Lessons from America’s Former Top Doctor – from COVID to the Opioid Crisis

SPEAKERS
Dr. Jerome Adams, Heather Howard

Heather Howard 00:02
Hi, and welcome to the Princeton Pulse Podcast. I'm Heather Howard, professor at Princeton University and former New Jersey Commissioner of Health and Senior Services. On campus and beyond. I've dedicated my career to advancing public health. That's why I'm excited to host this podcast and shine a light on the valuable connections between health research and policy. Our show will bring together scholars, policymakers, and other leaders to discuss today's most pressing health policy issues, domestically and globally. We'll highlight novel research at Princeton, along with partnerships aimed at improving public health and reducing health disparities. I hope you'll listen in as we put our fingers on the pulse and examine the power and possibilities of evidence informed health policy.

Today's episode takes us to the frontlines of the COVID-19 pandemic and other public health crises with Dr. Jerome Adams, former US Surgeon General. Serving as the nation's doctor during the height of the pandemic and as a member of the President's Coronavirus Task Force, Dr. Adams was an integral part of the US response to COVID-19. A public health expert and key spokesperson for the administration, Dr. Adams was uniquely responsible for not only understanding the science related to COVID-19, but also relaying accurate, trusted information to American families. And of course, that was no easy task, as the virus rapidly evolved and spread around the world -- and misinformation spread just as rapidly as researchers tried to keep pace. Now out of public office, Dr. Adams is Executive Director of Health Equity initiatives and distinguished professor of practice at Purdue University. He also authored a new book called "Crisis and Chaos: Lessons from the Frontlines of the War Against COVID-19."

I'm delighted Dr. Adams is here with me today to share the lessons he learned from his mistakes and successes as Surgeon General, including the importance of de-politicizing public health, improving science and health literacy, preventing misinformation, and preparing for the next public health crisis. We'll also delve into his experiences as Indiana's Health Commissioner, and how he incorporated harm reduction practices into the response to the opioid crisis. Dr. Adams, welcome to the show.

Congratulations on the book, Dr. Adams. I stayed up late last night reading it and really enjoyed it. It's remarkably frank and immensely readable. One thing I particularly appreciated was how you included actionable recommendations. You're saying "here's how we can improve public health," and you recognize the faults of our public health system, and even the role you played in it in a way that's rare often for public officials. So congratulations. What's it like being out on the book tour talking about it?
Dr. Jerome Adams 02:53
Well, it's really great to be at a point where I have the book. I've written lots of journal articles. I've written academic books and chapters. This was something that was completely different. You know, I'm a co-author in a book called "Clinical Anesthesia." And there was no fighting over the title; the title was "Clinical Anesthesia." And to go back and forth with my publisher over the right title for the book, we had to tell them in a narrative format. In the books and journal articles I've written, you aren't telling a story, you're just giving the facts. And so it was a really neat experience, to learn how to write something different. But I'll be honest, it was also therapy. There's so much that we don't remember. For instance, do you remember when we didn't know if you could bring your groceries in, when we didn't know if you should wipe your mail down before you open it up? There's so much that we blocked out because of the fog of war. But those things are important to remember, so that we can make better decisions moving forward.

Heather Howard 03:52
Well, this is great, because I want to dive deep into the lessons of COVID-19. And I also want to go back. Even before you were US Surgeon General, you were Indiana's Commissioner of Health. Tell our listeners what you are up to now.

Dr. Jerome Adams 04:05
Well, now I am the Director of Health Equity at Purdue University. And that's an interesting role, because Purdue University does not have a human medical school. And I said that very specifically because we have a veterinary school, and they will get mad at me if I say we don't have a medical school. We don't have a human medical school. I had opportunities to take on health equity roles at many different places. And one of the things that that I've always said and tried to point out is that health is so much more than health care. Only about 20% of our health is determined by what happens in a traditional hospital or clinic. And I think one of the reasons why we're going in the wrong direction in terms of trying to lower health costs and improve health outcomes is we keep trying to change the system by only focusing on 20% of the problem. So going to Purdue was actually a challenge to myself, but also an opportunity. We've got, as I mentioned, a veterinary college. COVID was a zoonotic disease. We have one of the largest departments of "Ag" in the country. So when you talk about obesity, and diabetes, who better than the people who are actually designing and growing our food. We have a robust engineering program. That's what we're known for; we're one of the top universities in the nation for engineering. And when you look at AI and biomedical innovations, who better than Purdue. So I'm leaning into those social drivers at Purdue in a way that, quite frankly, I couldn't from within the hospital system.

