

Using Storytelling to Teach Medicine

What Happens Next - 11.18.2023

Larry Bernstein:

Welcome to What Happens Next. My name is Larry Bernstein. What Happens Next is a podcast which covers economics, political science, and medicine.

Today's topic is Using Storytelling to Teach Medicine.

Our speaker is Dr. Ari Ciment who is the author of a new book entitled *Breathless Tales: Life, Laughter, and Lessons*. Ari managed the Covid ward at Mt. Sinai Hospital in Miami Beach when I was a patient recovering from COVID in December 2020. Ari has spoken more times on this podcast than any other guest.

I want to learn from Ari about how he uses stories to teach his medical students, his doctor colleagues, and his nursing staff. I want to find out what we learned from his COVID experiences, and why certain patients live because of sheer will.

Buckle up.

Ari, in your new book, you tell the story about how you almost did not get into medical school because of your poor performance on the English section of the MCAT, what happened?

Ari Ciment:

The first time I took the MCATs, I was convinced that I'm just going to ace the test because I went through high school and college, and I was a straight-A student. So why do I have to take a preparatory course when I'm getting an A in chemistry and physics, and biology? All my friends were taking all these courses and doing the tests, and I know it was arrogance thinking that you're better than everybody else.

You really had to study for the test. People were telling me that, but I was very nonchalant. Then I went in the test and I remember freezing when I took the English part. I bombed it. It just took me a long time to read the questions. I didn't finish the test.

Larry Bernstein:

So, you took a gap year. I always tell my kids that life does not go in a straight line. Mistakes are made, and you need to make the most of it. What did you do?

Ari Ciment:

I took a year off. I did liver transplants at Mount Sinai in New York and I taught at Yeshiva University as a chemistry TA.

Larry Bernstein:

Your parents wanted you to be a doctor. Did they put a lot of pressure on you after your MCAT hiccup?

Ari Ciment:

It was more than just a hiccup because not only did I do poorly on that first test, but then I was taking a repeat test in the summer so that there was a lot of stress. My father would open up the mail and he would see that I got another wait list, another rejection, and he was telling me “why don't you become a teacher? Why don't you do something else?” I was going to take the test over in the summer and I did great on the math and chemistry part, and then when it came to the English part, again, I froze. I had severe PTSD at the time. I just stood up. I ripped the test and I said, I'm not doing this. And I left and then I came home.

I had to confront my parents and they looked at me like, “how'd the test go?” And I said, “I just couldn't do the English part, the timing. I can't do it.” There's a story in the book that my father said, “just take some time. Just go on the boat. Just take it easy, clear your mind.” I put the boat in the water, and I forgot to take out the damn bilge button, and as I undid the davits, the boat was literally sinking. I'm like, “oh my God, this is like an episode from Ferris Bueller's Day Off. I just failed my MCATs the second time. I'm not going to medical school. I'm a complete failure.” I was able to click on the front davit just in the nick of time, otherwise the boat would've sunk.

Larry Bernstein:

Your dad is also a leading pulmonologist at Mt. Sinai Hospital in Miami Beach. How was your father-son relationship, and did he teach you to be a better physician?

Ari Ciment:

I worked with my father who was by far a better clinician, diagnostician when it came to pulmonary. So, it was just incredible to be able to witness that. I developed into a better doctor than what I started out as because I was with my father and my partner Robert Galbut. He's a great role model, but he's more like a brother, best friend, unique relationship we had. And my father obviously just a brilliant diagnostician and very good with his hands.

Larry Bernstein:

My dad was a cardiologist and he trained at Cook County Hospital in Chicago, and he told me stories about the place that made it seem absolutely insane. The crazy patients, the mindboggling

situations every day. You also trained at Cook County, how was your experience working there and how did it compare with Mt. Sinai in Miami Beach?

