Fixing Healthcare Podcast Transcript

Interview with Zeke Emanuel

Jeremy Corr: Hello, and welcome to our Fixing Healthcare podcast show Breaking Healthcare's Rules. I am one of your hosts, Jeremy Corr. I'm also the host of the popular New Books in Medicine podcast and CEO of Executive Podcast Solutions. With me is Dr. Robert Pearl. For 18 years, Robert was the CEO of The Permanente Group, the nation's largest physician group. He is currently a Forbes contributor, a professor at both the Stanford University School of Medicine and Business, and author of the bestselling books Mistreated: Why We Think We're Getting Good Health Care—and Why We're Usually Wrong and Uncaring: How the Culture of Medicine Kills Doctors and Patients. All profits go to Doctors Without Borders. If you want information on a broad range of healthcare topics, you can go to his website RobertPearlMD.com.

Our guest today is Dr. Ezekiel Emanuel. He is an oncologist, medical ethicist and a major contributor to the Affordable Care Act legislation. On a variety of healthcare issues, he has challenged the medical establishment, and in today's episode, we plan to explore many of them.

Robert Pearl: Hi, Zeke, and welcome to season seven of Fixing Healthcare.

Zeke Emanuel: It's nice to be here and I laugh at Fixing Healthcare because it seems like a Sisyphean task.

Robert Pearl: Absolutely. What is it? We push the rock up and it rolls down, or we get our livers pecked out and we end up having them regenerate. So it's a long mythology dating back, but we're continuing the process. This season, Zeke, is dedicated to breaking the rules, and if you've done anything in your career on behalf of patients and the health of our nation, it has been to challenge the norms, to challenge the beliefs, and to make the changes. The rules I'm talking about aren't the ones found in textbooks or learned in academic lecture halls, and they're not the legal or regulatory ones.

Robert Pearl: They're the ones you and I learned in medical school, in residency training by observing our senior residents and the attending physicians. Most of these rules and norms that have never been spoken and none of them are written, but they're all communicated effectively. We know they're a rule because we can observe nearly all doctors across the country following them, and even when the data says there are better ways to treat a patient or to move the policy of our country, we continue to follow the rules left over from the past. So let's start at the beginning. You seem to come from a family of rule breakers, including your two brothers, Rahm and Ari. Where does that come from and how are the three of you similar and different?

Zeke Emanuel: I thought this was about healthcare.

Robert Pearl: It will be. But I have to start with the foundation of breaking the rules.

Zeke Emanuel: First of all, I think you're right, Robbie. We are rulebreakers. My partner is always saying, "You think a rule is a good suggestion and not as a rule in the sense that most people think about it." I would say that it comes from our parents in two ways. My mother, very early on, and I mean very early on, when she was a teenager, was very dedicated to Civil Rights well before white people and white women were heavily involved in Civil Rights. And she was offended after World War II years when Blacks got housing and then when they were trying to move in, whites would prevent them, would stone them, would break up their furniture and stuff. She witnessed some of this in Chicago, and that got her heavily involved in Civil Rights. She was very much a rulebreaker in that way.

Zeke Emanuel: And then subsequently she was very much a rulebreaker in the sense of being anti-Vietnam well before everyone else in the country found out about all the mistakes, the lies and all the other things. I mean, I'm talking about the early '60s. I would also say that she has a sort of impish personality, maybe I can put it that way. She met my father. She was a radiology technician. In the current era she definitely would've been a doctor, but in that era, A, her family didn't have any money, and B, there weren't that many women going to medical school, so she became a radiology technician taking X-rays. My dad was a foreign resident at a hospital and he had brought a kid down. They were looking for intussusception in the kid and he asked her to take some X-rays, and in those days, 100, 120 hours a week work was the norm. And he laid down on a gurney in the emergency room while she was taking the X-ray. Fell asleep.

Zeke Emanuel: She took the wheel release on the cart and released it and his gurney and cart slid out the emergency room door into the very cold night air and he woke up. So that just gives you a sense for where that comes from on my maternal side. And my father is similar, or, well, I mean, he's no longer alive, but when he was he would constantly be breaking rules, constantly doing things for patients that were against the rules. I very vividly remember he was one of the first physicians, I think it was 1963 or '64 in Chicago campaigning to get rid of lead paint because of the terrible problem of lead poisoning among children, and he was incredibly outspoken about that. There's a famous case of the TV's truck coming to the house to interview him about his campaign.

