

[Transcript] Honestly with Bari Weiss / How to Live Longer and Healthier with Dr. Peter Attia

Hi guys, it's Barry with a really exciting announcement for you.
As listeners of the show will know, one of the reasons that this exists in the first place is to embody and promote honest, frank conversations and good faith debates, both of which feel increasingly rare in our polarized country.
That is why I'm so excited to announce that the Free Press, along with FIRE, the nation's leading defender of free speech rights, are hosting a live debate on a very sexy and contentious subject on Wednesday, September 13th at 7 p.m. at the historic Ace Theatre in downtown Los Angeles.
The proposition? The sexual revolution has failed.
Arguing for the proposition is co-host of the podcast Redscare, Anacachian, and author of the case against the sexual revolution, Louise Perry.
They're going to be facing off against musician and producer Grimes, and writer and co-host of the podcast A Special Place in Hell, Sarah Hader.
I'm going to be the moderator and I couldn't be more excited.
This is going to be an amazing night.
It's a chance to meet other people in the real world who also like thinking for themselves and who listen to this show.
You can get your tickets now by going to [thefp.com backslash debates](https://thefp.com/backslash/debates).
Again, that's [thefp.com slash debates](https://thefp.com/slash/debates).
I can't wait to meet some of you guys in person.
And now here's the show.
I'm Barry Weiss, and this is Honestly.
You know, if you were to follow a busy doctor as he makes his daily round of calls, you would find yourself having a mighty busy time keeping up with him.
I want to take you back to the 1950s.
Timeout for many men of medicine usually means just long enough to enjoy a cigarette.
When smoking cigarettes was widely perceived not just as glamorous, but actually as a health enhancing activity.
Doctors in all parts of the country were asked, what cigarette do you smoke, doctor?
Once again, the brand named most was Camel.
Yes, according to this repeated nationwide survey, more doctors smoke camels than any other cigarette.
Why not change to Camel?
In many cases, promoted or endorsed by doctors.
You know, this night works kind of rough, isn't it?
That's right.
But a camel is always a pleasure.
Yes, folks, the pleasing mildness of a camel is just as enjoyable to a doctor as it is to you or me.
In a nationwide survey, doctors in all branches of medicine were asked.
There was also Tab.
She's stuck, stuck in his mind.

[Transcript] Honestly with Bari Weiss / How to Live Longer and Healthier with Dr. Peter Attia

You remember the diet soda drink that was marketed as a low calorie alternative to regular soda.
Have a shape you can't forget.
Tab can help.
It's sugar free.
How does it taste?
Here's a clue.
The Coca-Cola company makes it and Tab tastes better than any diet cola.
Tab is a taste to remember.
Or fast forward a few decades.
If you grew up like I did in the 80s in America,
you might remember those green boxes of fat free cookies in your parents' pantry.
Excuse me.
Do you make these delicious fat free snack well double scoop cookies?
Why, yes, I do.
You want to tell us why we can't find them in the stores anymore?
Well, what is this?
You got some explaining to do, Cookie Man.
Yeah, a little more popular than we expected.
Oh, this guy's quick.
We're making more as fast as we can.
Oh, you're brave.
Eat as many snack wells as you want, they said.
As long as they don't have fat, you're bound to lose weight.
That was evil.
Carbs were our salvation.
Of course, all of these trends, and many, many more,
have since been proven to be entirely incorrect.
In some cases, even harmful.
Like, cancer causing, this will likely kill you over time
if you continue to do it harmful.
It seems like the health industry turns through information and trends
faster than anyone can keep up.
As soon as you're gearing up to start a juice cleanse
or go on a Costco rampage for keto friendly ingredients,
a new diet, a new drug, a new piece of equipment
is here to tell you you're wrong, you're foolish.
This new thing is actually the key to your health.
We're a New York City tech company changing the lives
of millions of people around the world
through a global fitness platform we're building from the ground up.
92% of households that kick off the year with Peloton
are still active a year later.
Fast Longer with Keto Fasting Team.

I love the new My WW program because you get matched
with a plan tailored to you.
Whether you're a dine out or take out.
It's more than just a meal you make every night.
It's a chance to slow down and catch your breath.
To be fully present in the moment,
you can do this with any Hello Fresh recipe.
See yourself.
Welcome back to the mirror.
And no, you're not alone because this is not just a mirror.
It's an unstoppable community.
Jenny Craig is Weight Loss Made Simple.
Click or call to learn how to get a free week of food with purchase.
This is not about a class.
It's not about a bike. It's about you.
This is about you.
This is about you.
You.
Your purpose.
Your goals.
Your drive.
This is about you.
Find your truth.
Find yourself.
Find your soul.
Find your soul.
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Find it.
My guest today is here to cut through all of that noise
and to tell us, based on the best available science and data,
what it really takes to live a healthy life.
And not just a healthy life, but a longer life.
Peter Atea is a world-renowned, Stanford, Johns Hopkins, and NIH-trained physician.
And he's at the forefront of some of the most important conversations in medicine today
around health and longevity.
He just wrote a book about all of it called Outlive,
The Science and Art of Longevity.
Peter's work is at the center of a very buzzy new industry
that's been booming in Silicon Valley over the past several years.
Tech giants from Jeff Bezos,

to Peter Thiel, to Sam Altman, Larry Page, to Brian Armstrong
have poured billions into startups that research the extension of human life.
As Susie Weiss recently put it in an article for us here at the Free Press,
deciding that death is just another coding error
has become something of a Silicon Valley bar mitzvah of late.
When you reach a certain age in net worth,
it's time to start figuring out how to live forever.
But Peter Atea doesn't think life extension
should only be for the elites of Silicon Valley.
He thinks there are many everyday changes,
from what we eat, to how we move, to how much we sleep,
to scans and blood tests and other kinds of early intervention,
to our psychological and emotional health,
that can give all of us extra years in the very short lives we have here on Earth.
So on today's episode, The Pursuit of Forever,
what's possible in the uncharted science and art of life?
And from our broken medical system, to our truly unhealthy lifestyles,
what are the major things preventing us from living longer, healthier lives?
And last, most importantly, what makes a life worth living anyway?
That's all coming up. Stay with us.
Hi, honestly listeners.
I'm here to tell you about an old book called The Pursuit of Forever.
It's about an alternative investing platform called Masterworks.
I know investing in finance can be overwhelming,
especially given our economic climate.
But there's one thing that will never go in the red,
and that is a painting from Picasso's Blue Period.
Masterworks is an exclusive community that invests in blue chip art.
They buy a piece of art, and then they file that work with the SEC.
It's almost like filing for an IPO.
You buy a share representing an investment in the art.
Then Masterworks holds the piece for three to ten years,
and then when they sell it,
you get a prorated portion of the profit's minus fees.
Masterworks has sold \$45 million worth of art to date,
from artists like Andy Warhol, Banksy, and Monet.
Over 700,000 investors are using Masterworks to get in on the art market.
So go to masterworks.com slash honestly for priority access.
That's masterworks.com slash honestly.
You can also find important regulation aid disclosures at masterworks.com slash cd.
Peter Atea, welcome to Honestly.
Thank you so much for having me. It is an honor.
Peter, a lot of us have a sense that Americans are way less healthy