Ari Ciment:

I was in the old Cook County Hospital, which was the same one that your father trained. It made you prepared for anything that you could possibly see. Mostly because you were everything for that patient. You had to do transport, you had to put in the catheter, and you had to be the nurse. And that was a great experience. Nowadays, doctors are prima donnas, spoon-fed, and they don't realize that there's a whole team that's needed to take care of a patient.

There was a great story in the book about a patient gang member. I'll never forget that he was shot and he had severe pain. This guy was not a nice guy. He probably killed a few hundred people. He looked scary, but he was writhing in pain, and I felt bad for him. And the neurosurgery team came by and they said, there's no indication for surgery because he's able to move his toes. And so I wheeled him down to get a CT myself. We reviewed it with the radiologist. At that time, you had to see the film, it wasn't a picture on your computer. We reviewed it together and you could literally see the bullet impinging on the spinal cord. So, I called the neurosurgeon over as a medical student. I said, "please, why can't you operate on it? You see it?" He said, "there's no neurologic dysfunction. If he could lift up his toes and then we're not doing surgery."

I went back to him, and I explained to him, I said, "I know you're in a lot of pain, and I'm telling you, if you get that bullet out, you will not be in a lot of pain, but you're going to have to maybe be a little weak on your right side." So, then he said, "I can't move my leg, doc. I can't move my leg." We got to take him upstairs to surgery.

Of course, I transported him up. The surgeon looked at me and said, "okay, Ari Ciment, Mr. Know it all. You're going to operate." And he made an incision line. He said, just follow the incision. And I did it for the first 10 minutes. I made some of the cuts through the fascia and then as soon as the bullet came out, he was no longer in pain, and he was very thankful; he didn't kill me.

Larry Bernstein:

Ari, you ran the COVID ward at Mt. Sinai Miami Beach. When I was admitted to the hospital with COVID, I was your patient. You were incredibly kind, and you also exuded confidence that I would get better and quickly, so I immediately felt better. I think the doctor-patient relationship is very important.

Next topic is being your own best advocate.

I had a relative with COVID pneumonia who was struggling with low oxygen levels in the 80s. You told me at the time that the patient desperately needed monoclonal antibodies so that the lungs could be spared further damage.

Unfortunately, the hospital had a set of rules that prevented access to the medicine. The COVID protocol required that a patient with oxygen saturation in the 80s must be admitted to the hospital. But admitted patients could not get the monoclonal antibodies because the study for the use of monoclonal antibodies was performed only on outpatients. Tell us about your solution to this conundrum.

Ari Ciment:

That was a unique time. However, it just didn't make sense. Doctors like myself would try to find ways to bend the rules to make it. The studies were designed in a certain way, so there's no evidence-based reason why a patient would benefit by having outpatient monoclonal infusion because the study was done in a hospital setting. But you and I and anybody smart would know, okay, what's the difference where you get the treatment? You just need to get the treatment as fast as possible, but for hospitals to get reimbursed, part of it is the cash problem.

Larry Bernstein:

For the benefit of the audience because the original study for the monoclonal antibodies was outpatient only, the Federal Government refused to pay hospitals for admitted patients. Ari came up with a solution. Get the antibody injection, don't get admitted to the hospital, and stay home for a couple of days, and if necessary, then later get admitted to the hospital. But if the antibodies work as planned, then you are all set. With my relative, the patient never had to be admitted because the antibodies kicked-in with a supplement of some heavy dose steroids and oxygen. Nothing is better than healing from home with Ari on stand-by.

Next topic is why was the original COVID alpha virus so deadly. Was the problem that alpha caused havoc on the lungs?

Ari Ciment:

The mortality of COVID. Very rarely did I have a patient come in with severe diarrhea, dehydration, and that's why he died from COVID. It was mostly pulmonary related.

Larry Bernstein:

We heard that co-morbidities with heart, liver, kidney disease also was problematic, why was that?