Heather Howard 05:32
Well, that's great. We'll have to have you back then, after you've been involved in all those other worlds. But for now, with the book, you mentioned that writing the book was part therapy. But I also noted, you dedicated the book to those who were lost during the pandemic. And you say that this book was written in the hopes that their suffering can help prevent the future suffering of others, which was a really moving way, I thought, to start the book. And you also use a Titanic metaphor throughout the book, talking about helping our health care system avoid that next iceberg. So can you talk about that motivation to sort of go through the fog of it, to revisit all of it, but to pull out the lessons?
Dr. Jerome Adams
Well, I'll cut to the question that many reporters have asked me: Why now, after three years, are you writing a book? When I first came out of office, all anyone wanted was a book about Trump. They wanted the dirt. And there have been lots and lots of books on COVID purportedly. But in many ways, they've just been people slinging mud at one another, pointing fingers at one another. The good thing is, I had time to really think about and reflect on what went wrong. And one of the things I bring up in the book is that we keep making the same mistakes over and over again, despite a completely new administration, a new CDC director, and new FDA commissioner. So this premise that simply changing the people in charge was going to change our course -- and that's the Titanic metaphor -- was false. It was false. We have to admit that and we've got to undo. We've got to understand there are structural issues at play here that we need to focus on and address. And you mentioned the lives loss. They say those who don't know their history are doomed to repeat it. We want to learn from our history. Also, some of the greatest advances in health and in health policy have come during times of war and crisis, because nobody wants to change the course of the ship when the seas are calm. Everything's fine. We're doing all right. But when you're in a storm, you're forced to acknowledge the problems and to adapt. In World War I, we saw massive increases in innovation around blood transfusion technology... too many lives lost, but those lives were then used to save lives in the future. People don't know that World War II was actually our first operation warp speed. We saw massive increases in the production and utilization of penicillin, during World War II, to respond to battle injuries. The Gulf War actually saw big changes in the way we treat trauma patients. Because we had very different kinds of injuries occurring. And COVID is no exception. And just one example I'll give you is the 7,000% increase in telehealth we saw during the pandemic. Telehealth is not new. We've been talking about it for 30 years. But COVID forced us to get off the fence and actually lean into new ways to provide care to folks. And so we've lost over a million lives during this pandemic. It's a tragedy by any measure, here in this country. But we honor those lives by saying, "okay, we're going to use the lessons learned from what went wrong with you to save 10, 100, 1,000, 10,000 lives in the future," the way we've done with penicillin and with blood transfusions.

Heather Howard 08:58
One through line in the book is the vital role that communications plays in public health. You were our nation's top doctor, a Surgeon General, you were Indiana's Commissioner of Health, but you grapple with how hard it was communicating about the pandemic, especially early on, when I think you say we didn't even know what we didn't know. Right? And we were getting probably a lot of incomplete information from China. And you went out there and said things that you now reflect on, things you wouldn't have said if you'd had more information, but you had to communicate. So how do you do that? How do you communicate when you have incomplete information, but someone needs to be communicating?

Dr. Jerome Adams 09:39
You're right. That's a common theme in the book. I tried to help people understand the challenges that we had so we can do better in the future. One of the challenges that we had is, as you mentioned, we didn't have complete information from China. General Colin Powell was someone who advised me throughout the pandemic, and he has a famous 40/70 rule that he talks about. He says that when you
have to make critical leadership decisions, if you make those decisions before you have at least 40% of the information, you're likely to be wrong. And if you wait until you have more than 70% of the information, you're likely to be irrelevant. We constantly found ourselves on the wrong end of that 40/70 rule in both directions. Example... early on in the pandemic, we did not know about the high degree of asymptomatic spread of the virus, because China was not forthcoming with the information. So Dr. Fauci and I went out and told people not to wear masks, because that's what we told them for every other respiratory virus we'd encountered in history. Well, once we got that information, we had to change our recommendations. And people said, "See, we can't trust you." On the other end, we know the CDC oftentimes won't make a recommendation or put out a guideline until they have 110% of the information. And so they were irrelevant, in many, many of these discussions, because people had already decided what they were going to do by the time the CDC made the recommendation.

