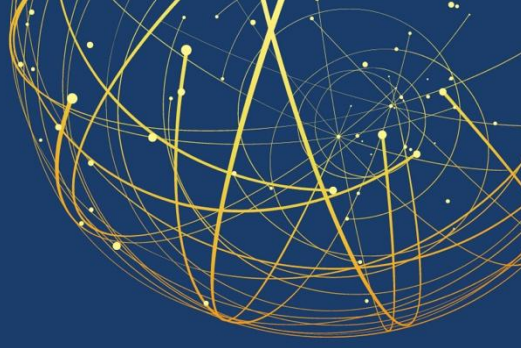

PART 2: MIND OVER MATTER: HOW NEUROSCIENCE IS REDESIGNING THE WORLD AROUND US

Sylvie Raver 00:05

Alright. Hi. Hello. Already? Okay, great. We haven't even started. Well, hello, and welcome to "Mind Over Matter." This is the second of two conversations today on science, investment, and human potential. Thank you all for being here, staying here, if you joined us for the first part. I'm Sylvie Raver. I'm a senior director at the Milken Institute, where I lead our brain and mental health philanthropy portfolio. You just heard from this group of extraordinary funders and innovators and leaders about the bets that they're placing on science, including backing ambitious, unconventional ideas across biomedicine, technology, and really beyond. Now we're going to explore what it looks like when those ideas move from discovery to application in the real world. So consider this sort of a case study from the previous discussion, where we can examine how the funding for neuroscience, in particular, has reconceptualized a wide breadth of activity, from behavioral change, abilities like speech and movement, even once numinous experiences like viewing art are now directly connected to what we know about the brain. Right now, investment in brain science is paying off and showing up in our everyday lives in ways that probably seemed unimaginable decades before. According to *The Transmitter*, neuroscience-related projects comprised more than a quarter, 28 percent, of NIH's budget in 2024, a number that's more than doubled in 16 years. And in 2025 alone, private investment in neurotech, especially brain-computer interfaces, exceeded a billion dollars. And returns are beginning to show up in the world around us, not only in medicine, which we'll hear about in a little bit, but also in physical spaces, lifestyle products, digital platforms that we interact with. So our panel today brings together three leaders who are each applying our deep but evolving knowledge of neuroscience in really interesting, creative, and innovative ways. Tom Oxley is CEO and founder of Synchron. Your team is developing brain-computer interfaces that allow people to control technology using only their thoughts without open brain surgery. It sounds like science fiction, and he's going to tell us why the future is here. Anne Kraybill, CEO of Art Bridges Foundation, is connecting the science of how art and the built environment affect the brain to expand access to cultural experiences across the country.

And Geoff Cook is CEO of Noom. His team has built a platform that uses behavioral science to close the gap between what people know is good for them and what they'll actually do. Together, these leaders represent how neuroscience moves from the lab to everyday life, and I'm excited to get into it today. All right. So an opening round of questions for each of you first. I'll start with Tom. Synchron's brain-computer interface technology enables someone to control a digital device with their thoughts. And with the Stentrode device, which I'm sure you'll talk about, the technology uses a minimally invasive procedure. So it's really revolutionary. It avoids open brain surgery. It's remarkable, and I'd love to hear from you about what brain-computer interfaces can do today, and where maybe the public perception is either ahead of or behind the science.

Tom Oxley 03:16

Sure. Thank you for having me. I guess public perception is clouded by *Black Mirror*, science fiction, popular culture. It's been around for decades, been written about for decades. It's been in the academic domain for—probably since the '70s and '80s, moved into, let's say, human studies in the 2000s, and now in the 2020s, we're getting the first companies that are getting FDA-approved clinical trials. No company yet has an approved device. So the field is called implantable brain-computer interface. The concept is that your brain has different areas that are functioning to provide your experience, your existence, your consciousness. The field is starting in the domain that has probably been the best understood part of the brain, which is called the motor cortex, which makes up about 20 percent of your brain, controls the movement, somatic control of my limbs, my lips. It is how we communicate. So we communicate through the control of muscles. And probably importantly for the digital age, we use our hands and now our voices to control technology. So millions of people who exist with various types of conditions that cause paralysis, that impair your ability to move your body, and the idea is the device goes in the brain, it detects when the brain is trying to move the body. The signal can't get through, and then it converts that into control of a joystick or a mouse or a keyboard. That's the first iteration of the technology. My background is as a neurologist, so I started working in the field with NIH, US Defense funding in the space, which is a key part of the early triggering of this field. And now, Synchron, along with Neuralink, are the two companies that have FDA approval for permanent implanted devices that are currently in clinical trials, primarily for people with paralysis, such as ALS and stroke.