Ari Ciment:

Well, I think the co-morbidities you mentioned were important, but even more than that, obesity was the thing that we saw. Obesity and diabetes and hypertension.

Larry Bernstein:

Why was obesity such a problem with COVID? Why did it increase mortality so dramatically?

Ari Ciment:

It wasn't that surprising. Typically, not in the best shape, and they're hard to ventilate, but I don't know the exact reason why, but every time, every patient that did poorly was, somebody said it early on, he was sort of joking, but COVID was against fat people.

The ICU, there was one time I could remember that all 25 beds, every single patient was an obese patient. So, it almost felt like, oh my God, this is a ward of obese patients.

Larry Bernstein:

One aspect of COVID, it was the body's response not the virus that was killing people. The body overreacted filling the lungs with fluid. That causes pneumonia and a collapse in oxygen levels. Steroids are fabulous drugs because they can slow down the body from attacking itself. What was the magic weapon?

Ari Ciment:

Decadron.

Mount Sinai Hospital, we were a cutting-edge hospital. Our infectious disease doctors were incredible. Dr. Tuda, Dr. Rivera, Dr. Camps, Dr. Isabelle they really took charge from the minute the patient came in. Other hospitals did it too, but we combined it with steroids very early on. Whereas other hospitals say, "oh, you can't do that. It's going to cause GI perforation. It's going to cause severe immunosuppression."

But we noticed that it really created a suppression of the inflammation to avoid ICU admission a lot of times. Sure enough, within a month, everybody was doing that high dose steroids.

Larry Bernstein:

In retrospect, the benefits of steroids seem obvious, why were high dose steroids not part of the original drug cocktail?

Ari Ciment:

The answer to your question is that some of the early data from China were really misleading. If you look in the very first studies on ARDS and COVID, which I studied right from day one,

you'll notice that the patients that got steroids early, did worse. So, everybody was like, don't give steroids to your COVID patient.

Larry Bernstein:

From a medical ethics perspective, vaccine makers could not purposely expose patients to COVID to see if the vaccine worked. Given the need for a working vaccine and the ongoing mortality of COVID, was that a good decision to only expose patients to COVID naturally?

Ari Ciment:

They could have done it the other way with a deadly disease at that time, the mortality was thought to be greater than 10%, and they also didn't know that young people would do better than older people initially. So, it would be very hard to have your inclusion criteria early on because the data wasn't so clear who was better, who was worse. Also, you would've had to have so many patients in the younger population because people that were younger didn't get so sick if they got COVID, so you wouldn't see a mortality benefit. So you would've needed thousands and thousands of volunteers, which you would not have gotten at that time. I know that they tried some early studies with people that wanted to be exposed.

Larry Bernstein:

I had COVID a few times and have had COVID shots and multiple boosters. Should I get another booster?

Ari Ciment:

The CDC now recommends another booster for Covid. I just finished my ICU rotation, and I have seen more patients with problems from a COVID booster than I have had with COVID pneumonia at this very point in time. It could change. You have to be open-minded. I believe if you had many COVID shots already, you had COVID already, you have to weigh the benefits of whether or not you really need the COVID vaccine. I am not a CDC expert, but I am a pulmonary critical care doctor, and I'm just saying what I see. I see COVID pneumonia for sure, but it is interesting to me that I see quite a bit of COVID vaccine related side effects like myocarditis. I was the first proponent of 1, 2, 3, and even 4 COVID vaccines. But now I am a little skeptical. For myself, I'm 49. I didn't take the COVID vaccine booster now.

Larry Bernstein:

Should I get the flu vaccine?

Ari Ciment :

The flu vaccine is tried and tested over the years, and I get the flu vaccines.

Larry Bernstein:

Should I get the pneumonia vaccine?