Dr. Jerome Adams 11:00
So you'd rather be on the field than on the sidelines?

Dr. Jerome Adams 11:04
Exactly. And you've got to make tough decisions. And you've got to be able to explain to folks what you know, what you don't know. And you've got to have the humility to say, "Hey, we made our best guess. We were wrong. And we're going to pivot." And that's what we had to do with masking and the masking recommendations. But the one other point that I'd make, that I make in the book, is that we need to really work on our science and math education in our country. It's very hard to have these complex conversations, where the information coming in is changing rapidly, with a populace that is ranked outside the top 20 in science and math, and every day on Twitter, and on Instagram, and on Facebook, I'm arguing complex journal articles with people who don't understand basic statistics. That inhibited our ability to really have the level of conversations that we needed to have during the pandemic. Final point is that we need to have more communications training for public health and medical officials. So when you asked me a question as a doctor, and I spent my career in academic medicine, I am going to give you the best possible answer I can if it takes an hour and a 60 slide PowerPoint presentation to communicate that to you. That's the way I was taught. But that is not the way you communicate. When you're on Fox News with Sean Hannity or on NBC with Rachel Maddow, we need people who understand the science behind effective communication to help public health officials become better at speaking to the public.

Heather Howard 12:39
That stood out to me in the book. You end with some concrete recommendations, and one of them is increasing scientific literacy and health literacy. Early in the pandemic, it seems like there was a struggle to explain to people who don't understand the scientific process, the fact that knowledge evolves.

Dr. Jerome Adams 12:57
Exactly.
Heather Howard 12:58
And it doesn't mean you that you were lying before. You just know more now. Does that go back to high school science education? How do we address that?

Dr. Jerome Adams 13:09
It absolutely does. I mean, it goes to elementary science education. We need to recognize that if we continue to fall behind in math and science, and in reading, compared to the rest of the planet, we're going to struggle in an array of ways moving forward, particularly when you're in a crisis situation. And you've got to rely on that education as a foundation for being able to have discussions and form policy decisions that, in many cases, are going to be tough no matter what. When you're dealing with 350 million people, there's no policy that doesn't harm someone. We need to be able to have conversations about those trade-offs. And I don't think we did a good enough job of having those difficult conversations about the trade-offs from a governmental and a public health perspective. But I also think it was difficult, if not impossible, to have those conversations with people who weren't equipped with the foundational knowledge to understand what you're talking about.

Dr. Jerome Adams 14:10
Some of this relates to another core recommendation you have, which is that we need to enhance trust in our institutions, right? And it's obvious that they're related. People don't trust what they're hearing if they don't understand what they're hearing. Do you despair about where we are now, in terms of trust in our institutions?

Dr. Jerome Adams 14:30
I'll be honest with you, that is one of the things I do despair about, and I talk about this in the book over and over and over again. Health is inextricably political in the United States. But it doesn't have to be partisan.

Heather Howard 14:47
So for those of us in public health, vaccines are one of the greatest achievements over the last 100 years. But it seems to me that the rapid development of a safe and effective COVID vaccine was both the greatest achievement of the pandemic and the greatest disappointment in terms of the uptake.

Dr. Jerome Adams 15:08
I would agree with that.

Heather Howard 15:10
So how do you situate that? You've put your finger on the politicization of public health. Sadly, the COVID vaccine, most prominently, but many vaccines now have become politicized. How do we think about that?

Dr. Jerome Adams 15:25
Well, that's interesting is that COVID wasn't anything new. And what I mean by that is the problems were already there. COVID was just a massive magnifying glass on a lot of the issues that were simmering in America for quite a while. Again, history. In 2019, prior to the pandemic, I spent most of
that year traveling around the country dealing with measles outbreaks... and the American Samoa, where we had 83 children die from vaccine misinformation, and Oregon and into the state of Washington. And in Rockford, New York, we almost lost our measles eradication status because of vaccine hesitancy in 2019. So it's not like it happened all of a sudden, that it came up out of the blue in 2020. COVID was just kerosene on the fire.