than people in other countries.
And this is true by so many different measurements.
We're the wealthiest country in the world based on GDP,
but we're rated number 35 in terms of our overall health.
More than a third of people in this country are considered obese,
which is kind of an unbelievable statistic.
Roughly 60% of us, 60% of Americans,
live with a chronic health condition.
And when compared to other peer nations,
we have the highest rate of avoidable or preventable deaths.
And that's just the tip of the iceberg.
I think though maybe the simplest way to measure overall health
is just to look at a simple number.
And that is life expectancy.
We don't perform well there.
In fact, the United States ranks at number 51.
The average life expectancy in America is around 77 years old.
And in Japan, where life expectancy is at the highest,
it's 85 years old.
And there's 50 other countries between us and Japan.
So Peter, explain it to me.
Why are Americans living shorter and less healthy lives
than billions of other people in the world?
So I would say there are a couple of things at play.
First of all, the derivative is probably more troubling
than everything you've said.
In other words, it's not just that our life expectancy is 77 years.
It's that it's 77 and falling.
So I think we're now standing in the third year
of declining life expectancy in the United States.
And that's perhaps the most startling feature of everything.
Now, of course, part of that can be attributed to COVID,
except that COVID sort of affected everybody in the world,
although you could argue it disproportionately affected,
at least in developed nations, the United States,
because of its impact on those with a chronic condition,
which you've already alluded to.
So compounds in that effect.
But secondly, you have these deaths of despair.
And that's really where the United States
is getting hammered in the life expectancy data.
Last year was the first year we surpassed 100,000 deaths
due to accidental overdoses,

virtually all of those due to opioids.
And when you compare all deaths of despair,
which includes alcohol-related death,
so that includes everything from acute alcohol toxicity
to chronic liver failure associated with alcohol use,
alcohol-induced auto fatalities,
and then you add suicide to that
and you add opioid poisoning,
so unintentional death.
The rate at which those deaths of despair
are increasing is about 20% per year.
I don't know that that's a uniquely American situation,
but I think we would score very low
relative to the rest of the world.
Now, as it pertains to some of these other things,
there are obvious explanations in some regard.
I'm sure you've spent time in Europe
and you probably appreciate that when you're in Europe,
you live a very different life,
to the life you would live when you're here.
You're walking much more.
You're typically cooking much more.
You're buying groceries in smaller amounts.
There's less processed food.
And there's just no doubt that those things play
an enormous role.
And you're working less,
or at least you're looking at other people
who are working less who live there.
Well, yes, that's what I was going to sort of get at,
which is I just think when I contrast my life
and the life of everybody I know here
with all of my friends who live abroad,
there is a difference in the level of societal stress.
And part of that is, as you said,
it's perhaps magnified through how much we work,
but I think it goes deeper than that.
So, Peter, let's dive into the specific things
that you think are preventing us from living
our longest and healthiest lives.
And let's start with the big picture,
which is our healthcare system.
You begin your book by describing a recurring dream

that you had while you were in med school at Johns Hopkins.
And the dream has to do with eggs falling on you
from the top of a building.
Tell us a little bit about that dream.
Yeah, that was actually in residency.
I slept much better in med school,
but the dream was basically that I was trying to catch eggs
that were being dropped from a not particularly high roof,
you know, three, four stories up.
And, you know, I had a padded basket,
so as long as the egg would hit the basket, I was fine.
But invariably, the eggs would come down
at too great a frequency,
or I simply couldn't get to them in time,
and invariably, they would hit the ground.
And this was kind of a frustrating and weird dream
which had obvious implications,
though I didn't put two and two together.
But many years later, kind of looked back at that
and realized exactly what it meant
and was frankly surprised
that the answer wasn't obvious to me.
In other words, the way out of this miserable dream wasn't clear.
Well, I don't want to steal the punchline,
but what was the conclusion of the dream?
Yeah, no, I'm sure anybody listening already knows it
without us stating it,
which is you have to go up to the rooftop
and basically take the basket away
from the guy who's tossing them over the edge.
Right, so rather than focusing on catching the eggs
at the bottom with the padded basket,
you have to stop the guy who's throwing them off.
The problem is, is that it seems to me
like the guy throwing the eggs off the top of the building
is like the entire structure of our healthcare system.
So I hope this isn't too broad a question,
but why is our healthcare system so reactionary?
So I think there are many problems
with our healthcare system.
So the first is risk ownership is broken.
There is no incentive on the part of a payer
who has a relatively short window

in which they own your life,
i.e. own your risk to do anything for prevention.
So Barry, you're 25 years old.
Yes, I am, yes, I am, Peter.
Yeah, no, exactly.
And whether or not you have type two diabetes,
high blood pressure, bad lipids, anything like that,
none of that is going to matter in the next 10 years.
Like there's nothing you can do.
You could smoke, you can do whatever you want.
If you're 25, by the time you're 35, you're still fine.
Well, the portability of health insurance
is such that if I'm your carrier or your employer,
for that matter, because remember,
you're either covered by your employer
or you're covered by a carrier,
one of these private health insurance companies,
they're not going to be around in 40 years
when the consequences of that come to bear.
And so that creates an enormous perverse incentive,
which is how little can I spend now
because all I care about is right now.
And yes, I understand that I'm bearing
the consequences of that because I also have lives
that are much more expensive to ensure
that someone else kicked down the road
20 years ago or 30 years ago.
So that's a big part of it.
And by the way, that's a slightly US specific example, right?
But we can go beyond that and we can talk about
how we are educated and how the system works.
And I think in some ways we are a victim
to the amazing success of what I describe
as Medicine 2.0 in the book.
And so Medicine 2.0 was such a remarkable success story
for our species.
I mean, it catapulted us out of misery
in the late 19th century and early 20th century
by finally coming up with a way to treat
and nearly eradicate infectious diseases,
communicable diseases, and trauma
as an all but guaranteed cause of death.
If you think about it, Barry, in the span of 50 years,

we doubled human life expectancy from an evolutionary perspective that's unprecedented, unheralded, and remains the most remarkable achievement of human civilization.

And the playbook for Medicine 2.0, which was largely based, of course, on treating infections, was you treat the problem when it shows up for the most part.

That became the piece that got more ingrained than the other part, by the way, which was we could vaccinate against polio and make it go away too.

That's the preventive piece.

But the real piece was we treat, we treat, we treat.

So we come up with a diagnosis, we put a number on it, we can bill for it, we have a drug for it, and away we go.

And it turns out that that playbook has really reached its capacity.

It's not working for chronic diseases.

Right.

So let's talk a little bit about where Medicine 2.0, which did incredible things, where it falls short.

You write in the book about how there are kind of two broad ways to die, the short way and the long way.

And our current medical system, which you call Medicine 2.0, is very, very good at stopping the short way, like a bad infection, as you mentioned, saving someone who's bleeding out after a shooting, things that are sort of acute, sudden emergencies.

But we're extremely bad at saving people who are suffering from the long way of dying, from cancer, from diabetes, from heart disease, from neurodegenerative diseases, chronic illnesses.

Why is it that we've become so good at solving these short, sudden potential deaths, but continue to fall so short when it comes to these long chronic health issues?

You know, I think it's just kind of an extension of what we talked about a second ago, which is that these fast deaths, as I refer to them, you can't really do much in advance of them, right?

Like, if you get a pneumonia, there's no value in me giving you an antibiotic

10 years before I think you're going to get a pneumonia.
I kind of have to wait till you get the pneumonia
and give you the antibiotic.
Similarly, if you're giving birth as a mother,
there's nothing I can really do
nine months in advance of that.
You know, if you think about maternal and infant mortality,
what it was like 200 years ago, it was insane.
But once we had procedures, antibiotics,
blood, you know, all sorts of things
to help reduce that to near zero,
those things were instituted only at the moment of crisis
or, you know, shortly before.
The same is true with trauma, right?
Like, you know, yes, is what we can do
for people who are stabbed, shot, and car accidents
is remarkable, but there's not a lot we're doing ahead of time.
And unfortunately, the nature of those other diseases
you mentioned, cardiovascular disease, type 2 diabetes,
Alzheimer's disease, you run the list.
Basically, those that account for 80% or 90% of deaths today,
those diseases take decades.
They move at such a glacial pace
that even when a person dies suddenly of a heart attack,
which we hear that story all the time,
this guy was completely fine and at 65, he just dropped dead.
Yes, but I can promise you,
if you looked at his coronary arteries for the last 30 years,
this was happening.
So the playbook doesn't make sense.
If you just come in when a car is one meter
from the edge of a cliff that it's been driving towards
for an hour, it's very difficult to stop the car.
Of all of the catalysts of these long deaths, right,
the heart attack that appears to be sudden
but isn't actually sudden,
you identify what you call the four major horsemen.
Heart disease, metabolic health or diabetes,
cancer, and neurodegenerative diseases like Alzheimer's.
And you say in your book that in order to solve for these diseases,
medicine itself is in need of a total revamp.
And you call that medicine 3.0.
What does medicine 3.0 look like?

