescribing them these medications. We're following up with them to follow up on the progress or lack of their condition, of their health. So we're not just having people come in just so we can give them prescription and make money on the side, which we don't anyway. So I think just a lot of the argument is being lost, but we, I think, agree on the base point that improvement on diet, exercise, physical activity, mental health, stress, and sleep are the fundamentals and

everything else is just added tools. The one thing I wanted to add was, I just think that the answer is somehow going to be more than just dietary advice. To really cut the head off the snake, I think you do have to reform lobbying in Congress for these agricultural firms, for school, all these sorts of programs, lobbying around pharmaceutical firms. I think we have to start thinking about built environment. Should everything be a sprawling suburb and we be in our cars all day and the sorts of incentives that drive the way we develop? And these are really deep problems. And that's why I think simply telling people eat less sugar and avoid seed oil, I think Chica sees every day, that's not going to get you that far. I think the temptation is we'll reach for ozempic. The reality is it's going to take a lot of work and that work is not easy to do to sort of stop these sorts of political problems. I want to kind of step back and look at where we are as a culture. We're living in a country in which one in six Americans take some kind of psychiatric drug, mostly antidepressants. 25% of university students use Adderall, which is astonishing to me. 70% of Americans take at least one prescription medication. And now we're giving them another drug for another problem that a lot of Americans are facing. So I guess I want to ask, are we experiencing a fundamental change in how human beings in wealthy Western countries live? Are we entering an era in which, and this is to say nothing of AI and what that's going to do to what it means to be a human, where we can afford, because of prescription drugs, to eat badly, exercise rarely, stare at our phones all day. I'm describing myself here. I'm not describing other people. And then pump ourselves full of drugs that big pharma gets rich off of. Is that the future that we're sort of tumbling toward or perhaps already in? Vinay, maybe start with you. There's a quote by William Osler, the desire to take medicine is perhaps the greatest feature which distinguishes man from animals. And it speaks to what you speak of. To me, what you're talking about is a dystopia. I mean, it's a hellscape where our lives are so ruined by what we think of as the conveniences of modernity that we have to medicate for all the side effects of the conveniences we've imposed in our lives. And so to me, it is a bleak hellscape you describe. And I hope we're not going there. And I think much of the prescribing you talk about is irresponsible prescribing because it's going beyond what the evidence has shown. And that's also really sort of why I fundamentally disagreed with semi-glutide in a 12-year-old. So it's not good. It's not desirable. And there are ways, and it really requires us to deeply reexamine sort of the core assumptions of our society, including to one point you're making, which is the kid doesn't sit still for eight hours in class. So we have to medicate him. Maybe the answer is, you shouldn't be trying to sit him still for eight hours a day in class. And so I do think we have to reassess all these assumptions. This to me is an unacceptable hellscape you describe, Barry. And I don't want that to be the future. I fear we're already halfway there. Chika? Well, I think also this comes down to the question of the decision makers, the policy makers, which physicians are just one piece of that puzzle. So yeah, it is up to a lot of these institutions and power-wielding conglomerates, I guess you can put them, to kind of set the scene, set the scene for what we want as our population health. And so physicians play a role in some degree in terms of what we're saying day to day, but we don't really have the power as prescribers or providers of health care to kind of set the recommendations that are coming up from the top down. Certain of us obviously do that hold those positions, but the majority of people in their day to day practice don't have that type of power. And so what I think we want, and ideally how these medications are supposed to be used, are as part of a healthy overall plan as a tool, again, to allow people to do those day to day things. But if you're ignoring those

