SPECIAL TIME EDITION

100 Health Innovations

THE PEOPLE, PROGRAMS, AND IDEAS THAT ARE SAVING LIVES

TIME

100 Health Innovations

How We Chose the 2026 Most Influential People in Health

THE PAST YEAR HAS BEEN A BUSY ONE FOR THE GLOBAL HEALTH SECTOR. Innovation shot forward when Dr. Kiran Musunuru and Dr. Rebecca Ahrens-Nicklas administered the first-ever customized CRISPR therapy to treat a baby's genetic disease. In promising trials, new immunotherapies cured cancers, and the search for cancer vaccines advanced. Novo Nordisk, led by CEO Mike Doustdar, released the first GLP-1 pill to the market. And, after the Trump Administration cut funding for international aid and medical research, leaders around the world stepped up to try to fill the funding voids. This year, the TIME100 Health—the people most influential in the world of health right now—are more pivotal than ever.

To select these 100 individuals, our team of health correspondents and editors, led by Emma Barker Bonomo and Mandy Oaklander, spent months consulting sources and experts around the globe. What emerged is a community of scientists, doctors, advocates, educators, policymakers, and others—all leaders in their own ways—who are changing the health of the world.

FEATURES

Mike Doustdar

MULTIPLYING WEIGHT-LOSS MEDS

WHEN MIKE DOUSTDAR STARTED AS A SUMMER employee making copies at Novo Nordisk—a teenager living in Austria after fleeing unrest in his home country of Iran at 12—he never imagined he would remain at the company for more than 30 years, let alone lead it as CEO.

Doustdar now heads the Danish company that makes the popular diabetes drug Ozempic and weight-loss medication Wegovy, both of which contain the GLP-1 compound semaglutide. In January, Novo Nordisk launched the first GLP-1 pill for weight loss, marking a significant step in making the drugs more convenient and less expensive to take than the injectable forms previously on the market. It's a critical test.

Doustdar was tapped as CEO last summer in part to restore the company's presence in the diabetes and obesity space, after ceding ground to competitor Eli Lilly. Lilly's weight-loss drug Zepbound comes at higher doses and so tends to produce greater weight loss than Wegovy. Novo Nordisk needed a chief executive with resilience and flexibility to lead the comeback, and Doustdar says he adopted those skills moving to a country where he didn't speak the language. "I learned from an early age to build a bit of resilience and to manage uncertainty," he says.

The new GLP-1 pill for obesity, the rollout of which he's overseeing, boasts several advantages. Studies the company conducted showed that people taking the pill every day lose about the same amount of weight as those getting weekly injections—about 16% to 17% of their body weight. And because pills are cheaper to produce, more people may be able to afford a Wegovy pill. In an agreement with the White House, Wegovy pills cost $149 for a month's supply of the starting doses, and $299 for the two higher doses, for people paying out of pocket as well as those on federal insurance plans. People whose private insurance plans cover the drug may pay as little as $25 a month.

Doustdar says the White House announcement was the result of several months of discussion to reach a mutually agreeable price plan for the drug. "For us to be able to make any deals, it has to not be a zero-sum game, but a win-win situation," he says. "We needed to explain that the cost of operations in the U.S. is very different from the cost of operations in Europe."

"On the other hand, we also recognize that at higher prices, we will not get access to bigger volumes," he says—and with hundreds of millions of people around the world who could potentially benefit from a weight-loss drug, Doustdar hopes Wegovy pill will be more convenient, and accessible, for them.

Later this year, Doustdar also plans to introduce a higher dose of Wegovy's injectable form, which the company's studies show leads to about 20% weight loss, comparable to Lilly's Zepbound, to "close the gap with our competitor." Both are also studying a different group of compounds called amylins that could expand the range of weight-loss drugs even further.

While Novo Nordisk was also studying semaglutide's potential to slow the progression of Alzheimer's disease, a highly anticipated study revealed little difference between people injecting the drug and those getting placebo. Doustdar says his team will continue to analyze the data, but has decided to stop any additional studies on Alzheimer's. Still, he is confident that there may be other health benefits of semaglutide, which amounts to what he calls "secret sauce."

Doustdar's strategy to grow Novo Nordisk's presence involves building a portfolio of diabetes and obesity treatments that can meet the needs of as many people as possible. "We're talking about 2 billion people, and eventually someone has to produce all the doses for them," he says. "We are sitting in the right spot right now, and still only touching a fraction of the people who are in need." —*Alice Park*

***Left:** Doustdar speaks in the White House Oval Office in November 2025.*

Sabin Nsanzimana

STOPPING A VIRAL OUTBREAK

IN SEPTEMBER 2024, DR. SABIN Nsanzimana, Rwanda's minister of health, was in a training exercise simulating an outbreak of hemorrhagic fever. Later that month, he and his colleagues confronted an eerily similar situation: In Kigali, a tin miner and his wife were ill with an acute disease that soon began to spread.

It was Marburg virus, a deadly hemorrhagic illness with Ebola-like symptoms that in past outbreaks has killed up to 88% of people afflicted. There had never been an outbreak in Rwanda, but Nsanzimana and his colleagues leapt into action, contact tracing and testing. They also reached out to the Sabin Vaccine Institute in the U.S. (no relation to Nsanzimana), which has a Marburg vaccine in clinical trials. The institute sent more than 1,700 experimental vaccine doses to Rwanda, and a vaccination campaign was soon in full swing.

By December 20, 2024, the outbreak was over. Out of 66 cases, only 15 people died, and Marburg was prevented from spreading beyond Rwanda—a testament to Nsanzimana's swift action, yielding key lessons for stopping future viral outbreaks that the Sabin Institute has implemented already in a 2025 outbreak in Ethiopia.
—Veronique Greenwood

Nsanzimana (right) greets journalist Adriana Diaz at the Gates Foundation's annual Goalkeepers Event in 2024.

Luciano Moreira

PROTECTING PEOPLE FROM MOSQUITO-BORNE DISEASE

IN JULY 2025, WOLBITO DO BRASIL, A JOINT venture of the World Mosquito Program and partners headed by CEO Luciano Moreira, opened the world's largest mosquito biofactory in Curitiba, Brazil, to help stop the insects from spreading illnesses like dengue and Zika.

Wolbito-bred *Aedes aegypti* mosquitoes are exposed to the naturally occurring bacterium *Wolbachia*, which inhibits the host's ability to spread disease. The bacterium is maternally transmitted to offspring, and when released into the environment, the *Wolbachia*-treated mosquitoes breed generations of mosquitos unable to spread disease. The method has so far protected more than 5 million people in 16 cities across Brazil, says Moreira. With the new factory, those numbers will go up. "The biggest facility is up and running, with the capacity to produce 100 million eggs per week," says Moreira. "This protects 14 million people every year." *—Veronique Greenwood*

Delese Mimi Darko

BUILDING A UNIFIED MEDICINES AGENCY FOR AFRICA

DURING THE COVID PANDEMIC, PHARMACIST Delese Mimi Darko, then head of Ghana's Food and Drugs Authority, saw how efficient Europe's vaccine rollout was: A single approval by the European Medicines Agency (EMA) got the process started. In Africa, by contrast, medicines and vaccines are handled by individual nations. In 2025, Darko became the first head of the African Medicines Agency, a new entity modeled after the EMA, which will streamline the approach for approving and delivering medical treatments across the continent to patients in need. Her goal is to get all 55 nations of the African Union on board with the AMA—so far, around 30 have joined. *—Veronique Greenwood*

Robert Davis

IMMUNOTHERAPY GAME-CHANGER

WHEN YOU'RE THE HEAD OF THE COMPANY that makes the top selling drug in the world, you focus on making sure there's enough supply of your product to keep sales strong. As CEO of Merck, Robert Davis supervises the manufacturing and distribution of Keytruda, or pembrolizumab, the game-changing immunotherapy drug that has saved the lives of millions of cancer patients. Keytruda releases the brakes that keep immune cells from attacking cancer, and while successful on its own, doctors are increasingly combining the drug with other cancer therapies to improve outcomes for patients with a range of cancers, including head and neck, cervical, and kidney cancers. In coming years, Davis anticipates further expanding Keytruda's reach; last fall, the FDA approved a more convenient form of the drug that doctors can inject, removing the need to install a port.

To account for the demand, in April Davis announced plans to build a $1 billion biologics center in Wilmington, Delaware, and expects that eventually most of the world's supply of Keytruda will be made there. *—Alice Park*

Jennifer Mensik Kennedy

CHAMPIONING NURSES

JENNIFER MENSIK KENNEDY IS PRESIDENT OF the American Nurses Association (ANA), which represents 5 million nurses in the U.S. and has been advocating for policies that support and protect nurses in their jobs. Recently, the group gathered a coalition of over 90 organizations to support the ICAN Act that was reintroduced in 2025, which would remove federal barriers preventing Advanced Practice Registered Nurses from providing care without doctor supervision. "The research has been clear for decades that nurse practitioners and other advanced practice roles provide quality patient care equal to, if not better than, primary care physicians," says Mensik Kennedy. ANA also pulled together a collective petition to Congress to requalify nurses as professionals following the U.S. Department of Education's new proposed definition of professional degrees, so loan limits don't become a barrier to entry. Their activism has drawn international support. "We've gotten letters from across the globe," Mensik Kennedy says. *—Charlotte Hu*

Rosemary Mburu

CHAMPIONING AFRICAN HEALTH LEADERSHIP

WHEN PRESIDENT TRUMP'S CUTS TO international aid budgets in 2025 impacted work to eliminate malaria, HIV, and TB, Rosemary Mburu knew it was time for a bold new global health strategy.

Mburu, a civil society organizer who is the executive director of NGO WACI Health in Kenya, is also a coordinator for the Global Fund Advocates Network Africa hub, which generates local community support for the Global Fund. Mburu rallied African donor countries to support the fund, and helped others speak on the global stage to drum up further support. "We saw African leadership stepping up to champion this moment," Mburu says. Several African countries substantially increased their contributions, marking a shift from a model where low-income countries are beneficiaries of aid to one where they are co-investors, a model that Mburu has championed publicly. *—Veronique Greenwood*

Daniel O'Day

ADVANCING THE FIGHT AGAINST HIV

THE HIV EPIDEMIC HAS BEEN SIMMERING FOR more than 40 years, and while antiviral medications have saved millions of lives, there is still no vaccine to protect people from getting infected in the first place—crucial to eliminating the disease. Anti-HIV medications can reduce the risk of getting infected, but people need to take the oral medication daily, a barrier that prohibits many from taking advantage of the therapy. CEO Daniel O'Day's team at Gilead changed that in June 2025, when its drug lenacapavir became the first twice-yearly medication approved by the U.S. FDA to prevent HIV infection. People at high risk of being exposed to HIV can receive the injections from their doctor and reduce their chances of getting infected and of passing along the virus. The World Health Organization now recommends the drug for HIV prevention, and the U.S.'s President's Emergency Plan for AIDS Relief (PEPFAR) program has committed to providing lenacapavir to eight to 12 countries most heavily affected by HIV. *—Alice Park*

Kennedy discusses mental health and addiction in Washington, D.C., in 2026.

Robert F. Kennedy Jr.

RESHAPING PUBLIC HEALTH

SINCE ROBERT F. KENNEDY JR. became secretary of the U.S. Department of Health and Human Services in February 2025, he has advanced his "Make America Healthy Again" agenda and played a pivotal role in reshaping federal healthcare and public-health policy.

Kennedy has made changes to long-standing vaccine policies, including reducing the number of diseases covered by the U.S. childhood immunization schedule. In March, a federal judge temporarily blocked Kennedy's changes. Meanwhile, vaccination rates nationwide have continued to decline, alongside increases in outbreaks of diseases such as measles and influenza. He has also highlighted research exploring possible links between autism and factors including the widely used painkiller acetaminophen, despite recent research refuting this.

Under his leadership, research priorities at the U.S. National Institutes of Health have shifted: Some studies on mRNA vaccines have been cancelled; a network of centers focused on pandemic preparedness closed; and attention on chronic disease, autism, and nutrition has increased. Staff have been cut across health agencies, including at the U.S. Centers for Disease Control and Prevention (CDC). In 2025, Kennedy drew scrutiny after dismissing CDC Director Susan Monarez, who later said she had been pressured to preapprove vaccine recommendations before reviewing data. Kennedy denied her allegations in Senate testimony.

Kennedy has also prioritized changes to the American diet and food system, including encouraging higher protein consumption and reduced intake of processed foods, and advocating for the phaseout of synthetic food dyes—efforts he says will improve long-term public health. *—Dominique Mosbergen*

A JUDGE DECLARED THE GOVERNMENT'S VACCINE ROLLBACKS INVALID. WHAT HAPPENS NOW?

The former vaccine schedule is back, but that's not the whole story

BY ALICE PARK

SINCE BECOMING SECRETARY of Health and Human Services (HHS), Robert F. Kennedy Jr. has targeted national vaccine policies and attempted to reshape federal health recommendations to reflect more skeptical and anti-vaccine views.

On March 16, a federal judge in Massachusetts blocked some of those changes and reversed dramatic alternations to the country's main advisory committee of experts on vaccines that makes national immunization recommendations.

So what happens next? Here's what you need to know.

What changes to vaccines has Kennedy made since he took office?

Kennedy's recent changes include yanking the recommendation of annual flu and COVID shots for most children and adults, including pregnant women. He also removed all members of the CDC's Advisory Committee on Immunization Practices (ACIP), a panel of independent vaccine experts that makes recommendations about vaccine schedules, and replaced them with people who have less or no expertise in vaccines—and who hold more skeptical views on immunizations. That committee recently decided to remove the long-held recommendation for the hepatitis B shot that newborns receive.

How did doctors respond to Kennedy's changes to vaccine policy?

Last July, several professional medical organizations sued HHS and Kennedy over the changes, saying that deviating from established vaccine policies would put more Americans, particularly children, at risk of preventable diseases. The groups also said the decisions made by HHS were not based on scientific evidence and that Kennedy acted "arbitrarily and capriciously" by changing COVID vaccine policies. In firing and replacing ACIP members, the medical experts said Kennedy acted unlawfully and failed to follow proper procedures for appointing members of that committee.

Other groups, like America's Physician Groups, which represents more than 340 physician groups including 260,000 doctors, filed briefs in support of the suit, adding concerns about how the vaccine-policy changes undermine the push toward value-based care that focuses on prevention to avoid costly illnesses that burden the health care system. "We know effective prevention strategies are key to value-based health care and that vaccines are key to prevention," says Susan Dentzer, president and CEO of the group.

Dentzer says the amicus brief could be useful in the appeals process, since appeals courts often

seek to understand the broader context of lawsuits beyond just the plaintiff and defendant. HHS spokespeople have said they plan to appeal the judge's ruling.

What does the judge's decision mean?

U.S. District Court judge Brian Murphy declared decisions made by Kennedy's reconstituted CDC committee invalid and ordered a stay on changes to vaccine policies that Kennedy and HHS have announced so far. "Essentially the court has nullified everything that [Kennedy and the CDC committee] have done," says Sara Rosenbaum, professor emerita of health law and policy at the Milken Institute School of Public Health at George Washington University. "Your doctor is now guided once again by the routine CDC schedule before they started to screw with it."

This also means that Kennedy's new ACIP is invalid and therefore not allowed to meet. Planned meetings scheduled for March 18 and 19 were postponed. The judge's ruling means that "for the time being we are functioning without an ACIP," says Rosenbaum, "which is going to be a problem the moment a new vaccine has to be considered or a change in the existing vaccine schedule is needed."

How does the judge's ruling affect the vaccines my family or I can receive?

Despite the changes Kennedy made to the annual flu and COVID vaccination recommendations and to the childhood vaccination schedule, professional medical organizations such as the American Medical Association and the American Academy of Pediatrics issued recommendations continuing to advise people to get these shots. Many doctors have followed these guidelines since they are rooted in scientific evidence, and the changes Kennedy made were not prompted by any new evidence. Since the changes, many states have also ensured that doctors would not be penalized for providing the shots, and insurers have continued to cover them—so for many, the judge's ruling doesn't materially change their access to vaccines, but provides more legal support behind the previous, decades-long and scientifically backed policies.

Some experts see the ruling as the first conflict in a long battle over re-establishing trust in science and public-health systems that have long struggled to implement programs like vaccinations for children. "The short version is that I don't think this amounts to much," says Dr. Tyler Evans, CEO and co-founder of Wellness Equity Alliance and former chief medical officer of the New York City Emergency Management System. "This is just a stay, not a final decision. The jury is still out on this situation. From a material standpoint, it's not going to change how the current system is set." But with the weakening of ACIP and vaccine recommendations, "we are basically increasingly seeing the destruction of any uniform public health system."

ACIP's immunization recommendations are important because they provide a uniform framework that states, cities, insurers, and individual doctors then followed, leading to a consistent and effective way to respond to disease. "While states aren't required to follow them, they often did, because they followed the science," says Evans. "Now we are destroying confidence in science and increasingly seeing more fiefdoms of public health with states having their own policies."

Still, Evans agrees that the lawsuit—should it become mired in extended appeals proceedings—was a reasonable response to the dramatic changes occurring in U.S. vaccine policy.

'Essentially the court has nullified everything that [Kennedy and the CDC committee] have done.'

— SARA ROSENBAUM, PROFESSOR EMERITA OF HEALTH LAW AND POLICY AT THE MILKEN INSTITUTE SCHOOL OF PUBLIC HEALTH AT GEORGE WASHINGTON UNIVERSITY

MEET THE NEW DIETARY GUIDELINES

Doctors and nutritionists say some of the recommendations are positive, but others could have negative consequences

BY DOMINIQUE MOSBERGEN

THE TRUMP ADMINISTRATION ON JANUARY 7 unveiled new U.S. dietary guidelines that encourage Americans to eat more protein, and less sugar and highly processed foods.

The guidelines also soften recommendations on alcohol and laud the benefits of red meat, dairy, and butter, worrying some doctors and nutritionists who say such guidance could be confusing and even harmful.

U.S. Health and Human Services Secretary Robert F. Kennedy Jr. said the updated guidelines—which include a new, inverted food pyramid that prioritizes the consumption of protein, dairy, healthy fats, vegetables, and fruits—highlight the importance of eating "real" food. "Nothing matters more for health outcomes, economic productivity, military readiness," Kennedy said at a White House press briefing.

The guidelines reflect many of Kennedy's own positions on nutrition and the priorities of his Make America Healthy Again movement. They advise people to significantly limit highly processed foods, which Kennedy has repeatedly blamed as a source of what he refers to as America's chronic-disease epidemic. The term "highly processed foods" is not clearly defined in the guidelines, but are described as foods "laden with refined carbohydrates, added sugars, excess sodium, unhealthy fats, and chemical additives."

The guidelines also encourage the consumption of greater amounts of protein—including from animal sources such as red meat, poultry, and eggs—than what previous guidelines advised, and recommend that people eat full-fat dairy and cook with butter and beef tallow. These foods contain saturated fats, which earlier dietary guidelines had urged people to avoid. Research on the health hazards of saturated fats has been mixed, but has largely shown that consuming too much of them can increase cardiovascular risks.

U.S. Secretary of Health and Human Services Robert F. Kennedy Jr. unveils the new dietary guidelines in January 2026.

Kennedy and others in the Trump Administration have contended that saturated fats have been unfairly vilified and are actually essential to a healthy diet. "We are ending the war on saturated fats."

However, while Kennedy and other Trump officials had previously hinted that they were seeking to loosen restrictions on saturated fats, the revamped dietary guidance maintained the longstanding recommendation of limiting consumption of such fats to 10% of daily calories.

Marion Nestle, a professor emerita of nutrition, food studies, and public health at New York University, said this advice was contradictory. "If you increase the amount of protein, meat, and full-fat dairy in your diet, you will not be able to keep your saturated fat intake below 10% of calories, and will have a harder time maintaining calorie balance," since fat has twice the calories of proteins or carbohydrates, Nestle said in an email.

The American Heart Association, which recommends that people limit consumption of saturated fats to 6% of daily calories, said it was concerned about some of the protein-related recommendations in the updated guidelines.

"Protein is an essential component of a healthy diet, and we urge more scientific research on both the appropriate amount of protein consumption and the best protein sources for optimal health," the group said in a statement. "Pending that research, we encourage consumers to prioritize plant-based proteins, seafood and lean meats and to limit high-fat animal products including red meat, butter, lard and tallow, which are linked to increased cardiovascular risk."

Some doctors and nutritionists said they generally approved of the advice to eat less sugar and fewer highly processed foods. "That is the one great strength of these recommendations," Nestle said.

Dr. Bobby Mukkamala, president of the American Medical Association, said in a statement that the group applauded the updated guidelines "for spotlighting the highly processed foods, sugar-sweetened beverages, and excess sodium that fuel heart disease, diabetes, obesity, and other chronic illnesses."

Some, however, cautioned against rejecting all processed foods. Dr. Neal Barnard, president of the Physicians Committee for Responsible Medicine, said that some foods that are considered processed can be healthy, such as breakfast cereals and breads that are fortified with vitamins and other nutrients.

"The Guidelines err in promoting meat and dairy products, which are principal drivers of cardiovascular disease, diabetes, and obesity," Barnard said in a statement. "The Guidelines take a sledgehammer approach to processed foods, but plant-based and vitamin-fortified processed foods actually reduce the risk of birth defects, diabetes, heart disease, and cancer."

Some health experts said they also worried about the Trump Administration's decision to ditch specific alcohol consumption limits. Previous dietary guidelines had advised men to restrict alcohol consumption to two beverages a day, and women were urged to have no more than one drink per day. The updated guidance says only that people should "consume less alcohol for better overall health" and that certain people, including pregnant women and people who are recovering from alcohol use disorder, should avoid alcohol completely.

"Alcohol is a social lubricant that brings people together," said Dr. Mehmet Oz, administrator of the Centers for Medicare and Medicaid Services, when asked to clarify the change at the White House press briefing. "In the best-case scenario, I don't think you should drink alcohol, but it does allow people an excuse to bond and socialize, and there's probably nothing healthier than having a good time with friends in a safe way."

The World Health Organization said in 2023 that no amount of alcohol is safe for health. The U.S. Centers for Disease Control and Prevention says that drinking alcohol increases a person's risk of developing several kinds of cancer, including mouth, colon, and breast cancer.

The Dietary Guidelines for Americans is updated every five years. The guidelines set standards for many government-funded food assistance and meal programs, including the National School Lunch Program and the Supplemental Nutrition Assistance Program (SNAP).

Jixun Lin

AT-HOME VIRUS TESTING

ACON LABORATORIES, FOUNDED BY JIXUN LIN, makes the Flowflex at-home COVID-19 tests that took off during the pandemic after receiving U.S. FDA authorization for emergency use in 2021 and clearance for over-the-counter sale in 2023. (The tests are also available across the EU, U.K., Singapore, Canada, and Australia.) In October 2025, the FDA cleared the company's 4-in-1 home test—the first home test that can detect protein antigens for respiratory syncytial virus (RSV), influenza A, influenza B, and SARS-CoV-2 with greater than 90% accuracy, building on its previous 3-in-1 home test for COVID and flu. The new test includes a special pediatric swab guard for children 6 months to 2 years old, for whom RSV is especially dangerous. It's currently available at CVS, Walgreens, and Albertsons, plus via delivery services like Instacart; the company is ramping up manufacturing at its San Diego factory to meet demand. —*Charlotte Hu*

Jo Feng

A GROWING FORCE IN GLOBAL PHARMA

HENGRUI PHARMA IS EMERGING AS A LEADING innovation incubator. Led by president Jo Feng, it is one of the biggest sponsors of clinical trials in the world, with dozens of its drugs already approved in China, and its portfolio of more than 100 compounds in development has attracted other large drugmakers. In 2025 alone, U.K.-based GSK paid Hengrui $500 million up front for a licensing deal that could be worth $12 billion; India-based Glenmark paid $18 million to access a cancer drug candidate that would rival Daiichi Sankyo and AstraZeneca's blockbuster Enhertu; and U.S.-based Braveheart Bio and Merck paid $65 million and $200 million respectively to license different heart disease drugs. "We follow a 'play-to-your-strength' approach," Feng says. She says each successful partnership signals that their science is "globally competitive." To strengthen its international presence, Hengrui debuted on the Hong Kong stock market last year, raising nearly $1.3 billion in its IPO. —*Charlotte Hu*

Peter Sands

FINDING FUNDING GAPS

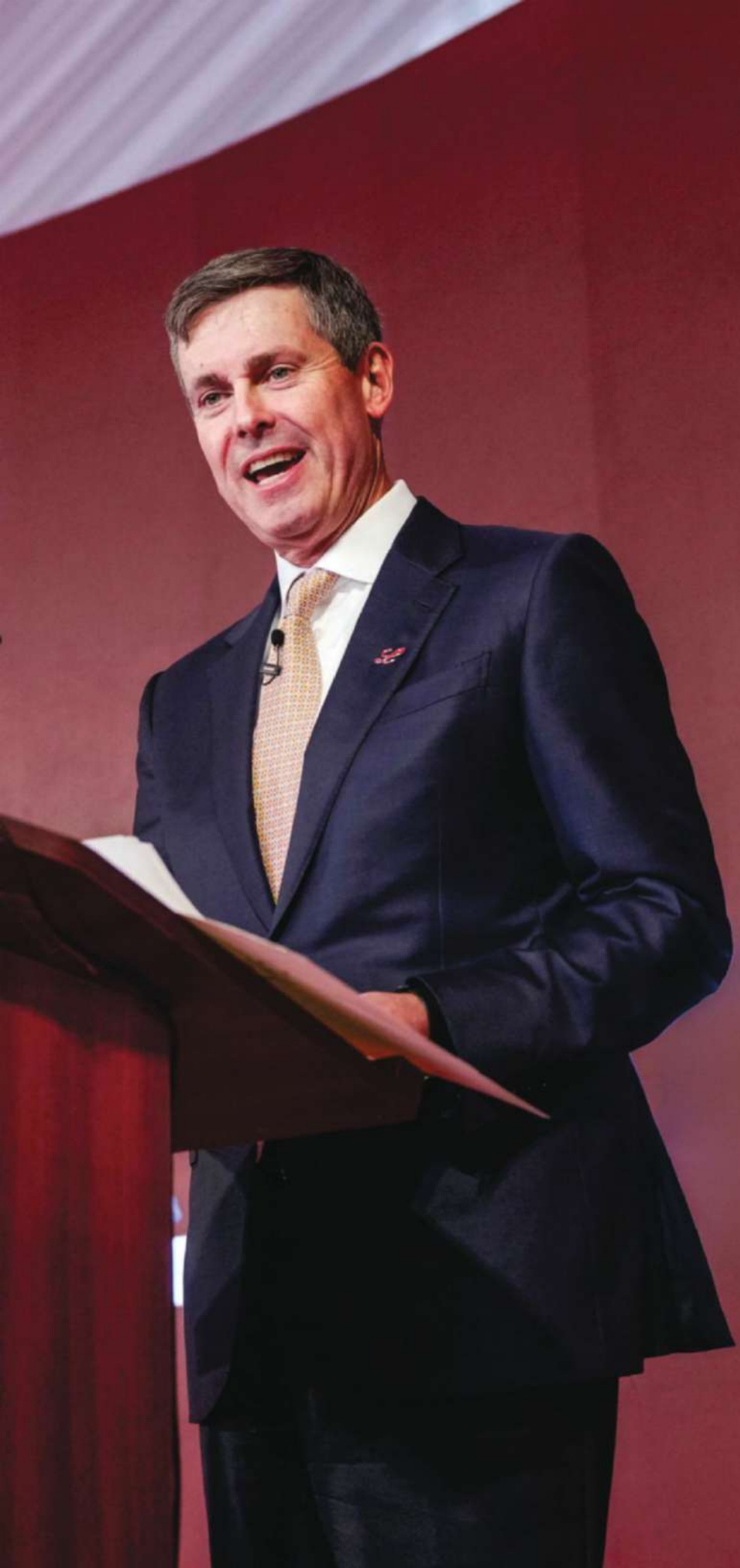
PETER SANDS, THE EXECUTIVE DIRECTOR OF the Global Fund to Fight AIDS, Tuberculosis, and Malaria, knew that 2025 would be an unusual year for the NGO, which provides funds to combat public health threats in low- and middle-income nations. As the HIV drug lenacapavir, which Sands calls "the biggest thing to happen in HIV prevention for a very long time," became available, cuts to U.S. foreign aid and geopolitical struggles meant that more people than ever were depending on the Global Fund. Thanks to Sands' and the Global Fund's efforts, the drug was rolled out at the same time in both rich countries and poor ones; the first doses arrived in Zambia and Eswatini in November. Sands also raised more than $12 billion to replenish the Global Fund in a difficult funding year, and the Fund was one of the few major global health groups in which the Trump Administration continued to invest. —*Veronique Greenwood*

David Ricks

SPEEDING DRUG RESEARCH

ELI LILLY CEO DAVID RICKS oversees some of today's most prescribed medications, including tirzepatide for both diabetes (Mounjaro) and weight loss (Zepbound). Lilly also produces one of only two approved treatments for Alzheimer's, donanemab. And in December, it submitted the pill version of its weight loss drug for FDA approval. The agency will review under an expedited process, so Lilly could soon begin competing with rival Novo Nordisk's pill, which was approved in December.