Give me the big picture of how it works,
especially as compared to what you've just called medicine 2.0.
So in medicine 2.0, we treat things
when it's really obvious that there's a problem.
That's often referred to, for example,
in cardiovascular disease as secondary prevention.
There's no ambiguity about whether or not
you should take a person who's already had a heart attack or a stroke
and get very aggressive about managing their lipids
and their blood pressure, for example.
The question is, what should you do about primary management?
How do you prevent these things in conditions
in people who have not already exhibited heart attack stroke
or what we call major adverse cardiac event?
And in medicine 2.0, we rely on short-term risk models.
And I say short-term because they sound long-term,
but in the span of your life, they're not.
So a five-year or a 10-year risk model might say,
well, Barry, you're 35 years old now,
and what is your risk of a major adverse cardiac event in the next decade?
And I'll tell you that if we actually plug that in,
the model will not spit out an answer.
The model is incapable of generating an answer
if the person is younger than 40.
So the model would say, well, no matter how bad your lipids or blood pressure are,
we can't really offer any input on how to prevent.
Because your 10-year risk is so low.
Now, again, if you think about that through the lens of trying to really live long,
or at least live longer than you would otherwise live,
you can't afford to take such a short viewpoint.
You have to look at lifetime risk.
This is an enormous limitation.
So the diseases that you refer to as the four horsemen, cancer, heart disease,
diseases like Alzheimer's, these are frankly diseases we think of as people
that people that are older tend to get.
What can we be doing to vastly decrease our chances of getting these diseases later in life?
So each of these diseases, I think, has to be thought of in two ways.
One way that I think about them is, what is common to all of those diseases?
So what are the things that we want to do that are going to risk reduce across the board?
And then what might be unique to each of those diseases?
So broadly speaking, I kind of think of three horsemen
sitting on the foundation of the fourth horseman.
So the foundational horseman is indeed the metabolic diseases.

So when we talk about everything that ranges from something called hyperinsulinemia, high levels of insulin, insulin resistance, non-alcoholic fatty liver disease, type 2 diabetes, that's just a continuum, a spectrum of metabolic disease.

And truthfully, the death certificate toll that they take directly is quite low.

In other words, if you pulled all the death certificates in the country and said, how many times do those things appear on it?

The answer is actually quite low.

Conversely, the impact that they have on the other three horsemen is enormous.

And while the other three horsemen are doing the lion's share of killing, they're the ones that are actually showing up on death certificates, right?

Heart attack, stroke, cancer, Alzheimer's disease,

the fuel that's being poured on the fire of those things is the metabolic precondition.

So step one is the more healthy you can be from a metabolic perspective, right?

So the lower your insulin, your glucose, your inflammation, all of these things, across the board, that's a significant reduction in risk.

So one way to just look at that at an extreme is if you have type 2 diabetes, which is the furthest example of that metabolic dysfunction, your risk of every one of those other diseases is about 2x.

Your risk of all-cause mortality, death from any and all causes, is about 40% higher than someone without type 2 diabetes.

In any given year, you have a 40% higher chance of dying than someone without.

So that has to be step one.

Well, in the book, you basically say there are four categories of changes you can make.

And none of them are revolutionary.

It's just that they're harsh.

What you eat, how much you sleep, how much you exercise, and medications.

So I want to kind of take each of those in turn, starting with what we eat.

What the internet tells me about you, Peter, we've gotten to know each other only kind of recently, is that you used to be a major nutrition buff.

Like you were the intermittent fasting guy on the internet, which for those who haven't heard of intermittent fasting, is basically giving yourself an eating window.

Call it from like 2 p.m. to 6 p.m. every day.

You eat all of your calories during that four-hour timeframe.

And I will say that my sister and her husband, who's a firefighter, are major intermittent fasters, and they look incredible.

So they've sort of made me true believers in it, even though I don't have the discipline to do it myself.

Anyway, in the last few years, you realized that intermittent fasting wasn't cutting it.

No pun intended.

You had dreamt a bunch of weight, it sounds like, but your muscle mass and your health weren't optimal.

And overall, it seems to me that you've come to the conclusion

that nutrition is a little bit overstated when it comes to overall health.
When other people are like really, really focused on that, you're saying, maybe we're overstating the case for what we eat a little much.
So give it to us straight.
How much just what we eat matter or not matter for health and longevity?
So I'd preface all of this again by saying, nutrition is one of the hardest and messiest of all those things that we just mentioned.
You know those four pillars you just talked about?
This is the hardest one to study.
It has the noisiest data, and it has the lowest signal-to-noise ratio.
So with all of that said, it's easiest, I think, to start with what is abundantly clear, and that's a relatively short list.
There was a glib version of my book when the nutrition section, instead of being two very long chapters, was going to be one page that said the following.
Don't eat too much. Don't eat too little.
Don't succumb to food-borne illnesses like E. coli.
Get the right amount of micronutrients in your food.
That's pretty much the only thing that we can take to the bank as guaranteed true.
Okay, so here are the things that I'm surprised aren't on that list.
Don't eat processed food.
Sure. So I think the problem with processed food and sugar, which I'm not advocating we eat, and I certainly do my best to avoid them, especially processed food, I avoid as much as possible, and I definitely try to minimize sugar.
The reason I'm trying to avoid those is indirectly in service of one of the other rules, which is don't eat too much.
Because the problem is when you eat processed food and sugar, they are so void in nutrition that almost any normal person will end up overindulging.
So here's where the data, and I didn't always believe what I'm about to say.
So I was firmly in the opposite camp of what I'm about to say now, but it's very difficult for me to deny the overwhelming body of literature on the following statement.
Energy balance is solely determined by input less output.
In other words, all calories are created equal when it comes to energy balance.
The implication of this is a person who's eating 1500 calories a day of Twinkie bars when compared to an equal person, eating 2500 calories a day of healthy food is actually going to be losing more weight.
The Twinkie person.
That's right, because they're eating far fewer calories.
Now, two points to make.
One is, are they healthier? Not necessarily.
In fact, they're almost assuredly not.
Secondly, will they feel satiated? Almost assuredly not.
So this becomes a bit of a thought experiment more than a real life example.

In other words, people who are eating processed food and eating junk food and eating lots of sugar end up overeating dramatically.

So you're right to say those things should be on the list, but what I'm kind of arguing in my cheeky way is they're not necessary to put on the list, because principle one is you need to maintain energy balance.

One other question I really have wanted to ask you about food and nutrition and the question of obesity, I'm sure you saw the 60 minutes a few weeks back where a Harvard doctor named Fatima Cody-Stanford went on and basically said something that has, to my mind, shockingly become a consensus at least in some quarters, which is that obesity is not about what you eat.

Obesity is a genetic disease.

It's a brain disease.

And she testified, she talked about how she had patients who were eating vegetables and whole grains and not overeating and still weren't losing weight.

Is obesity about what we eat, about our energy intake, or is it somehow a kind of genetic or brain disease?

Well, you know, I'm not an obesity researcher, though I know many of them, and this is certainly a topic that I've discussed with a number of people.

So I worry that the message that was put forth on that 60 minutes is a bit misleading.

So I don't know that physician personally, and therefore I'd hesitate to try to...

I'm not asking you to shadowbox with her.

I'm asking you to contend with the idea.

Yeah, so I would disagree with that, right?

I would say that clearly genetics plays a role in obesity, but there clearly has not been enough genetic drift in the last 50 years to explain how obesity rates have gone from 15% of the population to nearly 40% of the population.

In other words, there must be something environmentally that is driving obesity that is not genetic.

And I think that the answer to that is multi-pronged, right?

The New York Times ran a piece, God, probably about four or five months ago, where they had every obesity expert in the country in Europe for a sort of symposium.