Zeke Emanuel: And then in 1965, right after the election when Medicare was being debated and legislation was moving and the AMA opposed it, he quit the AMA. Now, people today listening, it's like, "What's the big deal?" In the '60s, as you well know, Robbie, it was... I mean you had to be part of the local medical community to get referrals. You had to be in good standing and being part of the local medical association and the AMA was an essential element of being in the group who got prestige and referrals and considered a good doctor. And my dad was like, "This is unethical what they're doing. Everyone should have health insurance." And he opposed them. And as I said, he quit. So this streak of the rules are mere suggestions, and when the rules are wrong, you take a stand, was very much part of my family heritage. And my mother, not infrequently,

would have to be in school because her sons were opposing rules and speaking out when everyone else was silent.

Robert Pearl: I love these stories. In addition to having a PhD in political philosophy, you're an oncologist trained in the treatment of cancer. You were the Chief of the Department of Bioethics at the NIH, and now you serve as the chair at the Department of Medical Ethics and Health Policy at the University of Pennsylvania.

Zeke Emanuel: Well, let me correct you. I resigned the chairmanship of the department at UPenn.

Robert Pearl: Okay, well, maybe your answer will be even more interesting. How do you see these careers connecting and where do they conflict?

Zeke Emanuel: Oh, boy, this is a long answer. I would report myself as a reluctant physician in the following sense. When I was in college I was a chemistry and philosophy major and my father really wanted me to be a doctor. And I like to say that being a doctor was kind of overdetermined. I'm the son of an immigrant. I'm an immigrant myself because I was born overseas. I'm the eldest boy in the family and I happened to be very good at science and a very good student. And so being a doctor was what my dad wanted and there was a ton of family pressure on me to do it. After college, I went to England for two years to see if I could, or wanted to do, basic biomedical research. I actually did some immunology research, which ironically 40 years later turns out to be relevant to COVID and the activation of the complement pathway.

Zeke Emanuel: But I decided I really didn't like being in the lab and doing the actual work. It just wasn't satisfying intellectually to me. Came back to med school because I didn't have another plan and I really was not very fond of medical school, mainly because I didn't like the hierarchy of medicine that everyone deferred to whoever was the most senior person around as opposed to, let's have a discussion about this. And I also did not like all the memorization of medicine and what really appeared to me during medical school to be a lot of irrelevancy that I couldn't imagine would be really related to treating patients and making advances like relearning the Krebs cycle, like the Startling law and things like that.

Zeke Emanuel: So between my first and second year of medical school when a lot of my peers were in labs, I went off to try to be a journalist and see what being a journalist was like in Washington D.C. I decided there were a lot of people who were better writers than I was, and more importantly, I did not want to just look and report on what was being done. I wanted to actually actively partake in shaping policy, but it did give me a taste for policy. When I returned to medical school, I was fortunate enough we had an afternoon off a week, and most people, again, worked in labs to see about where they would spend some time. There's a active encouragement of students to get PhDs.

Zeke Emanuel: Instead, I ended up teaching and being a teaching assistant at Harvard in what's called social studies, which is basically great books in political and social philosophy since Thucydides. And I realized, A, this was very satisfying, and B, I was pretty good at it. So I stopped medical school and did a PhD in political science, and I also then realized something about myself, but also in... My father really loves people. It's what drove him is interacting with people. We would go into a restaurant, we would sit down and literally within five minutes he was talking to the people at the next table. Often that led to being invited to their house or being invited to something. That's not me. Solving each individual's personal... That's just not what drives me on a day-to-day basis.

Zeke Emanuel: And I learned that what really drives me is thinking about problems where, "Okay, what's the big solution, the policy solution here where we can solve this problem that happening for thousands, or in some cases, millions of people?" That was much more motivating to me, and that's where my sort of policy bent, political science, came in. I also realized through medical school that there were a lot of bioethical issues coming up, but not a lot of people who were really trained. A lot of the people who were commenting were not trained to comment on them and were not giving very deep, thoughtful answers in that if I could bring to bear my training in philosophy and then in political science to bear, I could make a much bigger contribution there.