Ricks joined Lilly straight out of business school in 1996, and oversaw the launch of the first genetically engineered human insulin, among other roles. Known for his emphasis on speed, Ricks isn't above directly visiting research teams to resolve holdups and develop drugs more efficiently. In January, he announced a new, AI-based innovation lab with Nvidia. Both companies are investing up to $1 billion to address ways that robotics and AI can streamline drug development and manufacturing. —*Alice Park*



Ricks, in 2025, announcing plans to build a $6.5 billion biomanufacturing plant in Houston.

Mohamed Muizzu

PRIORITIZING PUBLIC HEALTH

IN NOVEMBER, THE MALDIVES BECAME THE FIRST country to implement a generational smoking ban, barring anyone born after January 2007 from purchasing or being sold any tobacco products—ever. The policy was an initiative of President Mohamed Muizzu, who has made public health one of his focuses since being elected in 2023. The new law adds to a 2024 ban on the import, sale, and use of vapes and e-cigarettes, and is part of a plan to eliminate smoking and tobacco use in the country. "Mostly in the government, the policy has been to take curative action towards health issues instead of focusing more on the preventive side," Muizzu says. "We are focusing equally on both sides."

Muizzu's administration has sometimes been accused of overreaching policies, but in addition to the ban, it also established free tobacco cessation clinics on each of the islands, and started a free 24/7 mental-health helpline in 2026. And last year, the nation, made up of some 1,200 islands off the coast of India that are home to about 550,000 residents, became the first country to eliminate mother-to-child transmission of HIV, syphilis, and hepatitis B.

"All these things are done together to bring a meaningful, measurable, sustainable change to our lifestyle, the health of the whole country," Muizzu says.
—Charlotte Hu

Thierry Diagana

A NEW TREATMENT FOR MALARIA

MALARIA DEATHS WERE declining not that long ago. Now, they have ticked back up. The disease, spread by mosquitoes, currently kills more than 600,000 people annually, most of them children under 5 in Africa. While swift treatment, insecticide-treated bed nets, and other interventions have been effective in bringing new infections down, the emergence of drug-resistant strains is imperiling those advances. Resistance is caused by a number of factors, including when patients don't complete a course of treatment, which allows some malaria parasites to escape. Those with mutations enabling them to brush off treatment then explode in numbers.

In 2007, molecular biologist Thierry Diagana, head of global health biomedical research at Novartis, and his colleagues were searching for fresh drugs to combat malaria, medicines that the parasites had never encountered before. While drug-resistant malaria was less common then, "a lot of visionary people had seen this threat coming," Diagana says. As part of a partnership between Novartis, the Wellcome Trust, the Medicines for Malaria Venture, and several other groups, they screened more than 2 million compounds, looking for any that killed the parasite.

In 2025, that project came to fruition: A fresh malaria drug, called ganaplacide, cleared one of the final hurdles to commercial release. In a Phase III trial with more than 1,600 people in 12 African countries, ganaplacide, combined with existing antimalarial lumefantrine, cured more than 97% of patients.

The treatment eliminates malaria parasites that are resistant to earlier therapies. What's more, the treatment affects the parasite in its sexual stage, a period in its life cycle when mosquitoes can pick it up and transfer it to a new host. "That is something that we're quite excited about," says Diagana. In some countries, where malaria numbers are low enough that eradicating the disease may be possible, "those types of features are going to be very important, because they're not only going to treat the patients, but they're also going to prevent the propagation of the parasite to other people," he says. The treatment, if it is approved, would be a major innovation in a field that has seen few new drugs in the past 25 years.

The search that led to ganaplacide has brought other molecules to light as well. One drug candidate in Phase II trials, cipargamin, holds promise for treating severe malaria, a stage in the disease in which patients, often tiny children, go into a coma. Another, INE963, has the potential to be a component of a single-dose cure, a feature that could help slow the evolution of drug-resistant strains.

INE963 also has another unusual feature. In the lab, scientists perform experiments to see if malaria parasites exposed to a new compound quickly evolve resistance to it, Diagana says. "This compound, we've tried pretty much every trick under the sun to raise drug resistance, and it resists all our efforts," he says. "That makes it very, very exciting." —*Veronique Greenwood*

Darrell Irvine

ENGINEERING CANCER IMMUNITY

DARRELL IRVINE HAS figured out how to make treatments and vaccines more potent so they do a better job at safely triggering the immune system to fight diseases such as cancer and HIV.

His lab, for example, has engineered vaccines so the active ingredients "hitchhike" on a common protein in blood and tissue fluids, and are carried more effectively to the lymph nodes. The lymph nodes are where immune cells are activated and "all the action happens," says Irvine, a professor of immunology and microbiology at Scripps Research Institute.

Elicio Therapeutics, a biotech firm Irvine cofounded, announced last August that a vaccine that utilizes this technology was correlated with a reduced risk of death or relapse in more than two-thirds of patients with pancreatic or colorectal cancer in an early-stage clinical trial. Irvine says the vaccine's efficacy needs to be confirmed in a larger randomized clinical trial, which is ongoing. "In the not-too-distant future, we can imagine really engineering the immune response in a way that we haven't been able to do before," he says. *—Dominique Mosbergen*

Songyang Zhou

DEVELOPING FAST, ACCURATE TESTS FOR TUBERCULOSIS

TUBERCULOSIS KILLS MORE than 1 million people annually, and every year, 10 million new cases are diagnosed. The early stages of TB, when it's already infectious, can be hard to recognize, and existing diagnostic tests are resource-intensive and may take days or weeks to process, which can delay medical intervention. To help stop the spread, biomedical company Pluslife created a rapid test for TB that provides results in under 30 minutes using only a cheek swab and an inexpensive, palm-sized machine that can read test cards. Songyang Zhou, the company's founder and head scientist, says that its results are comparable to traditional methods at a fraction of the cost; and orders are already coming in. In 2025, the Global Fund to Fight AIDS, Tuberculosis, and Malaria approved the test for purchase by countries using Fund resources. *—Veronique Greenwood*

Katherine Stueland

CATCHING GENETIC DISEASES EARLY

ONE IN 10 AMERICANS HAS A RARE disease, and about half of them are children—but it takes about five years on average for kids with rare diseases to get a diagnosis in the U.S. Parents of children who show signs of developmental delay are often told by doctors to "wait and see," partly because testing can be onerous, says Katherine Stueland, CEO of GeneDx. The company specializes in testing for thousands of rare diseases and genetic causes of conditions including cerebral palsy and autism, and aims to help every child who needs it to get tested early and efficiently, so they can get help as soon as possible. The company can provide a diagnosis in as little as 48 hours, Stueland says.

Last June, the American Academy of Pediatrics issued new guidance that empowers pediatricians to directly and promptly order genetic testing for children who show early signs of developmental delay—a change that Stueland has advocated for. GeneDx also joined a multi-state initiative in 2025 that aims to screen some 30,000 newborns for hundreds of genetic conditions over three years. And in October, the company was granted a special designation from the U.S. Food and Drug Administration, which recognized its tests as having the potential to provide more effective diagnoses for debilitating diseases. *—Dominique Mosbergen*

Max Hodak

RESTORING SIGHT

IT'S NO SMALL THING TO bring eyesight to the blind—or nearly blind. But that's what Max Hodak, founder and CEO of Science Corporation in California, has helped achieve. The breakthrough: a pair of glasses with a tiny camera that can capture a scene and beam it onto a chip in the back of the eye by infrared pulses. The company worked with surgeons to implant the computer chip into the retinas of 38 people with age-related macular degeneration (AMD), and showed in a study published October 2025 in *The New England Journal of Medicine* that it significantly improved vision. Nearly 80% of the subjects performed better on an eye chart by 20 letters one year post-op, and 84% of them could once again read letters, numbers, and words at home. "I've spent most of my life," says Hodak, "trying to answer the question: What are the ultimate brain-computer-interface technologies that will get us to some of what science fiction promises?" *—Jeffrey Kluger*

Martin Fitchet

PROTECTING BABIES FROM MALARIA

THE WORLD HAS MADE GREAT ADVANCES IN tackling malaria, but the disease still imposes a huge global health burden—and 75% of the hundreds of thousands who die from the disease annually are children under 5. Swiss nonprofit Medicines for Malaria Venture worked with Novartis in 2025 to bring to market Coartem Baby, the first malaria medicine for newborns and infants. "Babies under five kilos, they haven't had any drugs studied in that particular population. These are the most vulnerable kids that when they get the disease, have the highest risk of death," says MMV CEO Martin Fitchet. "Getting this data, and getting this unique new combination of an existing medicine…that was fantastic because we were able to plug the last evidence gap for malaria." *—Charlotte Hu*

Adam de la Zerda

RAPID HOME STI TESTING

UNLIKE OTHER AT-HOME STI TESTS, WHICH require shipping samples to labs, Visby Medical's new FDA-approved 3-in-1 women's test for gonorrhea, chlamydia, and trichomoniasis is a miniaturized PCR machine that runs tests just as accurately in 30 minutes. Through a partnership with Google, the company also launched a companion smartphone app that reads results and connects patients with 24/7 telehealth providers nationwide who can then send treatment prescriptions to pharmacies. "We're closing that cycle of care very quickly," says Visby founder and CEO Adam de la Zerda. The company inked deals with DoorDash, EverlyWell, Quest, and Labcorp to sell the test for $149—comparable to the cost of STI testing at an ER or urgent care—and de la Zerda is working to bring that number down. Visby plans to launch an STI test for men and a full respiratory panel in the future. *—Charlotte Hu*

Ghyslain Mombo-Ngoma

BLOCKING DRUG-RESISTANT MALARIA

MALARIA KILLS MORE THAN HALF A MILLION people a year, mostly children. Treatment requires repeated doses over time, a tall order for those who might have to travel many miles to reach a clinic, and in recent years, drug-resistant strains of the parasite have exploded. To help stem the tide, Dr. Ghyslain Mombo-Ngoma, head of clinical operations at the Centre de Recherches Médicales de Lambaréné (CERMEL) in Gabon, and his colleagues came up with a daring new plan.

Last year, Mombo-Ngoma led a trial of a new single-dose treatment containing four different drugs, called SPAP, that each attack the parasite from a different angle. The team reported in November that it is just as effective as prior treatments immediately, opening the door to reining in malaria's evolution and saving lives. With plans for the treatment to be rolled out this year, Mombo-Ngoma expects it will act as a stop-gap until exciting new malaria therapies arrive. *—Veronique Greenwood*

Brian Bigger

A GENE THERAPY FIRST

MOST CONGENITAL GENETIC DISEASES HAVE very limited treatment options since they affect so few babies and drug developers don't prioritize them. In 2006, Brian Bigger, then a professor at the University of Manchester and now at the University of Edinburgh, began developing a gene therapy for Hunter syndrome, a rare, potentially life-threatening condition that can lead to a dementia-like decline, as well as deterioration of other organ systems in children. The novel treatment is especially challenging because it involves getting a missing gene that makes a critical enzyme into cells in the baby's brain. In February 2025, as part of the therapy's first clinical study, a California boy with Hunter syndrome became the first to receive infusions of the therapy Bigger developed. Now 3 years old, his condition has improved dramatically. "He has huge amounts of the enzyme," says Bigger. "While it's early days, that's incredibly encouraging." *—Alice Park*

Kevin Tracey

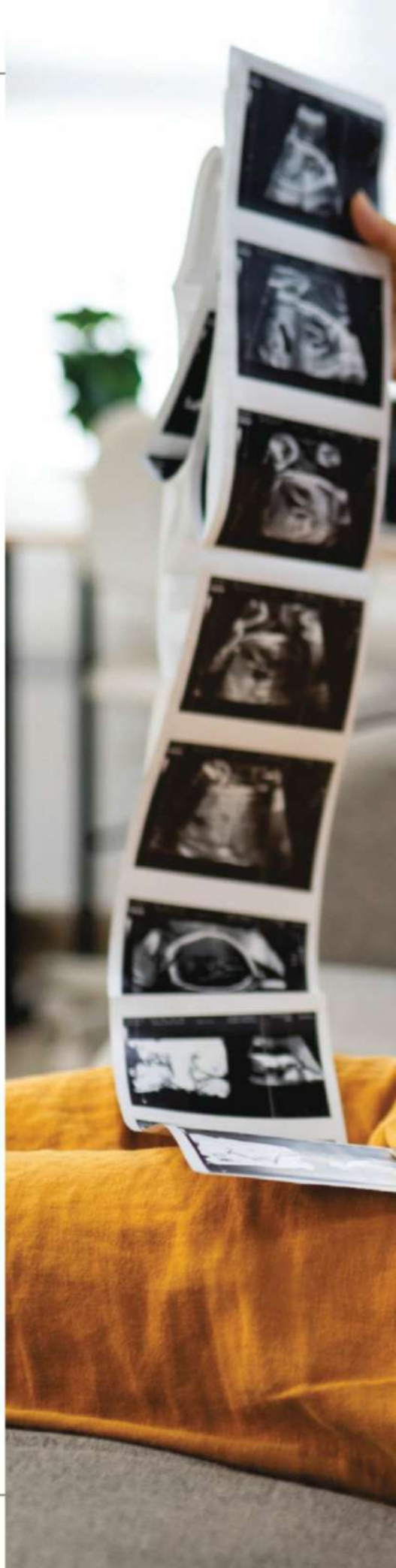
AN IMPLANT FOR AUTOIMMUNE DISEASE

THERE IS NO CURE FOR RHEUMATOID arthritis, and treatments like corticosteroids generally suppress the immune system. Dr. Kevin Tracey, president and CEO of the Feinstein Institute for Medical Research and the director of the Laboratory of Biomedical Science, took a different approach. He developed the SetPoint system, a small device that is surgically implanted near the vagus nerve in the neck and modulates the immune system in a more consistent way than medications can. It targets the specific neural signals that go awry in rheumatoid arthritis and brings inflammation and immune activity back into balance. The device was approved by the FDA in July 2025, based on studies from his company, SetPoint Medical, showing that over a year, half of people using SetPoint experienced low disease activity compared to those not using it. Tracey believes the implant could be used to treat other autoimmune and inflammatory diseases. *—Alice Park*

Zev Williams

AI FOR INFERTILITY

MALE INFERTILITY ACCOUNTS FOR ABOUT half of all infertility issues among couples. Dr. Zev Williams found a way to address one of the most common causes using AI. In men with azoospermia, doctors generally can't detect any sperm in the semen. Williams knew that didn't mean that the sperm were absent, just harder to find. He and his team developed an AI-based system, Sperm Track and Recovery, or STAR, that detects and isolates sperm in semen samples with impressive results; in one sample in which technicians could find no sperm after analyzing it for two days under a microscope, STAR found 44 in an hour. The process led to the first successful pregnancy in a couple that had been trying to start a family for nearly two decades. In November, they welcomed a healthy baby girl. *—Alice Park*



DOCTORS REPORT THE FIRST PREGNANCY USING A NEW AI PROCEDURE

The tech was inspired by the work of astrophysicists

BY ALICE PARK

DOCTORS AT COLUMBIA UNIVERSITY FERTILITY Center have reported what they are calling the first pregnancy using a new AI system, in a couple that had been trying to start a family for nearly two decades.

The pregnancy was possible due to an advance developed by the Columbia team, led by Dr. Zev Williams, director of the center, to address azoospermia, or a lack of detectable sperm in the ejaculate. Male factors account for about 40% of infertility in the U.S., and azoospermia is responsible for about 10% of those cases. Until recently, there was little doctors could do to address the lack of sperm needed to fertilize an egg, other than using donor sperm.

While to the naked eye, a sperm sample from a man with azoospermia might look normal, the microscope tells a different story, Williams says. Highly trained technicians rarely find any sperm in these samples, which are often filled with other debris. Add to that the fact that sperm are the smallest cell in the body, and it's not surprising that even the best fertility technicians rarely find sperm in azoospermia samples.

That's where AI comes in. Williams and his team spent five years developing a system that combined an AI algorithm for detecting sperm with a fluidic chip that passed the semen sample through a tiny tubule on a plastic chip. If the AI picked up sperm, that tiny portion of semen would be directed to a separate tubule and collected. The few sperm isolated in this way could then be stored, frozen, or used to fertilize an egg.

Called STAR, for Sperm Track and Recovery, the system was inspired by similar approaches that astrophysicists use to enlist AI to detect new stars and planets. "If you can look into a sky that's filled with billions of stars and try to find a new one, or the birth of a new star, then maybe we can use that same approach to look through billions of cells and try to find that one specific one we are looking for," says Williams. In this case, STAR is trained to pick up "really, really, really rare sperm," he says. "I liken it to finding a needle hidden within a thousand haystacks. But it can do that in a couple of hours—and so gently that the sperm that we recover can be used to fertilize an egg."

STAR is distinct from AI systems that have been developed to scan and detect specific features, Williams says, because it combines that analysis with the ability to also actively isolate the target in question—in this case, any sperm found in a semen sample. The system can scan eight million images in about an hour, and Williams remembers the moment when he was convinced that STAR could become a powerful tool for treating certain forms of infertility. "To test the system, before we discarded samples where embryologists could not find any sperm, we decided to run those samples through the system. The embryologists really worked hard to find sperm, since they didn't want to be outshone by a machine. In one of the samples they analyzed for two days and found no sperm, STAR found 44 in an hour."

Rosie and her husband became the first couple to get pregnant using STAR in March 2025. The couple spent nearly 19 years trying to get pregnant, and Rosie—who asked to use a pseudonym to protect her privacy—says their Orthodox Jewish faith kept them hopeful during 15 unsuccessful IVF cycles. Prior to the pregnancy, they had explored multiple options to address her husband's azoospermia, including surgery and enlisting an expert from overseas to manually analyze and isolate sperm from his samples. They also researched efforts to extract sperm that were more controversial because they involved using chemicals that could potentially be detrimental to the quality of sperm.

"There really was nothing else out there," says Rosie, 38, of their options before learning about STAR. "Especially because I am running quite a few years ahead of where we should be [for fertility]. I'm not that old, but in fertility years—egg-wise—I was reaching my end."

They were introduced to Williams and his fertility program through a community group and learned everything they could about the system. "We knew exactly what it was, and knew what they were trying to do," says

In cases of azoospermia, using STAR can be a game changer

Male factors account for about 40% of infertility in the U.S., and azoospermia is responsible for about 10% of those cases.

Rosie. "If they could get sperm in a more natural way without chemicals and hopefully chose the good ones—if the program was able to do that, we knew we had a better chance."

For the couple, using STAR did not require any additional testing or procedures; their successful cycle in March 2025 proceeded no differently than any of the other IVF cycles they had experienced. "We were keeping our hopes to a minimum after so many disappointments," says Rosie. "We came in, did what we had to do for the cycle, knowing there was probably a very small chance of anything happening. Why should this be any different from every other time?"

Usually in an IVF cycle, there are far more sperm than eggs, says Williams, but in cases of azoospermia, the opposite is true. So to ensure that a couple has the best chance of a pregnancy, Williams and his team collect several batches of sperm using STAR and freeze them. Then they coordinate the mother-to-be's ovulation cycle on IVF, and on the day they retrieve her eggs, they collect a fresh semen sample, run it through STAR, and use any sperm collected to fertilize any available eggs. The frozen sperm serve as backup in case no fresh sperm can be found.

Within two hours after collecting her husband's sperm last March, they learned that Rosie's eggs had been successfully fertilized and were ready to be transferred to her uterus a few days later. "After the transfer, it took me two days to believe I was actually pregnant," says Rosie.

Rosie received standard obstetric care, and her pregnancy proceeded well. The couple welcomed a healthy baby girl in November 2025.

Williams says azoospermia is only one of many infertility issues that AI could address. "There are things going on that we are blind to right now. But with the introduction of AI, we are being shown what those things are. The dream is to develop technologies so that those who are told 'you have no chance of being able to have a child' can now go on to have healthy children."

Constance Lehman

SCORING BREAST CANCER RISK

DR. CONSTANCE LEHMAN, A PROFESSOR OF radiology at Harvard Medical School, founded the company Clairity to reshape how women are screened for breast cancer. Clairity Breast received de novo authorization from the U.S. FDA as the first AI-based platform that can predict a woman's risk of developing breast cancer in the next five years, based on a standard mammogram. Rather than following the traditional age-based recommendations for screening, Clairity Breast mines years of research Lehman conducted to understand the risk factors that contribute to breast cancer, to give a woman a more precise, individualized report on the health of her breast tissue. She then gets a baseline score against which she can evaluate changes to her risk, and whether she needs additional screening. Clairity is being rolled out at two hospitals so far, and Lehman aims to increase access and affordability for the screening test in the coming year. *—Alice Park*

Brian Ahmedani

PREVENTING SUICIDE WITH RISK ASSESSMENT

NEARLY THREE DECADES AGO, BRIAN AHMEDANI was part of the Henry Ford Health team that developed the Zero Suicide model for health care providers: a novel framework built on the idea that suicide is preventable when health systems take responsibility for identifying risk and providing consistent, evidence-based care. That means that, for example, all patients are routinely screened for suicide risk, and clinicians and staff are trained to recognize and have direct conversations about it. In 2025, a major study published in *JAMA Network Open* showed that the model—which has been adopted throughout the U.S. and in more than 30 countries—decreased suicide attempts from as much as 11.3 to 0.3 per 100,000 people in participating health centers. "We pursue zero because we don't accept that we shouldn't try to prevent every single suicide," Ahmedani says. "We're not going to stop until we do." *—Angela Haupt*

Jonathon Whitton

GENE THERAPY FOR HEARING LOSS

ABOUT 1 IN 500 INFANTS IN THE U.S. IS BORN with hearing loss, most often caused by genetic factors. Hearing aids or cochlear implants can help children hear better, but kids fitted with these devices still often have a hard time hearing sounds that are far away or in noisy environments.

Jonathon Whitton, a clinician-scientist, is leading Regeneron's efforts to develop gene therapies to treat hearing loss in children. In October, the company announced promising results from a small trial that tested a gene therapy in children with profound hearing loss caused by a genetic deficiency of the protein otoferlin, which affects an estimated 50 newborns in the U.S. every year. Of the 12 children who received the gene therapy, 11 experienced meaningful improvements to their hearing, including some who developed normal hearing within a few months. *—Dominique Mosbergen*

John Evans

REALIZING GENE EDITING

IN MARCH 2025, BEAM Therapeutics and its CEO John Evans announced the results of an early-stage but groundbreaking clinical trial: A single infusion of its gene-editing therapy fixed a genetic mutation in nine people with a debilitating disorder called alpha-1 antitrypsin deficiency (AATD) that can cause lung and liver damage. "For the first time in history, we corrected a misspelled gene that was causing disease," Evans says.