Sylvie Raver 05:16

Incredible. That's incredible. And we'll hear a lot more about that throughout our time together. My next question is for Geoff. Noom is built on this core insight from behavioral science that knowing what's good for you and changing your behavior are two entirely different things. I think we can all relate to that. Why is that gap so hard to close? And what does the science say about behavioral change?

Geoff Cook 05:37

Yeah. So, I joined Noom three years ago, and Noom at the time was being disrupted by GLP-1 medications. So, Noom is known as a habit program. It's not a diet, it's a mindset. And what I've helped

spearhead is bringing Noom into that GLP-1 age, where we use the GLP-1 to basically open a window into change. Because what we find is that when you bring a GLP-1 into play, not only is the appetite being reduced, the food noise is also reduced, and that's a cognitive manifestation of food noise. We believe that opens up mental space for maybe more adaptive prospection, thinking about maybe healthier habits. Self-control improves, especially food-related self-control. And so when you realize that most people who start on a GLP-1 come off of it—11 out of 12—what we've found is if we can take that pharmacological window where you have less food noise, more self-control, and then pair that with theory-led behavioral economics, social cognitive theory sort of interventions, we can have lasting outcomes for our members. And so that's really what we do, combine the medication with the behavior change.

Sylvie Raver 07:14

It's really powerful. Multiple different intervention points. Anne, to kind of intro your perspective here, Art Bridges is expanding access to American art across the country. What does research suggest about why engaging with art matters, not only culturally, but for our health and how we feel all innately in our brain?

Anne Kraybill 07:33

Sure, and I will preface this with, I went to art school. I am not a neurologist. But I find myself in part of an ecosystem that was founded by Alice Walton. The first project she brought online was Crystal Bridges Museum of American Art, and it was all about access in her hometown of Bentonville, Arkansas, where she wanted to be able to make sure that future generations had access to art in a way that she did not have access to art. Simultaneously with that, Art Bridges Foundation was born, where she has a belief that art just can't exist without a viewer. And so 95 percent of art collections are in storage, and so our foundation, our North Star, is to get those artworks out of storage and then share them, redistribute them with museums across the country. And where this intersects with wellness is, at the same time, she started to realize, when I go into a museum or when I engage with art, there's things that are happening. My blood pressure is going down, my cortisol is going down. And we now know there's a lot of studies out there that really demonstrate empirically the evidence in this space. So we've been working a lot with Susan Magsamen, who wrote *Your Brain on Art*. We just had Jeremy Nobel, who wrote *Project UnLonely*, around how the arts can unlock unloneliness, which is a huge part of our epidemic this country is facing, where your brain can actually become inflamed when you suffer from this. So she's opened the Alice Walton School of Medicine, fondly known as AWSOM, and the Heartland Whole Health Institute. And so as an ecosystem, we're really looking at what is this intersection of art and wellness? How can we take what art museums are able to do and bring that to a broader public more accessibly, and sort of dismantling what had been preconceived of as an ivory tower.

Sylvie Raver 09:31

Yeah. You're each working at that. That's a good bridge to a question about sort of scaling, which I think each of you are tackling in different ways. You're all at different stages of bringing neuroscience from concept to mass adoption. Tom, you're navigating regulatory pathways to get there. Geoff, you're scaling

this consumer platform to millions of people. And Anne is democratizing access to art nationally. So my first question was for Tom a little bit about the scaling. You moved this BCI technology from a lab at University of Melbourne into human clinical trials, and through regulatory, and now you're telling us into consumer device integration. What is the hardest transition of that journey from research, from academia to commercialization, and how have partnerships, such as ones that you've created with some of the consumer product organizations, changed your approach?