**Heather Howard** 16:20
But it's got to have a long tail. Right? I was just looking at the data out of the CDC. The CDC expects to give 10 times as many flu shots this year as the updated COVID vaccine. So people are getting the flu vaccine, but not the COVID vaccine.

**Dr. Jerome Adams** 16:35
Well, it shows you the politicization and the partisanship that has occurred around COVID. And my worry, to your point, is the spillover impact. So we do know that we're getting less uptake with childhood vaccinations. More and more people are hearing misinformation that's being perpetuated because of COVID partisanship, and it's impacting other areas. So we really do need to lean into this. And that goes, again, back to basic education. We need to make sure every kid in middle school understands how vaccines work, how they're developed, the processes that we have in place. And we need to be very careful about the way we discuss and frame this issue.

**Dr. Jerome Adams** 17:18
I'll be honest with you, I have been on the record consistently as expressing my frustration with the current administration for calling this a pandemic of the unvaccinated. It was framed in a very political way. It was essentially saying that those Republicans who won't get vaccinated are the reason we still have this pandemic. And, once again, a few months passed and we realized that the vaccines are no longer as effective against transmission as we thought they were. And everybody goes, "See, you all lied to us again." I've never found shaming and blaming people to be an effective public health strategy. It can work in a very short term, but long-term, you need to focus on engagement. And that's where I'm trying to spend my time, on engaging. There's a saying that I love: People need to know that you care before they care what you know. I don't think we did a good enough job with anyone in the country, over the last several years, of showing people that we cared. And, in many cases, we tried to bludgeon them with what we know.

**Heather Howard** 18:21
It's such an interesting point. You didn't use the word harm reduction, but you just talked about not shaming people. So can we travel a little bit further back in time, before you were Surgeon General? You were Commissioner of Health in Indiana when Vice President Mike Pence was Governor of Indiana, and you were facing, I believe, the worst HIV outbreak related to injection drug use in the history of the United States.

**Dr. Jerome Adams** 18:48
Yes, we had a small rural community with over 200 cases of HIV in less than a year. Previous to that, they'd never had more than two HIV cases.
Heather Howard 19:00
Wow. Clearly you were able to tell that it was tied to injection drug use. And, in other parts of the country, one public health tool is a syringe exchange program. But Indiana did not allow them, right? So tell us, how did you navigate that and eventually get Indiana to the place where they would adopt a best practice?

Dr. Jerome Adams 19:25
I love telling the story, particularly to public health students, because that's another situation, when I was Health Commissioner, that I got ripped to shreds by people at Johns Hopkins, by people at Yale, by people at UCLA.

Heather Howard 19:25
No one at Princeton, right?

Dr. Jerome Adams 19:31
No one at Princeton. I was ripped to shreds because we didn't move fast enough, in their opinion, to force syringe service programs on that community. I often tell students how I went down to that rural community, and I went to churches, and went to the police station, and did HIV testing in the jails. I did a "ride along" with the local police chief, and the local police chief told me to my face, while I was in his car, "If you all come down here and start passing out syringes, I'm just going to set up a perimeter around your syringe service program and search the first couple of people who come through, and that will be the end of your syringe service program." So what I found was that going down there, and having meals with people, and going to church with people, and hearing their stories, created a relationship that allowed them to see me not as a government official who was coming there trying to bludgeon them into doing what I felt was the right thing, but as a friend who was working with them to help them get through a difficult time. (As some people know, my own brother is literally in rehab right now. He was released from prison, into rehab, but has substance use disorder.) I created that connection. Remember, people need to know that you care before they care what you know. And once they saw me as a friend, they were more willing to listen to my advice about a syringe service program. And eventually they went to the governor and the legislature and said, "This is what we want for our community." And it gave it staying power. Number one, it gave it credibility because, especially with elected officials who need to hear from their electorate, and it gave them cover. I am as proud of that as anything I've done in my career. And here's why. Not only were we able to legalize syringe service programs in Indiana, under a super majority Republican legislature and one of the most conservative governors in the country, but we also were then able to use that as a model in places like Ohio and Kentucky and Arizona and Florida. Literally, Kentucky went from zero syringe service programs to over 70 in their state based on Indiana. And I've had people tell me that their argument in the legislature was that if Mike Pence can do it in Indiana, we can do it here.