Beam's therapy successfully changed an incorrect DNA letter in the patient's body through a process known as base editing. That gene will now likely function normally for the rest of that patient's life, potentially stopping further damage to their lungs and liver, Evans says. Beam has also found preliminary success with another base-editing therapy designed to treat severe sickle-cell disease. The company said in December that early trials of the therapy had helped restore red blood cell health in about 30 patients. *—Dominique Mosbergen*

Cindy Eckert

ADDRESSING WOMEN'S SEXUAL DESIRE

CINDY ECKERT, CEO OF Sprout Pharmaceuticals, has been battling regulatory agencies for decades to bring "the pink pill," the first treatment for women's low sexual desire, to post-menopausal women. The drug was approved in 2015 to treat hypoactive sexual desire disorder (HSDD) in premenopausal women, but the FDA wanted additional review for women up to 65 (who are most likely to experience changes in sexual desire due to dramatic drops in hormone levels after menopause), which Eckert says reflects the stigma surrounding women's sexual desire, and a double standard. While the condition is recognized and treated in men, it's been less accepted, and therefore less effectively treated in women. Finally, in December 2025, the FDA approved Addyi to treat low sexual desire in women up to age 65. The approval, Eckert says, marks "an historic first" and "a cultural recognition that we value sexual health as part of a woman's overall wellness." —*Alice Park*

Q&A WITH CINDY ECKERT, SPROUT CEO

Eckert developed a groundbreaking pill for women—against the odds

BY ALICE PARK

IN DECEMBER 2025, SPROUT PHARMACEUTICALS RECEIVED approval to use its pill, Addyi (flibanserin), to treat low sexual desire in women who are past menopause.

Addyi works by addressing neurotransmitters like dopamine, serotonin, and norepinephrine in the brain, balancing them to stimulate sexual desire signals while suppressing inhibitory ones. The pill has been approved by the U.S. Food and Drug Administration (FDA) since 2015 to treat hypoactive sexual desire disorder (HSDD) in pre-menopausal women, and the expanded approval includes women under age 65 who are past menopause, a time when hormone levels drop and libido changes.

The FDA required an additional review of data on women after menopause to ensure the drug's safety and efficacy in the larger age group—a requirement that Cindy Eckert, Sprout's CEO, says represents a double standard and stigma against addressing sexual desire in women, since that data was part of the company's original submission for approval and included women 18 to 80 years old. Eckert discussed with TIME the company's long road to the approval and the larger issues facing certain medicines for women.

This interview has been condensed and edited for clarity.

What does finally receiving FDA approval for Addyi in post-menopausal women mean for women's health?

I might not have fully processed yet how big this win is. It's an historic first in women's health. I think this signifies not only scientific recognition of a medical condition that affects millions of women that had been previously discussed only with stigma, not science, but also a cultural recognition that we value sexual health as part of women's overall wellness, their longevity, and their well-being. And that their sex life doesn't end at menopause. To me, we played the long game, and culture caught up.

Why did Sprout have to file a separate request to treat decreased libido in women past menopause?

I built a male sexual health company at a time when there was only long-acting testosterone treatment for men. Now there are 26 FDA-approved treatments for some form of male sexual dysfunction, but there were none for women. I watched the big guns not do anything about the science, and that was a commentary on the perspective they had on women's health: They don't value sexual health in women the same as they do in men. We left women out of the conversation.

So Sprout took it on. And I should have anticipated that the first-ever drug for women's sexual pleasure would not follow a straight line. To me, it's about the science. HSDD was characterized in 1977. Medicine has understood it for some time now, but what crept in was social commentary, a societal bias that questions whether pleasure matters for women.

In the end, Addyi was approved [in 2015 for pre-menopausal women] on the basis of science, with clinical trials involving 13,000 women, which was three times the size of the trials conducted on Viagra at the time of its [FDA] submission. Granted, erectile dysfunction is different from HSDD in women, but the FDA took six months to approve Viagra, and by contrast it took us six years to earn approval for Addyi.

Addyi works on neurotransmitters in the brain. If you think of other drugs that work in the central nervous system, we don't separate populations by age in the same way. But that was the FDA mandate. It's the same molecule, and the same dosage as Addyi that was approved for HSDD. But there is a pattern in women's health where we lead with a skewed point of view on the importance of factors—including the desire for sex—that are societally conditioned. The world wasn't ready for a female Viagra.

Why did it take so long to earn FDA approval for Addyi in the first place?

Not only do we rule out anything a woman is experiencing as probably emotional and not medical, if there is a medical solution, we lead with its risk. The reason for that is that we have already dismissed that there is any benefit in addressing her symptoms.

When Addyi first came out, there were discussions about the risks when taken with alcohol. Studies showed that some women experienced side effects including dizziness, sleepiness, and nausea, and less than 2% had to discontinue Addyi because of them. So if you have one or two drinks in the evening, wait a couple of hours before taking Addyi at bedtime. Or if you have more than three drinks, then skip Addyi that night. It's common sense.

We [as a society] talk about the risks of Addyi and alcohol in every article. But it's not our call, it's every woman's call. She gets to weigh the benefits—more desire for sex, more interest in sex, more satisfying sexual events, and less stress over her condition.

What challenges have you faced in bringing a pill for women in menopause to market?

More women experience sexual dysfunction than men globally. The expansion to post-menopausal women is long overdue. As a female founder in health, even when raising money for this product that has a higher prevalence than erectile dysfunction, we weren't getting any money from Sand Hill Road [a part of Silicon Valley rife with venture capitalists].

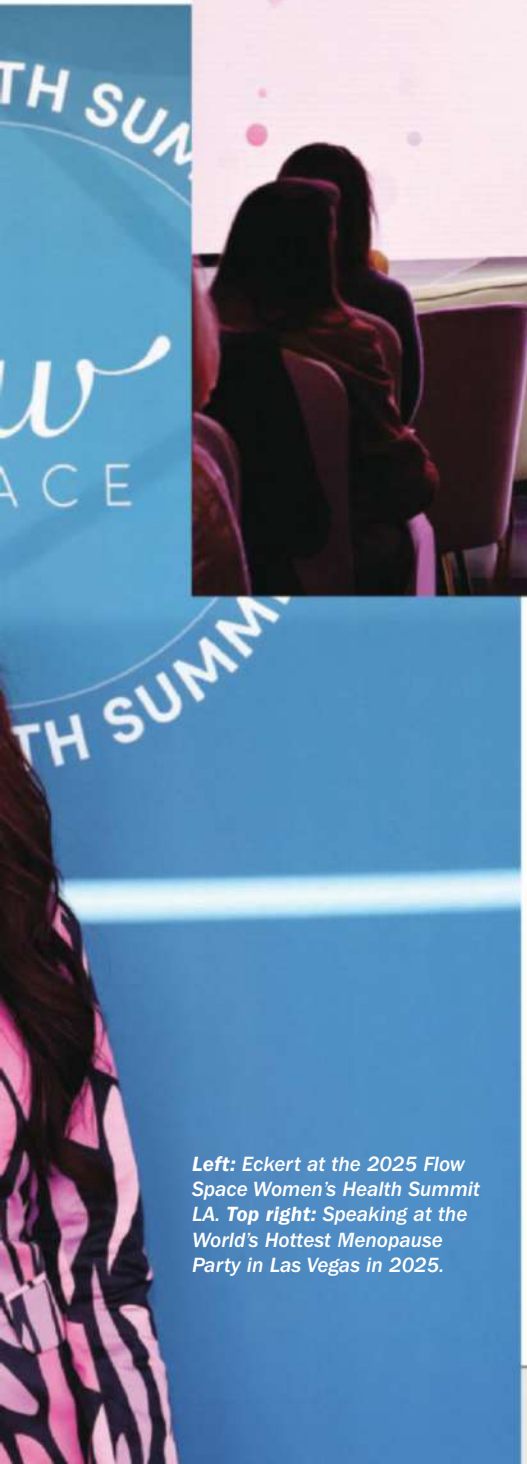
I had built a successful company in men's sexual health. I had seen what the standard was there. When the same standard wasn't applied for women, I questioned it and pushed back. I had a six-hour, very public conversation with the FDA about this, and there was a lot of manufactured controversy—because of how we feel about women and sex.

Why do you think sexual desire in women is not treated seriously by the medical community?

The fact is that 50% of the population goes through menopause, and we're told, "Just relax, take a bubble bath; it's just a transition period." It's literally a biological phenomenon, and we treat it by telling people to just calm down.

There's a concept in medicine that women's symptoms are considered more likely to be psychosomatic and more likely based in emotions. It shows up in the way we treat women's heart attacks, and that it takes longer to prescribe pain medication for women than for men.

To me, the basis of that is that we believe women are entirely psychological creatures rooted in emotion, while men are biological creatures. That gives us as a society extraordinary permission to dismiss what women are experiencing, because once we decide that women are emotional, any symptom women report, they're patted on the shoulder and told to relax. We've created a culture of dismissal.



Left: Eckert at the 2025 Flow Space Women's Health Summit LA. Top right: Speaking at the World's Hottest Menopause Party in Las Vegas in 2025.

What does this approval mean for other women's health products?

To me, this is a litmus test for what this conversation is going to be like. Now we are saying half of the population goes through this thing called menopause. Now we are taking it, I hope, a little more seriously. It will be fascinating if this conversation is fundamentally different this time around. Addyi is a case study for whether things have actually changed.

Finally, Addyi is a pink pill, and you often dress in pink. How did that start?

Pink is a bit of active defiance to me. When people were patting me on the shoulder, saying, 'Oh the little pink pill,' I recognized that in that was dismissiveness and trivialization, and that was the very conversation I wanted to have: You perceive [women's loss of sexual desire] as weakness or unimportant, but I see it very differently. I was criticized for wearing pink and was told people wouldn't take me seriously. But I believe you always get two choices. You either lean back away from it and distance yourself, or you lean right in toward it. I always loved pink, and never saw it as a sign of weakness. I see it as a strength to show up exactly as you are.

Florent Geerts

MONITORING MATERNAL HEALTH

EACH DAY, HUNDREDS OF WOMEN WORLDWIDE die from preventable causes related to pregnancy and childbirth, according to the WHO. A simple ultrasound can be life-saving, but many women globally don't have access to that care. Since 2012, Dutch medical technology company Delft Imaging has been developing BabyChecker AI, a smartphone-connected probe designed for health workers in rural areas with limited access to infrastructure, which can detect gestational age, fetal presentation, and placenta localization in just two minutes. In 2025, Delft added a feature to share 2D images with patients, expanded its language options, and made more features available offline. The company operates in more than a dozen largely low- and middle-income countries across Europe, Asia, Africa, and Central America. Florent Geerts, managing director at Delft, says the company is starting to see women coming in earlier and getting more frequent scans because they'd heard about BabyChecker AI. "We believe our tech can make a very real difference," he says. *—Charlotte Hu*

Zhen Xu

TARGETING TUMORS SANS SURGERY

BIOMEDICAL ENGINEER ZHEN XU CO-FOUNDED HistoSonics, which developed a groundbreaking non-invasive treatment for liver tumors that uses precisely targeted high-intensity soundwaves to break up tumors, without harming other tissues. Because the treatment is so focused, Xu says, it "allows the clinician to treat high risk locations, for example, a surgically inoperable location, like a tumor sandwiched between vessels." Having received the FDA greenlight in 2023, in June the company got approval for NHS patients in the U.K., and is seeking approval in Europe as well. It's also testing the technique on kidney and pancreatic tumors, and hopes to expand to other cancers, and even different ailments like stroke or epilepsy. In August, a consortium of private and public investors acquired a majority stake in the company, valuing it at $2.25 billion, an investment that will help it grow to global markets and treat more types of cancers. *—Charlotte Hu*

Takanori Takebe

VENTILATION INNOVATOR

LONG BEFORE THE COVID PANDEMIC, Dr. Takanori Takebe knew how damaging mechanical ventilators could be. He had seen them used on his father, who has had respiratory problems. It was so painful and invasive that Takebe, a doctor and biomedical researcher at Cincinnati Children's Hospital also affiliated with several institutions in Japan, decided to look for better ways. This year, he and his colleagues published the results of a clinical trial that demonstrates the first step in a surprising solution: enteral ventilation.

Lungs are only one way to get oxygen into the blood; other organs can still provide a way in. In Takebe's trial, which came after years of animal testing and was to assess safety in humans, people received infusions of an oxygen-carrying substance called perfluorodecalin via their anuses. Side effects were minimal, and the scientists concluded that perfluorodecalin was a promising substance deserving further study. *—Veronique Greenwood*

Karan Singhal

BRIDGING HEALTH AND AI

MORE THAN 40 MILLION people turn to ChatGPT with health-care-related questions every day—a level of demand that helped spur OpenAI's 2026 launch of ChatGPT Health, which lets users upload medical records and other personal information.

Karan Singhal leads the Health AI team at OpenAI. He's played a key role in the push into this sensitive space, aiming to prioritize the safety and reliability of the large language models that power ChatGPT Health. (OpenAI and TIME have a licensing and technology agreement that allows OpenAI to access TIME's archives.) Singhal worked alongside more than 260 physicians from around the world to shape and refine the system, and partnered on a clinical study that tests how artificial intelligence can function as a clinician copilot in care settings. That work has informed ChatGPT for Healthcare, a new suite of products designed to improve care and slash administrative burden.
—Angela Haupt

IS GIVING CHATGPT HEALTH YOUR MEDICAL RECORDS A GOOD IDEA?

Before you share personal information, review the risks

BY ANGELA HAUPT

YOUR AI DOCTOR'S OFFICE IS EXPANDING. IN January, OpenAI announced launched ChatGPT Health, a dedicated tab for health that allows users to upload their medical records and connect apps like Apple Health, the personalized health testing platform Function, and MyFitnessPal.

According to the company, more than 40 million people ask ChatGPT a health care-related question every day, which amounts to more than 5% of all global messages on the platform—so, from a business perspective, leaning into health makes sense. But what about from a patient standpoint?

"I wasn't shocked to hear this news," says Dr. Danielle Bitterman, a radiation oncologist and clinical lead for data science and AI at Mass General Brigham Digital. "I do think that this speaks to an unmet need that people have regarding their health care. It's difficult to get in to see a doctor, it's nowadays hard to find medical information, and there is, unfortunately, some distrust in the medical system."

We asked experts whether turning over your health data to an AI tool is a good idea.

What is ChatGPT Health?

The new feature will be a hub where people can upload their medical records, including lab results, visit summaries, and clinical history. That way, when you ask the bot questions, it will be "grounded in the information you've connected," the company said in its announcement. OpenAI suggests asking questions like: "How's my cholesterol trending?" "Can you summarize my latest bloodwork before my appointment?" "Give me a summary of my overall health." Or: "I have my annual physical tomorrow. What should I talk to my doctor about?"

Users can also connect ChatGPT to Apple Health, so the AI tool has access to data like steps per day, sleep duration, and number of calories burned during a workout. Another new addition is the ability to sync with data from Function, a company that tests for more than 160 markers in blood, so that ChatGPT has access to lab results as well as clinicians' health suggestions. Users can also connect MyFitnessPal for nutrition advice and recipes, and Weight Watchers for meal ideas and recipes geared toward those on GLP-1 medications.

OpenAI, which has a licensing and technology agreement that allows the company to access TIME's archives, notes that Health is designed to support health care—not replace it—and is not intended to be used for diagnosis or treatment. The company says it spent two years working with more than 260 physicians across dozens of specialties to shape what the tool can do, as well as how it responds to users. That includes how urgently it encourages people to follow-up with their provider, the ability to communicate clearly without oversimplifying, and prioritizing safety when people are in mental distress.

Is it safe to upload your medical data?

OpenAI partnered with b.well, a data connectivity infrastructure company, to allow users to securely connect their medical records to the tool. The Health tab will have "enhanced privacy," including a separate chat history and memory feature than other tabs, according to the announcement. OpenAI also said that "conversations in Health are not used to train our foundation models," and Health information won't flow into non-Health chats. Plus, users can "view or delete Health memories at any time."

Still, some experts urge caution. "The most conservative approach is to assume that any information you upload into these tools, or any information that may be in applications you otherwise link to the tools, will no longer be private," Bitterman says.

No federal regulatory body governs the health information provided to AI chatbots, and ChatGPT provides technology services that are not within the scope of HIPAA. "It's a contractual agreement between the individual and OpenAI at that point," says Bradley Malin, a professor of biomedical informatics at Vanderbilt University Medical Center. "If you are providing data directly to a technology company that is not providing any health care services, then it is buyer beware." In the event that there was a data breach, ChatGPT users would have no specific rights under HIPAA, he adds, though it's possible the Federal Trade Commission could step in on your behalf, or that you could sue the company directly. As medical information and AI start to intersect, the implications so far are murky.


AI

"When you go to your health care provider and you have an interaction with them, there's a professional agreement that they're going to maintain this information in a confidential manner, but that's not the case here," Malin says. "You don't know exactly what they are going to do with your data. They say that they're going to protect it, but what exactly does that mean?"

When asked for comment, OpenAI directed TIME to a post on X from chief information security officer Dane Stuckey. "Conversations and files in ChatGPT are encrypted by default at rest and in transit as part of our core security architecture," he wrote. "For Health, we built on this foundation with additional, layered protections. This includes another layer of encryption…enhanced isolation, and data segmentation." He added that the changes the company has made "give you maximum control over how your data is used and accessed."

The question every user has to grapple with is "whether you trust OpenAI to keep to their word," says Dr. Robert Wachter, chair of the department of medicine at the University of California, San Francisco, and author of *A Giant Leap: How AI Is Transforming Healthcare and What That Means for Our Future*.

Does he trust it? "I sort of do, in part because they have a really strong corporate interest in not screwing this up," he says. "If they want to get into sensitive topics like health, their brand is going to be dependent on you feeling comfortable doing this, and the first time there's a data breach, it's like, 'Take my data out of there—I'm not sharing it with you anymore.'"

Wachter says that if there was information in his records that could be detrimental if it leaked—like a past history of drug use, for example—he would be reluctant to upload it to ChatGPT. "I'd be a little careful," he says. "Everybody's going to be different on that, and over time, as people get more comfortable, if you think what you're getting out of it is useful, I think people will be quite willing to share information."

The risk of bad information

Beyond privacy concerns, there are known risks of using large-language-model-based chatbots for health information. Bitterman recently co-authored a study that found that models are designed to prioritize being helpful over medical accuracy—and to always supply an answer, especially one that the user is likely to respond to. In one experiment, for example, models that were trained to know that acetaminophen and Tylenol are the same drug still produced inaccurate information when asked why one was safer than the other.

"The threshold of balancing being helpful versus being accurate is more on the helpfulness side," Bitterman says. "But in medicine we need to be more on the accurate side, even if it's at the expense of being helpful."

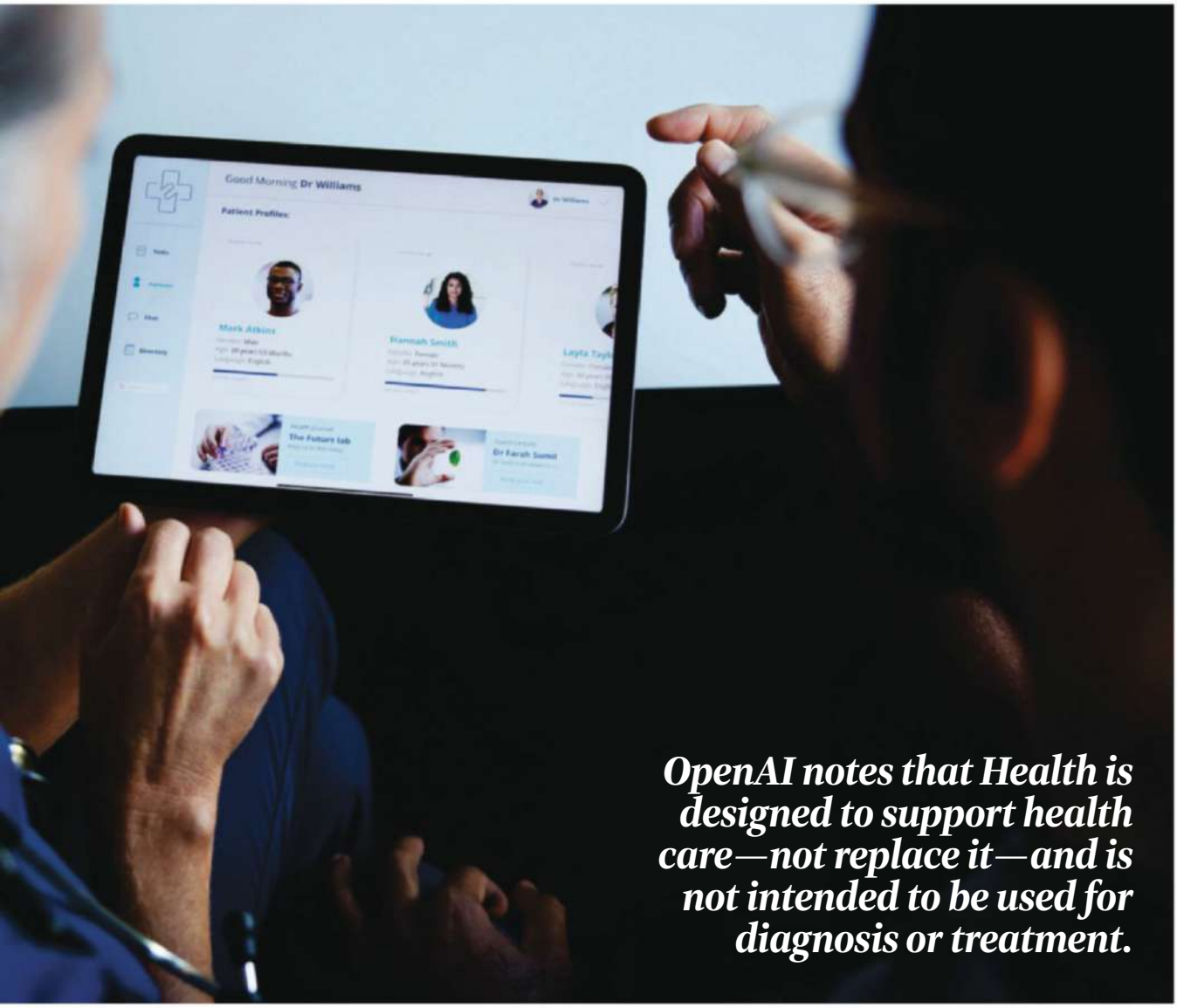
Plus, multiple studies suggest that if there's missing information in your medical records, models are more likely to hallucinate, or produce incorrect or misleading results. According to a report on supporting AI in health care from the National Institute of Standards and Technology, the quality and thoroughness of the health data a user gives a chatbot directly determines the quality of the results the chatbot generates; poor or incomplete data leads to inaccurate, unreliable results. A few common traits help increase data quality, the report notes: correct, factual information that's comprehensive, complete, and consistent, without any outdated or misleading insights.

In the U.S., "we get our health care from all different sites, and it's fragmented over time, so most of our health care records are not complete," Bitterman says. That increases the likelihood that you'll see errors where it's guessing what happened in areas where there are gaps, she says.

The best way to use ChatGPT Health

Overall, Wachter considers ChatGPT Health a step forward from the current iteration. People were already using the bot for health queries, and by providing it with more context via their medical records—like a history of diabetes or blood clots—he believes they'll receive more useful responses.

"What you'll get today, I think, is better than what you got before if all your background information is in there," he says. "Knowing that context would be useful. But I think the tools



OpenAI notes that Health is designed to support health care—not replace it—and is not intended to be used for diagnosis or treatment.

themselves are going to have to get better over time and be a little bit more interactive than they are now."

When Dr. Adam Rodman watched the ChatGPT Health introductory video, he was pleased with what he saw. "I thought it was pretty good," says Rodman, a general internist at Beth Israel Deaconess Medical Center, where he leads the task force for integration of AI into the medical school curriculum, and an assistant professor at Harvard Medical School. "It really focused on using it to help understand your health better—not using it as a replacement, but as a way to enhance." Since people were already using ChatGPT for things like analyzing lab results, the new feature will simply make doing so easier and more convenient, he says. "I think this more reflects what health care looks like in 2026 rather than any sort of super novel feature," he says. "This is the reality of how health care is changing."

When Rodman counsels his patients on how to best use AI tools, he tells them to avoid health management questions, like asking the bot to choose the best treatment program. "Don't have it make autonomous medical decisions," he says. But it's fair game to ask if your doctor could be missing something, or to explore "low-risk" matters like diet and exercise plans, or interpreting sleep data.

One of Bitterman's favorite usages is asking ChatGPT to help brainstorm questions ahead of a doctor appointment. Augmenting your existing care like that is a good idea, she says, with one clear bonus: "You don't necessarily need to upload your medical records."

Jesse Eisenberg

LIVING ORGAN DONOR

IN DECEMBER, ACTOR AND DIRECTOR JESSE Eisenberg donated a kidney to a total stranger. "It was immediately clear to me that I should do it," he says. "It just seemed like an obvious thing to do."

Of the 27,000 kidney transplants performed annually in the U.S., just a few hundred come from living donors who give up a kidney to someone they don't know. Many people aren't even aware they can make this kind of donation: Eisenberg, for instance, didn't realize it until last summer, when he told a doctor friend he'd been wanting to donate a kidney for 10 years. "It feels like it's almost an advertising problem rather than an empathy problem," he says.

The donation process was straightforward, helped along by a team of doctors and mental-health professionals. Eisenberg underwent surgery on December 30 (a great excuse, he jokes, for missing all the New Year's Eve parties he prefers to avoid). Midway through the procedure, doctors received word that the intended recipient was too sick for a transplant, so Eisenberg's organ traveled a different direction across the country to the person next in line.

Donating a kidney is considered a low-risk procedure, and donors are able to live full, healthy lives. Eisenberg says he didn't experience any complications, went home from the hospital after three days, and at five weeks post-op, was feeling close to baseline again.

"Altruistic" or "self-directed" donors, as they're called, often maintain their anonymity rather than meeting their recipients. Eisenberg also chose not to learn who received his kidney. In the months before the procedure, his friends posed a series of what-if's: What if the person who received his kidney had different politics? What if he wouldn't like them in real life?

"It was such a silly question to me, because the implication was it's not worth helping an individual unless that individual has the same set of beliefs," he says. "For me, it was much easier to think about the organ donation as the end in and of itself, rather than who the person is and how they're living with the organ, because then we start getting into a slippery slope of judgmental criteria about who deserves this thing. I don't think of it that way."

Did the experience change him? Maybe, he says. "I feel slightly—like I'm talking 1%—more comfortable in my own skin," he says. In the year leading up to the procedure, he was continually lauded for his latest cinematic accomplishments, which he says made him "existentially very uncomfortable." Now, "I in some ways have balanced the scale of being a recipient of so many things to also being helpful," he says.