And the way the Times wrote it is there was zero consensus on what was driving obesity.

And of course, I think part of the reason was every person is an inch wide and a mile deep in their area of expertise, and their area of expertise is didn't overlap.

So one person thinks it's carbohydrates, another person thinks it's hyperpalatability, another person thinks it's food availability, another person thinks it's protein deficiency.

And the reality is it's probably all of the above.
There are probably a little bit of all of these things, right?
Food availability, the default food environment,
the hyperpalatability of food, food availability,
all of these things are conspiring against us.
And therefore, I think it's an external thing.
Now, do certain foods hijack your brain and make you eat more?
Yeah, I think that is pretty clear.
I mean, I think we see those data that certain foods will drive you to overeat.
But again, I don't see that as a genetic problem.
Before we move on to the other changes we can make,
having to do with stress, emotional health, exercise,
I have to ask you about Osempic, because it's all anyone in LA is talking about.
Is Osempic, which is the brand name for semi-glutide,
a drug to treat obesity that has skyrocketed in popularity in the last few years,
is that a long-term approach to weight loss?
Is it the miracle drug that a lot of people believe that it is?
Or is it a quick fix that isn't really going to do much ultimately
to help people keep the weight off and address the root causes of obesity?
Well, it's clearly not addressing the root causes of obesity.
So we can definitely put that to the side.
Does it work?
Yes, it works.
Does it work in most patients?
Yes, it does.
How durable is it to be determined?
Meaning, how long does the effect last?
It clearly doesn't last in most people when you come off the drug.
So the data are pretty clear on this.
We now have published data from either JAMA or the New England Journal of Medicine
that show once a person comes off the drug,
they very quickly regain about two-thirds of the weight they lost.
And only people who lost prodigious amounts of weight
will still remain in some deficit to their starting point.
Many people will get right back to it.
So it's basically the more you lose, the more headroom you have to regain.
So if you acknowledge that, I think what you have to say is,
am I willing to go on this drug for life?
And the other question you have to ask is, what's my alternative?
So do we have patients in our practice that are on semi-glutide or trezepotide?
Trezepotide is a newer version,
by the way, that's a different class of drug that is actually more effective.
I'm actually surprised more people aren't talking about trezepotide over semi-glutide.

But regardless, we have patients in our practice on both of these drugs.
But I'll tell you what I tell them, Barry, which is,
one, I don't recommend this as the drug you take
if you're trying to get the beach body in eight weeks.
Like, let's come up with another strategy,
because I think that's a crap reason to use it.
Two, I say, have we really exhausted all alternatives?
What are the metabolic consequences of you not losing this weight?
In other words, I'm not a big fan of using it for vanity.
And I'm not suggesting I'm not a vain person.
I'm as vain as the next person.
But when I tell you in a moment what my concerns are with this drug,
it doesn't make sense for me to put somebody on this drug,
unless I'm also fixing their health.
And I think that for some people,
this drug absolutely does fix their health.
Remember, this is a drug that cut its teeth in type 2 diabetes.
So it's lowering blood sugar, it's improving insulin sensitivity,
and it's dropping weight.
People don't care about the first two, but they care about the third.
And that's why the drug left.
Remember, ozempic is the diabetes drug.
Wagovie is just the rebranded version of it for obesity.
So if I can improve your health,
if I can take somebody who has very high glucose,
they're very insulin resistant,
we aren't getting as much juice for the squeeze
as we want out of other things for whatever reason that I'm all for it.
Well, it's a perfect transition to talk about exercise.
Well, can I just say one other thing, Barry,
which is the concern I have with it?
That it's like making all of us like grow a third group or whatever
and cancer over time.
I mean, to me, it's like it's so good
that how could it possibly not have some dark shadow?
Yeah.
So I think there's one unambiguous dark shadow
that nobody really understands the clinical significance of,
but we see people's heart rate is going up about 10 beats per minute on it.
So I'm not aware of a physiologic condition
that raises your resting heart rate by 10 beats per minute
that's good for you, yet that's what this drug does.
And when they go off of it, does it change back?

Yes.

When they come off the drug, usually within,
depending on how long they were on the drug,
I've seen it take three months to return to normal.

I've seen it come back within a few weeks.

Depends how long they were on it.

I think that to me is the greatest concern of the drug,
notwithstanding the obvious stuff,
which is at the societal level, right?

Like, is this something we're going to ask insurance companies to pay for?

And if so, how will we, I mean,

we're just talking about health care costs.

We're already at bankrupt levels of health care costs
in terms of per capita spending.

If you want to add a drug that costs \$8,000 a year,
you're going to increase per capita spending by 20 to 25%,
given that half the country needs it.

So there's just no economically feasible way to do that.

There is some concern, by the way, about thyroid cancer,
medullary thyroid cancer.

I think it's a little too soon to see those data,
but fortunately or unfortunately,
with the ubiquity of these drugs,
we'll probably get an answer there.

I've taken Osempic.

I was introduced to it by, I mean, I was at a lunch.

There was a woman.

She was very chic.

She was saying to me,

you need to have your podcast on YouTube.

And I said something self-deprecating, like,
okay, I want to, but I want to lose 20 pounds.

First, I gained all this weight in COVID.

I've been a yo-yo dieter my whole life.

And she locked eyes with me, Peter.

And she goes, let me show you my secret.

And she pulls out a little needle.

This woman showed me her before and after picture.

And I was like, this works, clearly.

It absolutely does.

And lo and behold, I'm not hungry for like a week.

Like I'm talking, I can have a glass of water and I feel full.

But I have a spidey sense that anything this effective

can't be good for me.

And now I'm sitting here listening to you tell me that my heart rate is maybe beating out of control, although I don't feel it beating out of control.

So what would you recommend that I do?

Well, I'd love to offer you medical advice, but I can't do it without knowing a little bit more.

And you probably wouldn't want me to do it on a podcast.

So let's just pause it, for example, that I'm going to give you kind of general advice, which is another huge problem with ozempic, and terzepatide for that matter, is it seems to not just reduce your total intake, but obviously reduce the intake of the most important macronutrient, which is protein.

So when you say, Peter, I would like to lose weight, that's shorthand for I would like to lose fat, right?

You're not saying I want to lose muscle mass, right?

You're saying I want to lose fat mass.

And what we really want to do when we lose weight is maintain lean mass while losing fat mass.

And an ideal way to do that is to calorie restrict, which ozempic is clearly helping you do, right?

If water is satiating, you're probably eating half the calories you were eating pre going on this medication.

But the problem is I would bet and I would worry, Barry, that you are losing just as much muscle as you are fat.

So while the numbers on the scale are going down, your health isn't going up.

And so one of the things we tell our patients who go on ozempic or terzepatide is you're going to have to really focus on your protein intake.

In other words, we're going to still keep you on anywhere from 0.8 to one gram of protein per pound of body weight.

And that becomes actually quite challenging, because you're almost like force feeding yourself protein in the context of an otherwise significant caloric restriction.

We also say you've got to be strength training and exercising while you're on this drug.

So you can, I think, mitigate this.

And again, I don't want to suggest that there's something wrong with this drug.

Like, Peter's figured out something that the FDA hasn't, but I share your spidey sense.

And I just don't know if this is a great long term solution.
And I certainly worry that in 10 years,
we're going to look back and say, oh my god,
remember when people were putting ozempic in the drinking water?
How crazy was that?

OK.

Well, speaking of exercise, let's talk about the next pillar
of health that doesn't require any medication that
is fully within our control, which is exercise.

Exercise, exercise, exercise.

This was one of the biggest takeaways I got from your book.

You believe that exercise plays an enormous factor
in determining not only the length of our lives,
but the quality of our lives.

Why is exercise so important?

What does it provide that nutrition doesn't?

Because to be honest with you, the kind of conventional wisdom,
or at least the conventional wisdom of this moment,
is that exercise matters.

Food matters a lot more.

A little bit what I took from your book
is food matters, but exercise matters a lot more than we realize.
Yeah.