Heather Howard 22:20
And the evidence is clear that these syringe service programs do two things. One, they reduce the spread of blood borne illness. Correct? And two, they do not increase drug use, right? I think that was the message you were continually driving home.
Dr. Jerome Adams  22:35
Well, that's the science behind the message. Again, that's what I knew. But I had to connect with why they care. You have to understand that we're in the Bible Belt. In many cases, people thought that was what God was punishing you with, for your bad behavior. And so they didn't care about prevention of transmission of HIV amongst people who were injecting drugs. What they cared about was, when I showed them the data, was that we were getting more people connected with treatment and recovery. And instead of going to jail, those people were actually getting jobs. And they weren't breaking into their houses. They were actually reacquainting with their families. And so we had to show them as a metric connection to care. It's funny, I actually remember, when we were before the legislature, there was a "sunshine provision" in the bill where we had to keep going back and getting re-approval. We had it set up. We'd done our work behind the scenes. And then a public health advocate showed up and talked about all the syringes that we'd given out in that community, 60,000 syringes. From a public health standpoint, we're like, "yeah, we're preventing transmission of disease." The legislature said, "Wait a minute. You did what? There's 60,000 more syringes in our community. Oh, no. Oh, no." And so we were almost undermined because folks were speaking in a public health and scientific language, as opposed to speaking in the language that resonated in that community... of getting people treatment, recovery and making the community safer from a public safety standpoint.

Heather Howard  24:35
Well, it's super interesting when I teach your example, and how you did this, to students. Because it's pretty masterful how you figured out how to navigate those tough waters. When you became Surgeon General, you also focused on the opioid crisis and got a lot of attention. Can you talk about recommending Naloxone? Looking back, are you glad you did that?

Dr. Jerome Adams  25:03
So that's probably the other policy that I'm most proud of. I put out a Naloxone advisory when I was Surgeon General. One of the challenges of being a Surgeon General is that you've got to figure out what to prioritize, because everybody wants you to make their top priority your top priority. So you take 20 meetings a day, with people saying, "Why don't you focus more on cystic fibrosis? Why don't you focus more on sickle cell? Why don't you focus more on this or that?" Well, the opioid epidemic was killing a person every 11 minutes at the time I came into office. It was truly the crisis, the pandemic, before COVID. And it was also something that I had a personal stake in. As I mentioned, my brother has substance use disorder.

Dr. Jerome Adams  25:48
Once upon a time, people were dropping dead of cardiac arrest. And you got four minutes to respond. So we taught the entire populace how to do CPR. We said that we can teach you something that can help you keep this person alive until EMS can get there. And now you can't go into a room of average Americans and not find someone who knows CPR. Well, I wanted to do the same thing with Naloxone. Because the truth is, in many communities, you're far more likely to encounter someone having an opioid overdose than someone who's having a heart attack. And so I wanted Americans to know about Naloxone and to be willing to carry it if they were in a high-risk situation. And we're working now to try to get it placed with AEDs, with defibrillators, in public places, in restaurants and convention centers, on airplanes, so that if someone has an overdose, you're able to respond to it. We saw Naloxone
dispensing go up 400% nationwide after that Surgeon General's advisory. And what was interesting is another true story. My budget and staffing as Surgeon General of the United States were one percent of what they were when I was a state Health Commissioner. One percent. So I didn't have a lot of ability to actually move pieces around on the chessboard from a programmatic standpoint, when I was Surgeon General. But I had a tremendous bully pulpit. The Surgeon General said to know about and carry Naloxone. And the honest truth is that there are probably 10s of 1000s of lives that were saved by that advisory, and I continue to be proud of it.

**Dr. Jerome Adams** 27:36
The final point I'd make on that is that many of your listeners have said, and are saying right now, "How could you work for that man [Donald Trump]? If you're not on the field, you can't change the game. There are ways that I was able to improve health and health equity for people during the prior administration that aren't talked about and will never be appreciated.

**Heather Howard** 28:07
Well, I did want to make sure we touched on that. Now your job is focused on health equity directly. But health equity has always been a focus of yours. You talk about the importance of diversity of voices at the table. You talk about who was at the table during the COVID taskforce meetings. I'd be interested to hear your thoughts on diversity in clinical trials. Maybe you could tell us about the pulse oximeter example, because that seems to tie together a couple of these strands.