Advocates say high-profile donations like Eisenberg's can help encourage more people to consider becoming living donors. "What's so inspiring was how sincere he was about why he wanted to do it—and that he came out and talked openly about it," says Kevin Longino, CEO of the National Kidney Foundation (and the recipient of a kidney transplant). "The need is so great, and the opportunity for more living donors is right there in front of us."

What surprised Eisenberg most wasn't the physical toll, but how little emotional turmoil the decision caused. "I'm a very anxious person, but around this whole process I felt nothing but completely calm," he says. "I don't think of it as helping an individual as much as doing something that just feels right." —*Angela Haupt*

***Top left:** Presenting at the 2025 Producers Guild of America Awards in Los Angeles.* ***Left:** Eisenberg introduces a performance at the 2025 Tony Awards.*

Chris Hemsworth

PRIORITIZING BRAIN HEALTH

WHEN MARVEL ACTOR CHRIS HEMSWORTH decided to participate in a documentary about living healthier and longer, he never dreamed his own life would be affected by one of the most devastating diseases of our time. As part of the series, Hemsworth took a genetic test and learned he carries two copies of an Alzheimer's risk gene, significantly raising his chances of developing the neurodegenerative disease. So he dived into the latest science on living better, in particular for improving brain health. "I'm definitely someone who suffers from the all-or-nothing approach, and it's something I've had to temper over the years," Hemsworth says. "My 80-20 or 90-10 rule is to mostly do the right thing but occasionally just go, 'Hey, eat all the wrong things' or 'Do a few of the wrong things.' That, I feel, is a bit more compassionate to one's self."

After the series, Hemsworth's father Craig was diagnosed with Alzheimer's, and he is starting to show signs of memory loss. Hemsworth's team suggested a project that focused on how his father was managing with Alzheimer's. "This opportunity came up for an episode where we do a road trip together, focusing on this thing called reminiscence therapy that's about connecting with the memories from your past, stimulating the hippocampus and reigniting old memories," he says. Hemsworth cautiously asked his dad about participating, thinking he might be uncomfortable with exposing his declining memory in such a public way. But, Hemsworth says, "he immediately said, 'Yeah, sure, why not? If we can help educate someone, and someone can learn something from it, or benefit, then brilliant, I'm on board.' "

The documentary, *Chris Hemsworth: A Road Trip to Remember*, streaming on Disney+ and Hulu after premiering on National Geographic in November, follows Chris and Craig as they revisit a couple of their former homes, including one in Australia's remote Northern Territories where the family lived as part of a close Aboriginal community. The idea was to help Craig rekindle old memories and remember friends and experiences in an effort to keep his cognitive networks from declining. "It really became about connection, and the importance of relationships, our sense of community and belonging," says Hemsworth. He admits that sometimes during filming, when his dad would forget something he had just said, he would feel embarrassed for him and want to stop. "But I also knew from talking to him that he wanted to be raw and open about it."

Hemsworth hopes the documentary helps other families affected by Alzheimer's to understand that while science is working to develop new treatments and capitalize on deeper understanding of how the brain works, it's also worth spending time on the simple things—like connection, community, and compassion. —*Alice Park*

Siddhartha Mukherjee

UNDERSTANDING CANCER

IN 2025, 15 YEARS AFTER Dr. Siddhartha Mukherjee's Pulitzer-winning book, *The Emperor of All Maladies: A Biography of Cancer*, was first published, he updated it, adding four new chapters about detection, prevention, treatment, and overall understanding of the disease. "I felt an urgent need," says Mukherjee, an oncologist, "because much of what we know about cancer had changed."

In another 15 years, he expects AI will have played a key role in developing new treatments that are more precise and less expensive. It's why last year, he teamed up with LinkedIn co-founder Reid Hoffman to launch Manas AI, a startup using AI to aid drug discovery. "Manas has discovered medicines that were unimaginable in terms of their chemical composition," he says. "And within six months, we have probably virtually screened or created virtual medicines that number in the hundreds of thousands, and we will get into the millions."
—Angela Haupt

Jean M. Twenge

PARENTING IN THE SMARTPHONE AGE

IT'S BEEN NEARLY A DECADE since Jean Twenge started studying the ways screen time affects young people. As a psychology professor at San Diego State University, she was one of the first researchers to publicly connect rising rates of anxiety and depression in teens with smartphone adoption. Our understanding of the scope and complexity of the youth mental-health crisis in the smartphone era has grown since then—yet there's still a lack of practical guidance for parents trying to protect their kids without cutting them off from modern social life. Twenge's latest book, *10 Rules for Raising Kids in a High-Tech World*, offers realistic, evidence-based recommendations, including that teens shouldn't get their first smartphone until they have their driver's license, and even then should not keep devices in their bedroom overnight. "That's the best, most straightforward place to start," she says. "You don't need your phone in your bedroom overnight, period."
—Angela Haupt

KIDS NEED RULES ABOUT SCREEN TIME

It's tough, but enforcing clear boundaries is the best policy

BY JEAN M. TWENGE

ASK A PARENT TODAY WHAT they worry about, and many will mention screen time. Teens can't put down their phones, TikTok becomes pervasive by sixth grade, and is my kid really doing homework on their laptop, or have they been watching YouTube for four hours?

Despite these concerns, many parents are resigned. "You can't put the genie back in the bottle," they'll say if they've already given their kid a smartphone. Or they'll sigh that being constantly online is "just how kids are now." They'll tell their kids they aren't allowed on social media, only for their children to open accounts anyway. Many parents are beyond frustrated, and others have simply given up.

That's partially because much of the advice out there on kids and technology is difficult to follow. Experts often say there is no one right age to give a child a smartphone, that "every family is different." Eliminating screens entirely is not realistic for the average family with working parents and kids who do homework on laptops. The "digital literacy" approach says parents should educate kids about technology, and then expect them to make good decisions about how much time they spend online.

As any parent of teens can tell you, that doesn't work. We need something that does.

I've spent the past decade primarily focused on two things: researching the negative impact of screen time on teen mental health, and raising three kids from childhood to adolescence. Like many parents, I'm both scared for my kids and frustrated with my inability to completely protect them. But I've also become more and more convinced that this problem is fixable.

The solution is rules: not halfway or squishy rules, not "every kid is different" rules, not Luddite "no-tech-ever" rules, not "let's just talk to kids" rules, but concrete suggestions for delaying and limiting devices while still letting your kids participate in the modern world of technology.

Talking is just not enough. Kids need rules because they are kids. They simply don't have the same judgment or self-control as an adult. Imagine if we said, "Let's just talk to kids about why they shouldn't drink alcohol until they are older." Or "there's no one right age for kids to buy alcohol. Some might be ready at 12!" Or, if our kids and their friends started drinking at 14, "That's just how kids are now. I guess you can't put the genie back in the bottle!" As a society, we age-gate alcohol because we know kids aren't ready for it. We have rules.

We need similar clear rules around technology use. My book *10 Rules for Raising Kids in a High-Tech World* lays out, you guessed it, ten of them. But you don't have to follow all of them, or follow them perfectly, to have a positive impact.

Start with Rule #2: No electronic devices in the bedroom overnight. Six out of ten 11- to 17-year-olds use their phone between midnight and 5 a.m. at least once a week, causing them to lose sleep every time the phone buzzes and they grab their phone to see what's going on. The mere presence of a phone in the bedroom can disrupt sleep, kids don't even have to be using it in the middle of the night.

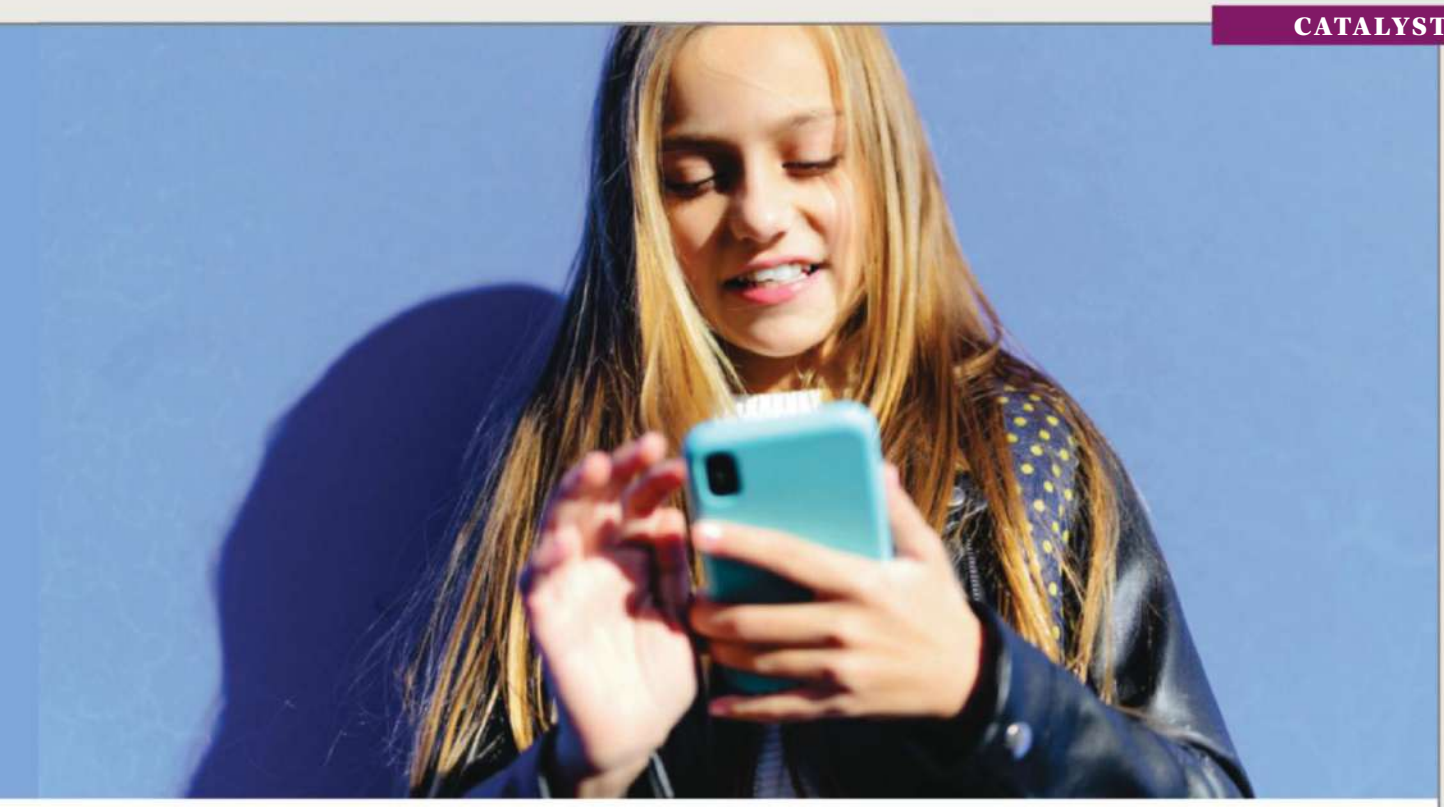
Using devices right before bed is also disruptive; 11- to 14-year-olds slept a half hour less on nights when they texted or played games on a device while in bed before they went to sleep. If your kid says, "I have to have my phone in my bedroom overnight. It's my alarm clock," then buy them an alarm clock.

Rule #4 is that first phones should be basic phones. Phone choices now go beyond flip phone vs. smartphone. Basic phones, such as Pinwheel, Gabb, or Troomi, are the training wheels of phones. They have no internet browser, no social media, and no AI companions, but they can call, text, and take pictures just like a smartphone (most are Samsung Android phones). If you don't want your kid on social media until they are 16 or older—and that's the growing consensus—basic phones make that much easier, while allowing kids to text their friends.

What if you've already given your kid a smartphone? You can indeed put the genie back in the bottle. If your kid is 15 or under, switch out the smartphone for a basic phone. They'll still be able to text their friends and contact you if they need help, probably the reasons you got them the phone in the first place. If they're 16 or older, put parental controls on their smartphone. Yes, you'll need to physically get the phone from them. If they push back, tell them that this is a condition of their having a phone. For the really tough customers, inform them you'll stop paying the cell service bill if they don't hand it over.

Implementing these rules is not always easy. But rules like these are much easier to follow than the unclear "every kid is different" advice. They're more effective than expecting kids to make good choices when they're up against companies pouring billions into making their products as engaging as possible. Even if you can only follow some of the rules some of the time, your kids will benefit. Don't let the perfect be the enemy of the good.

Together, we can get our children back.



The solution is rules: not halfway or squishy rules…but concrete suggestions for delaying and limiting devices while still letting your kids participate in the modern world of technology.

Kerry Burnight

EMBRACING AGING

GERONTOLOGIST KERRY BURNIGHT IS rewriting the aging narrative. Burnight's 2025 book *Joyspan: The Art and Science of Thriving in Life's Second Half* advises readers to prioritize four key ways to age with joy, not fear: grow, connect, adapt, and give. Burnight wants to encourage older people to lean into their age and live with gusto and deep-rooted well-being. The book became an instant hit, landing on the *New York Times* and *USA Today* bestseller lists. "Joy and purpose and vitality are not limited to younger years," Burnight says. "The idea that you have to be or look or feel young in order to fully participate in life is so limiting and so harmful." Burnight coined the term "joyspan"—a take on lifespan and healthspan that has caught on as readers embrace the positive outlook—to help people "see the incredible beauty and power and strength in being older," she says. *—Angela Haupt*

Q&A WITH DR. KERRY BURNIGHT

A geriatrician shares better ways to grow older

BY ANGELA HAUPT

PEOPLE AROUND THE WORLD collectively spend billions of dollars each year on products and services designed to extend their lives. But if they funnel all that money, time, and energy into the pursuit of longevity—only to reach those extra years and realize they're not exactly enjoying them—what's the point?

Such is the dilemma that inspired Dr. Kerry Burnight, a geriatrician who's treated thousands of older patients, to coin the term "joyspan"—what she sees as the third piece of the longevity puzzle, alongside "lifespan" (how many years you live) and "healthspan" (how many of them are spent in good health). Joyspan, as its name suggests, describes the experience of well-being and satisfaction in longevity.

"What motivated me is watching all the suffering," Burnight says. "For the first 20 years of my career, I kept seeing people alone, slumped over in wheelchairs, who were like, 'I don't have any purpose in my life.'"

At first, she assumed that was the inevitable result of reaching an advanced age. Then she realized that, actually, a robust body of research shines light on why some people thrive in their later years and others don't. In her 2025 book *Joyspan: The Art and Science of Thriving in Life's Second Half*, Burnight dispenses tips on how to achieve this better way of growing older.

We caught up with Burnight to talk about what the new "old age" could look like.

This interview has been condensed and edited for clarity.

When should people start thinking about cultivating their joyspan?

Joyspan is for anyone who's aging, and guess who that is? Everyone. The earlier you start, the better. What improves your life from 83 to 84 is the same thing that improves your life from 23 to 24.

In this emphasis on quantity of years, we've overlooked quality. Joyspan focuses on the quality of your long life—and it isn't just chance; it isn't just genes. It's these small, everyday habits and outlooks that we adopt. It's up to us to lean into growing older, and to change the question from how not to age, to how to age with vitality, with beauty, with relevance, with humor, and with gusto.

It sounds like the million-dollar question: How does one go about doing that?

It's very clear. The research groups it into four areas: grow, connect, adapt, and give. They're all verbs, because they all take effort. Just like with physical health, you don't just say, 'Oh, that person's just lucky.' No, every day they were choosing to do things that lowered their risk of cardiovascular disease and improved their flexibility and agility, and as a result, they changed their aging trajectory physically. Likewise, you can do these four things on the inside—and it's a lifelong practice.

Let's talk through each of these four actions. What does prioritizing growth look like as you age?

When we say things like 'I expect to grow, I'm going to put effort into my growth, and I'm going to push myself to do hard things, uncomfortable things, novel things, and fun things,' that's going to make you a different older person than an older person who's like, 'I can't do anything anymore. I can just stay in my house.'

Ask yourself: 'What am I currently doing that is growth?' It starts with curiosity, like if you have any tiny inkling of, 'What the heck is Bitcoin?' Or, 'I wonder if I could do stand-up comedy or learn how to do makeup so I can do it for women who have cancer, and draw on their eyebrows.' The next step is actually doing those things. We make kids do hard things all the time: 'You never jumped off a high dive? Too bad.' When we're older, we stop doing that—so we need to get back in the habit of pushing ourselves to do things that are a little hard.

Connecting is another key to aging well. How can people get better at it?

People who excel at connecting put time into new and existing relationships. We need to be that friend—the one who picks up the phone to call, who offers to drive you to chemo, who remembers that your dad died five years ago on this day. I have people come to me and go, 'Nobody calls me, nobody invites me anywhere. I don't have anything to look forward to.' I listen with love, and then I say, 'Tell me about the invitations you've extended. Tell me about the people you texted.' And every time, they go, 'Oh, shoot.'

At every age, we need to be putting ourselves out there, even if it takes knocking on five doors to find our person.

What does it mean to learn how to adapt?

Adapting means adjusting to changing and challenging situations. You're going to have to deal with hard stuff, and when you do, you can say: 'I have a choice on how I attend to this.' The way you're remembered in life is largely how you walk with your hard thing, whatever it is. There's this quote from Henry Miller I always think about: 'There is nothing wrong with life itself. It is the ocean in which we swim, and we either adapt to it or sink to the bottom.' We can do that through coping strategies like journaling, meditating, and adopting a gratitude practice.

That gratitude practice seems so simple, but it's really proven in the literature. I see it over and over again when people wake up in the morning and go, 'I have to do this, then I have this doctor's appointment, and this is wrong, and my daughter's getting a divorce.' This is the opposite of that. You proactively wake up in the morning and go, 'I have a soft pillow. I get to go downstairs and have some coffee. I'm going to call this person. I'm going to pet my cat.' And then, you start seeing things to be grateful for everywhere you look.

You've said your favorite element of aging well is giving. Why is it key to thriving in life?

When people give, they're sharing themselves. I like to recommend coming up with a giving goal, like doing one little kind gesture a day. Maybe you live next door to a single mother, and you tell her that at dinner time, you can go over and hold or entertain the kids while she focuses on cooking. Then it becomes a habit, and before you know it, you feel great, because these acts of giving feed you as much—if not more—than they do the person you're giving to.

I have a patient who's almost 100, and she is the best listener in the world. Everybody—her kids, her nurses, the grandkids—can't wait to be with her, because she's such an engaged listener. When I look at her, I think, 'Oh my gosh. Even if I have all these challenges, I could be like her, because she has something to give, and she's giving it.'

Joyspan doesn't just make you happier—it makes you healthier, too. What are some of the benefits?

That's the great news: The same things that increase your joyspan have also been shown to increase your lifespan and your healthspan. There's research showing that the "giver's high," for example, lowers inflammation, and that's correlated to a healthier and longer life. And when physical exercise releases endorphins that help you feel better, that enables you to go, 'Hmm. I think maybe I'll give it a go to try to make a new friend.' All these arrows point in the same direction.

Marty Makary

SHAPING AMERICANS' ACCESS TO DRUGS AND VACCINES

AS COMMISSIONER OF THE U.S. FOOD AND DRUG Administration since March 2025, Marty Makary is responsible for greenlighting and regulating treatments, from drugs to vaccines. While some health experts have praised his focus on bringing more breakthrough therapies—including gene- and cell-based approaches—to patients, they've also criticized the agency's decisions on some over-the-counter drugs and vaccine policies. In September, Makary authorized revising the label for acetaminophen—the generic of Tylenol—to include a warning about the risk of autism and ADHD in children of pregnant women taking it, despite research refuting this. And in November, in an action supported by the medical community, the agency removed the "black box" warning labels on menopausal hormone replacement therapies, citing that the warnings were based on decades of fearmongering and that the benefits of HRT for menopausal women—including reduced risk of Alzheimer's disease, cardiovascular disease, and bone fractures—outweigh the risks. *—Alice Park*

Ian Kunkler

CUTTING UNNECESSARY CANCER TREATMENTS

RADIATION TREATMENT IS ONE OF THE WELL-established ways to kill any cancer cells that surgeons can't find or remove. But it comes with a price—damaging some healthy tissue and organs, as well as raising the risk of additional cancer. Dr. Ian Kunkler showed in a study published in 2025 in *The New England Journal of Medicine* that women with early stage breast cancer who skipped radiation treatment after getting a mastectomy were just as likely to survive to 10 years as women who received radiation. The results are part of a growing body of evidence supporting the "less is more" approach that takes advantage of more sophisticated ways to stratify patients by their risk and better match them to the most effective treatments while avoiding exposing them to unnecessary harms. *—Alice Park*

Daniel Coleman

GETTING KIDS MOVING

IT'S BEEN A HECTIC YEAR FOR DANIEL COLEMAN, the co-creator and star of YouTube channel Danny Go!, which produces instructive music videos that get kids up and moving. He and the rest of the team behind the show—including his childhood best friends Michael Finster and Matthew Padgett and Coleman's wife, Mindy—saw their subscribers skyrocket to more than 4 million with over 5 million views a day, announced a forthcoming book series, launched Danny Go! toys in Walmart stores across the U.S., and toured with a live show that played to sold-out crowds. "Our goal is not for a kid to sit on the couch and just watch it," says Coleman, who describes his content as "silly, fun exercise." In the middle of all this success, the Colemans' oldest child, who has a rare genetic disease called Fanconi anemia, was diagnosed with cancer. Coleman uses his massive platform to advocate for organ donorship and joining a bone marrow registry, as transplants have saved his son's life. *—Veronique Greenwood*

Ryan Hampton

ADDICTION VICTIM ADVOCATE

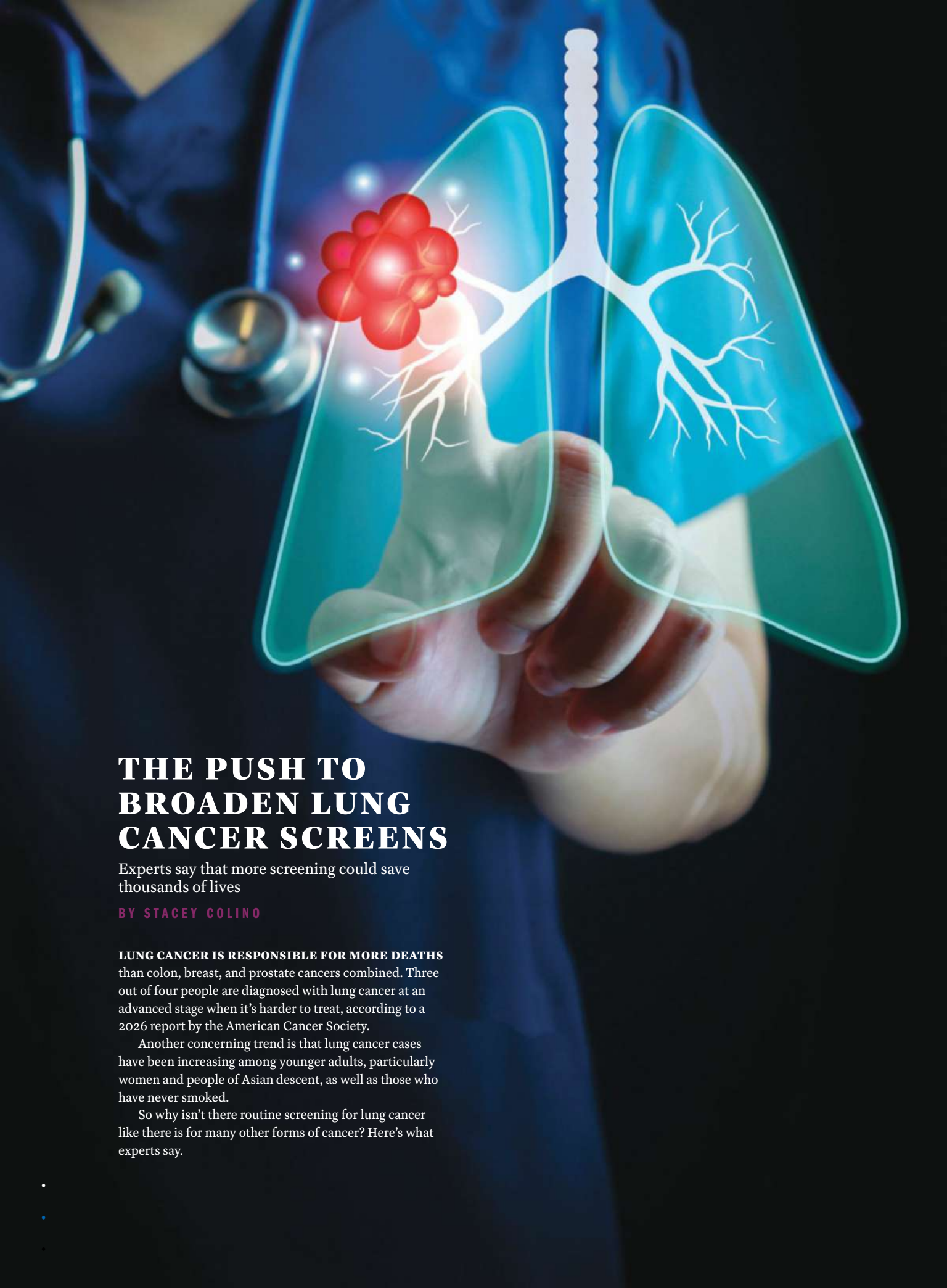
A HIKING ACCIDENT IN 2003 ALMOST COST RYAN Hampton his life—not because of the injury he sustained, but because of the addiction he developed to the opioid OxyContin, which was prescribed for his pain, and eventually led to a heroin addiction. That harrowing journey led to Hampton getting sober in 2015 and being named victim co-chair in the 2019 class-action lawsuit against OxyContin-maker Purdue Pharma and its owners, the Sackler family. Hampton represented 130,000 other victims, ultimately winning an $850 million payout—close to three times the settlement the company initially offered—last year.