There's no question that that's true.

And the good news is you don't have to take my word for it.

So this is not a Peter's opinion.

There are lots of Peter opinions out there,
and I try to always caveat them as such.

But there's no ambiguity here, Barry.

And the reason is we have really good integrators
for these behaviors.

So think of an integrator as something
that aggregates the total area under the curve of work
that you're going to do, or damage of a system,
and tell you an output.

So I'll give you an example.

Hemoglobin A1C, which is average measure of blood glucose,
is used to diagnose type 2 diabetes.

That's an integrator of total glucose
floating around your plasma for the last three months.

So we have three really good integrators of exercise.

How much muscle mass you have, how strong you are,
and how high your VO2 max is.

So I think you understand what muscle mass and strength are, but I'll spend 30 seconds on VO2 max.

That's a test that's done.

It's a cardiorespiratory test where you have a mask on, and you're either on a treadmill or a bike, and you're being pushed to your absolute limit of running or cycling until you reach the maximum point of oxygen utilization.

That number is called your VO2 max.

That number is more predictive of the length of your life than any number or metric about you that we know.

That includes whether or not you're a smoker, whether or not you have type 2 diabetes, whether you're on dialysis, pick the most grave medical condition.

It is not as predictive of your lifespan as your VO2 max.

So the fact that VO2 max, muscle mass, and strength are the three biggest predictors of lifespan tells us that exercise matters more than anything else, because the only way you get high values of those things is by exercising.

Just now, and also in the book, there's a lot of jargon that I didn't even know VO2 max, zone 2, aerobic breaks.

Peter, for those people, I'll include myself in this.

I love being outdoors, but I'm not very athletic.

What are the three things everyone can start doing today, regardless of how athletic they think they are?

So again, if you're starting from zero, let's just assume that for a moment, right?

Like you're a person who's just never enjoyed exercise, but you're hearing us talk today, and you come away realizing, oh my god, like I'm leaving the biggest opportunity on the table, literally a decade of my life, and more importantly, the much better quality of life at the end.

Okay, going from no exercise to three hours a week cuts your risk of death down by 50% in every given year.

That's it, right?

You'll never get a bigger jump than going from zero to about three hours a week.

So how would you fill that time?

So I would say if a person said, I'm only willing to do three hours a week, I'd say, okay, I'll take it for now.

Maybe we'll come back and revisit this in a year.
But if you spent 90 minutes of that
doing some form of low intensity cardio exercise,
low intensity is what I call zone two,
but don't get hung up on the name, what does it mean?
It's a level that is strenuous enough
that you can barely carry out a conversation.
So you can talk, you just don't want to, that's zone two.
So think about that for a moment.
If you're sitting on your Peloton and Nelly walks in
and talks to you, if you can talk to her,
but you don't really feel like it, that's zone two.
If you can't talk to her, you're in zone three.
If you can talk easily, you're in zone one.
That's not enough.
So you want to be in that zone two.
So if you did three 30 minute of those a week,
and then once a week, do a separate cardio session
where you're doing more intervals,
you're pushing yourself much harder for say three minutes,
and then you're recovering for three minutes.
You do a few sets of those once a week.
The other hour a week, if you could divide that
into two sessions where you carry heavy things.
So we might call that lifting weights, quote unquote.
But to sort of demystify it,
I would just start by having people carry things.
So pick up kettlebells and walk around with them.
Do some body weight exercises.
See how long you can do a wall sit, those sorts of things.
If you can get to a gym where they have various machines
that don't look particularly intimidating,
but at least guide your range of motion accurately,
just start working on those things.
Just doing those three hours a week,
enormous improvement in the quality of your life.
During COVID, when there was nothing in the world to do
other than cook and walk and drink,
I started getting obsessed with the amount of steps
that I wanted to hit every day.
Is there anything to that?
No, it's a pretty crap integrator.
So I come back to this concept of integrator.

So where does this idea of taking 10,000 steps a day matter?
Well, again, when compared to not taking 10,000 steps a day,
it's great, right?
It's a good integrator for somebody who's outside
and who's active.
So the truth of it is, it matters more
to somebody who does nothing.
So if you took a person who's sitting at a desk all day
and not exercising, if you say to that person,
I really want you to get 10,000 steps a day,
then yeah, I would say it's actually
moving the lever a little bit.
For most people, those steps are at too low an intensity
to produce a training effect,
and you do need a bit of that training effect.
But if you take our person who's a hypothetical person,
who's maybe not exercising at all,
and they're now willing to commit
to this three hours a week of that training we discussed,
I would rather you put that time into something
that's more structured and a little higher intensity,
and we'll get more bang for a buck.
Because 10,000 steps is a time commitment also,
unless you have a standing desk with a treadmill.
Okay, so we've covered food, we've covered exercise.
I know I need to be doing these three hours a week.
I am going to start swimming again, which I really missed.
Now they're sleeping stress.
And that's where I really get worried,
because I don't sleep a lot these days.
As you know, I'm running a company.
We have a seven month old, and my stress levels are pretty high.
How did these two factors, sleep and stress,
affect how long I'm going to live?
Well, I mean, you know, again,
we have to differentiate chronic from transient.
And I think that new parents are always going to talk about,
you know, exactly what you're talking about.
And I think it can be actually harmful
to tell someone in your situation, like, oh my God,
like taking care of your seven month old is going to kill you.
And, you know, we evolved pretty well
to cope with sleep disruptions.

So what could you do to accommodate for it?
Well, if you know that,
does your daughter sleep through the night yet?
She does. She's great.
Honestly, like, it's partially that once she's asleep,
that's when after Natalie and I have dinner,
I get a lot of work done.
And then I also just like want to have fun.
It's our alone time together.
And the whole sleep in the baby sleeping thing,
if you really can do that, I think that works.
It's hard when you don't.
So how many hours of sleep are you getting?
I don't, maybe six.
Okay. And you're in bed for how many of those hours?
You're in bed for six and a half to seven,
sleeping six, basically?
I don't know. I mean, I should be like one of those bros
that gets the ring that like monitors all my sleep.
What I'll tell you is I don't think I've slept
through a whole night in several years.
Like I will wake up at least twice in the middle of the night
and I will do every bad habit imaginable,
like looking at my phone.
Okay. So look, I would say there's no question
that this pattern of behavior is going to
cause some long-term consequence.
And by the way, let's bring it back to something
you care about in the short run,
which is if managing weight is an issue,
short sleep is a really unfortunate way
to amplify body weight.
So in other words, when you reduce sleep,
you increase insulin resistance.
When you increase insulin resistance,
you're more likely to overeat.
You're more likely to gain weight.
So a very important part of weight loss
is actually getting the appropriate amount of sleep,
which is seven to nine hours
for virtually every person out there.
So if you want short-term motivation,
that's short-term motivation.

Long-term motivation is your risk of all those horsemen goes way down when you're sleeping correctly than when you're not.

So let's talk about strategies.

So the first is really the sleep hygiene strategy.

So I don't have a phone in my room when I sleep.

It's just a non-negotiable.

So I would just say, unless you're on call

where someone's life is on the line,

if you miss the phone call,

I would not have the phone in the room.

The second thing is, is your room really dark and really cold?

No. I mean, when you're saying cold, how cold?
65.

Wow.

Yeah.

Peter, that's pricey.

I use a cooling mattress, though.

I have a little cover on the mattress that keeps it really cold.

And it's one of those things where everybody says, oh, it seems a little excessive.

And then they try it and they're like, holy cow, that's amazing.

Okay. So at least seven to nine hours a night, sleep in a cold room, sleep in a dark room.

And then hygiene.

I mean, don't look at social media before you go to bed.

Don't look at email before you go to bed.

I have this other weird hack, which is I have two phones.

So I have my work phone that has all the garbage on it that I hate.

And then I have a personal phone called my bat phone that has nothing on it.

It's literally just a phone and a camera.

That's it.

And that's the phone that's with me, because that's also the one that's got the TV remote on it.