Ari Ciment:

If you're older than 65, you should get at least one, and if you have a comorbid condition such as asthma or COPD, you should get it even before 65, and then another one when you're over 65. The pneumonia vaccine doesn't necessarily save you from getting the pneumonia itself. You can still get the pneumonia. You should not get as sick if you do develop the pneumonia. The pneumonia vaccine has a bunch of different serotypes or antigens included in that vaccine that cover all 23 different types of pneumonias. It's in one shot.

Larry Bernstein:

Your patients who had severe COVID pneumonia, are they experiencing long COVID? Do they have permanent damage to their lungs?

Ari Ciment:

I see a lot of long-term consequences COVID pneumonia. The post-COVID syndrome that's still out there. Most of the patients with pulmonary fibrosis are surprisingly getting better slowly. It's not a quick fix. Some of the patients with severe fibrosis are living a normal life, but there are still people with severe morbidity.

Larry Bernstein:

Next topic is the doctor-patient relationship. My father told me that when patients are in the hospital, they sense that no one wants to touch them, and they feel like a leper. My dad made a point to touch the patient's hand to make them feel comfortable and have an emotional connection.

Ari Ciment:

Nowadays it's trickier to make the doctor-patient relationship because touching a patient could be misunderstood. So sitting on the bed near a patient, that's an effective way to start that patient doctor relationship. Also making eye contact and showing a genuine interest in the patient's history, their upbringing; those things are very important. The problem that is that the hospitalist takes care of the patient in the hospital as opposed to their primary care physician who knows the patient. Nowadays a primary care physician admits the patient, but the care is taken over by some person who never met the patient. Your father in the olden days, saw the patient, admitted the patient took care of the patient. We have to do a better job as doctors to establish some relationship early on.

Larry Bernstein:

Based on my experience here at Mt. Sinai, your nurses are excellent. Do doctors help in their training? Do the nurses help train the doctors? What is that interaction like that produces such excellence?

Ari Ciment:

Okay, I love that question. That's the best question of the day. So Larry Bernstein said, "Ari Ciment, you saved my life or Claudio Tuda in infectious disease." But the reality is I didn't do anything. I might've ordered tocilizumab or might've ordered Regeneron.

Nurses don't get enough credit for the work that they do. Rarely do you say, hey to the nurse, you saved my life. But the reality is the nurses here, especially during COVID were beyond heroic.

Larry Bernstein:

What makes a great nurse?

Ari Ciment:

A great nurse is somebody who questions a doctor to try to understand the thought process and work together. Teamwork and communication. A great nurse is somebody who communicates effectively.

My success here at Mount Sinai is 1000% contingent on my relationship with the nurses in the ICU. The first thing I teach, the fellows that I train here and the residents, you always have to show respect to the nurses and show them that you value them. Try to teach them because they are the ones taking care of the patient that you're trying to help. The congeniality that comradery that relationship is the backbone of taking care of patients.

Larry Bernstein:

How do you train your fellows?

Ari Ciment:

I show them that there is a value of evidence-based medicine. I have more years as a practicing physician, but what will make me a better doctor is having these experiences. What's the takeaway message? When you have evidence-based medicine, when you could read a study from the New England Journal of Medicine, You have to focus now in your training to learn what studies are out there so that you could get ahead of the game by looking at other people's experiences and boom, you're ahead of the game.

Larry Bernstein:

My dad loved going to medical conferences and he would go and listen to the various presentations and then when he returned to Evanston Hospital at the cardiology meetings, he would present what he had learned at the conference. How do you educate your colleagues?

Ari Ciment:

That is the second best question of the day. When you have the same people doing the same things for many, many years, you're going to just do the same thing that you were trained to do. COVID taught us the power of reaching out and seeing what other people are doing and being open-minded. Reach out and say, "I heard you're using a rotational bed for COVID. How's that experience going?"

Larry Bernstein:

And how do you do learn across disciplines within your own hospital?

Ari Ciment:

I'm a fellowship director, so I'm always constantly doing conferences and grand rounds, but we also have meetings. We have three meetings a week amongst the fellows and the attendings, and we talk about different things. Every attending has a different vantage point history. We have one doctor here who trained at Montefiore or another one Texas and another one from Boston. You use those connections, and you review.