Hampton's nonprofit, Mobilize Recovery, now advocates for legislation, resources, and funding for addiction recovery programs from federal and state governments. Since 2019, the group has also distributed 900,000 doses of the anti-overdose drug naloxone in 24 states. *—Jeffrey Kluger*

Priti Bandi

TRACKING CANCER SCREENINGS

PRITI BANDI, SCIENTIFIC director of cancer risk factors and screening surveillance research at the American Cancer Society, has spent the last two decades trying to figure out what keeps people from getting screened for cancer earlier, when the disease tends to be much more treatable. Take lung cancer, the deadliest kind of cancer in the U.S. with one of the lowest screening rates. In research published in November 2025 in *JAMA*, Bandi and her team found that screening every eligible U.S. adult for lung cancer could prevent more than 62,000 deaths from the disease over five years. "Certain groups have low uptake year on year because the bigger picture questions are not being addressed, which is access to care," Bandi says. "Even a small cost burden can prevent you from taking up screening." So can external factors, she and her team have found, such as events like a pandemic, stigma or shame around smoking, and the availability of technologies like CT scans at rural facilities.
—Charlotte Hu



THE PUSH TO BROADEN LUNG CANCER SCREENS

Experts say that more screening could save thousands of lives

BY STACEY COLINO

LUNG CANCER IS RESPONSIBLE FOR MORE DEATHS than colon, breast, and prostate cancers combined. Three out of four people are diagnosed with lung cancer at an advanced stage when it's harder to treat, according to a 2026 report by the American Cancer Society.

Another concerning trend is that lung cancer cases have been increasing among younger adults, particularly women and people of Asian descent, as well as those who have never smoked.

So why isn't there routine screening for lung cancer like there is for many other forms of cancer? Here's what experts say.

Who currently gets screened?

The U.S. Preventive Services Task Force (USPSTF), an independent panel of national experts in evidence-based medicine, recommends annual screening for lung cancer with a low-dose CT (computed tomography) scan in only select populations. This includes adults ages 50 to 80 years who have a 20 pack-year smoking history and who either currently smoke or have quit within the past 15 years. (A pack-year equals smoking one pack—or about 20 cigarettes—per day for a year.).

But some experts believe these guidelines should be broadened.

"The current guidelines for lung cancer screening are based on a very outdated model for risk assessment," says Dr. Ankit Bharat, chief of thoracic surgery and executive director of the Canning Thoracic Institute at Northwestern Medicine. "It presumes smoking is the only cause of lung cancer. Anyone exposed to secondhand smoking, air pollution, or radon—risk factors that are well established—doesn't have any way of getting screened."

In a study published in a November 2025 issue of *JAMA Network Open*, Bharat and his colleagues examined the records of nearly 1,000 people treated for lung cancer and discovered that only 35% of them met the USPSTF criteria for screening. If lung cancer screening were expanded to include all people ages 40 to 85, the researchers estimate that this would detect 94% of lung cancers, preventing at least 26,000 deaths annually.

"People have to understand that if they don't smoke, they're not immune to lung cancer," Bharat says. "Early detection is the only way to treat early-stage lung cancer. Stage I lung cancer is completely curable, and treatment is an outpatient procedure."

There's no question that "screening definitely saves lives, and finding it early makes a difference," says Dr. Roy Herbst, chief of medical oncology and hematology at the Yale Cancer Center.

Obstacles to lung cancer screening

Even within the current guidelines, most people who are eligible to get screened don't get checked out. "The primary reason is lack of public awareness," says Dr. Samir Makani, medical director of the lung cancer screening program at the Scripps Cancer Center and an interventional pulmonologist at Scripps Memorial Hospital Encinitas. "Research shows that less than 20% of eligible people are getting screened. Responsibility for achieving greater awareness of lung cancer and the impact of lung cancer screening falls on all of us—patients, primary-care physicians, and the U.S. health-care system as a whole."

Part of the problem may be that getting screened is a "cumbersome process," as Makani puts it. "With lung cancer screening, you need to undergo a shared decision-making visit [with your doctor] to discuss the risks and benefits, then go get a CT scan." In other words, it's a two-step process, compared to simply getting an order for a mammogram or colonoscopy, for instance.

> ***'The current guidelines for lung cancer screening are based on a very outdated model for risk assessment.'***
>
> **—DR. ANKIT BHARAT, CHIEF OF THORACIC SURGERY & EXECUTIVE DIRECTOR OF THE CANNING THORACIC INSTITUTE AT NORTHWESTERN MEDICINE**

One of the arguments against expanding screening is that it will simply cost too much. Yet Bharat points out that "the cost of treating someone with Stage I lung cancer is a fraction of the cost of treating Stage IV lung cancer."

"The most important part of lung cancer screening is the survival benefit," says Makani. The five-year survival rate for Stage IA lung cancer is upwards of 90%, he says, compared to 20% for Stage III. This is especially important, he adds, because "the majority of patients we find lung cancer in are asymptomatic."

People are also concerned about being exposed to radiation with low-dose CT scans. "We don't want to give people radiation exposure unnecessarily," says Herbst. But the amount of radiation exposure is quite low—only slightly higher than with a mammogram.

There are also concerns about incidental findings on these CT scans. "We can find things that are not lung cancer—it could be a benign lesion or a fungal infection that causes a nodule that's harmless," says Dr. Kim L. Sandler, a professor of radiology at Vanderbilt University Medical Center and director of the Vanderbilt Lung Screening Program. The possibility of incidental findings may concern some patients, but "incidental findings can be beneficial if they're actionable," she notes.

Besides, there's another potential upside to low-dose CT screening for lung cancer: A single scan can assess heart and bone health, too, by providing cross-sectional images of the whole chest cavity, including the heart and thoracic spine.

A push for universal lung cancer screening

Bharat thinks lung cancer screening should be universal after age 40, regardless of whether people have a history of smoking. Many other experts agree.

Sandler notes that with a universal approach, the interval for subsequent low-dose CT screenings would differ based on people's personalized risk. "We have personalized recommendations for colon and breast cancer [screening] based on people's risk factors," says Sandler. "We need to find out how to do that with lung cancer as well."

Joe Sachs

BROADCASTING ER ISSUES

AS AN EXECUTIVE PRODUCER AND WRITER OF the HBO Max series *The Pitt*, real-life emergency physician Dr. Joe Sachs is integral to the Emmy-winning hospital drama's authentic portrayal of the gritty realities of emergency room care. Sachs earned a master's in filmmaking while simultaneously studying at Stanford University's School of Medicine, and previously advised for *ER*. Now, he's changing audiences' perception of issues prevalent in America's health care system. A 2025 study from USC's Norman Lear Center found that *The Pitt*'s depiction of working in an ER not only validated the lived experiences of medical professionals, but also, based on surveys, compared to nonviewers, people who watched the show had more positive attitudes toward organ donation and end of life planning, and had greater intentions to discuss care plans with loved ones. —*Megan McCluskey*

A. Eden Evins

VAPING ADDICTION TREATMENTS FOR TEENS

AMONG PEOPLE WHO STARTED USING A NEW drug in 2024, nicotine vaping was the top choice in the U.S. "It beat alcohol for the first time," says Dr. A. Eden Evins, director of the Center for Addiction Medicine at Massachusetts General Hospital. "Kids are initiating it at younger and younger ages." It's a worrying trend: Of the 1.63 million middle and high school students who use e-cigarettes, one in four do so daily. "Kids told us they never expected to lose control over their vaping," she says. To provide pediatricians and school counselors with an evidence-backed solution to the growing addiction problem, she tested varenicline, a tobacco cessation pill for adults, in this new population. A study published in *JAMA* in April 2025 of 300 adolescents found varenicline was a more effective quitting aid for vaping teens than a placebo or behavioral interventions alone. Her team is beginning a larger study to test varenicline across other nicotine products, including nicotine pouches. —*Charlotte Hu*

Pascal Geldsetzer

PREVENTING DEMENTIA

WHAT IF A VACCINE COULD CURB THE RISK OF dementia? Research led by Pascal Geldsetzer, a Stanford University assistant professor of medicine, suggests there's already a shot that may do just that. Recent studies published in 2025 and 2026 by Geldsetzer and his collaborators that analyzed the health records of millions of people in Wales, Australia, and Canada found that getting the shingles vaccine could prevent or delay dementia. Shingles vaccination appeared to avert about one in five new dementia diagnoses over a seven-year period, the research showed. Earlier research had pointed in a similar direction, though a causative link hadn't been established. By using an innovative research approach, Geldsetzer says he has been able to take existing data from electronic health records and generate comparison groups similar to a clinical trial, the gold standard for medical research. —*Dominique Mosbergen*

Eric Dane

ADVOCATING FOR AN ALS CURE

FOR THE MILLIONS OF PEOPLE WHO HAVE religiously tuned into *Grey's Anatomy* for decades, actor Eric Dane will always be the charming and confident Dr. Mark Sloan. But off the screen, Dane transitioned to the role of patient. In April 2025, the actor announced he had recently been diagnosed with the progressive neurodegenerative disease amyotrophic lateral sclerosis—ALS—which affects some 350,000 people worldwide and for which there is no cure. Most patients live 2 to 5 years after their symptoms start.

Dane became a dedicated advocate for others with his disease. He joined the board of directors of the nonprofit Target ALS, helping the organization surpass its end-of-year campaign to raise $500,000 for research, and launched a three-year "Push for Progress" campaign with the patient-led organization I AM ALS, aiming to secure more than $1 billion in federal funding for ALS research. Dane died on February 19 at the age of 53. —*Angela Haupt*

ACTOR ERIC DANE DIES AT 53

After his diagnosis, Dane became an advocate for ALS awareness and research

BY CHAD DE GUZMAN

ACTOR ERIC DANE, KNOWN FOR HIS MANY ROLES including on TV shows *Grey's Anatomy* and *Euphoria*, died February 19 at age 53 "following a courageous battle with ALS," a statement from his representatives shared. "He spent his final days surrounded by dear friends, his devoted wife, and his two beautiful daughters, Billie and Georgia, who were the center of his world."

"Throughout his journey with ALS, Eric became a passionate advocate for awareness and research, determined to make a difference for others facing the same fight. He will be deeply missed, and lovingly remembered always. Eric adored his fans and is forever grateful for the outpouring of love and support he's received. The family has asked for privacy as they navigate this impossible time," the statement added.

After announcing his diagnosis, Dane said he felt "fortunate" to continue working, including reprising his role in the HBO show *Euphoria* (the third and likely last season premiered on April 12).

Dane's rise to stardom

Per an ABC profile, Dane, born in November 1972 to an architect and interior designer father and a homemaker mother, was raised in San Francisco. As a high schooler, Dane was described as "excelling as an athlete" when he joined a school production of Arthur Miller's play *All My Sons*, which jump-started his love for acting.

In 1991, Dane appeared in an episode of teen sitcom *Saved by the Bell*. He moved to Los Angeles in 1993 and that year appeared on ABC comedy *The Wonder Years*. Since then, Dane snagged guest roles in other TV shows like *Roseanne*, *Married… with Children*, and *Silk Stalkings*.

His good looks landed him supporting and recurring roles in other shows. Dane played a doctor on the ABC medical drama *Gideon's Crossing*, and he played a San Francisco newspaper owner who became a love interest of Alyssa Milano's main character in the WB show *Charmed*.

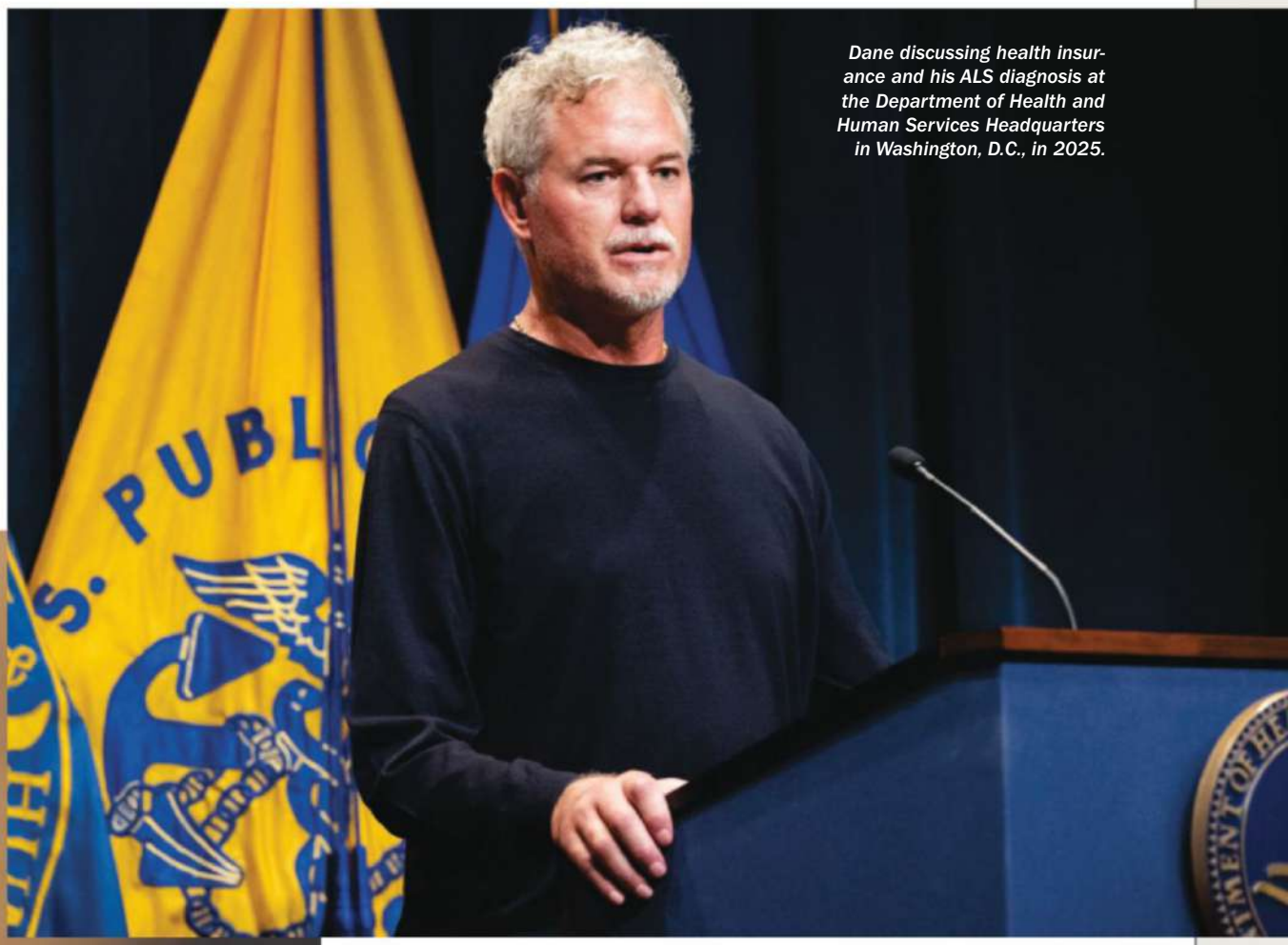
Dane's acting stints weren't limited to the small screen. In 2006, he portrayed a mutant in *X-Men: The Last Stand* and a co-worker of Owen Wilson's character in the 2008 movie *Marley & Me*.

Charming through Shondaland

But it was Shonda Rhimes' long-running medical drama *Grey's Anatomy* that catapulted Dane to stardom, where he portrayed the dashing plastic surgeon Dr. Mark Sloan, popularly nicknamed "McSteamy." He entered the show's second season in 2006 as a guest star but became a series regular for six seasons until his character faced a tragic death in 2012.

In a 2024 podcast with Dax Shepard, Dane explained his departure from the show, suggesting it was for financial reasons. "I didn't leave so much as I think I was let go," before Shepard pointed to Dane's painkiller addiction struggles at the height of the show's popularity. (Dane entered rehab in 2011 to address the addiction.) "They didn't let me go because of that, although it definitely didn't help." But his character would appear briefly in the show's 17th season in 2021 as part of a dream sequence by main character Meredith Grey.

ABC and 20th Television released a statement after Dane's passing: "We are deeply saddened by the loss of Eric Dane. His remarkable talent and unforgettable presence on *Grey's Anatomy* left a lasting impact on



Dane discussing health insurance and his ALS diagnosis at the Department of Health and Human Services Headquarters in Washington, D.C., in 2025.

audiences around the world, and his courage and grace during his battle with ALS inspired so many. Our hearts are with his family, friends, and colleagues, as well as the many fans whose lives were touched by his work."

Career after Grey's

After turning in his fictional scrubs, Dane appeared in movies and on several other shows.

From 2014 to 2018, he played Admiral Tom Chandler in Michael Bay's dystopian thriller series *The Last Ship*. Travis Van Winkle, Dane's co-star, posted a photo with him on Instagram Stories with the text: "I learned so much from Eric. He was a great man. I'm sad to see him go in this way. I'm sending love to his family. Thanks for the memories my friend."

In 2019, Dane joined the Zendaya-led ensemble cast of HBO teen drama *Euphoria*, portraying Cal Jacobs, the closeted, violent father of Jacob Elordi's character Nate Jacobs.

In one of his final roles before his passing, Dane took on a role close to his heart: a firefighter with ALS in a November 2025 episode of NBC drama *Brilliant Minds*. Michael Grassi, the series' creator, said in a statement: "Eric was a TV icon who lit up our screens for decades and it was the greatest honor of my career to work with him. Not only was he a tremendous talent, he was also generous, kind and brave. I'm thinking about his family and loved ones today."

Nathan Fielder

COMEDY FOR CHANGE

AT THE CORE OF COMEDIAN NATHAN FIELDER'S signature bits is an examination of human behavior. Last year, the subject of airline pilots' mental health challenges drove Season 2 of his HBO docu-comedy *The Rehearsal*, and his work may have had an indirect payoff. Months after the season aired, the U.S. House of Representatives passed the Mental Health in Aviation Act, which requires the Federal Aviation Administration to enable pilots to seek mental health treatment without fear of professional repercussions. Fielder said on a panel that John Goglia, an aviation safety expert who advised him during filming, believes the show pushed the legislation forward. Lauren Feldman, a communications professor at Rutgers University, says that comedians are in a unique position to draw attention to important issues outside traditional channels. "What's interesting and exciting about this example is [that it uses] different formats and genres of comedy to try to push social change," she says. —*Charlotte Hu*

Fielder speaks at the Writers Guild Theater in Beverly Hills in 2026.

Mikhail Varshavski

EXPLAINING HEALTH DATA

DR. MIKHAIL VARSHAVSKI—DR. MIKE TO HIS followers—started posting on social media to provide vetted health information with an easy-to-understand approach. Amid shifting recommendations from U.S. government agencies, "people are more confused than ever and looking for a trustworthy source," says Varshavski, a family medicine physician with Chatham Family Medicine in Chatham, New Jersey. He's gained more than 14.5 million followers on YouTube, 5.3 million on Instagram, and 2.7 million on TikTok. Last year, his debate with 20 anti-vaccine activists racked up nearly 1 billion views across platforms. Other notable posts include an animated explainer on smallpox, a confrontation with a doctor promoting controversial brain scans, and a survey of over-ordered medical tests. "To be able to reach people with valuable information in this day and age—responsibly, without attacking anyone, and leading with empathy and transparency—is the biggest badge of honor," he says. *—Angela Haupt*

Calley Means

DIET IDEATOR

CALLEY MEANS ROSE TO A KEY ROLE IN THE Trump Administration, helping U.S. Health and Human Services Secretary Robert F. Kennedy Jr. to craft and coordinate an overhaul of the American diet and food system. Means is now an influential figure in the Make America Healthy Again (MAHA) movement. In his 2024 book, *Good Energy*, Means and his sister, Dr. Casey Means, whom President Trump nominated to be U.S. Surgeon General, argued that the food and pharmaceutical industries are incentivized to keep people sick, and highlighted the power of diet and exercise changes to transform health. In 2025, Means, now a senior adviser in the health department, helped coordinate two federal reports, which asserted that poor diet and "overmedicalization" were driving a chronic-health crisis among children. He was also involved in creating the new U.S. dietary guidelines released in January. *—Dominique Mosbergen*

Sadiya Khan

ASSESSING CARDIOVASCULAR RISK EARLY

MORE THAN 99% OF PEOPLE WHO SUFFER A heart attack, stroke, or heart failure have at least one of four major risk factors beforehand. But many are unaware—a fact that supports the need for the new PREVENT Risk Percentiles tool, an online calculator that helps people understand their risk of experiencing a heart event in the next 30 years. In a 2025 study published in the *Journal of the American College of Cardiology*, researchers introduced the tool, which aims to spark dialogue between patients and providers. Dr. Sadiya Khan, the study's senior author and a professor of cardiovascular epidemiology at Northwestern Medicine, recommends people ages 30 to 79 calculate their risk annually. "We know that more young adults are facing obesity, diabetes, or hypertension, and we want to make sure we're starting that conversation early," Khan says. *—Angela Haupt*

THE NEW WAY TO PREDICT YOUR RISK OF A HEART ATTACK

Quantifying risk early can help save lives

BY ANGELA HAUPT

When you know your health metrics before problems arise, you can take preventative measures

MORE THAN 99% OF PEOPLE WHO SUFFER A heart attack, stroke, or heart failure have at least one risk factor beforehand—yet many have no idea until it's too late. That's part of the reason heart disease has been the leading cause of death in the U.S. since at least 1950. Now, scientists hope that a new generation of tools—like a first-of-its-kind risk calculator—can turn those invisible warning signs into something people can see, understand, and act on years before the worst-case scenario strikes.

"This is a disease that's impacted by choices we make in life. And I think that we as humans can make wiser choices if we understand our risk—and perhaps even more importantly, if we understand the connection between risk and the choices that we make," says Dr. Matthew Tomey, a cardiologist at Mount Sinai Fuster Heart Hospital. "Understanding and communicating risk are profoundly difficult things to do, and it's especially difficult for individuals who are younger and feel fine."

Here's a look at the new science of predicting heart risk, and what challenges remain.

A new way to assess risk earlier

In a study published in 2025 in the *Journal of the American College of Cardiology*, researchers introduced a free online calculator, the PREVENT Risk Percentiles Tool, that calculates a person's 30-year risk of developing heart disease. It's designed for adults ages 30 to 59, and people should ideally use it once a year, says senior study author Dr. Sadiya Khan, a professor of cardiovascular epidemiology at Northwestern Medicine.

The new calculator—which is based on the American Heart Association's PREVENT equations—is an update to an older tool that estimated a person's 10-year risk of a first-time atherosclerotic cardiovascular disease event, like a heart attack or stroke. The old version was geared toward people 40 or over, and research found that it often failed to identify a significant proportion of the people who ultimately went on to experience a heart attack.

In addition to including younger adults and forecasting predictions further into the future, the new model predicts a broader range of outcomes, including heart failure.

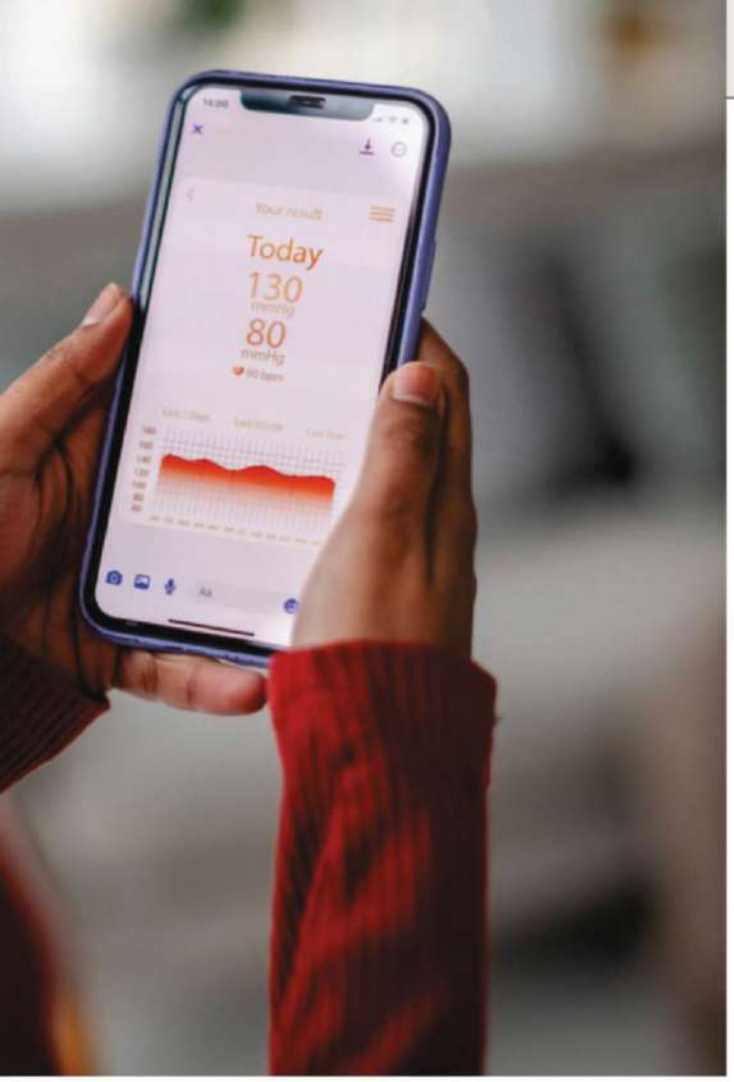
"It's really trying to push the envelope on prevention starting earlier," Khan says. "We know that more and more young adults are facing obesity or diabetes or hypertension, and we want to make sure we're starting that conversation early, so we're not waiting until someone has a heart attack or presents in heart failure."

The calculator is straightforward, as long as you have key health metrics in hand. Users plug in data like sex, age, body mass index, blood pressure, cholesterol, smoking status, and diabetes history, and then—based on that snapshot of their current stats—they're provided with both a 10-year and 30-year percentage risk for developing heart disease.

The value of taking early action

Many experts consider the new online calculator a promising addition to the repertoire of tools available to help prevent heart disease. It's meant to inspire conversations with clinicians, not replace care—an important distinction, says Dr. Nishant Shah, a preventive cardiologist at Duke University Medical Center.

The earlier these conversations start, the better, Shah says. He starts talking with people about their risk for heart disease around age 18, especially if they have a strong family history of disease. Online, easy-to-access tools like the calculator can open the door to those conversations—and meaningful change. "Talking about these things with patients before a problem happens is crucial," he says. After patients learn their heart disease risk score, he educates them on preventive



steps they can take, like exercising regularly, following a good diet, getting enough sleep, starting a medication like a statin if warranted, and keeping up with blood pressure and cholesterol screenings. "These are all really important things to prevent a surprise," he says. "A story I hear a lot is, 'He or she was doing great yesterday, and then today they just woke up dead.' That's what we're trying to avoid."