day to day behavioral lifestyle interventions and advice and doing as you please day to day and then using these medications as an escape or a way to solve these other problems, that's not what they're meant for, and that's not what we want them to be used for. And if that's the way that things are going, that's obviously not what is the ideal scenario. And so there's work to be done to kind of undo the bad habits that have been established and have been permeated through society, and it's going to take work and effort to do that.
Kelly? We need to speak clearly here. There's a $4 trillion of the medical system that wants, that just financially, just as a statement of fact, profits off people being sick, and $620 food industry that wants food to be more addictive, and that's what's going up. And you mentioned the political incentives, and more than 50% of U.S. states, the largest employer is a healthcare entity. Healthcare is the largest industry in the United States. The American Medical Association, which represents doctors, is aggressively lobbying for the center intervention-based system. They're not out there lobbying to cut soda on food stamps, right? They're arguing to propel this sick-based system, and it's bipartisan. I mean, it was recently in Texas where the governor who's a Republican there was arguing and bragging that the Texas Medical Center, the hospital in Houston, could be seen from space. Like it's seen as this jobs program, there's this force that's leading the medical system to be bigger and bigger, which necessitates, just by definition, more sick patients, which is what's happening. And I just, again, I just think, you know, I know that most folks at the obesity clinic or everyone, it wants their patients to be healthy. But the raw economic incentives, as it sounds like what you're saying, is that there's just this population of people that are getting more and more and more sick, and they're coming to you for care. I think there is a watershed moment, once again, here with Ozympic, where it's the wrong tool, as Barry, all the things she mentioned on all these drugs. I think, Vanne, you said earlier, we don't have the data. We do have the data. Chronic treatments that silo diseases don't work. Ozympic is not going to work. I think that is a statement we can make when we look at the complete and utter failure of, I would say, close to every chronic disease treatment to lower the chronic disease that's trying to treat. So I do think we can go off that data. I think we can really use this moment to not throw up our hands, but ring the alarm bell. And I would hope medical leaders who have a voice say, let's hold off on mass prescribing this to teens. And let's be clear, that is absolutely what is being pushed for by Ozympic. Let's hold off on approving this for anyone until we can really figure out what the root cause of diseases and create public policy solutions for that. And I will say, I am optimistic. We are able to change quickly in America. This is an existential problem that's going to bankrupt our country. We're going to have to solve it one time or another. And I think this is a better moment than any as we're on the verge of having taxpayers fund this ineffective and most expensive drug in American history. This is a moment where we can step back and say, hey, do we really want to be using our dollars for this or do we want to attack the root cause?
Chika, Vinay, Kali, I really appreciate you guys making the time and engaging in this conversation. Thank you. Thank you to Dr. Chika Anecway, Dr. Vinay Prasad, and Kali Means for joining me today. If you like this conversation, if it provoked you, it definitely provoked me. If it challenged you, if it made you rethink giving a cupcake to your one year old for his birthday, or if you're frantically trying to figure out how to make a sugar-free cake out of bananas, share it. Share it with your friends and family. Share it

with people in your community. And use this episode to have a conversation of your own.
And if you want to support honestly, there's only one way to do it, by subscribing to the free press at thefp.com. And one more thing, we are so, so excited to finally announce a podcast that we've been working really hard on over at the Free Press. It's called The Witch Trials of JK Rowling. It's a series hosted by Megan Phelps Roper, and it features the most famous writer in the world about one of the most contentious issues of our time, gender and sex. There's a lot of toxicity that surrounds that subject. But at the Free Press, we believe in the power of conversation. So Megan left Rowling's home in Edinburgh in August, and she went on a journey, speaking to dozens of the people on all sides of this topic. Trans teens, clinicians, advocates, historians, reporters, authors, Christians who boycotted Harry Potter in the 1990s, doctors, lawyers, even experts on witch trials. In a moment in our culture where black and white thinking abounds, we think the empathy of this series is essential. And we hope you subscribe wherever you get your podcasts. The first episode of The Witch Trials of JK Rowling drops Tuesday, February 21st. See you next week here on Honestly. Music in this episode was from Blue Dot Sessions.
This is Brian Dean Wright, former CIA operations officer. By now, you've probably heard of my podcast, The President's Daily Brief. We travel around the world talking about the most pressing news of the day. And the goal is to take complicated issues, both here and abroad, and make them really simple to understand. We also talk about solutions to the problems that we discuss, just like the actual brief delivered to the president each day in the Oval Office. So download and subscribe to The President's Daily Brief, available on all major podcast platforms starting at 6 a.m. Eastern Monday through Friday. It'd be a pleasure if you joined us.