Tom Oxley 10:22

The field's still very early. We've done 10 implants over two clinical trials over six years. The regulatory hurdles are very high, as they should be. It's a class III, it's a brain implant. I think the FDA is probably globally leading in navigating all of the risks around the implants. I think within the US, the reimbursement landscape for medical devices compared to, say, pharmaceuticals is probably more challenging, a longer road. There has recently been interesting geopolitical landscape where China, in the last 12 months, has announced a national innovation strategy around BCI. And they've made a fast track for this particular technology, which speaks to a question about where the view might be, where the technology's going eventually. It's still very much in the domain of medical. I think China's got a view, probably more than the US generally, that the convergence of BCI and AI is on a natural course. I think that's starting to emerge in the US. Sam Altman's recent company is very explicitly talking about, they call themselves Merge Labs, about the merging of humans and AI through BCIs, which raises a bunch of ethical questions, which I think you're going to ask me later. But the field is very early. I think, from an investment perspective, the relationship with Apple that we've developed has been very important for our fundraising. I think Apple has worked with us to release the first Bluetooth standard for brain interfaces. Why Apple wants to do that, I'll let you ask that question. But they're putting energy into it, and it's been great for the field. And NVIDIA has been very interested in how the use of brain data results in a compute problem that will unlock the ability to understand human intelligence from the perspective of AI placed onto brain to understand how the brain is operating, which still is a very complicated organ to understand. So I wouldn't say the field is yet scaling. I think scaling won't truly happen until post-FDA approval with the first product, which is going to require a mechanism of financing for the users. The users often won't be paying for their own devices. So I think we're still in the early regulatory phase and with reimbursement questions still to be unlocked.

Sylvie Raver 12:56

Okay, that makes sense. Maybe Geoff, could I ask you a similar perspective? So you opened by talking about the market opportunity and sort of the human opportunity with pairing the GLP-1s with Noom as a behavioral modification platform. How have partnerships maybe like this sort of enabled you to do that? How are you designing for the moment when the pharmacological support disappears and making sure that there's a path for sustainability for people?

Geoff Cook 13:23

Yeah. So, partnerships have been important. We often will partner for different AI models. An example is an AI body scan. So monitoring your lean mass is important when you're on a GLP-1, and you can't mind a metric you can't measure. And so we partnered with a company that spent tens of millions validating their lean mass, fat mass using just your smartphone camera. I think—other kind of ways that we think of bringing people—in this pharmacological window, we are focused on setting up your choice architecture for later. So you're building the routines. You might have a few months, you might have six months, you might have maybe 12 months. If we can get you to build a habit that becomes two months, three months long, then it may become part of your identity, and that is more likely to last. And so a lot of what we're trying to do is build up that kind of automaticity and really have it stick.

Sylvie Raver 14:40

We talked in our kind of pre-conference time about sort of the human element in all this, and both of you brought up AI, and so we should bring it to Anne and think about how you're integrating technology into the work that your foundation does, especially through maybe some of the partnerships and the programs that you're supporting and designing to focus on wellness and art.

Anne Kraybill 15:00

Fascinating. I'd say we're actually very analog, right? Because—

Sylvie Raver 15:05

That's a choice. Really cool, yeah.

Anne Kraybill 15:07

Right. So, I work with over 300 museum partners, and we are a logistics operation of just getting artwork redistributed throughout the country. And now we're really thinking about how can we partner with health care settings to bring artwork into those spaces. So there's lots of networks like Cleveland Clinic, MD Anderson, Stanford, that have these incredible collections. But clearly a lot of health care settings do not have the resources, nor is that their lane for them to be in. And so we're thinking about can we create these real—I don't mean that digital is not real, that's a real experience too, but these experiences with artworks that are made in real life, to patients in health care settings, in a space that is probably one of the most stressful spaces to be in. And so this idea of a lending library. So to that end, we use AI to measure our impact and things like that, but not in terms of actually facilitating the experience itself. I will say on the Crystal Bridges campus, they are using AI to have a sort of facilitated experience with the campus itself. But we never want that to minimize from the art experience.