One of the key reasons tools that predict risk can be so helpful is that many people simply aren't aware of their likelihood of developing heart disease. "A lot of these risk factors are silent," Shah says. "Someone could be running around with high blood pressure, and they're not going to feel the effects of it until it gets super high. People don't feel like something's wrong; it's different from if you have a rash on your face." For some people, he adds, quantifying risk is all it takes to get engaged with protecting their heart—and potentially saving their life.

Lingering pain points

No single risk assessment will ever perfectly predict someone's chance of having a heart event.

"By necessity, there's no risk calculator that incorporates every relevant variable," Tomey says. "The PREVENT equations are a really admirable advance in risk prediction, but they're parsimonious in the number of variables and the nature of variables that they include."

Other relevant factors, he says, include whether someone has calcification of a coronary artery or plaque in an artery; genetic risks; high levels of lipoprotein(a); and inflammation metrics, including C-reactive protein. It also doesn't account for most lifestyle factors, like exercise and sleep quality. All of these "might be important asterisks in any number you get from the calculator," says Tomey, whose research has found that the PREVENT equations underestimate risk in some people. "We can't just hang our hats on scores like this," he says. "It's really important to understand the value that they bring, but they're not some sort of guarantee of protection if you have a lower score."

Plus, risk scores in general resonate differently depending on the person. Some people take them seriously, while others shrug them off or misunderstand them. These scores are "only fruitful in so much as they motivate you to make healthy choices," Tomey says. If learning your risk score propels you to take stock of your daily choices, and how you can get healthier, then "that's something that can materially improve individual health and public health." Otherwise, it's just a number.

A multi-pronged approach

There are other ways to predict heart risk, too. Some people benefit from knowing their coronary artery calcium score, for example, which is produced by a low-dose CT scan that detects calcium buildup in the heart's arteries. That test can help diagnose early coronary artery disease and is often recommended for people with a family history of disease.

Compared to a risk calculator, "neither is superior," says Dr. Luke Laffin, a preventive cardiologist at the Cleveland Clinic. "They're complementary."

In practice, doctors rarely rely on a single test. Regular checkups and labs are still informative, and some people benefit from stress tests, echocardiograms, and advanced lipid testing—like for lipoprotein(a) and apolipoprotein B. Clinicians can also assess risk through taking a thorough family history and understanding lifestyle patterns.

No matter which tool or test makes the most sense, having a meaningful understanding of individual heart-disease risk gives people a chance to intervene sooner rather than later. "Everyone should have their cardiovascular risk calculated," Laffin says. He reports he's seeing interest increase: As people become more invested in longevity, more younger people are showing up in his office and saying, "My dad died of a heart attack or had a heart attack in his 50s. What can I do to not befall that fate?"

"There are all kinds of ways to calculate risk, but this PREVENT calculator is the most contemporary version that we have," Laffin says. "I'd encourage people to talk with their doctor about their risk, and that can help guide conversations about preventive actions they can take."

Susan Monarez

STEADFAST LEADER

SUSAN MONAREZ WAS FIRED in August 2025 as director of the U.S. Centers for Disease Control and Prevention, a move that drew attention amid broader debates over the direction of federal health policy under the Trump administration. That her dismissal was followed by the resignations of several other senior CDC officials underscored internal tensions over policy and governance at the agency.

Monarez says she was removed after resisting what she describes as pressure to sign off on vaccine recommendations without reviewing scientific data. A microbiologist by training and longtime civil servant, Monarez testified in September before a Senate committee that she was fired by U.S. Secretary of Health and Human Services Robert F. Kennedy Jr. after declining his requests to pre-approve vaccine recommendations and dismiss career scientists involved in vaccine policy. "Even under pressure, I could not replace evidence with ideology," she told lawmakers. Kennedy denied her allegations in Senate testimony. *—Dominique Mosbergen*

Laura Esserman

PERSONALIZING BREAST CANCER SCREENING

IN 2016, BREAST CANCER surgeon Dr. Laura Esserman launched the WISDOM study—short for Women Informed to Screen Depending on Measures of risk—to determine if more personalized screening could help detect cancers earlier. The study was controversial, since it required some patients to be randomly assigned to receive the standard mammogram screening recommendation, while others were screened either less or more regularly, depending on factors that contribute to breast cancer. In December, the results supported Esserman's hunch: Women following the more personalized screening regimen tailored to their risk level were not more or less likely to be diagnosed with cancer than women following the annual screening guideline. Even more encouraging, women with personalized screening were less likely to be diagnosed with stage 2B cancers, the stage at which deaths from the disease increase dramatically. In short: The standard screening schedule could be overdiagnosing low risk women, and missing cancer in high risk women. *—Alice Park*

RECENT STUDY CHALLENGES THE WAY WE SCREEN FOR BREAST CANCER

A more personalized risk-based approach might be more effective

BY ALICE PARK

A LONG-AWAITED STUDY SHOWS THAT SCREENING for breast cancer with annual mammograms may not always be the best way to catch the disease.

In a 2025 study published in *JAMA* and presented at the San Antonio Breast Cancer Symposium, Dr. Laura Esserman, a breast-cancer surgeon and director of the University of California San Francisco Breast Care Center, showed that more personalized screening schedules based on a woman's risk of developing the disease could be just as effective at detecting cancer.

Esserman launched the WISDOM (Women Informed to Screen Depending on Measures of Risk) study in 2016 to explore whether more personalized evaluations of a woman's risk of developing breast cancer could lead to alternative screening schedules that would serve them better than uniform yearly mammograms. The first results, which involved more than 28,000 women between ages 40 and 74, suggests that different screening regimens for women at higher and lower risk are as good as the existing annual screens.

The women, none of whom had breast cancer, were randomly assigned to receive either more personalized risk-based screening or the annual screening. They were followed for an average of about five years to see if they developed the disease. In this first analysis, Esserman and her team found that alternative screening regimens, including more-frequent or less-frequent screening, were similar to yearly screening in detecting breast cancer. That suggests cancers weren't being missed with the alternative screening schedules.

The number of Stage 2B breast cancers—the stage at which deaths from breast cancer rise sharply, from three- to eight-fold—was lower in the group with personalized screening compared to those getting yearly screening. "There was a one third reduction in the number of Stage 2B cancers; that's remarkable," says Esserman. "Even I am amazed by these results."

WISDOM also showed that altering the screening schedule was not harming women by missing cancers. "This study is absolutely a prerequisite to implementation of a risk-based approach," says Esserman. "The first thing we had to do was to show it is safe."

Esserman has long been bothered by the uniform screening guidelines for breast cancer. She and other experts have recognized that women have widely varying disease risk, and as researchers have learned more about genetic risk factors, for example, they have found several mutations that seem to be associated with higher risk. Studies also show that not all women who develop breast cancer have a family history of it, which has traditionally been one of the risk factors that doctors consider.

WISDOM's risk-based strategy included genetic testing looking at nine breast cancer genes. On their own, some don't have an appreciable effect on breast-cancer risk, but together research links them to higher risk. Other factors, like breast density, age, and a woman's own history of the disease, as well as her family's, were also included. Based on these risks, Esserman's team developed an algorithm for assigning women to one of four different screening regimens. All women received counseling about risk factors, and women at highest risk got alternating mammograms and MRIs every six months. Women at elevated risk got annual mammograms; women at average risk were assigned to mammograms every other year, and those at lowest risk did not receive mammograms unless their risk score changed.

'There was a one third reduction in the number of Stage 2B cancers; that's remarkable. Even I am amazed by these results.'

—DR. LAURA ESSERMAN, DIRECTOR OF THE UNIVERSITY OF CALIFORNIA SAN FRANCISCO BREAST CARE CENTER

The more personalized risk-based assessment provides more targeted screening that could benefit women, says Esserman. While the current study was just designed to show its safety, she plans to track treatments and outcomes. "We're working on improving our risk-reducing tools and predicting risk so we can improve our efforts in prevention [of breast cancer]," she says. Current screening methods are too broad and don't distinguish between high- and low-risk women, which leads to over-treatment of some and missing cancers in others. "We want to be finding people who have the highest risk of cancer," she says.

Key to using risk-based screening is a robust algorithm that incorporates the latest understanding on major risk factors for the disease, and that means revising long-held views. The findings also make a strong case for routine genetic testing of women, beginning at relatively early ages, says Esserman, since many highest risk breast cancers begin when women are in their 30s or so. In the study, for example, 30% of women with high-risk genes did not have a family history of breast cancer. "That surprised everybody including us. It goes to show that family history is not a reliable way to determine who should have a genetic test," says Esserman.

The WISDOM results support other studies in breast cancer that are exploring whether aggressive treatments for very early, low-grade cancers like DCIS are necessary. In 2025, the COMET study, led by Dr. Shelley Hwang at Duke University, showed that for some women diagnosed with DCIS, careful monitoring with more frequent mammograms did not lead to any higher risk of developing breast cancer than those who chose to do surgery and radiation to remove the lesions.

The current findings are just the start for WISDOM, which has already enrolled women for the next stage focusing on whether personalized risk-based screening can help to prevent cancer. "I would love to see this country adopt a comprehensive risk-based screening program," says Esserman. "It's pretty thrilling to have these results. More screening isn't better; smarter screening is."

Rebecca Ahrens-Nicklas & Kiran Musunuru

SAVING A BABY FROM GENETIC DISEASE

AS A DOCTOR WHO TREATS BABIES WITH RARE genetic diseases, Dr. Rebecca Ahrens-Nicklas, director of the Gene Therapy for Inherited Metabolic Disorders Frontier Program at Children's Hospital of Philadelphia, is accustomed to sharing difficult news with families. For many of the babies, the only treatment available is palliative care.

To change that, in 2023, Ahrens-Nicklas partnered with Dr. Kiran Musunuru, director of the Genetic and Epigenetic Origins of Disease Program at the University of Pennsylvania Perelman School of Medicine, who has been researching ways to use the CRISPR gene-editing technique to treat such conditions. Their goal was to use the new method to correct the mutations that Ahrens-Nicklas' patients were born with, so babies weren't as severely affected by their conditions. But the timing was critical, since often the longer babies live with the effects of their mutations, the more severe their symptoms become.

When KJ Muldoon was born in August 2024 with mutations that led to a missing enzyme he needed to process proteins properly, Ahrens-Nicklas knew she had to act fast. Most with his condition need a liver transplant—but they have to live long enough to be able to handle that major surgery. Without the enzyme, KJ's body built up dangerous levels of ammonia, and the longer this toxic process continued, the more it would affect his development. There was no CRISPR-based treatment for his mutation yet, so Ahrens-Nicklas and Musunuru worked with the team of CRISPR co-discoverer Jennifer Doudna to create a world-first customized gene therapy for KJ.

Trying a new therapy on an infant is risky, and Ahrens-Nicklas rallied the team to push KJ's therapy through the normal testing process, which starts in animals, to ensure it was safe and likely to help him. At just 6 months old, in early 2025, KJ received the first personalized CRISPR therapy, designed to address his specific mutation, given via three infusions.

KJ has now celebrated his first birthday, and the treatment seems to have spared him from the severe effects of his disease, says Ahrens-Nicklas. The team will continue to monitor his progress.

Beyond KJ's success, his treatment has spurred Ahrens-Nicklas and Musunuru to work on developing custom therapies for other patients. And Doudna (who received a Nobel Prize for her CRISPR work) is also focused on expanding the applications of her groundbreaking discovery. Last year, she partnered with Priscilla Chan Zuckerberg of the Chan Zuckerberg Initiative to create a new center, housed at the University of California, San Francisco, and the University of California, Berkeley, to bring bespoke gene therapies to more patients like KJ.

"I don't think it's exaggerating to say that this is the future of medicine," says Musunuru. *—Alice Park*

Tariro Makadzange

AN AFRICAN NETWORK FOR CLINICAL TRIALS

FEWER THAN 4% OF CLINICAL trials are done in Africa, so Dr. Tariro Makadzange, a clinical assistant professor at Stanford University, founded the Africa Clinical Research Network (ACRN) in 2024 to radically increase that number. The organization provides support for researchers and institutions that would like to perform clinical work on the continent, in order to develop a system that centers on African patients and needs. While it is in its early days still, ACRN has partnered with the Gates Foundation to lead an HIV vaccine trial and begun to build a database of hospitals interested in participating in future trials. In 2025, Makadzange and colleagues put out a call for sites, with more than 500 institutions across the continent replying to sign up.
—Veronique Greenwood

Nima Nassiri

A WORLD-FIRST SURGERY

IN 2021 DR. NIMA NASSIRI HAD PULLED OUT AN envelope to scribble notes on how a bladder transplant could be accomplished in a living person—a surgery that had yet to be performed successfully. It was 2021, the COVID pandemic was raging, and Nassiri, then a medical resident, was brainstorming ideas with urologist Dr. Inderbir Gill in a school cafeteria. About four years later, on May 4, 2025, Nassiri—now 37 and an assistant clinical professor of urology at the University of California, Los Angeles—and Gill performed a bladder transplant on a 41-year-old father of four. The procedure, a world first, was a tremendous success. The patient recovered well and has excellent bladder function, Nassiri says.

Nassiri now plans to perform several more bladder transplants in 2026 as part of an ongoing clinical trial. Patients who need these transplants are often people who are "out of options," Nassiri says. "If we're able to develop something that can help them, that's huge. *—Dominique Mosbergen*

Joseph Turek

HEARTS FOR BABIES

BEFORE A DONOR HEART CAN BE TRANSPLANTED, it must be effectively reanimated to make sure its tissues are healthy and it is fit to resume beating in the recipient's chest. This can be a problem when the donor and recipient are babies, since a critical piece of equipment that does the reanimation is designed for adult-sized hearts. The result: Babies are limited to receiving hearts from brain-dead donors whose hearts don't stop beating while they're in the donor's chest. Enter Dr. Joseph Turek, chief of pediatric cardiac surgery at Duke Health. Turek and his colleagues have developed equipment that can reanimate baby-sized hearts, expanding the donor pool by up to 20%. It was first used in 2025 to successfully give a 3-month-old baby a new heart. "We do about 500 heart transplants a year in children," says Turek. "That number could go up by 100, which is pretty incredible." *—Jeffrey Kluger*

Gideon Lack

PREVENTING ALLERGIES

NEARLY TWO DECADES AGO, DR. GIDEON LACK, professor of pediatric allergy at King's College London, and his colleagues asked: Would giving infants peanuts protect them from developing peanut allergies? At the time, U.S. standard practice was to cocoon babies from allergens until they were toddlers. But the team discovered in 2015 that this avoidance might have been causing the epidemic of peanut allergy that had engulfed children in the U.S. and elsewhere—children given peanuts in the first months of life were around seven times less likely to develop a peanut allergy. Recommendations were revised in 2017, and in October 2025 a paper in *Pediatrics* revealed that the alteration led to a 43% drop in peanut allergy incidence in the years following. In the period covered by the study, "about 200,000 cases of peanut allergy [were] prevented in the U.S. alone," says Lack. *—Veronique Greenwood*

Catherine Wu

PIONEERING PERSONALIZED CANCER VACCINES

FOR DECADES, SCIENTISTS HAVE SOUGHT TO create vaccines that treat cancer. Researchers like Dr. Catherine Wu, a professor of medicine at Harvard Medical School and the Dana-Farber Cancer Institute, are moving the field closer to attaining this goal. Wu and her colleagues have developed some of the first personalized cancer vaccines, which train a person's immune system to recognize and attack specific mutations, known as neoantigens, that are unique to their own tumors. Her lab designed an algorithm that uses genetic sequencing to identify the neoantigens in individual tumors that would elicit a strong immune response, then crafted vaccines targeting them. These vaccines have been tested in early-stage clinical trials on patients with different types of cancer, with results suggesting they could be effective at preventing cancer recurrence in some patients. "Our mission is to be a frontrunner in testing new directions and technologies," Wu says. *—Dominique Mosbergen*

Claire Tomkins

IVF INSURANCE FOR FAMILIES

CLAIRE TOMKINS UNDERSTANDS THE emotional, physical, and financial toll of in vitro fertilization. All three of her children were born via IVF, which inspired her to co-found Future Family, a fintech-health startup that's reshaping how people pay for fertility care. In 2025, the company introduced the first nationwide IVF insurance. Families can purchase insurance for an average of $3,000 up front, followed by $999 per month for five months. Policyholders who don't have a live birth after two IVF cycles—which can cost up to $25,000 per cycle, according to federal estimates—can file a claim and receive a refund. "You struggle to get pregnant, which is very emotional, and then it's another thing to also be like, 'And now I may have this huge financial outlay,'" Tomkins says. "The vision is to get to a point where people have peace of mind and financial confidence around starting a family." *—Angela Haupt*

Emil Lou & Emma Dimery

A PIONEERING IMMUNOTHERAPY CANCER TREATMENT

EMMA DIMERY WAS JUST 23 YEARS OLD WHEN she was diagnosed with late-stage colon cancer. For nearly a decade, she fought with every tool medicine made available to her. "I was at a point where it was starting to look bleak," she says. Everything changed in 2022, when one of her oncologists, Dr. Emil Lou at the University of Minnesota, approached her about participating in a clinical trial using a new form of immunotherapy. Lou and his colleagues extracted Dimery's own immune cells from a tumor, used gene editing to render them resistant to her cancer's immune suppression, and injected them back into her body. "It was a single infusion," says Lou, who calls the effects "remarkable." Within months, Dimery's cancer was gone. The procedure, detailed in a *Lancet Oncology* study last May, has the potential to be a useful addition to the arsenal of immunotherapies for cancer. Dimery is still in remission today. *—Veronique Greenwood*

Kara Egan

MAKING WOMEN'S HEALTH CARE CONVENIENT

LAST YEAR, THE TAMPON-shaped Teal Wand became the first FDA-approved device for at-home cervical cancer screening, offering a private alternative to the pap smear. Users of the wand also get access to Teal's telehealth service that matches patients with clinicians who can walk them through the testing process and review results. The swab, which is analyzed for HPV, has been shown in clinical trials to be as accurate as a collection in a doctor's office. She believes the wand could help improve cancer detection rates. "We have so much to do in cervical cancer: 92 million women need to be screened, almost a third are behind," Kara Egan, CEO and co-founder of Teal Health says. In 2026, the wand was endorsed by the American Cancer Society and recommended by the Health Resources and Services Administration, part of the U.S. Department of Health and Human Services. —*Charlotte Hu*

Egan speaking at the Flow Space Women's Health Summit in Los Angeles in 2005.

Goki Ishikawa

EASIER ALZHEIMER'S DIAGNOSIS

FUJIREBIO HAS BEEN DEVELOPING TESTS FOR Alzheimer's disease for decades, but it wasn't until May 2025 that it received approval from the U.S. Food and Drug Administration (FDA) for the first Alzheimer's blood test. Previous tests relied on detecting markers of Alzheimer's proteins in cerebrospinal fluid—often requiring a lumbar puncture—but the latest test looks for the ratio between two hallmark disease proteins in blood, offering a less invasive option and the opportunity for more patients to be diagnosed early and potentially benefit from treatment.

Goki Ishikawa, Fujirebio's new president and group CEO, will face challenges in establishing the new test in real-world lab settings; at a conference of experts in December, doctors raised concerns about the test's high false positive rate. But the test marks a significant step toward better Alzheimer's screening options. —*Alice Park*

Waseem Qasim & Alyssa Tapley

A BREAKTHROUGH BLOOD CANCER THERAPY

IN 2022, ALYSSA TAPLEY, THEN 13, WAS TOLD that her cancer—a form of T-cell acute lymphoblastic leukemia—was terminal. As a last resort, she enrolled in a clinical trial at the U.K.'s Great Ormond Street Hospital that involved tailoring donor immune cells to attack cancer using base editing—a new type of gene editing that allows for faster, more precise changes, says Waseem Qasim, the trial's leader and a professor of cell and gene therapy at University College London. That year, Tapley became the world's first patient to receive a base-edited cell therapy. The response, detailed in a *New England Journal of Medicine* study in December, was remarkable. Tapley has been in remission for three years after a successful bone marrow transplant and plans to pursue a career in cancer research; the trial's 10 other patients also saw a substantial reduction in disease, with eight others in remission deep enough to enable bone marrow transplants, too. *—Veronique Greenwood*

Douglas Melton

CHASING A CURE FOR TYPE 1 DIABETES

DOUGLAS MELTON'S CHILDREN SAM AND EMMA have Type 1 diabetes. After decades teaching at Harvard, he left in 2022 to work at Vertex Pharmaceuticals to turn his research into a stem-cell treatment for the disease into reality. In 2025, he and his team reported the results of the first small study: A dozen people with Type 1 diabetes received pancreatic cells, made from stem cells that were trained to make the insulin their bodies could not. One year after just a single treatment, 10 of them no longer need insulin to regulate their blood sugar (and the other two patients require lower doses than they had previously used). Vertex plans to continue studying the therapy in hopes of one day helping many of the 9.5 million people worldwide living with the disease. *—Alice Park*

Sarah Tabrizi

A HUNTINGTON'S BREAKTHROUGH

DEVELOPING A TREATMENT FOR HUNTINGTON'S disease has taken decades, and yielded disappointing results. Uniqure, a gene therapy company, is hoping to change that with a promising genetic treatment that, for the first time, appears to slow progression of the neurological condition. Dr. Sarah Tabrizi and her team at University College London have been studying Huntington's treatments for two decades, and led the small but groundbreaking study of Uniqure's treatment. Results announced in September showed that the highest dose of gene therapy slowed disease advancement by 75%. Huntington's is caused by mutations in the huntingtin gene. The gene therapy turns off the gene, preventing it from making toxic forms of the huntingtin protein that harm nerve cells. In January, the U.S. FDA agreed to meet with Uniqure to discuss accelerating the review of the Huntington's gene therapy so it can reach patients sooner. *—Alice Park*

A HUNTINGTON'S DISEASE TREATMENT IS CLOSER THAN EVER

Gene therapy may slow the progression and someday even prevent symptoms of this debilitating disease

BY ALICE PARK

GENE THERAPY IS BECOMING a powerful way to treat challenging diseases that don't respond to traditional treatments, and researchers now report the first success in modifying genes to slow Huntington's disease.

In a study reported by Uniqure, which developed the experimental gene therapy, scientists found that it slowed progression of Huntington's disease by 75% over three years. The study has not yet been published in a scientific journal.

"I went into the trial cautiously optimistic but very anxious, as one does when starting a gene-therapy trial," says Dr. Sarah Tabrizi, director of the University College London Huntington's Disease Center and a lead investigator on the study. "I was blown away when I saw all of the data and it was very, very clear that the gene therapy worked."

The study involved 29 patients with Huntington's disease who were given one of two doses of gene therapy that targeted the huntingtin gene, which is mutated in the disease. The aberrant gene makes a form of the huntingtin protein that clumps into toxic aggregates, which prevent nerves from functioning normally. Eventually, nerve cells—particularly those in the part of the brain that regulates movement and cognitive skills like motivation, habit formation, and decision-making—degrade, leading to physical and cognitive symptoms.

Everyone in the trial was monitored for a number of biological and behavioral measures, including markers for degraded nerve proteins in spinal fluid and their ability to perform normal daily activities, manage their finances, and keep working. The gene therapy involved a 12- to 15-hour brain operation in which surgeons drill through the skull to access a deep part of the brain called the striatum, where nerve cells are most affected by the damaged huntingtin protein. The surgeons injected the gene therapy, which included DNA delivered by an inactivated virus vector, coding for instructions to turn off production of the huntingtin protein.

The 17 people who received the high dose showed a 75% slowing in the progression of their symptoms overall. The 12 people who got the lower dose—which was 10 times less concentrated—showed similar

progression as placebo, although some of their symptoms improved.

Because the brain surgery was invasive and risky, the researchers had to find a reliable way to evaluate what effect the gene therapy was having without subjecting some patients to a sham surgery, says Dr. Walid Abi-Saab, Uniqure's chief medical officer. The participants who received the gene therapy were monitored for several years and compared to a group of about 2,000 untreated Huntington's patients—because there are currently no treatments for the disease—who were matched to the study patients getting the gene therapy by factors like age and stage of disease.

The 75% slowing in the progression of the disease among those receiving the gene therapy is "huge," says Tabrizi, who has been studying potential therapies for Huntington's for two decades. "I have never seen anything that shows that [benefit]," she says. In Huntington's patients, levels of neurofilament, which is produced by damaged nerve cells, in the spinal fluid increase by 30% to 45%

The 17 people who received the high dose [of gene therapy] showed a 75% slowing in the progression of their symptoms overall.

in the early years of the disease, Tabrizi says. People receiving the gene therapy in the study actually showed drops in their levels—below their baseline levels, in some cases. "That tells you that neurons are being saved," she says.

She says that the encouraging results are inspiring her to think about extending the benefits to people even earlier in their disease, with the hope that they might be able to prevent many of the disease's worst symptoms from ever appearing. The patients in the trial were at Stage II or III, but, "when people who carry the Huntington's gene are completely well, we might be able to prevent the disease from ever occurring and prevent the symptoms from ever occurring," she says. "I personally want to start thinking about how we can get this therapy to people at Stage 0 or I to prevent this disease."

Matt Kapusta, CEO of Uniqure, says the therapy is "transformational" and that giving patients more time with loved ones, with milder or fewer symptoms, is "priceless." Uniqure met with the U.S. Food and Drug Administration in January to discuss the regulatory path forward. They will be meeting again in the second quarter of 2026.