**Dr. Jerome Adams** 28:42
Well, it does. I'm an asthmatic. I've been carrying an inhaler around in my pocket for the last 42 years of my life. I've almost died multiple times from asthma, and I tell a story about that in the book. But unfortunately, despite Black boys being three to four times more likely to die from asthma, they represent less than 2% of the people in clinical trials. And you mentioned the pulse oximeter. For those who are not medically inclined, the pulse oximeter reads the amount of oxygen in your skin. It is highly dependent on your ability to transmit light through your skin, which is impacted by your skin color. Pulse oximeters were not tested on people of darker skin color before they were FDA approved. And it took us decades to realize that pulse oximeters were giving falsely high readings for people of darker skin tone. What does that mean? That means there are countless times I went to the hospital as a young black male asthmatic and may have been turned away because they said my oxygen level was fine. They said that I didn't need to be here. And that was not necessarily true.

**Heather Howard** 29:52
So we're setting the level of the cause for concern too high, and people are falling through the cracks.

**Dr. Jerome Adams** 29:59
Exactly. We've seen that also for spyrometry, which is another type of lung test. We've seen it for kidney function tests. We've seen it for heart assessments, where there is bias baked into the way we diagnose and treat people. And in many cases, that bias is baked in because they're not part of the clinical trials. If they were, we would understand that you get differential outcomes based on factors such as race. So I'm now the Chair of the Board of the Association of Diversity and Clinical Trials. And one of the areas I'm leaning into is trying to make sure we have trials that are representative of the
disease burden in the community. It may be race. It may be that we have a disease that impacts women more than men. It may be that we've got something that impacts older people more than younger people. But either way, we want to make sure that the studies are being done on the population in whom the product is going to be utilized. Unfortunately, that hasn't happened in the past, and it's caused health disparities.

Heather Howard 31:02
I thought maybe we would end the interview the way you end the book, which is you have lessons for improving public health. We've discussed several of them already... the importance of de-politicizing public health, improving science and health literacy, health equity, but one we haven't yet touched on that maybe we could end with is disinformation and misinformation? Of course, all of these issues are related, but how can we address them? We're seeing more and more of that, especially in social media.

Dr. Jerome Adams 31:33
Yes, well, the current Surgeon General has called this a public health crisis. And I agree with him. We saw it during the pandemic. I always try to help people understand the full spectrum, because we spend too much time pointing fingers. Some of the problem lies with communicators, and some of the problem and fault lies with us as individuals. So let's start with us as individuals. We need to understand that we have a responsibility to vet our sources of scientific information. We shouldn't just trust anything that we read on social media. And what I say to folks is, "When in doubt, talk to your health provider. Don't believe me. Don't believe Dr. Fauci. Don't believe Joe Rogan. Talk to your health provider, the person you would go to for any other medical issue, and verify it with them before you decide to believe something or engage or not engage in a medical intervention." So that's on us. In the last few chapters of my book, I break down personal and societal changes. From a larger societal standpoint, we need to do a better job in terms of studying how to communicate effectively with people. There are people who know how to do this. We can sell an Oreo cookie to a kid anywhere in this country. We know how to micro target. We know when they're going to like the vanilla Oreo, and when they're going to like these new mint Oreos that we have. We know how to do this. And I say, kind of tongue in cheek, that we need more "Mad Men" in public health. We need to teach public health folks how to be better communicators, so that we can actually help us get past that misinformation and disinformation. And, as public health communicators, we need to understand when we are endorsing policies for political reasons over scientific reasons.

Heather Howard 33:42
Well, that's probably a good place to end. We'll take that deep breath and focus on better public health communications. Thank you, Dr. Jerome Adams. And your book is "Crisis and Chaos: Lessons from the Frontlines of the War Against COVID-19."

Dr. Jerome Adams 33:54
Thank you. It's available on Amazon, at Barnes and Noble. I hope people enjoy it. It's very different than most of the other COVID books out there. Because it's not at all policy heavy. It's more storytelling. I just want people to understand what it was like being in the room where it happens. And to know the different variables I was weighing. You are a wonderful health communicator. And I really appreciated this conversation. Thank you, and hope to work with you moving forward.
Heather Howard 34:23
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