Larry Bernstein:

Some of these longevity doctors want to do additional tests when there's no condition, full body scans, and oftentimes when you do these full body scans, something is going to show up. My father opposed getting these full body scans. He said, "we'll find something. Odds are it's nothing and it's can either drive you crazy or result in a procedure you don't need." What are your thoughts on body scans?

Ari Ciment:

This is your third best question of the day. This is an amazing and very important question because on one hand, you want to diagnose early. On the other hand, you don't want to have over-diagnosis, right? Eight years ago, I was asked to give a discussion on lung issues in women. And so I went and I gave a symposium. I showed them different things about lung cancer and asthma and COPD, and one of the things I mentioned is that if you're a heavy smoker, you should get a screening CAT scan of your chest. And two ladies raised their hand and they said, really, if you're a heavy smoker, you could get a low dose CT of your chest?. If somebody is 20 year smoker and they quit within the past 15 years and they're over 50 years old, they should get a screening CT. I bet you there are some listeners here on your show today that will get a screening CT and sure enough will find the nodule.

It doesn't necessarily mean it's cancerous. Two sisters, HK and Ik, very nice ladies. They came to my office afterwards. They both had lung nodules. They both had lung cancer. From that meeting that I had gave on topic of women issues in lung, two patients, one had stage one lung cancer and she did fine. The second one was stage three cancer. So she needed chemo. She lost her hair. Beautiful lady. She looked like Julia Roberts. And then I saw her after the chemotherapy. Thank God she's still alive eight years later because she's on some immunotherapy now. So things have changed. Lung cancer is a whole new different thing nowadays. Had she not come to the conference, it would've been game over. But the point, going back to your question, there are definite indications for screening, CAT scans. The problem with getting a full dose body scan when it's not warranted is you end up finding things that just give you anxiety and create issues. The one cancer that irks me more than anything we don't have screening for pancreatic cancer, and that bothers me.

I'm in talks with a company from Israel that analyzes your breath and can hopefully see if you're likely to have certain cancers. One of them is pancreatic. The future is going to be somewhere in a nasal test or a breath test for the screening of cancers, which is probably a better idea than doing a pan scan, which could over-diagnose.

Larry Bernstein:

Recently, whenever I try to make a doctor's appointment, I need to wait three to six months. Why is the demand for medical care outstripping supply?

Ari Ciment:

Surprisingly it seems that there is a shortage of primary care physicians and so much so that there are medical schools opening up that fast track from med school residency right into internal medicine. You don't have to spend three years, you could spend two years in medical school and then go right into internal medicine because we definitely have a shortage and not only that, we are seeing the burgeoning of concierge physicians.

Everybody is becoming a concierge doc.

Larry Bernstein:

Why are there delays in seeing a specialist like a dermatologist?

Ari Ciment:

It's just a backlog because again, a lot of them are working for hospital systems, so that removes a lot of the incentive.

Larry Bernstein:
It reminds me of socialized medicine.

Ari Ciment:
We're moving more and more towards socialized medicine here and that's the reason why there's more of a wait.

The advantage for hospitals is that they get to hire less physicians and it covers the same amount of patient visits to the hospital, and they make a larger amount of everything coming in. They limit how many doctors they hire and maximize the profits.

Larry Bernstein:
How is telemedicine working?

Ari Ciment:
We use it daily for elderly patients that can't make it to the office. That's one of the great things that came out of COVID.

Larry Bernstein:
Does telemedicine work?

Ari Ciment :
It's very effective.

Larry Bernstein:
You wrote a book on being a pulmonologist and your life as a physician. Why'd you do it?

Ari Ciment:
I did it because I meet the most amazing people. I have the best stories and I wanted to share it. I know if you don't write it down, you forget it. Nobody ever will hear it. It's like hitting a hole in one on the golf course. Nobody to tell that.