David M. Brandman & Sergey Stavisky

RESTORING SPEECH FOR ALS PATIENTS

THERE IS A SPECIAL cruelty when amyotrophic lateral sclerosis (ALS) robs patients not only of the ability to move, but the ability to speak. A recent breakthrough in brain-computer interface (BCI) technology—led by neurosurgeon Dr. David M. Brandman and assistant professor of neurological surgery Sergey Stavisky, both of the University of California, Davis—aims to help patients communicate. In studies published in the *New England Journal of Medicine* in 2024 and *Nature* in 2025, Brandman, Stavisky, and their co-authors report implanting four microelectrode arrays in the left precentral gyrus of an ALS patient whose speech had deteriorated to the point of unintelligibility. After the surgery, the electrodes read the patient's brain activity and translated it into voice-synthesized speech with up to 97% accuracy—and in the patient's own voice. In the future, says Savisky, "I think motor-speech BCIs will be widely available." Adds Brandman: "The potential is enormous." *—Jeffrey Kluger*

Aaron Williams

MAKING MORE HEARTS TRANSPLANT-READY

WORLDWIDE, ONLY ABOUT 5,000 people each year get a heart transplant, from a waitlist of 50,000, in part because most donated hearts must be harvested still beating from people who have been declared brain dead. Many more could come from donors whose heartbeat and breathing have stopped, if only those hearts could be better preserved. Now there may be a way. A team at Vanderbilt University Medical Center, led by Dr. Aaron Williams, assistant professor of cardiac surgery, has developed a preservative fluid that includes oxygen-rich red blood cells and a muscle relaxant with which the heart can be flushed before being placed in a cooler—immersed in the solution—for transit. The team published the results of early trials last July, and further results in January, which showed the solution could triple the time the heart can survive outside of a body from as little as four hours to as many as 12. *—Jeffrey Kluger*

Robert McFarland

REDEFINING REPRODUCTION

MITOCHONDRIAL DISORDERS CAN BE devastating, since they affect the energy centers of cells, damaging the brain, heart, kidneys, and muscles. Mothers pass on these conditions to their children, since children inherit mitochondrial genes from the egg. Robert McFarland, professor of pediatric mitochondrial medicine at Newcastle University in the U.K., pioneered a way to potentially avoid that devastating legacy.

A decade ago, he figured out a way to use IVF to replace a mother's defective mitochondrial genes with healthy ones from a female donor. This modified form of fertilization increases the chances of a healthy fetus since it combines the healthy donor mitochondrial DNA with DNA from the mother's egg and father's sperm.

In 2025, McFarland and his team reported in *The New England Journal of Medicine* the births of eight babies using this method, called mitochondrial replacement therapy. All eight were born without signs of mitochondrial disease. *—Alice Park*

Ilaria Villa

A NEW MODEL FOR RARE DISEASE TREATMENTS

IN DECEMBER, THE U.S. FOOD AND DRUG Administration (FDA) approved the first gene therapy, Waskyra, for the rare condition Wiskott-Aldrich syndrome which affects the immune system. What's even more remarkable is that it's also the first FDA-approved cell or gene therapy—which are notoriously expensive—sponsored by a nonprofit. "Rare conditions have become less and less attractive for industry, because the value proposition from a commercial standpoint is pretty limited," says Ilaria Villa, CEO of Fondazione Telethon, the Italian charity behind the drug. The organization was founded more than 30 years ago by the families of people affected by muscular dystrophy with the goal of collecting funds from TV marathon donations to finance research for rare conditions. Since then, the group has invested heavily in turning their decades of funded research into medicines. Although it's uncharted territory for their nonprofit, the approval of Waskyra is a positive sign for their model. "We have to keep the balance between making the product as [accessible] as possible to the patients, but at the same time, containing the costs," says Villa. "We have to find a better approach to make those products available, sustainable, and scalable over time." *—Charlotte Hu*

Michelle Lujan Grisham

FREE CHILDCARE FOR ALL

RESEARCH SHOWS THAT access to high-quality childcare can improve cognitive, academic, and social development in children, while free childcare can boost the emotional well-being and financial stability of parents and families. But across the U.S., the cost of high-quality care can be overwhelming. After years of effort by Governor Michelle Lujan Grisham and the state legislature, New Mexico in 2025 became the first U.S. state to offer free universal childcare, covering children from six weeks to age 13. The program, which expands a 2022 initiative that offered free childcare for families earning up to 400% of the federal poverty level, includes before- and after-school care. Lujan Grisham says access to childcare is essential not just for public health and child development, but also the state's economy. "It puts people who want to work back into the workforce. It brings real money into the state, she says. *—Dominique Mosbergen*

Lynn Kramer

ADVANCING ALZHEIMER'S TREATMENTS

IT TOOK DECADES TO develop the first treatments to address the root causes of Alzheimer's disease, and when they first reached patients, they weren't exactly convenient to take. Patients have to visit infusion centers to receive the IV drug every two weeks for about an hour. Dr. Lynn Kramer, chief clinical officer at Eisai, which developed one of the medications, Leqembi, spearheaded a program to transfer the IV infusions into an auto-injector pen that patients can use themselves at home—similar to the pens that dispense the GLP-1 diabetes and weight loss medications. In September, the FDA approved Leqembi Iqlik, a self-injecting pen that Alzheimer's patients can use once they finish a course of the IV infusions. Eisai is now also studying whether people with early Alzheimer's who don't yet show signs of memory loss could start giving themselves the drug and potentially slow down the progress of their disease. *—Alice Park*

A SELF-INJECTABLE ALZHEIMER'S DRUG IS NOW AVAILABLE

The at-home version eliminates the need for maintenance infusions

BY ALICE PARK

SELF-TESTING AND SELF-TREATING ARE becoming bigger trends in medicine, and now, you can conduct part of your treatment at home by yourself if you have Alzheimer's disease.

In August the U.S. Food and Drug Administration (FDA) approved the first at-home treatment for Alzheimer's. Lecanemab, sold under the brand name Leqembi—which the FDA approved in 2023 as the first medication to treat the memory disorder—is now available in a self-injecting pen, Leqembi Iqlik. People can use the pen to give themselves weekly maintenance doses of the drug. Lecanemab, made by Eisai and Biogen, was originally approved as an IV infusion that took about an hour and required patients to visit infusion clinics twice a month. The at-home version is approved as a maintenance therapy that people can give themselves after they have finished a course of the infusion treatment.

"We think this is really going to change patient treatment," says Lynn Kramer, chief clinical officer at Eisai.

The self-injectable version works in a similar way to the auto-injector pens that deliver weight-loss drugs like Wegovy and Zepbound, and could make the Alzheimer's drug accessible to more people. In January 2025, the FDA approved lecanemab for maintenance therapy, but patients still had to get the drug via infusion at infusion centers. Now, Iqlik will give people more flexibility to continue their treatment. Once they complete the initial treatment regimen over 18 months with the IV version of lecanemab, they can either continue to get an IV infusion of the maintenance dose or give themselves an injection—or switch back and forth, says Kramer. "One week after their last IV dose, they can start Iqlik injections once a week," he says. "They could then continue with the IV therapy for maintenance; then, if they are going on vacation, they can convert to Iqlik."

Continuing treatment with lecanemab is important for managing the disease, since the drug reduces buildup of the amyloid, in either plaques or protofibrils; protofibrils can be toxic to brain neurons and lead to tau accumulation, which can strangle and impair the function of these nerve cells. "Alzheimer's is a progressive disease," says Kramer. "It starts even before plaque development, and those pathophysiologic processes still occur even after you remove plaque. That's the reason why maintenance therapy is required."

In the study supporting Iqlik's approval, Eisai and Biogen showed that among people with early Alzheimer's disease who had completed 18 months of IV treatment and transitioned to the lower dose maintenance therapy, those giving themselves Iqlik weekly showed similar benefits in reducing amyloid buildup compared to those receiving the IV dose. The Iqlik users also showed similar rates of side effects—most importantly, a type of brain inflammation—as those receiving the IV maintenance.

For patients without insurance, the cost for a year's supply of Iqlik will be $19,500 according to Eisai, compared to $13,316 for a year of the IV maintenance therapy. Medicare currently covers lecanemab if doctors enroll patients in a registry, and costs for those with Medicare Part D are capped at $2,000 annually.

Those giving themselves Iqlik weekly showed similar benefits in reducing amyloid buildup compared to those receiving the IV dose.

Using a self-injecting pen could help some Alzheimer's patients manage the disease

Julie Inman Grant

PROTECTING KIDS FROM
SOCIAL MEDIA'S HARMS

IT'S A PECULIAR SORT OF IRONY THAT THE country that made millions of dollars by enforcing its patent for WiFi was also the first country to attempt to set up a suite of regulations that would limit teens' use of social media. Australia's so-called social media ban went into effect in December. It forbade 10 tech giants, including Google's YouTube, Meta's Facebook and Instagram, and SnapInc's SnapChat, from opening or maintaining accounts for any Australian under the age of 16. And it put the responsibility for figuring out a user's age on the platforms, so that no identification documents were necessary.

Many hands went into crafting Australia's regulations, but most of the finer detailing and heavy lifting was done by a Seattle-born former tech executive, Julie Inman Grant. As Australia's eSafety Commissioner, she formulated the set of guidelines for what social media companies can and cannot do in her adopted homeland, where more than 97% of the population are online. She also advised the government, liaised with tech companies, and spearheaded its promotion to the public.

Several studies—although not all—have shown a decline in mental health among young adolescents who use social media heavily. To Inman Grant, interacting on digital platforms presents health hazards in the same way swimming at Australia's beaches does; not all the dangers are visible and swimmers need to be trained in how to handle them, lest they get swept away. "We're basically restricting access from young people holding an account until the age of 16," Inman Grant told TIME in October, "to give us precious time to build their digital literacy, critical reasoning skills, resilience, and the like."

A little over a month in, the impact of the changes has been neither as negative as some feared nor as positive as some hoped, according to local reports. The Australian government announced that 4.7 million accounts had been "deactivated, removed, or restricted." Unsurprisingly, teens have found work-arounds—sometimes with help from a sympathetic adult—but Australian parents have largely welcomed the extra support in managing their children's engagement with the vastness of the online world. In some cases, digital platforms had already started to adjust their teen-safety protocols ahead of the changes. "We've said from the beginning that we weren't expecting perfection straight away," said Minister for Communications Anika Wells in a statement, "but early figures are showing this law is making a real, meaningful difference."

More significantly, Inman Grant has changed the tide of the conversation. Now that she has demonstrated it is legally and logistically possible to limit tech companies' access to young people's attention, parents in other countries are asking their governments to step up. Many are following Australia's lead—including Spain, France, and the U.K., where leaders recently began the process of imposing age-verification requirements from tech companies.

The U.S. has not been so receptive. In November, Inman Grant was summoned to testify before the House Judiciary Committee about whether Australia's laws are imposing on Americans' freedom of speech. The congressional attention has not dampened her enthusiasm; she's now turning her focus to the health effects of young people's interactions with AI.
—Belinda Luscombe

***Left:** Inman Grant (right) speaks to the press at Australia's Parliament House alongside Minister for Communications and Minister for Sport Anika Wells in 2025.*

Nathan White

STRENGTHENING RURAL HOSPITALS

MANY RURAL HOSPITALS ARE STRUGGLING, IN part because they lack power to negotiate payments with private insurers. Some have either joined bigger health care systems or sold to private equity to survive. Nathan White, CEO of Cibolo Health, had an idea that would allow small rural hospitals to stay independent: create a clinically independent network of hospitals that would operate like a cooperative, sharing resources and pooling patient numbers to better negotiate contracts and pricing with insurers.

As of 2025, Cibolo helped start networks in eight states, including Nebraska, Ohio, and Wisconsin, with more states already expressing interest. The scale provided by the network allows the more than 400 member hospitals to enter into value-based care arrangements with payers. "We ran a pilot for our Medicaid population in 2025 and we're starting to get really remarkable data," White says. "We're talking like 90% improvement on closures in gaps in care." —*Charlotte Hu*

Manica Balasegaram

BRINGING NEW ANTIBIOTICS TO MARKET

MORE THAN HALF A MILLION NEW CASES OF gonorrhea were reported in the U.S. in 2024, and worldwide, the sexually transmitted disease, which can cause infertility, has growing resistance to existing treatments. In 2025, the Global Antibiotic Research & Development Partnership announced that a new antibiotic, zoliflodacin, specifically intended to treat gonorrhea in a single dose, had been approved by the FDA. GARDP's executive director, Dr. Manica Balasegaram, cites the approval as a success of the partnership between the nonprofit, which organized the clinical trials that showed the drug was 90% effective and will be commercializing it in many countries, and Innoviva, the pharmaceutical company that developed the drug. "It's a sign that we can develop very successful public-private partnerships in an area that is of critical public health need globally: the development of new antibiotics to address the emerging threat of antimicrobial resistance," he says. *—Veronique Greenwood*

Victor Bultó

PIONEERING SAFER RADIATION

CANCER TREATMENTS ARE MOVING TOWARD more precision-based strategies that target just cancer cells and leave healthy ones alone. Radiation therapy, however, has been slow to fully optimize this approach since it's challenging to target radioactive material without harming nearby tissue. But Victor Bultó, president of Novartis U.S., and his team have been leading the way with the first approved radioligand therapies, which link radioactive material with markers designed to find and bind just to tumor cells. The therapy allows doctors to treat even difficult-to-find cancers that have spread.

The approved treatments target prostate and pancreatic cancer, but Bultó says the company is studying the therapy for other cancers as well. In 2026, Novartis announced plans to build its fourth U.S. manufacturing site for radioligand therapies. "We believe this will become a mainstream technology to fight cancer," Bultó says. *—Alice Park*

Mehmet Oz

DEFINING HEALTH CARE COVERAGE

SINCE BECOMING HEAD OF THE CENTERS for Medicare and Medicaid Services, which covers health care services for about 140 million Americans, Dr. Mehmet Oz has brought a prevention-focused mindset to the federal health program. Oz tells TIME he hopes to "push primary care into a leadership position" to catch more maladies before patients end up in the ER. At the same time, he's introducing more accessible and user-friendly health records that would give patients more control over their health information. He's also taking aim at what he says is waste and fraud in the department, with a controversial goal of reducing federal Medicaid funding by roughly $1 trillion over the next decade and enforcing stricter employment verification requirements. Other government agencies predict that millions will be left with less or no coverage in coming years. Oz says the cuts are necessary to ensure coverage "for people who are most vulnerable." *—Alice Park*

Nabarun Dasgupta

COMBATTING THE STREET DRUG CRISIS

ALTHOUGH REPORTED OPIOID OVERDOSE deaths in the U.S. dropped 25% from 2024 to 2025, new synthetic opioids more addictive and potent than fentanyl continue to appear in the street drug supply. Nabarun Dasgupta, an epidemiologist at the University of North Carolina at Chapel Hill, leads the school's Opioid Data Lab, working to identify emerging compounds of concern, like medetomidine, and study how street drug use is changing generationally. This is a "moment of hope," Dasgupta says, but he emphasizes that fighting the opioid epidemic is a continuous and collaborative effort, crediting Eliza Wheeler and Maya Doe-Simkins, co-directors of Remedy Alliance (a nonprofit he co-founded), for using his research to create frontline solutions. Since 2022, Remedy's disruptive distribution model has provided over 6 million doses of naloxone at low or no cost to at-risk communities across the U.S., as well as training for community-based drug checking programs. *—Charlotte Hu*

Kevin Díaz

END-OF-LIFE ADVOCATE

KEVIN DÍAZ HAS SEEN "GOOD DEATHS"—THE kind that are directed by and aligned with the values of the person dying—and he's seen bad deaths. The latter haunt him and inspire his work as president and CEO of the nonprofit Compassion & Choices and its Action Network, which focuses on legislative advocacy.

"We advocate for patient-directed care, where clinicians bring expertise, and loved ones and communities provide the support, but patients are the ones who set the goals," Díaz says. That includes giving terminally ill people who meet certain criteria the ability to decide when they die, as in the case of medical aid in dying. The movement is at a turning point, thanks in large part to Diaz's advocacy: As of early 2026, 12 states and Washington, D.C., authorize medical aid in dying, and the nonprofit expects legislation to be introduced in at least 15 states this year. *—Angela Haupt*

Warris Bokhari

FIGHTING HEALTH INSURANCE DENIALS

WHEN DR. WARRIS BOKHARI WAS WORKING FOR a large U.S. health insurer, he witnessed a fundamental problem firsthand: Since health insurance companies make financial products, they have competing priorities beyond patient care. U.S. insurers deny some 850 million claims every year and that number is growing, Bokhari says, and fewer than 1% of people appeal. "For cancer patients, if you have a one-month delay in treatment, that's a 10% drop in your survival," Bokhari says.

Bokhari's solution is Claimable, a startup he co-founded and launched in 2024 that uses AI to help patients and providers appeal health-insurance denials for a growing list of conditions, including rheumatoid arthritis, asthma, and obesity. Patients pay Claimable a service fee of around $50 per appeal. So far, Bokhari puts Claimable's success rate at 80%, recovering more than $30 million for patients to date. *—Dominique Mosbergen*

Susan Kressly

FIGHTING CHILDREN'S HEALTH CHANGES

AFTER U.S. HEALTH AND Human Services (HHS) Secretary Robert F. Kennedy Jr. announced that healthy children would no longer be advised to receive the COVID vaccine, the American Academy of Pediatrics (AAP) released its own vaccine guidance that recommended the shots to all children under 2. It was the first time in 30 years that AAP had issued vaccine recommendations that substantially differed from U.S. government guidelines.

As the 2025 president of the AAP, Dr. Susan Kressly has challenged the Trump Administration on health-related policies that she and her organization—which represents 67,000 pediatricians—deemed harmful to children and their families. The AAP sued HHS and Kennedy twice in 2025: first over the changes to COVID vaccine policy and Kennedy's decision to replace members of a key federal vaccine advisory panel, and next to challenge HHS over its decision to cut millions of dollars in federal grants to AAP.

The AAP efforts are paying off. In January, a federal judge restored $12 million in funding for children's health programs. In March, a federal judge blocked some of Kennedy's vaccine policy changes and reversed the alternations to the country's main advisory committee of experts on vaccines.

—Dominique Mosbergen

Michael Osterholm

PRESERVING MEDICAL EXPERTISE

MICHAEL OSTERHOLM IS A WELL-known figure in global health, heading up the University of Minnesota's Center for Infectious Disease Research and Policy and establishing himself as an outspoken critic of recent changes in the U.S. government's vaccination policies. Osterholm and his team launched the Vaccine Integrity Project last spring to address misinformation about vaccines that has proliferated as the Trump Administration has dismantled longstanding vaccination policies, including no longer recommending immunizations for most children against flu, RSV, rotavirus, and COVID. The group aims to provide scientifically validated information on vaccine safety and effectiveness, and to track and provide quick responses to changes in vaccine policies. Osterholm says the initiative provides evidence-based analysis for both doctors and the public. —*Alice Park*

Q&A WITH MICHAEL OSTERHOLM

We're even less prepared for the next pandemic, he says

BY ALICE PARK

AS A LEADING EXPERT ON THE VIRUSES, BACTERIA, FUNGI, AND parasites that make us sick, Michael Osterholm knows what happens when humans underestimate infectious diseases. Osterholm, who is director of the Center for Infectious Disease Research and Policy (CIDRAP) at the University of Minnesota, was a leading voice during the COVID-19 pandemic.

Now, he's watching the dismantling of the U.S.'s public-health infrastructure with a sense of informed alarm. Osterholm's new book, *The Big One*, assesses the response to COVID-19 and highlights the urgent lessons we need to, but haven't, learned to better handle the next inevitable pandemic.

In September, shortly after Health and Human Services (HHS) Secretary Robert F. Kennedy Jr. canceled millions in funding for mRNA vaccine development, Osterholm spoke to TIME about why the world, and the U.S. in particular, may be even less prepared for a pandemic now than we were before COVID-19.

This interview has been condensed and edited for clarity.

You've written other books about the dangers of infectious diseases. Why did you feel the need to write this one about COVID-19?

We have never done a hotwash of any kind on what happened with COVID-19, and to me we're missing an incredible opportunity to learn what went right and what went wrong, in a nonpartisan, no-finger-pointing way. What could we do better for the next pandemic?

Right now everything is about finger pointing. We're hung up on the issue of what was the source of COVID-19—a lab leak or a spillover? We will never know the answer. We are never going to know that.

Since I've had the opportunity to be very involved in the COVID-19 response—I wasn't just a distant bystander—I tried to summarize lessons we should have learned and haven't.

What are some of the lessons we have not learned?

Given what is happening in the current Administration with vaccines, I think we are in free fall. We are in worse shape now than we were literally before the COVID pandemic. No one in the White House is in charge of leading the country through the potential next hit from an infectious agent, which could be more deadly than if somebody launched a physical war against us on our own shores.

You have some specific proposals for how we might avoid things like universal lockdowns, border closings, and mask mandates—which, in retrospect, turned out not to be very effective in controlling COVID-19. What are some of those strategies?

The No. 1 way to save lives if we don't have a vaccine is to ensure that our health care system is not overrun. When hospitals are operating at 130% capacity, some people won't get care, and those who do won't get care that is sufficient to save their lives.

That's where snow days come in. Imagine if we set up a system where every day, you knew the hospital census for the hospitals in your community. Once that capacity reached, let's say, 85% or 95%, then the community could take action and say we need to shut down for a couple of days here and change what

we're doing to reduce the number of infections, and the number of people likely to need hospital care. This is all knowing that people will still get infected, but some will get infected in the first six months, others in the second six months, and others in the third six months. If the infections are spaced out enough, you can basically keep the health care system operational.

Communities would have to make a decision that their hospitals are overrun right now, so they need to back off. During such snow days, you don't shut the entire system down, but some people may take a few extra days off work, or work from home, or schools may be canceled for a few days.

You also propose a more comprehensive monitoring system, including medical IDs, to keep track of infectious diseases.

It would take a federal effort. The idea of a medical ID is to help track your information so health officials can tell where and which populations are hard hit by an infectious disease. That would be helpful to know, so officials would know that they need to scale back on what people are doing every day to lessen the number of new infections and therefore give hospitals an opportunity to catch up.

There is a lot of opposition from people who automatically say they don't want the government to have more information on them, but they don't realize that the government already has a great deal of information on us, including through our Social Security, Medicare, and Medicaid numbers.

Government health agencies now have differing vaccine recommendations from some professional medical groups like the American Academy of Pediatrics (AAP). How should the public make sense of the conflicting advice?

I've been asked how to interpret the AAP not following the recommendations of the ACIP [the Advisory Committee on Immunization Practices, which makes recommendations to the U.S. Centers for Disease Control and Prevention (CDC)]. I say you are asking the wrong question. The question is, how did the ACIP get to the point where it is scientifically inconsistent with all the rest of the scientific world? The question should be, 'What happened to the ACIP?' Not 'what happened to the AAP?'

Who can the public trust when it comes to health information now?

The bottom line is that we cannot trust the Department of Health and Human Services (HHS) and CDC right now. It's a terribly hard thing for me to say. The CDC is such a very important voice. There are still very talented and highly trained professionals at the CDC, but what is happening to the leadership has brought it to the point where it can't be trusted.

We don't have to agree about what happened in Wuhan…but what we need to do is prevent something similar from happening in the future.

What does that mean for the health of Americans?

I have never seen [so many] dangerous and potentially catastrophic decisions being made by HHS as I have in the last 10 weeks. We need mRNA technology for our influenza vaccines to have any hope of having enough vaccines available for the first year to year and half of the next possible flu pandemic. Now, we can make enough vaccine for a quarter of the world's population during the first 15-18 months of a pandemic, with the chicken-egg culture we use today. That is an example of a very dangerous situation that we could basically take off the table if we have research and development invested in mRNA technology.

My point is that we can't stop a pandemic. Once a virus takes off, nothing really can be done. When a spillover happens from animals to humans in any part of the world, when people travel, that virus can quickly spread. That's why we have to prepare for that and minimize the impact of that spread with vaccines that we develop as quickly as possible to that specific virus. We need to make lots of it and to get it out, and mRNA is an important part of being able to do that.

During and after the pandemic, there was a lot of criticism of the World Health Organization (WHO) and how it responded. How can the response of organizations like WHO be improved?

The WHO is absolutely important, and it's absolutely critical that we have a strong WHO for these kinds of events. The challenge is that during COVID-19, the WHO was one of the real obstacles to getting good recommendations to the public about respiratory protection. To me, that says that just because there are official government health bodies, it doesn't mean they get it right.

To address that, we need to have discussions about the response. The WHO used to do a hotwash of its response. Why did it take almost two months to declare a pandemic? I put out a document through CIDRAP on January 20 saying that this is a pandemic situation, and the world needs to deal with it. Why were they so slow off the block?

We all did good things, and we all did some challenging things. What's important now is to ask, 'What happened?' and use that information to improve in the future.

Osterholm discusses COVID-19 testing in St. Paul, Minnesota, in April 2020.

What are some of the biggest lessons learned from COVID-19 and actions that shouldn't be repeated in the next pandemic?

We need to come together and not finger-point. We don't have to agree about what happened in Wuhan…but what we need to do is prevent something similar from happening in the future. If it does happen, how do we respond? In answering these questions, none of it should be partisan. It should all just be about what science tells us.

And we need to stop doing border closings. They are useless. We have no evidence that border closing materially affects any emerging pathogen that shows up, but it's often politically what people think should be done. And to oppose them makes it look like we don't care, which is not true at all.

What we have to do [a better job of] in public health is understand that we are not the only answer that will be on the table. There will also be social and political issues to consider.

Are we now in a better position to meet the next "big one"?

No. I would have to say that we are in worse shape. We don't have the opportunity now to use tools like mRNA in a meaningful way. If a pandemic begins to emerge, we will divide up into camps to go at each other. We would right now have major challenges bringing people together, and if there were ever a time when we needed to bring people together against a common enemy—i.e. a virus—it's during a pandemic.

We need to do that. But we have nothing at this point to support that. We should deal with all of this now, game the situation, and work out what we would do.

Josephine Barasa

CONTINUING TO CARE FOR THE MOST VULNERABLE

COMMUNITY HEALTH workers across the globe were affected by public health funding cuts by the Trump Administration—in Nigeria alone, for example, 28,000 community health workers had their USAID-paid salaries evaporate. In Kenya, community health worker Josephine Barasa has been mentoring and advising young women in Nairobi on issues related to sexual health and gender violence. There's plenty of need: Many of the girls she works with have no money for school supplies or period products, and may be pressed into paying for them with sex. In early 2025, however, Barasa's job disappeared when the funds from USAID paying her salary were eliminated. Barasa, who has formed relationships with girls and their families over the years, felt so strongly that her work was needed that she has continued to show up as a volunteer. "I talk to them about how they can empower themselves, either by starting small income generating activities within their reach," she says, "or sometimes I link them to organizations which can support them. They have the ability. They can still do something, with whatever they have."
—Veronique Greenwood

Patrick Morrisey

BANNING FOOD DYES

LAST YEAR, REPUBLICAN GOVERNOR PATRICK Morrisey hosted Health and Human Services (HHS) Secretary Robert F. Kennedy Jr. in Martinsburg, West Virginia, to promote Kennedy's Make America Healthy Again crusade in one of the least healthy states in the country. Then, Morrissey got to work. He collaborated with his state lawmakers to adopt the first ban on certain food dyes in school lunches, which went into effect on August 1. Lawmakers also approved a statewide ban on the same dyes in all food sales to take effect in 2028. (A federal judge has put that on hold while chemical companies challenge it in court.)