Sylvie Raver 16:23

Augmented experiences with the campus itself. Oh, interesting. Well, you brought up measurement a little bit, and you're using AI for measurement. Each of you, obviously, you said you can't measure what doesn't matter, or—I mangled it, but you said something pretty equivalent like that. So maybe tell us a little bit about how you are intentionally designing your products, your programs, your devices, based on what you can measure, because each of you are tackling this challenge, and I'm from the neuroscience world, we think about data and hard evidence all the time. How's it showing up for you?

Geoff Cook 16:57

Sure. So, there's a number of things we're measuring. So for one, if you're familiar with the Noom program, weight is something that we incent you to do. We have this concept of streaks and levels inside of Noom. We have a virtual currency that we're rewarding. But we're measuring not only the weight, but also whether you're taking the medication, if you're on a medicated plan, any side effects. We actually recently rolled out Tasso blood tests, which are these little devices that you put on your arm. They fill up, and then you can get your A1C, your ApoB, your LP(a), among other biomarkers. And then interestingly, what we've started measuring is different validated measures of flourishing. I think PROMIS-16 is one of them. And part of what led us there actually was launching a digital art therapy aspect inside of Noom, which we launched in order to help people reduce stress. And so we actually measure different sense of their kind of wellbeing across different dimensions. But the way we come at art is really trying to get you to feel awe. That's one of the main areas we're in. Beauty. And we find that those things correlate with stress relief.

Sylvie Raver 18:30

That was a new knowledge to me about the integration of the art platform with Noom. I thought that was very exciting. How about you, Anne? How do you measure something like awe? How do you measure the impact of what your programs are focused on?

Anne Kraybill 18:42

I think it's still very early days, right? So we have a great Petri dish at Crystal Bridges campus, where we have the art museum, we have a medical school. Very soon we're going to be having a health care campus, 100 acre, with specialty care. One of the things that we have been doing, not only at the campus, but nationwide, is something called the Collaboration for Ongoing Visitor Experience Studies, and this is a visitor intercept survey. We have over 90 partners in art museums across the country. This is in collaboration with the Museum of Science in Boston, where we are looking at not only who is coming, but why are they coming? And we're measuring things like a sense of belonging in these spaces. So, do you feel an affinity to these spaces where we're looking at group composition, deep demographics, motivations for coming, but also behavioral changes when they come to these spaces. So I think for art museums, it's something that we've always intrinsically felt, or just the art in general, and just very recently do we

actually have data to say that what we intuitively thought was happening is happening, and we still have a long road ahead.

Sylvie Raver 19:51

How long do you think you'll be able to measure that for after someone has what might be just a one-time experience? How long can you go out?

Anne Kraybill 19:56

This is simply an intercept, and there's lots of other researchers that are doing things that have more of a longitudinal, but RCTs, all of that, it's really hard.

Sylvie Raver 20:07

Oh, yes.

Anne Kraybill 20:08

And it takes quite a bit of money and resources.

Sylvie Raver 20:10

Oh, well, as though you just handed it to Tom. That's my next question. Take it away. The FDA wants clinical endpoints, like can you send a text or control a cursor? But your patients describe something very similar to what Anne was just saying, like restored dignity, reconnection with family. How do you measure that, and why must regulators care about it?

Tom Oxley 20:31

Yeah, there's a tension between this kind of technology race for the most data possible out of the brain to build the best models versus building the product that's most easy for the patient to use that actually does something useful, which as you say, is restoring some degree of autonomy in people who've lost capability. But in terms of measuring, so the way we do that is by building sensors that go distributed into the brain. And so the sensor is made up of the material that does not get rejected by the body that can stay there for a lifetime, connection to an electronic circuit that has an ASIC, a recording device, a communication protocol that can capture the information, bring it out of the body, a battery to supply it, and then the

communication protocol itself is all very challenging. So you go to, like I said, the field starting in the small area of the brain called the motor cortex to decode movement control. One of the debates happening in the field right now is how is the distribution of increasing scaling, exponentially increasing amounts of sensors into the brain without destroying the architecture? How is that achieved? So all of those fields of science I mentioned are all kind of converging into this field of BCI, and it's been in the academic domain for decades now finally getting into the commercial domain because of the supply chain for all of those becoming possible. But you've got hundreds of components, and then they all have to be put together into a system. You have to stop changing all the pieces, submit that to the FDA after implanting a large number of people to check that it works. So it's taken a long time for the field to move forward.