Larry Bernstein:
Well, I would tell people.

Ari Ciment :
Exactly. The point is also that these are shared experiences and any healthcare professional who reads these stories will know that this is exactly my story, but they never had the time to write it.

Larry Bernstein:

Oliver Sachs was a famous neurologist, and he wrote books about his experiences and his colleagues who were in the same field could not believe he had access to these highly unusual patients. I heard that it was because he was such a good diagnostician that whenever a bizarre case would arise nationwide, Oliver Sachs would be consulted. Why did you get to see so many interesting cases?

Ari Ciment:

The field of pulmonary critical care opens you up to seeing the most unusual diseases. Like one patient came in on a flight and had a ruptured OC cyst. It was a parasite in his lungs that popped. Of course he's going to come into the ICU. He can't go on a regular floor. I took care of him, sent him to Bulgaria where they do hundreds of these surgeries a year, which is incredible. They don't do any of them here. Our surgeon here was going to take out the whole lung. Instead, he went to Bulgaria, and they did a special procedure. We see things in an ICU. I don't think Ari Ciment sees more unusual diseases than any other ICU doctor in a busy area. In Miami Beach you see everything. 14 years ago I saw a lot more HIV patients, so I had a great case. Silicone embolism syndrome and that was incredible.

This patient came in and was short of breath, had a CAT scan that showed the opposite of COVID pneumonia. The ring of the lung was all-white and then that showed you the power of taking a good history. I went up to the patient and I said, "Hey, what's your story?" He said, "oh, I just came back from a party. I was injecting my boobs with some of the silicone." The story was he's HIV homosexual had a party and with a bunch of his friends and they were trying to get stronger looking breasts. They all injected silicone and he ended up having a silicone embolism from the injection and it went to his lungs, and it caused this reaction. And oddly enough, I go look online and there's a case report four years before from Miami Beach, Mount Sinai Medical Center, same hospital. This is Miami Beach, it's a party town. People do these interesting things.

Larry Bernstein:

How is working as a pulmonologist different from other specialties?

Ari Ciment:

So a straight up pulmonologist, you could just look at lung nodules and do procedures, bronchoscopies, biopsy, lung nodules, asthma, COPD. When you mix it with critical care, which is an extra year of fellowship, then that's when it can get more exciting or more difficult. And you see patients with all types of diseases, infections, septic shock, toxic shock, blood pressure issues, ventilator needs, pneumonias, COVID.

Larry Bernstein:

What is the future for solving lung disease? Most of us catch a virus, we get a cough. It's an irritant, not deadly. We suck on some Hals. We take some cough syrup and then in a few weeks it goes away. What's the future?

Ari Ciment:

The future is definitely monoclonal antibodies. Regeneron, the miracle monoclonal antibody, which I think was the early MVP in COVID for sure. It was the only thing that you took, and then right away you were better. You had to get it early. But if there are cases I had three weeks out, people fevers and chest pain, shortness of breath. They got the infusion, boom, boom, better. I mean, it was the most incredible medicine that I've ever seen. It is changing the landscape.

Larry Bernstein:

Your dad is 80 years old and is still practicing. What motivates him to come to the office every day?

Ari Ciment:

He still has his faculties. Anybody who can still work, they should try to keep themselves active physically and mentally. And he's still very sharp. I call him every day with a question on a patient, and he guides me in the right way. As a general rule, being a critical care doctor, I have noticed that people that do retire.

Larry Bernstein:

Die.

Ari Ciment:

It's not a good thing to retire.

Larry Bernstein:

Why does working matter to longevity?