Separately, West Virginia banned poor families from using food stamps to buy sodas, a move that hits about one in six houses in Morrisey's state. In December, HHS awarded the state $199 million to improve rural healthcare. *—Philip Elliott*

John & Hank Green

SUPPORTING MATERNAL SURVIVAL

BROTHERS JOHN AND HANK GREEN, BOTH novelists and YouTube creators whose Vlogbrothers channel has more than 4 million subscribers, have given global health a platform through their social-media fundraising. They've featured efforts to fight tuberculosis, and since 2019 they've trained their focus on improving maternal mortality rates in Sierra Leone, which are among the highest in the world. John recalls asking women at a birth education class there if they knew anyone who had died in childbirth; everyone did. In 2025, state-of-the-art maternity facilities—and the country's first Neonatal Intensive Care Unit—were completed at the Paul E. Farmer Maternal Center of Excellence, thanks in part to the Greens' fundraising, which, combined with their personal gifts and donations of the profits of their businesses, garnered more than $31 million for the project. The brothers plan to continue their support. "People are pretty good at reacting to sudden, significant crises…people are very bad at reacting to long, ongoing crises," says Hank. *—Veronique Greenwood*

Margaret Carpenter

PRESCRIBING ACCESS

DR. MARGARET CARPENTER CO-FOUNDED THE Abortion Coalition for Telemedicine (ACT) after the overturning of Roe v. Wade to help women across the U.S. access abortion care. The group provides clinicians with legal and technical support to enable them to provide abortion care via telehealth—which makes up about 27% of abortions nationwide—to people in all 50 states.

On January 31, 2025, Carpenter, a New York-based physician, became the first U.S. doctor to be criminally charged for providing abortion pills across state lines after a Louisiana grand jury indicted her for alleged "criminal abortion." About a month earlier, she had been sued by Texas' attorney general for allegedly prescribing abortion pills to a woman in the state.

But, Carpenter has so far avoided arrest and other penalties thanks to a New York "shield law" that protects providers who offer out-of-state abortions, and ACT's work continues. *—Dominique Mosbergen*

Nick Allardice

OFFERING A FINANCIAL LIFELINE

LAST YEAR, A DECADE-LONG STUDY published by the National Bureau of Economic Research found that when poor families in Kenya received $1,000, infant mortality rates fell by a striking 48%. The nonprofit GiveDirectly, helmed by Nick Allardice, has applied the same model around the world, including in the U.S.: In 2025, the organization sent emergency cash to 238,153 American families in just under two weeks to subsidize a potentially devastating pause in SNAP grocery benefits.

Over the past year, GiveDirectly sent more than $145 million to over 443,000 of the world's poorest households. Unlike many aid models, the money—from philanthropists, foundations, individuals, and institutional partners—is not designated for specific purposes. Recipients decide for themselves how to use it to improve their lives.

"When you trust people with the resources that they need to make their own decisions," says Allardice, "they use that money and those resources far more effectively than anyone else could." *—Angela Haupt*

THE GIVEDIRECTLY CEO ASKS FOR COMPASSION

Natural disasters do not strike on party lines

BY NICK ALLARDICE

"NO! THEY VOTED FOR THIS TO happen," a donor wrote in response to our call to give cash relief to the Texas flood survivors in July.

Normally, my organization GiveDirectly receives donations, not anger, when we respond to disasters. But after at least 120 people, many of them children, died in the Texas floods, we were inundated with messages implying that the victims had brought this on themselves by helping elect Donald Trump and that the politics of the state should dictate the response.

"Future Trump voters. Oh well." "Go ask Elon for help." "Are you Texans feeling that you voted for the right man?" A longtime donor said our Texas response has "shattered" their image of our work.

This has played out on social platforms as well, prompting some liberal commentators to speak out against the dehumanization of Texas communities. Political trolling online is nothing new, but its spillover into blaming victims and survivors of disaster is a dangerous new low.

Our support for low-income families impacted by the January 2025 Los Angeles wildfires received a positive response. There were no bitter comments blaming liberal forest-management policies. We simply offered aid, and people gave generously.

The contrast with Texas is disturbing. We had to stop promoting our online ads as the comments below a photo of a Kerr County flood survivor filled up with sentiments of "they deserved it" and "thoughts and prayers—well, not really."

Aid organizations are nonpartisan so we hesitate to weigh in given the current political climate. But as we are in the business of helping people, we have to speak out against a troubling trend: American disaster relief is being politicized, and with it, our shared humanity is at risk.

We saw the effects of this polarization from the other side when responding to Hurricane Helene in North Carolina in 2024. Some survivors refused federal aid, fearing that FEMA agents were part of a political conspiracy. In one county, responders paused operations after reports of an armed militia "hunting FEMA" turned out to be credible enough that responders had to evacuate.

It's fair to disagree with policy decisions and believe those decisions leave communities exposed. The Trump Administration slashed FEMA and USAID, and disaster declarations are increasingly wielded as political tools.

But you can hold that truth and still feel empathy for the families who lost everything. Anger at a broken system should never cancel out compassion for the people caught in its collapse.

In fact, the cracks in that system are why nonprofits like ours now play an outsize role in disaster response. FEMA itself has said it can't act alone, relying on local groups, volunteers, and mutual aid to reach those in need. Our response as citizens cannot mirror the dysfunction at the top. It cannot become, "I only help those who voted like me."

We should all be alarmed if liberals donate to only blue-state relief and conservatives support only red-state relief. Such behavior is deeply corrosive. It suggests that our compassion is conditional. That our help is earned only by ideological alignment. It's a slippery slope, and one that undermines both disaster recovery and the social fabric it depends on.

To those wondering if Texans, who Trump quickly promised would receive federal aid, should receive donations at all: Nonprofits like ours help reach those missed by or awaiting FEMA's cash aid that will take a month or more to reach them. Within a week, we paid impacted families already on food stamps, living paycheck to paycheck. Many had no flood insurance. Three-quarters of the low-income Los Angeles families we reached said ours was the only support they received.

Floods and fires don't check party registration before they destroy a home. Aid groups will continue sending emergency cash to families in Texas just as we've done for other disasters, agnostic to how the victims vote.

And we hope, sincerely, that Americans of all backgrounds and beliefs will choose to respond with empathy rather than enmity.

Anne-Claire Amprou & Precious Matsoso

DRAFTING THE GLOBAL PANDEMIC AGREEMENT

IN MAY 2025 THE WORLD HEALTH Organization's member states adopted the first-ever global pandemic agreement. Co-chairs Precious Matsoso, former director-general of South Africa's department of health, and Anne-Claire Amprou, French ambassador for global health, guided the three years of negotiations, which were often contentious. "One of the most difficult things we had to do was to build trust" between regions, says Matsoso. "I kept on asking them—look, we're negotiating at a time where we're no longer wearing masks and we're no longer social distancing. If we're in this room at a time when we're wearing masks, would we come up with a different outcome?" The next step is agreeing on an addendum that provides for quick information sharing about pathogens, which is proving controversial. Then, for the agreement to enter into effect, 60 countries will need to ratify it. *—Veronique Greenwood*

Angela Doyinsola Aina

ADVOCATING FOR BLACK MOTHERS

THE U.S. HAS THE HIGHEST MATERNAL mortality rate of any wealthy nation. The crisis facing Black mothers is even starker: Black women in the U.S. are three times more likely to die from a pregnancy-related cause than white women. This disparity is partly what drove Angela Doyinsola Aina to co-found Black Mamas Matter Alliance in 2016. "We wanted to be able to define the solutions we know can end maternal mortality for Black women," including addressing structural racism in healthcare, improving access to high-quality and patient-centered maternal care, and supporting other reproductive-health professionals, she says. Since its founding, BMMA, an alliance of Black women-led reproductive-health organizations and professionals, has mobilized global support, fundraised, and helped craft and push legislation to improve Black maternal health, such as the historic Momnibus Act. *—Dominique Mosbergen*

Loeto Mazhani

PROTECTING BABIES FROM HIV

WHEN DR. LOETO MAZHANI WAS A YOUNG pediatrician in the 1990s, infants in Botswana began dying in terrifying numbers, having contracted HIV from their mothers. By the late 1990s, as much as 30% of Botswana was HIV positive.

He helped start Botswana's Prevention of Mother-to-Child Transmission program, deciding to try an experimental strategy to treat mothers with the anti-retroviral drug AZT at the onset of labor to protect their babies. Mazhani and his team trained healthcare workers, and the numbers came down. When the program started, "around 40% of infected mothers had transmission," Mazhani estimates. By 2025, a baby of an HIV-positive mother had less than a 1.2% chance of being infected. *—Veronique Greenwood*

Mona Hanna

INVESTING IN FAMILIES

AS THE FIRST PROGRAM OF its kind in the U.S., Rx Kids gives moms in select Michigan communities no-strings-attached cash during pregnancy and early infancy to improve health and economic stability.

"It's this bold effort that says, 'Hey, we're not OK with babies being born into poverty in the richest country in the history of the world,'" says Dr. Mona Hanna, a pediatrician who launched the program in 2024. "We can do better."

Participating moms receive $1,500 during pregnancy, and babies get $500 a month for six to 12 months after birth. According to the organization, the moms who go through the program tend to have a 4.2% lower risk of eviction, greater food access, a 14% lower likelihood of postpartum depression, and increased confidence as parents. Rx Kids has distributed more than $22 million to over 5,600 families in Michigan and will soon launch in its biggest city yet, Detroit.

—Angela Haupt

Matthew P. Bergman & Laura Marquez-Garrett

CHALLENGING TECH'S MENTAL HEALTH IMPACT

MORE THAN 4,000 FAMILIES have enlisted the Social Media Victims Law Center (SMVLC) on behalf of their children, who they say were irreparably harmed by social-media apps and AI chatbots. Founder Matthew P. Bergman has led the charge alongside fellow attorney Laura Marquez-Garrett, propelled by what he views as a "public-health emergency." Since January 2022, the SMVLC has filed lawsuits against tech giants—like Meta, TikTok, OpenAI, and Character.AI—including cases in which victims have died by suicide after allegedly being encouraged to do so on the platforms. In May 2025, a federal judge ruled that a first-of-its kind wrongful death suit against Character.AI and Google could move forward—a milestone in holding platforms accountable. (The two companies settled with the family in January.) "These are people who have suffered the worst loss anybody could imagine," Bergman says. "I've never had clients who care less about the money and more about the justice."
—Angela Haupt

'It's not just the court of law, it's also the court of public opinion. And we need to win in both.'

—LAURA MARQUEZ-GARRETT, ATTORNEY AT THE SOCIAL MEDIA VICTIMS LAW CENTER

THE LAWYER SUING SOCIAL-MEDIA COMPANIES ON BEHALF OF KIDS

Kids won't be safe until the companies are held accountable

BY CHARLOTTE ALTER

ONE AFTERNOON IN THE SUMMER OF 2024, MATTHEW BERGMAN SAT on a bench outside a courtroom in downtown Manhattan. The founder of the Social Media Victims Law Center (SMVLC) was there representing a client named Norma Nazario. Her 15-year-old son, Zackery, died in February 2023 while "subway surfing"—riding on the outside of a moving Brooklyn-bound J train, a stunt his mother believes was encouraged by his social media algorithm. Bergman was representing Nazario in a lawsuit against TikTok and Instagram, which alleges Zackery was "targeted, goaded and encouraged" to engage in subway surfing because of their products' "unreasonably dangerous design." As the sun streamed through the windows of the court building, the lawyer let out a long sigh and jiggled his leg. Then he turned his yellow legal pad to an empty page, wrote "230" in the center of the page, and drew a circle around the number.

Bergman spends his time suing social media companies, but Section 230 of the Communication Decency Act is his other adversary. The 1996 law provides broad immunity for digital communication platforms, largely shielding them from liability over the content they host. For years, those protections have frustrated parents, lawyers, advocates, and mental-health professionals who say the statute prevents attempts to hold companies accountable for the alleged harms suffered by users of their platforms.

In recent years, Bergman has become one of the go-to lawyers for families who say their children have been harmed by social media. His clients include the parents of kids who have died by suicide and drug overdoses, kids who have allegedly been groomed and sexually abused by predators they met online, and kids who have developed debilitating anorexia. In November, the SMVLC filed seven cases against OpenAI, three of which involved individuals who had allegedly been encouraged to commit suicide by ChatGPT. (The company did not respond to a request for comment.)

To advance many of these cases, Bergman has promoted and deployed a pioneering strategy to circumvent Section 230. If the platforms can't be held responsible for the content they host, Bergman argues, they can instead be sued for alleged negligence in their design and for allegedly misleading the public about the safety of their products. This tactic—applying so-called product-liability theory to social-media platforms—has formed the basis of thousands of lawsuits he's filed in state and federal courts around the country. Over the past four years, he has taken on all the major players in social media, from Instagram to TikTok to Snapchat. (Meta, TikTok, and Snap all declined to comment for this story.)

Bergman isn't the first to sue digital platforms on these grounds. A product-liability suit against Myspace in 2009 and another against Grindr in 2017 were both dismissed because of Section 230. It's not yet clear whether Bergman will succeed either. But he has become the most famous proponent of the theory, amassing more than 4,000 clients and making him one of the go-to lawyers for families who say social media platforms have exposed their children to irreparable harm. In the process, he's transforming a legal battle against some of America's most formidable companies into a movement for digital justice.

"He has raised the profile of this issue tremendously," says Previn Warren of Motley Rice, the colead plaintiffs' attorney in a federal multidistrict litigation against social media companies that includes more than 1,300 of Bergman's

clients. "He's done an incredible job uniting these families and rallying them together and making them a powerful political lobbying force."

So far, roughly 1,500 of Bergman's social media cases have been allowed to proceed despite Section 230, and many of those are bundled in larger lawsuits moving through state and federal court. Yet it seems that Section 230 is not as impenetrable as it once appeared. "It was long thought that Section 230 was like this immovable beast," says Danielle Citron, a professor at the University of Virginia Law School and Vice President of the Cyber Civil Rights Initiative. "What we've seen is a chink in that armor."

Not everyone is convinced of the legal merits of Bergman's approach. "Product liability was designed to cover physical products that cause personal injury, like Coke bottles that explode and take people's eyes out," says Eric Goldman, co-director of the High Tech Law Institute at the Santa Clara University School of Law. Online harms, he says, are impossible for digital platforms to prevent. "If we establish liability for those kinds of harms," Goldman says, "those risks are legally unmanageable."

In March, the SMVLC secured a landmark $6 million verdict against Meta and YouTube. But Bergman says in all his years as a plaintiffs' lawyer, he has never had clients who cared less about financial damages. Instead, he hopes that his cascade of lawsuits will force the industry to change its business practices and make their products safer for kids.

"Kids are dying every day. This is not simply a question of seeking recompense for past wrongs," he says. "This is a moral crusade to stop the killing."

WHEN HE'S IN NEW YORK, which isn't very often, Bergman lives in a pre-war two-bedroom on the Upper East Side. On the day I visited, he sipped seltzer at his dining room table and vacillated between taciturn and vehement. "Clearly, moral suasion hasn't worked," he says of the social media companies. "Clearly, public humiliation hasn't worked. Bad PR hasn't worked," he adds. The only way to change these companies, he says, is "if they have to pay the cost."

Bergman grew up in Seattle, the son of a prominent Jewish physician. His grandfather was a lawyer who kept a book of Clarence Darrow's closing arguments on his bookshelf. Bergman grew up idolizing the famed attorney: "the spokesperson for the voiceless," he says. He quit college in 1982 to go to New York to live as a "bohemian socialist," as he puts it, and did a stint at the AFL-CIO. Bergman ultimately went back to college, graduated in 1986, and headed to law school. Then came a clerkship on the 10th Circuit and a job at a big law firm in Seattle.

It was there that he tried his first asbestos case, on the defense side. But two years later he decided to switch to the plaintiffs' side. In time, he came to run one of the preeminent asbestos litigation firms in the Pacific Northwest, spending 30 years suing asbestos companies and recovering over $1 billion in damages on behalf of his clients.

By the fall of 2021, Bergman was ready to hand the baton to his younger partners. He was feeling restless and wanted to try something new. He didn't feel like Clarence Darrow anymore. Meanwhile, he had noticed the cracks beginning to appear in Section 230. In May 2021, the Ninth Circuit ruled in *Lemmon v. Snap* that Section 230 didn't protect Snap from litigation over negligent product design. On October 4 of that year, Facebook whistleblower Frances Haugen testified to Congress that the company was aware of the mental-health risks its product posed to kids.

The day after Haugen's testimony, Bergman says he accidentally took 20 mg of Ambien before driving to the ferry in his small island community near Seattle. He fell asleep at the wheel, crashed into an embankment and flipped his car. The car was totaled, but Bergman walked away unscathed. "I should have died," he says. Instead, the accident gave him a new sense of purpose. A month later, he set up the SMVLC, the first and only firm focused exclusively on suing social media companies on behalf of kids.

He sees similarities in his past adversaries and his new ones. "The asbestos companies knew that their products were killing people and deliberately hid the evidence and skewed the scientific literature," he says. "That's exactly what the social media companies were doing."

Bergman hired a partner, Laura Marquez-Garrett, a Harvard-educated corporate litigator who took a six-figure pay cut to join him. In the beginning, she says, Bergman paid her salary from his own savings account. But Marquez-Garrett believed in the mission—"I said: If you go bankrupt tomorrow, I will liquidate my 401k and work for you for free"—and wanted to work with families to tell their stories rather than simply chase billable hours.

"It's not just the court of law, it's also the court of public opinion," she says. "And we need to win in both."

ONE OF THE FIRST EMAILS Bergman got at the Social Media Victims Law Center was from a Connecticut single mom named Tammy Rodriguez. Rodriguez said that her daughter Selena had become addicted to Snapchat when she was 9. Selena would become physically violent if her phone was taken away, Rodriguez says. If she turned off the WiFi, Selena would run out of the house to find WiFi somewhere else.

Soon, Rodriguez says, Selena was getting Snapchat messages from strangers online. She received photos of penises and started getting sexually groomed by adults. Eventually, Selena became suicidal and was hospitalized. In July 2021,

Meta's Mark Zuckerberg apologizes to families who have been harmed by unsafe social media at a Senate Judiciary Committee meeting in 2024.

Selena filmed herself taking an overdose of antidepressants and posted it on Snapchat. She died at age 11. Snap did not respond to a request for comment on Rodriguez's case.

In the months that followed Selena's death, Tammy Rodriguez couldn't sleep. She spent her days and nights scrolling through her grief. She came across an ad for the SMVLC, and became one of the new firm's first clients, filing a suit against Snap, Meta, and TikTok. Eventually, Rodriguez joined fellow plaintiffs in Washington to lobby Congress to pass the Kids Online Safety Act. "When [Mark] Zuckerberg had to stand up and apologize," Bergman says now with a hint of a smile, "those were my clients he was talking to."

Rodriguez's case is also part of the multidistrict litigation currently working its way through federal court in Northern California. Bergman and the other plaintiffs' attorneys on the case hope it will ultimately force tech behemoths to change their business models to reduce teen addiction and protect kids online.

Rodriguez says she hasn't paid the firm a fee of any kind, and has never discussed recovering financial damages from the companies. "I've never asked about money," says Rodriguez. "To me, that's not the focus of the lawsuit. I want to hold the company accountable." Bergman says this is typical of his clients. "They want justice, they want accountability, and they want to prevent more families from suffering what they did."

Rodriguez says litigation has given her an outlet for her grief. She has stopped blaming herself and her family for her daughter's death. "Now," she says, "I'm able to direct my anger to the right people."

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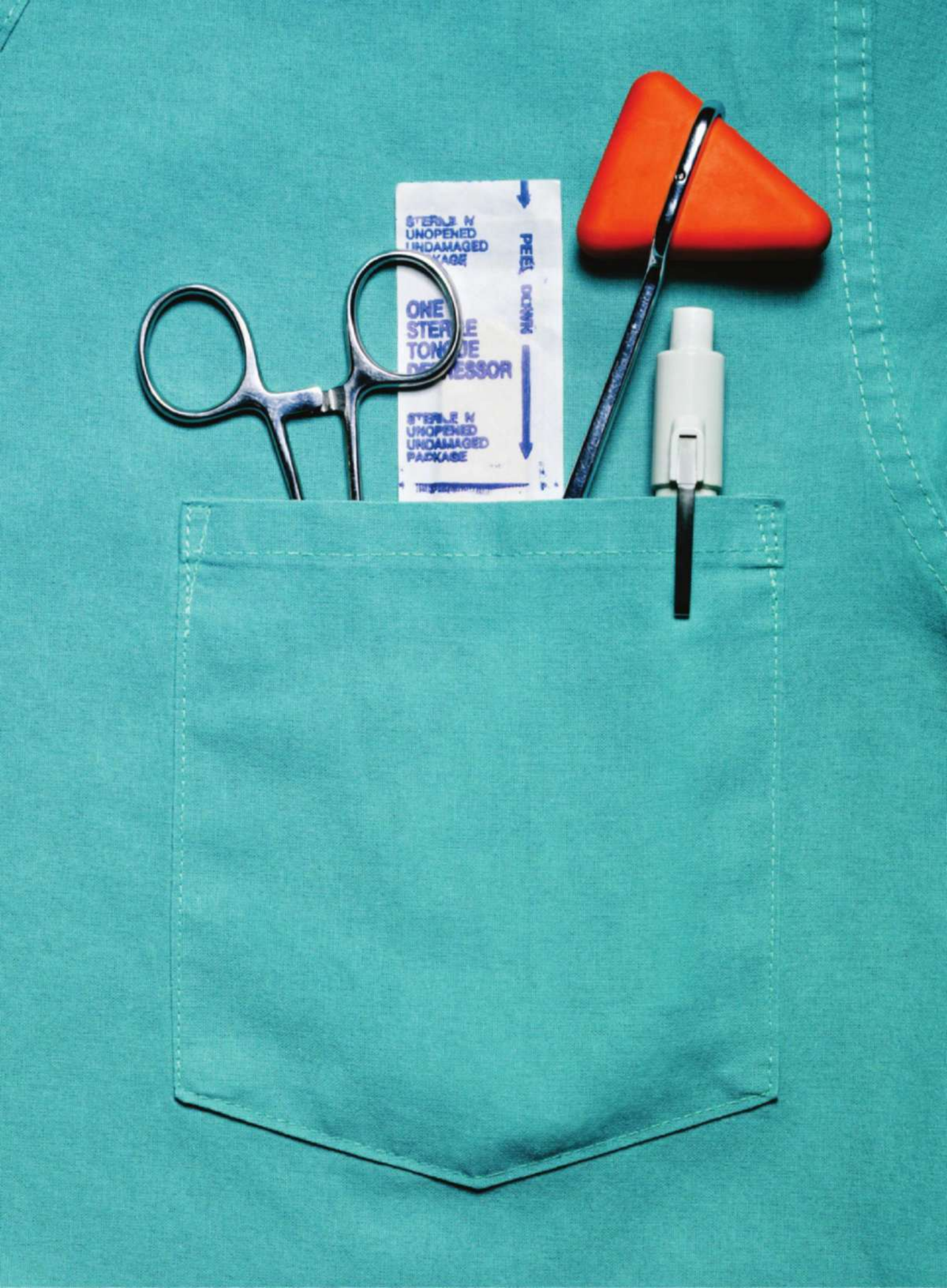
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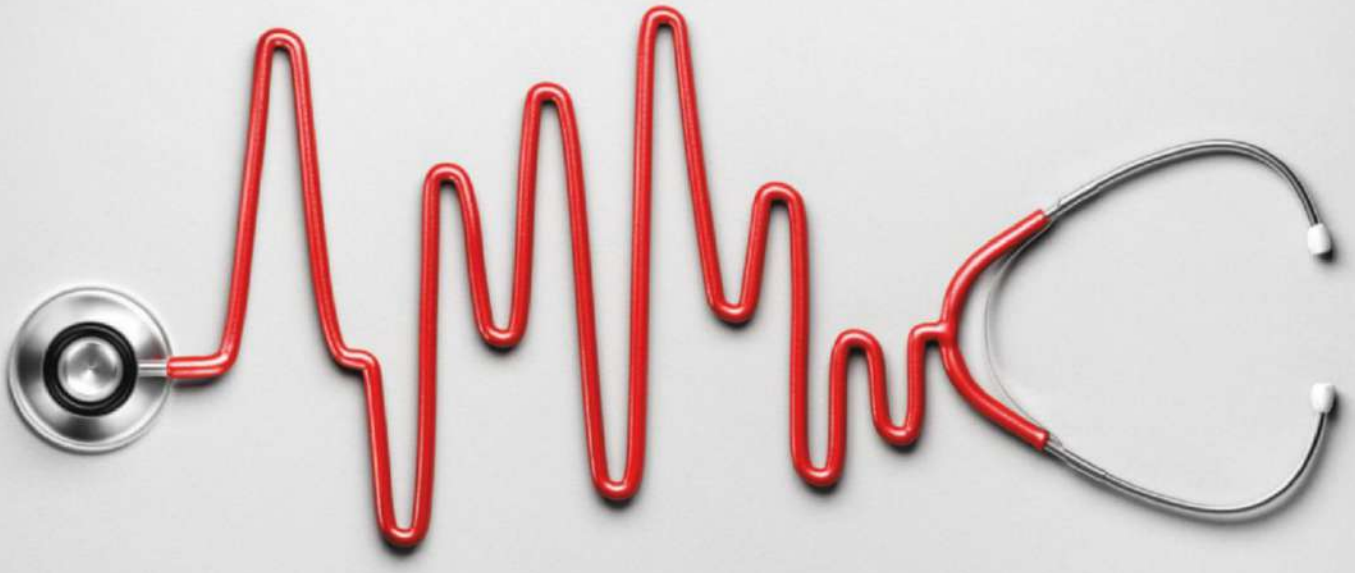

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100 Health Innovations

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