Zeke Emanuel: And so that's how I ended up more or less bringing together all these things. And then I went into oncology mainly because oncology brings to bear all these ethical and policy issues. Every case has a big question about informed consent. Every patient, there's something about end-of-life care, and every patient, increasingly, there's issues about cost and financial toxicity and things related to how we're going to pay for all this complex stuff, as well as social priorities about prevention of cancer versus treatment of cancer. So I thought cancer had everything going for it in terms of my interest.

Robert Pearl: It's interesting, Zeke. I, too, was a philosophy major in college. I wanted to be a university professor, and when my mentor failed to get tenure because of his political views, he went on to become the chairman at Reed, so he was quite a skilled academician, but when he didn't get the tenure, I decided to become a doctor because I was certain in medicine there were no politics. I was 20 years old, what did I know? We went the opposite direction. So now, okay, let's now dive into the medical aspect. So you worked in the Obama administration and your ideas of how to transform American healthcare broke the rules of medicine at the time. What were your contributions, and how well have they played out in your mind 15 years later?

Zeke Emanuel: Well, I would say, there are a number of areas where I think I had some contributions, but maybe most distinctively I was an internal advocate for payment reform, that we really needed to focus on how to pay doctors differently so that we could get them to behave differently and focus on improving quality, lowering costs, getting rid of unnecessary and inefficient care. And I pushed things like bundled payments, pushed things like CMMI that

dedicated to lowering costs in the system, refining the ACO, trying to get the right structure for PCORI, the Patient-Centered Outcomes Research Institute. In addition, I also was a big advocate internally of malpractice reform, which didn't go anywhere.

Zeke Emanuel: It's a complicated story, and the main reason I wanted malpractice reform is not that I think it would lower costs or there were frivolous lawsuits. I just thought and still think that it's a excuse doctors invoke to not focus on the other stuff that we're supposed to be doing. So that's not the only thing I did as part of the Affordable Care Act, but that is one of the things. Obviously expanding coverage, debating and trying to sort out the subsidies for the exchanges, how much we could afford, how much cost control we could get. All of those things were part of what I did. There are a lot of things I wish I had pushed harder on, and a lot of things I wish I had thought more deeply about.

Zeke Emanuel: I would say top of that list of things that I wish I had thought more deeply about and emphasized more is more simplicity in our system. One of the things I think that the Affordable Care Act unfortunately did is to actually make the system much more complicated, and I think that is a problem. I think it's one of the major problems of the American healthcare system. It's so damn complicated to use. It's really, really hard for people who aren't focused on health. And even if you are focused, we had to invent the whole new category of employment called Navigators because it's become so mind-numbingly complex. If we had focused on simplicity, it might have helped in many, many different ways.

Robert Pearl: We have a rule that tells physicians to save a life at any cost, but we now have the ability to prolong life to the point that treatment becomes torture. How does that rule need to evolve?

Zeke Emanuel: Well, first of all, I think what's fascinating is, if you have talked to patients, many of them do not have that view of save me at any cost. There are some, and I think if you look at most polling over time, there's probably around 20% of people fall into that category. Mostly people will say, "I want quality over quantity," but they don't really know what quality they're really looking at and where that tipping point would be, so that sort of general advice is often not helpful and therefore not heeded. I do think that medicine has moved on since the time that you and I trained in the sense that when we were training almost every patient who died in the hospital got resuscitated. DNR orders were still controversial.

Zeke Emanuel: Withdrawing treatment was still controversial. We didn't talk to patients about it, and the majority of patients were dying in the hospital. Well, I spent a lot of time in the end-of-life care field, first of all trying to understand what really motivated patients and then trying to change our norms about it. And I think in all three of those areas, the norms have changed. First we've realized that you can talk to patients about end-of-life care. Most of them want to talk about it. We just haven't figured out how to overcome that nervousness that we have as doctors, nervousness that patients have in bringing up the subject.