That's the one that I have podcasts on.

So once I'm done working,

let's say I'm not going to work after 8 p.m.

And I go to bed at say 10.

That's the only phone that's with me.

So I can't see an email or a text or get a phone call
for those two hours before bed.
There's no social media on that phone.
So even if I'm tempted, I can't look at social media.
And then I just go to bed.
You know, of all of these tactics,
I know this is a hard question,
but like if you had to make the case for which one is the most important,
which one would it be?
Like if someone's listening and they're like,
shit, Peter does all these healthy things,
I do none of them.
Where should I start?
Should it be sleep?
Should it be exercise?
Should it be nutrition?
Should it be de-stressing?
Where should I begin?
It's probably the one for which you have the greatest deficit
would be my guess.
At least that's how we do it with our patients, Barry.
I mean, there was a day when a patient walked in the door.
I wanted to do everything on day one.
It's like, oh, we got to get you working out more,
eating better, sleeping more, doing this, doing that, doing that.
We're going to make you a perfect little humanoid.
And I realized that just doesn't work for real people.
And if you're trying to make changes that are sustainable,
you're less interested with how dramatic a change is.
And frankly, smaller changes make more sense.
And so now it's a combination of what I might see as the biggest opportunity,
coupled with some sense of where they might have the greatest chance of success.
Because I do think success breeds success here.
So for example, in your case, if you're telling me,
Peter, I'm not exercising that much.
And if I go off of Zempik, I'm tempted to go back to McDonald's
and I'm sleeping like crap.
I sound like a disaster.
Yes, go on.
No, no, I'm saying hypothetically, right?
Just hypothetically.
But I would say, OK, let's just pick one.
Hypothetically, if I'm addicted to hash brands for McDonald's.

Yes, go on.

By the way, they are the greatest things in the world, aren't they?

Wait, is that actually your favorite fact?

To me, there's something about that product that is worthy of some kind of fast food prize that doesn't exist, except for in my head.

It's an incredible product.

Yeah, if there was the Fields Medal or Nobel Prize of fast food, you've got to have the McDonald's hash brown on that list.

And they're French fries for that matter.

Like, their French fries are simply amazing.

I took my kid to McDonald's about three months ago on a daddy, Reese's date night, and I hadn't been there in years.

And I'm not saying that like, oh, look at me.

Because I eat plenty of junk food,

but I hadn't been to a McDonald's in about five years.

And I was like, buddy, we are going to McDonald's tonight, and we are ripping that place up.

And he was like, daddy, I've never seen you eat so many French fries.

And I was like, oh, yeah, this is good.

I might not be back here for another three years.

We're doing it.

But going back to your question, Barry,

I would say of those three, let's pick the one

that you think you have the highest chance of succeeding in.

And let's make that the only change we make for a couple of months.

And I want you to get that win under your belt, right?

Because one, you're going to improve your health, right?

You will.

We just pick any one of those things you're going to get better.

And then you're going to get this sense of ownership and agency.

And like, hey, I can do this.

And then we go to the next one.

So aside from making these daily changes to food, to sleep, to our exercise habits, when it comes to chronic illnesses, including cancer, you talk about getting screened at much younger ages than I've heard of, like 30-year-olds getting colonoscopies.

Tell me what types of screenings and blood tests are essential?

And if we were to sort of enter this ideal world of medicine 3.0, would be considered normal?

It's very hard to say.

And again, when we're talking about this through the lens of society versus the individual, there's a huge divide there, right?

So if you talk to our mutual friend, Vinay, you know.
You mean Vinay Prasad, the doctor, the hematologist, oncologist who contributes to the free press.
Yeah.
He would argue the exact opposite side of this to me, right?
So Vinay would argue we're screening way too much.
It's not cost-effective, et cetera, et cetera.
And perhaps at the population level, you could maybe make that argument.
But at the individual level, that's the only place I care about.
And at the individual level, there is also no ambiguity that the earlier you catch a cancer, the greater your odds of beating it.
And there are a handful of cancers for which we are well equipped to detect them early, colon cancer being one of them.
Colon cancer is the third leading cause of cancer death for both men and women.
So I view it as kind of an inexcusable, unforced error when a person detects a colon cancer very late in the game.
It means they weren't screened adequately.
So answer one is colonoscopy is an essential part of the cancer screening toolkit.
When you go through the other cancers, you have to basically ask the question, well, what are the other big killers?
So you're going to look at breast cancer for women, prostate cancer for men, lung cancer for both, colon cancer for both, pancreatic cancer for both.
And then it kind of falls off from there.
But those five do the lion's share of the killing.
And for breast, as you probably are aware, there's great controversy about how to screen for breast cancer.
It varies over the course of a woman's life.
Her breast tissue changes dramatically over the course of her life.
But what I can tell you is that single modality screening is not effective by itself, just a mammogram.
And the reason is no single cancer screening outside of the colonoscopy in terms of in the body screen.
So colonoscopy is an out of the body screen, if that makes sense, because your colon is outside your body, you can look directly at it.
Same with the cervix, you can look directly at it.
But when it comes to your breast, for example, which is inside your body, all the tests have a limitation.
All of these tests are flawed by themselves, and you have to stack them on top of each other.
So to me, a mammogram should only be done when it's being done in concert, either directly or at a later date with an ultrasound or an MRI, because they complement each other's strengths and weaknesses.
For example, MRI, very good in glandular tissue without calcification.

Mammography, very good in low glandular tissue, for example, in women postmenopausal, and very good at picking up small calcifications, which can be indicative of cancers. But each of them has blind spots. So you want tests that complement each other blind spots. I think in the future, we're going to see much more use of something I write about called liquid biopsies. So these are blood tests that look for circulating, cell-free DNA. And they basically can detect the DNA from cancer cells that have left their primary source. So if a breast cancer cell leaves the breast, you'll get some of its DNA broken down. Again, this is in incredibly small quantities. So these tests really have to be doing herculean things to even detect these trace-trace-trace amounts of DNA. And then they can say, yes, cancer is present, and by the way, we think it's coming from this tissue. But we're still in the infancy of that technology, but that's probably one of the most exciting things we see on the horizon for cancer screening. Peter, people like me and you are... I don't even want to use the word privileged, although we are that. But we're just the luckiest of the luckiest people, right? We have insurance that allow us to get the best health care. You are at the cutting edge of the best health care. You know, I can get a trainer if I was really disciplined. I could probably even find a dietitian. I can get childcare to ease my stress. And I look at what many people in this country are experiencing, and there's an element a little bit to this topic that feels like it has the potential to be a little out of touch with the way that many people are living, right? Almost 10% of Americans do not have health insurance. Almost half of Americans are struggling to pay for the insurance that they do have. So I wouldn't blame someone who's listening to parts of this conversation and is rolling their eyes saying, this is just out of reach for me. Is preventative medicine reserved for those like you and me that have the ability to invest in our longevity? Or is there a way that you imagine it

that it becomes accessible to everyone who wants it?
Well, I think there's sort of several parts to that, Barry.
There's no question that if we wanted to make preventive medicine more full-scale available,
it requires systemic change of our health care system.
So you already alluded to the fact that we have an enormous population of uninsured and underinsured people in this population.
We also know that health care costs are the leading cause of personal bankruptcy in the United States.
So even people who are insured can still end up going broke due to medical problems.
So the question is, what's the alternative, right?
And if you're putting on your policy hat,
the alternative is a system of medical coverage that leaves no one behind, right?
So you have universal coverage,
but universal coverage that focuses on prevention.
So here's the problem.
If you just say, we're going to have universal coverage,
all you're going to do is raise the price of health care as you treat more chronic diseases at the end of the line.
So it's got to be universal medicine 3.0,
not universal medicine 2.0.
We can talk about what actually has to happen to make those things happen.
And that's something that I enjoyed talking about,
but maybe that's not for today.
Because I think the more important question is,
shy of waiting around for that to happen, what can you do?
And I think, frankly, it comes down to all the things we've talked about, Barry, and we acknowledge that some of those things are harder to do if you're a single parent working two jobs and you don't have the disposable income.
Now, the good news is I do think that a lot of those things don't require an enormous amount of disposable income, but what they do require in some cases is a bit of disposable time.
Getting an extra hour of sleep is going to come at the expense of doing something.
And it might not be just an hour of social media where you can easily say, well, clearly,