Ari Ciment:

There's a famous story in the Talmud. A lady who is sick of life and she goes up to the rabbi and she says, "I want to die," and she's asking for advice. What can I do? So the rabbi said, what do you like doing? She said, well, I go to the synagogue every day. So he said, don't go to the synagogue three days in a row. By the third day she died. The point of that is that where your body's used to it and your rote, you get into that rhythm. The emotional connection creates chemical connections, and you break that. There's a problem. There's also, well-known studies about men who lose their wives. They're more likely to die within the first year.

Larry Bernstein:

In the longevity literature, they find that when men lose their wives, they are dead men walking, but when women lose their husbands that has little influence on mortality. Those women who are very social live a long life while solitary women die sooner.

Ari Ciment:

Yeah, I couldn't agree more. I see the same story. I always ask people that are older than 90, 95 and look great.

What are they doing? What is it about you? And more often than not, and I know it sounds trite.

Larry Bernstein

They mentioned being your patient.

Ari Ciment:

Yeah, it's true that I'm taking care of them. No, more often than not, I take things easy. I try to be always happy, always try to be happy, find happiness in what I have. People that let things slide a little bit, those are the ones that seem to have a longer life.

Larry Bernstein:

I am a happy guy, but it's not like I think about being happy. I wake up happy. I'm not sure it's possible to be happy. I think you are happy.

Ari Ciment:

Couldn't agree more. There's a genetic predisposition. But you could work on it.

Larry Bernstein:

Not sweating the small stuff.

Ari Ciment:

For sure.

Larry Bernstein:

My maternal grandfather was a physician who trained at the University of Vienna Medical School in both general medicine and psychoanalysis. He studied under Freud and became a tenured professor at the Freud Institute at the University.

My grandfather was both an internist and a psychoanalyst and he believed that the physician needs to understand both the mind and the body to cure a patient.

Ari, in your book you told several stories about miraculous medical recoveries because of the patient's sheer will. Why do you think the will to live is critical to survival?

Ari Ciment:

A hundred percent. It's just like tennis. You could be an amazing tennis player. You could be so gifted with skills, but if you don't have the mind. Why is it that Djokovic is number one every year? Djokovic is not more skilled than some of these new guys coming out. It's greater than 50% in the mind. The same thing as with a patient. If two patients could have the same disease, one gives up hope and the other one is hopeful. The hopeful patient will more than likely, somehow survive, or the hopeful family will enable that patient to somehow survive.

It probably has a hormonal and chemistry balance. It really can't be understated. The psychological impact of both families and patients, both negative and positive, I see both sides. And not only that, but there's also an influence on the team taking care of the patient. If there's a negative attitude, a negative feeling, there's more of a disconnect of the treating team with the patient, there's less of a will, a desire to help that patient get through because it's a more difficult experience.

Larry Bernstein:

I end each episode with a note of optimism, what are optimistic about as it relates to pandemics?

Ari Ciment:

COVID in a weird way was a blessing because we had world unity. Nobody was messing around with other countries. I think that we'll have a very good response to the next pandemic, how to do things faster, and just take care of it.

Larry Bernstein:

Thanks to Ari for joining us today.

If you missed last week's show, check it out. The podcast's topic was Antitrust Enforcement with Big Tech. The speaker was my college roommate Josh Soven who is a partner at Paul Weiss.

Lina Khan is the Chair of the Federal Trade Commission, and she is going after big technology companies. For the past 25 years there was a bipartisan consensus that anti-trust policy's goal was to maximize consumer welfare. We discussed why Lina Khan has abandoned that goal and the new objective is to undermine big firms with significant market power like Amazon and Google.

I now want to make a plug for next week's podcast with Jeff Speck who is the author of the classic book entitled Walkable City: How Downtown Can Save America, One Step at a Time.

I want to learn from Jeff why walkable cities are better places to live. Why bike lanes and active pedestrian traffic make vibrant cities, and that speedy cars are problematic.

You can find our previous episodes and transcripts on our website whathappensnextin6minutes.com. Please subscribe to our weekly emails and follow us on Apple Podcasts or Spotify.

Thank you for joining us today, good-bye.