Sylvie Raver 22:08

Time and expense, you're just saying. Yeah. I want to ask a little bit about ethics, which you introduced earlier, because I teed it up to you. Synchron's current use case is restoring communication and independence, but the technology also obviously has other potential applications, including for enhancement. And we didn't even talk about read and write. Where is the line for you between restoring lost function and enhancing human capability, and how do you think we should be talking about that line now before the technology scales? Like you said, it's still early days, so let's get ahead of it.

Tom Oxley 22:42

Well, you mentioned read and write. So, reading is what the sensors do. So live stream of data, use the data to then build product that's useful. In the case of people with paralysis, millions of people with paralysis, it's allowing them to restore communication. And so if you have a disease like stroke or ALS or multiple sclerosis, cerebral palsy, a range of conditions that stop—the input-output problem comes to the fore because you realize—I've realized through my career, surprisingly, that the output problem of the human body is that all of your ability to communicate your internal state comes through your motor cortex. So all of your thinking, all of your emotions, all of your reactions, all of your planning, all of your everything that's circulating in your brain, responding to the environment, all of it comes out through this same tract. And if that gets disturbed, then you're kind of locked inside your body. That's where the term locked-in syndrome comes from. So ethically, there's two sides of it we think about ethically. On the one hand, you've got the potential for improving autonomy, improving self-determination, especially in people who have that output impaired. But on the other hand, you've got the concern around privacy because for it to work, you have to decode thoughts or elements of the brain that are otherwise protected by that same thing, which is you've got sovereignty with inside your skull. No one can read your thoughts. You control how you communicate those thoughts outward. So ironically, there's a popular culture fear about the erosion of privacy. But if you speak to patients, they're like, "Well, I don't have any privacy because my ability to communicate is completely dependent on other people anyway." So I think for the next 10 years, primarily focused on improving self-determination, privacy is, for the most part, captured by the FDA through cybersecurity and requirements. But it's a major concern. But I think as the field progresses and we move, now there's speech decoding, there'll be emotional decoding, there'll be planning decoding, there'll be an ability for the technology to extrapolate or predict what your brain will do given a certain circumstance, and make inferences on your behavior, which are very personal. So that pushes then into

the privacy domain. So I think the field will exist between a pull between those two. And I think it'll be upon the regulators, especially the FDA, to manage that or to help industry manage that.

Sylvie Raver 25:17

And getting the right perspectives to help influence their thinking too, for sure. Your patients. I bet you have some thoughts about privacy as well. You're working in a place that's very personal to people, weight and motivation and behavioral change is so personal. How is Noom considering some of those?

Geoff Cook 25:38

Privacy is obviously all important to our members, especially as we're taking blood data and various other types of data. I would say what we've seen is, and one of the newer things that we've really been working on is creating kind of a free experience of Noom. And what we've seen is that if we can be that healthy aging companion for someone, not just the weight loss companion, so we've been really trying to expand beyond just the lane of weight into a much broader kind of living healthy segment. And, I think, obviously, follow all of the various privacy laws and protect members' data. Generally don't sell it, of course. So I would say where we kind of focus is trying to bring access. And so go from just paid subscriptions, paid programs, and really have a robust free experience of Noom. And I guess what we are seeing is a tendency for members to want to share certain amounts of their data with their friends on Noom. So, like, we've created this ability to add a friend and share your step count with your friend. And when you hit your step goal, I'll earn some virtual currency, and when I hit my step goal, you'll earn some. And so it creates this collaborative element. And so we're thinking of more things like that, where you could share data like that.

Sylvie Raver 27:17

I didn't know that. More competitive. Very cool.

Geoff Cook 27:24

Could be competitive.

Sylvie Raver 27:26

Depends on the friends, though, I suppose. Or the family. You just mentioned access. Access is the core of what you're doing, a core value. How are you ensuring, and how can we ensure, that the cognitive and emotional benefits of art and culture are accessible across communities and not just to the privileged few? You're in a well-resourced setting, but you obviously think constantly about other communities that don't have access to art.