there might be one that you prefer to do,
but there's no doubt about which of those is better for you.
But that might not be the case if you're a shift worker.
You might be sort of like, I'm in the warehouse
because I don't have a choice to be in the warehouse.
Exercise, of course, is very time consuming.
Even that three hours of additional exercise
I'm asking for from somebody might come at the expense of work.
So I guess the question becomes, what is the alternative?
I don't have an answer to that other than
when you're at the end of your life,
are you going to look back and say,
I wish I did a little bit more when I could have
to improve that quality at the end of my life
from a physical standpoint.
And I do believe that for most people,
maybe not everybody, but for most people,
small changes made that are maintained
can compound over time, irrespective of access to care.
Now, where I think it gets problematic is
some of these things also require medical management.
We didn't talk about that stuff, right?
We didn't talk about how you manage lipids and blood pressure
when the lifestyle stuff doesn't fix it.
And therein lies a big problem, right?
Is that some people don't have access to doctors
who even understand kind of the nuances of that thing
if they have access at all.
And unfortunately, that's the kind of thing
that you can't take into your own hands, you know,
unless you're, you know, someone like you
who has a friend who's just handing you illicit, those empaths.
After the break, why Peter Atia, at the peak of his career,
at the peak of his physical health,
not addicted to alcohol or drugs,
found himself in rehab in Kentucky?
Stay with us.
All right, Peter, let's talk a little bit about emotional health.
The last chapter of your book is devoted to the subject
of what you call emotional health.
And even though it's the shortest section of the book,
it was my favorite because essentially it said this,
for all of these years, I, Peter Atia,

was taking a kind of Silicon Valley approach to longevity.
You were like this perfect humanoid trying to live until 120.
And this was like an engineering problem
that with enough like fine-tuning and science,
you would be able to solve.
But it took many years and two inpatient stays
that you write about.
And frankly, a lot of personal pain for you to realize
what good is it to live longer if you're really unhappy.
Talk to me about coming to that realization.
Yeah, it was a remarkable discordance
between internal and external,
between how I appeared and how I functioned at a superficial level
and how I felt and how I functioned internally
or with those closest to me.
And unfortunately, I was not able to fix this problem
before it got so bad that it began to really hurt people around me,
most notably my family.
And in 2017, I was really not left with much of a choice anymore.
It was, in fact, they had no choice but to go and get treatment.
And when you say treatment, most people hear that
and they think is Peter a secret heroin addict
or an alcoholic, but you were neither of those things.
What do you mean when you say treatment?
Yeah, I went, I ended up going to a place that deals with trauma.
So it was a facility for understanding how trauma
leads to maladaptive behaviors.
And as you pointed out, lots of maladaptive behaviors,
when we think of that, we think of drug addictions
or gambling addictions or alcohol addictions
or sex addictions or things like that.
You know, those weren't my addictions.
My addictions were much more socially acceptable,
namely workaholism and perfectionism.
But with it, it was sort of bathed in a constant state of anger,
a simmering rage that just could not go away.
And again, I got pretty far in life.
I got to 45 because the perfectionism and workaholism
had produced good results.
And most people didn't see the simmering rage
that came along with it and the detachment
and the selfishness and the lack of connectivity
and all of the interpersonal pain

that I was basically giving to everyone in my wake.
And at that point, just my selfishness and my behavior
was escalating to a point where my wife couldn't take it anymore.
And my closest friend, who I write about in the book,
again, named Paul Conti, who's a psychiatrist,
basically said, look, I don't think you have a choice anymore.
I think you have to go and confront your past.
Well, you allude to that past in your book.
You experienced quite a bit of childhood trauma,
some of them small tea trauma as you write about it
and some big tea trauma.
Small tea is obviously little bits of trauma
that when added up can cause as much damage.
You write as a big traumatic life event.
Last year on the show, I talked to George Bonanno,
a clinical psychology professor at Columbia,
who said essentially that humans are more resilient
to trauma than we believe.
And that delayed reactions to trauma and grief
are actually rarer than we think.
Do you agree with that?
How do you think about trauma, little tea or big tea trauma?
And how does it affect human health and longevity?
So I agree that we are remarkably resilient.
I mean, not all trauma by definition
leads to exclusively bad things, right?
So in the book, I write about maybe how I distinguish
between hardship and trauma.
And I do think that trauma is generally net negative,
but adaptations that come from trauma can be beneficial.
I think that in my case, many positive attributes about me
probably stemmed from the adaptations to trauma.
What I'm really saying is at some point,
there were enough negative adaptations.
In other words, we talk about the inner child
that we all are born as these sort of,
think about your daughter, right?
Like just this perfect little child that has no baggage.
And as that inner child gets exposed to negative experiences,
including those that are traumatic, right?
Traumatic meaning it comes with a sense of helplessness.
That child turns into an adaptive child.
And that adaptive child sometimes becomes a maladaptive adult.

And I guess that's all I'm really saying.
In my case, it was pretty clear
that there was a maladaptive adult there.
And it just wasn't the guy I wanted to be anymore.
I just, you know, for whatever reason had enough and decided,
that's not who I want to be.
I'd like to keep some or all of the positive things
I gained from that experience and figure out a way
to shed the negative ones and learn from scratch
how to behave in a certain way and be a certain type of person.
To what extent was the work that you had to do
to remedy your mental health issues,
the anger, the depression,
working through the trauma you experienced?
Can you compare it to exercise?
Was it like a practice and a practice you're still working on?
You worked, as you write in the book,
with some of the best psychologist therapists in the world.
You know, what did they do for you?
Were they essentially like almost like a coach?
You know, it is a pretty good analogy
in that it is rooted in daily practice.
So it's, you know, if you go to the gym
and have the best workout of your life,
it doesn't really matter if you don't keep exercising.
I think in my case, I don't think I could have made the changes I made
and made the recovery that I made without these two stints of,
you know, inpatient care.
I mean, a total of five weeks of very difficult work, right?
So, you know, doing therapy seven days a week,
13 hours a day approximately,
the entire time I'm in these places.
And even when I got out,
it was probably five hours a week of therapy for six months
and lots of work.
And these things are important
because even though we are plastic,
when you're breaking habits that are ingrained in a very rigorous way,
you've got to put in the reps.
And I will say that, you know,
I experienced some remarkable successes
and that gave me great confidence
that I could push even harder

and really try to improve other features.
So there were just things about my personality trait
that I assumed were hardwired,
like certain asshole behaviors that I just thought,
this is encoded in my genes.
Like, can you give us an example?
Sure, I think my internal monologue was so vicious and so brutal
that I didn't have any conscious memory of speaking to myself in any other way.
So anytime I made a mistake,
the way I spoke to myself was in a very eviscerating tone,
which of course just meant I was just as hard on everybody, right?
Like, I'm as hard on myself than anybody,
but if I'm a 10 out of 10 on myself,
I'm a 7 out of 10 on everybody else,
and that 7 is still pretty harsh.
So there was just a demand of perfectionism
at every level of every human beginning with myself,
and what became clear to me through therapy is
I couldn't be better to others until I got better to myself.
So how could I learn to stop whipping myself
when that voice of whipping myself was so constant, so ubiquitous?
And as David Foster Wallace talks about
in the commencement speech at Kenyon College,
this is water, initially I didn't even notice it.
Like, I mean, it was water.
It was the water that I swam in.
So there was a very interesting exercise
I went through for six months to break those habits,
and it actually worked.
It only took about six months to get rid of a monologue
I had heard for more than 40 years.
And was it like the monologue is starting,
and was it a matter of saying to yourself,
no, I know better how to redirect this?
Is it, is it a matter of like replacing the words
with another word?
No, no, this was a direct action.
So I'll give you an example.
So the monologue would come up many times a day,
any time I did something where I needed to perform.
So if we want to get a little more technical,
a big part of my problem was something
called performance-based esteem.

So my self-esteem was exclusively rooted in performance.
So the drug that I needed, Barry, was performance.
That was my drug.
It wasn't food.
It wasn't alcohol.
It wasn't sex.
It wasn't gambling.
It was performance.
My whole life is a journey to find things to do well in.
How well can you do in school?
How well can you do in surgery?
How well can you do in swimming?
How well can you do in boxing?
How well can you do in work?
How well can you do in this?
How well can you do in driving?
But I think, Peter, most of us hear that and we think,
oh, just like type A, high-performing person.
Well, it depends on what the root of that is.
There are some people who I think are type A,
and the root of that is love of the thing that they're doing.
And I'm not saying that I didn't love the things I was doing,
but the main impetus to do these things was to get the esteem,
was to be worthy.
So every time I did something for which I wanted to be worthy,
when I flubbed it, I would scream at myself.
So the exercise was every time you do something and you flub it,
which is going to happen three times a day,
you take out your phone and you speak into the phone.
You use the little voice memo thing.
And you speak to your best friend,
pretending that they just made the mistake you made.
What would you say to them?
So for example, if I'm shooting my bow and arrow,
and I shoot horribly, instead of screaming at yourself,
taking an arrow, snapping it on your thigh,
which gives you a welt that's going to stay there for a week,
pick up your phone and pretend your friend, J.R., just shot poorly.
What would you say to him?
And of course, you wouldn't scold him.
You would talk to him kindly.
And I would then send that memo to my therapist.
So a woman named Katie, who was my therapist,

received each of these multiple memos every single day for six months.

And then lo and behold, the voice just went away.

Wow.

I don't hear it anymore.

I don't hear it anymore, Barry.

It is unbelievable.

It must have been so strange to not have that companion with you anymore.

I never thought it would be possible.

So when I set out to do this exercise,

I did it because I felt like,

where do I have a place to argue anymore?

Like I give in.

I submit to the therapy and the therapist, and I'll do whatever you tell me.

And I'm kind of broken.

But deep down, I was like,

maybe this will work by the time I'm 85.

But there's no way we are rewriting this narrative.

And there was even a name for this character.

He was my inner Bobby Knight.

You know, Bobby Knight, the famed Indiana basketball psychopath coach.

And so it was like, I'm never going to get rid of Coach Knight.

He lives in my boardroom.

He's the chairman of my board.

And as this transition happened,

we got to the point where he was no longer the chairman.

And then he was outside of the boardroom,

but still yelling through the door.

And now it's like, he's not even in the building.

No one even remembers him.

Peter, if you hadn't done these,

well, you've probably added up how many hours it is,

thousands of hours of therapy,

and these weeks long 13 hours a day days,

which really is a huge commitment.

Where do you think you would have wound up

if you didn't make these interventions?

Do you think you would have lost your marriage?

Oh, there's no question I would have lost my marriage.

I think the sadder question for me to contemplate

is if I would have lost my life.

And I think I probably would have given where I was in 2017.

And even a little bit beyond.
I think I probably would have lost my life.
There's a man that you quote often in the book, Terry Reel,
who wrote the book.
I don't want to talk about it
overcoming the secret legacy of male depression.
And this topic, I think, is really important
and really, really under discussed.
While women are twice as likely
to be diagnosed with depression as men,
male deaths represent almost 80% of suicides.
And there's this idea that we've already referenced
in this conversation, the idea of deaths of despair.
Something that disproportionately plagues Americans.
We had a writer called Jeff Bloodsworth
wrote this beautifully moving essay for us last month
in a piece called My Best Friend Died from Loneliness.
And he was reporting that white working class men
are committing suicide at alarmingly higher rates
than other demographics.
Why is this happening to men?
How do you understand what is happening right now
to men in our culture?
What do you think is going on there?
I think one of the issues is probably
that men are less likely to seek help.
I do think that's changing, by the way.
But I think historically,
men are far less likely to seek help.
And by the way, help might mean professional help,
but help might just mean talking to their friends.
I think back to my adolescence and being in college
and being in med school,
and just all the periods of my life
when I was sort of struggling,
it never occurred to me to talk to anybody about this.
And even when I was married,
I would talk about this stuff with my wife.
So she's watching this behavior.
She's watching this person spiraling out of control.
But it would just never occur to me to talk to somebody.
And I do think that that might be a fundamental difference
in socialization between men and women.

And I think that men are probably paying a greater price for that.
How do you think we should be thinking about sort of general mental health maintenance, right?
If a rule of thumb and an easy rule to follow in food is eat more protein,
and a rule of thumb is exercise more and harder,
is there a similar prescription?
I mean, I think there are some no regret moves that everybody should be thinking about.
So, you know, I kind of harken back to what Michael Easter wrote about in The Comfort Crisis, which is we spent 99.999% of our evolutionary past living outdoors.
That's just a fact, right?
I mean, we just lived outdoors for virtually all time. Our brains, our bodies are sort of wired to be in nature. So it's very difficult for me to make the case, Barry, that part of the emotional health maintenance program doesn't involve being in nature and being outside every single day and being away from the symmetry and perfect climates of indoors and being outside, being a little hot, being a little cold, sweating, looking at the fractal nature of the, you know, non-perfect geometry of the outside world.
And by the way, if you can do this without electronics, all that much better.
I try to spend at least three hours a week outside walking around with a heavy backpack on my back with no phone, no iPad, you know, no nothing, just kind of experiencing nature.
So that I would put in the category of like, everybody should be doing this no matter what.
I think another thing is relationships matter so much. Having at least one person in your life that you feel you could call no matter what, no matter when is important.
And I definitely worry about the epidemic of loneliness. I worry, and I don't remember the stats, Barry, you might know this, but there's a staggeringly high percentage of the population that can't answer the question,

yes, when asked, is there at least one person
you can call any time of day if there's a crisis
in your life, if something is really wrong.
And an upsetting number of people
can't answer yes to that question.
Now, how do you get that?
Well, I think you have to first be vulnerable, you know,
you're not going to get that on bumble necessarily, right?
Like you probably already have people in your life
that could be that person,
but maybe you're not giving to them
what you will need from them.
And I know this stuff sounds so soft and touchy-feely
and nonsensical, but the truth of it is,
you have to sort of get in the ring and do the work.
We started this conversation by me asking you
why some people live longer than others.
And I want to end it by asking,
should people want to live a long life?
What would make a long life worth it?
What makes longevity worth it?
And are we sometimes, or some people,
obsessed with longevity for the wrong reasons?
Yeah, I think I was, Barry.
I mean, I started writing this book in 2016.
So that's seven years ago.
And I sort of touch on this in the epilogue,
but when I started this book,
and you referred to this already,
it was really a book about how not to die.
And when I ended this book, it was a totally different book.
It was a book, I hope, about how to live.
And I think that it goes back to kind of one of the questions
that Esther Perel posed to me,
which I referenced twice in the book,
I believe in the first and final chapter,
which is, what is the purpose of living longer
if the quality of your life is piss poor?
And she was referring to it
in terms of the quality of your relationships,
both with others and yourself.
And I guess to your question,
should people want to live longer?

I think it depends on what they can do with that time.
But if the answer is, I want to live longer
so I can sit and suffer in misery,
then I don't think the answer is yes.
If the answer is, I want to live 10 years more
so that I can get to know my grandchildren more
and play a bigger role in their lives
and be a mentor to more people
and do more good in the world,
then I think the answer should be yes.
Peter Atia, thank you so much for coming on, honestly.
Thank you, Barry.
Thanks for listening.
If you liked this conversation, if it inspired you,
and I hope it did, to go on a run,
or if you're me, go for a fast walk,
to get a peloton, to sign up for trampoline aerobics,
to decide to eat a little healthier today, that's great.
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