Anne Kraybill 27:52

Access is at the core of everything that we are founded on. The idea that arts are pretty inaccessible, or inequitable, I should say, across this country. Oftentimes it's in major metros, such as Los Angeles. And so making sure that people have access no matter where they are in the country. The same goes for health care. So putting those two things together, and then when you think about the idea that engaging with the arts is an upstream preventative measure for so many things. For loneliness, for self-awareness, for mental health, that being able to have that access is a critical public investment. So, part of what we do as a foundation is not only trying to bring that again to art museums, but now expanding that into other sectors, such as the health care sector.

Sylvie Raver 28:52

Health care. We started off with you giving a *Black Mirror* reference and kind of talking about some of the misconceptions and we're on a stage. We have the opportunity to dispel some maybe myths about our sector and myths about the brain or neuroscience. What is a misconception that you feel that people have about the space that you're working in? Maybe BCI or the community behind it that you feel like doesn't hold up and you'd want to dispel?

Tom Oxley 29:18

I think reading thoughts is a big one. The first iteration do read the thoughts of like, I'm trying to push left or push right or push a button. So from that perspective, it would be the same like capturing what your hand is doing on a mouse or a keyboard. The field, I think, has the potential to grow into interpretation of semantics, which is the ideas behind the words rather than the actual words that you're articulating themselves. But I think the field is going to move very slowly, so I think there's a public fear around, "Oh, this technology can read my thoughts, and it's the end of days." That's probably the major myth.

Sylvie Raver 30:08

I'll correct that at all the dinner tables I'm at in the future. Thank you. How about you, Anne? Any misconceptions around the space that you work in?

Anne Kraybill 30:16

Oh, I think people often, and it's not necessarily a misconception, it can be a truth, but people often think of the arts as for the elite. That they're not accessible to all, not available to all. I think unfortunately our industry has a lot of responsibility in making that perception sometimes a reality. And so there's a lot of

work to be done in dismantling that, and for arts museums and the cultural sector to work with communities to really make sure that these are accessible and representative to people. And then I think it's also this misconception that the arts are the cherry on top. They're not an essential part of our health. And when you look back at just the history of arts, this is how we've engaged with what it means to be human. Right? It's critical to what we are. It's foundational to what we are. And so it's a critical, I think, element in our public health sector.

Sylvie Raver 31:15

Agreed on that. Preaching to the choir, but I—and probably the folks in the room, too. But how about you? Any misconceptions?

Geoff Cook 31:22

So, misconceptions. I think—obviously in a field of obesity, there's this misconception that it's willpower. And as a result, there's been stigma, of course, around that. And I think over the last few years in particular, it's become increasingly clear that it's not really a function of willpower as much as a function of chemistry, and kind of dopamine and urges. When you look at some of the fMRI studies under GLP-1, it's just clear that it reduces wanting, while actually increasing liking. And so, to be able to now kind of level that playing field from a chemistry perspective, I think there's still stigma out there, but frankly, I see it going away quickly in terms of stigma to saying you're on a GLP-1. Like it seems it's almost going the other way, where it's like, "Hey, I'm on the GLP-1, and I'm on all these—I'm on all these other peptides, too."

Sylvie Raver 32:36

Yeah. That's very true.

Geoff Cook 33:36

Everybody wants to say what their stack is.

Sylvie Raver 32:37

Oh, my. I'm not in those circles. Maybe I should join them. Fascinating. Well, we started the conversation as rooted in neuroscience, and at its most reductive, the brain is an input-output machine. And so you're each working on this input-output problem from different angles. Tom, your technology is reading output and extracting intention directly from neurons. Geoff, you're considering mindfulness and the brain networks to manage incoming information, and then nudge output. And Anne, environmental input, art, and physical spaces to shift these internal states. What inputs have you each maybe learned to guide the

outputs that you're putting forward into the world? It's one of our last questions. I'm curious to kind of end on a high note like that. What have you learned? What is your output going forward based on the inputs?

Geoff Cook 33:37

So one of the more interesting things I've learned actually is that the GLP—so there's the default mode network of your brain, which is what your brain is doing when it's not doing something else, and it's where you spend about 50 percent of your waking time. It may be the seat of food noise, it's the seat of prospection generally. And the GLP-1 will quiet that brain network. Interestingly, art will quiet that brain network, and that's partly why we launched that Art Breaks feature. We call it Mindful Art Breaks. But also cognitive behavioral therapy will quiet the DMN, using kind of executive function to notice interoceptive body cues will quiet the DMN. So I've kind of come to view Noom basically as just an exercise in quieting the DMN in one form or another.

Sylvie Raver 34:29

But accessible, so how about you?

Anne Kraybill 34:31

I mean, I'll just share a personal story when I was more of a practitioner in an art museum setting, where we had a program for individuals with Alzheimer's and their caregivers. And this one instance, it was a grandson that came, and being able to facilitate a conversation between this group with him and his grandmother, and have this shared experience that had nothing to do with her disease. It just had to do with experiencing this work of art together. It created a new memory for both of them, and she wasn't struggling to try and access memories beyond being in the moment. So again, intuitively kind of seeing the effects of what the arts can do, and now seeing that bear out in the science has just been really, really rewarding.

Sylvie Raver 35:20

That's fantastic. How about you, Tom?

Tom Oxley 35:23

I think what's a hot topic at the moment in the field is that this sort of latest ML technique, the GPT, generalized pre-trained transformers, are kind of a representation. Neural networks are based upon how the brain works. And I think ironically, what people are predicting is going to happen, is we're still having trouble fully understanding how the brain works, and there's a belief now—it's called neuro AI—that those

techniques are going to—in the same way that like GPT can provide wisdom in a way where it's sort of hard to sort of see how it got there on the basis of huge amounts of compute, that applied to the brain is going to help us understand how the brain works, and this weird kind of art-imitates-life thing. But that's going to require huge amounts of data. But ironically, I think the artificial intelligence is going to tell us more about how human intelligence is actually working.

Sylvie Raver 36:22

I hope so. Well, we've talked before, it's each of your first time at the Global Conference. I hope this is the first of many. But it's such a unique community that we gather here of decision-makers, funders, peers, innovators. And before we close, I'd love to give each of you the final floor to convey to the folks around us, the folks at this conference, if there's one thing that you need to meaningfully accelerate the impact of what you're doing, what would that be? I'm going to start with Tom and work forward.

Tom Oxley 36:56

Oh, I'll go last.

Sylvie Raver 36:57

Oh, you'll go last. Okay. Final say. Alright.

Tom Oxley 36:59

I just gave it up.

Sylvie Raver 37:01

Got to have time to think. Geoff, would you like to start on the spot?

Geoff Cook 37:05

So, I'm very interested in this concept of a habit window. Right? And so, we're actually going to be publishing a report tomorrow, a survey of 5,000 GLP-1 takers, and what we've found is that it really is a privileged window. And so if I think about forward five years, 2030, 2031, what we're thinking about is how do you combine behavior change with the pharmacological agent in order to produce more durable outcomes? And we're seeing some real clear evidence that you can drive people to adopt habits. You could

get them to adopt cascades of habits if you could keep them on the med a little bit longer. And so I'm interested in that intersection of basically behavior change and pharmacological agent.

Sylvie Raver 38:07

All right. Partners to help you get there. How about Anne?

Anne Kraybill 38:10

I'll just keep it real simple. Go visit your local art museum. Engage with your local arts community, yeah.

Sylvie Raver 38:17

And tell your friends.

Anne Kraybill 38:18

Yes. Become a member.

Sylvie Raver 38:20

Even better. Yeah. Alright. Final just for you.

Tom Oxley 38:23

Well, it's a global conference. I think—I pointed at it before, but I think China is poised to surpass the US with this critical new field, this neurotechnology space. They've made it a federal priority, and I think the US needs to do something similar if it's going to keep up its leadership, and it's going to require high-level focus. The FDA's brilliant, reimbursement's brilliant in the US, but the bureaucracy levels have become quite thick, and we need ways to be able to move faster with new technologies that have such potential impact for patients.

Sylvie Raver 38:58

A new decade of the brain.

Tom Oxley 39:00

Yeah.

Sylvie Raver 39:00

Look forward to that. All right. Well, thank you all for your perspectives and your time. Thank you for coming. Thank you for being here.

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