Zeke Emanuel: This has actually led to some of my thinking about how to change that whole issue. The second thing is, almost no patients any longer in the hospital get resuscitated. DNR orders are much more than norm. 90 plus percent of patients have DNR orders and if they die in the hospital they don't get resuscitated. That's a huge change and I think a huge change in the perception of the medical community. And the third thing is the majority of patients don't die in the hospital anymore, and we've shifted more to the outpatient setting, home, nursing home when patients are living in the nursing home, the site of death. I think that does suggest that this notion of do everything no matter what has evolved, and I think that's super important.

Robert Pearl: And yet I just read about a patient with COVID who was on a respirator for three years.

Zeke Emanuel: Yes.

Robert Pearl: And I do head and neck cancer surgery and I know patients who have their tongue removed and a variety of other procedures done so they never will speak again, eat again, be able to effectively communicate, be able to maintain their saliva in their mouth, and yet they move ahead and we don't really explain to them what their life is going to be like until it's so late that there's little that can be done. So I don't know how much progress we've actually made. Do you have a view on where we are?

Zeke Emanuel: Yeah, I do think we've made progress. Is there way more that we need to do? Absolutely. You're talking to a guy who's done some comparative research. We have more patients admitted to the ICU at the end-of-life, certainly with cancer, than other countries. We have a very high proportion who get chemotherapy. Not the highest. I think Belgium's the highest in the last 30 or 60 days of life. So we have plenty more to do. Nonetheless I do think we have had a important shift. What I would say is, and I think you are getting, Robbie, to a major point, which is, we often are hesitant about raising the topic of end-of-life care, or do you really want this treatment? And I think it's natural, right?

Zeke Emanuel: Who wants to go into those deep conversations? All of us, even inside our own family, have had difficulty raising very, very emotionally-charged issues, and I don't know that there are many more emotionally charged issues than how you want to live and die. So I think that's a natural thing. So one of the things I have been thinking a lot about is, how do we get over that hump as it were? How do we initiate those conversations? How do we try to elicit patients' views without putting a lot of pressure on doctors who are hesitant, don't feel like they have the time to do it. And I think there's a lot of ways we can try to do that. It will help if we have better predictive models and things like that.

Robert Pearl: We have a rule that says, it's wrong to pay people to donate organs such as a kidney. And yet we have tens of thousands, actually over 100,000 people who are waiting for an organ, many of whom will die unnecessarily while they're waiting for transplant. As you know, when a person donates a kidney to a

stranger, they're automatically put at the top of the transplant list should they need an organ at any time, and rarely does one kidney fail. Most of the time people lose both kidneys from diabetes or hypertension, and despite the very low risk to donors, this unwritten rule persists. Should we keep it, or does it need to evolve in light of modern medicine?

Zeke Emanuel: Which unwritten rule? Of donor-

Robert Pearl: Who want to pay. You can't pay patients for donating kidneys.

Zeke Emanuel: Well, for donating any organs. So let me say, I know that there's a lot of people who advocate that we should pay. I'm not sure the evidence supports that. We do know from certainly blood donation, it hasn't necessarily led to more blood donation. It has somewhat undermined the notion of volunteering and giving. It hasn't necessarily improved the quality of the blood supply. I am not against experiments and seeing how paying influences the donation. I am skeptical that the free marketeers who are very supportive of this, that it will actually increase the net number of organs. I think there are better ways of going about this than payment. For example, we are harvesting your organs as a default unless you tell us not to. We know, and by the way, we're not going to ask your family for permission because your view on this is much more important than your family's view. It's your body, not your family's body.

Zeke Emanuel: I think trying that first would be a very important approach, in my humble opinion. I would like to do that before paying people to donate, living organ donors. As you well know, Robbie, the donor in the case of kidneys, goes through a much more difficult time and longer recuperation than the recipient of the donation of a kidney, which is maybe contrary to most people's expectation. And I think that's a nontrivial aspect as well. So I do think harvesting more from cadavers is probably what we're really going to have to do. And in that context, flipping the default, as they say in behavioral economics to, not that we're going to ask at the moment of your death or when you get a driver's license, but the culture is going to assume you are donating unless you say 'no.' We'll give you multiple opportunities to opt out like at the driver's license and other places.

Robert Pearl: Some people, however, might point out that if you're going to go through all of that discomfort, you should be compensated as a consequence, and that by being able to get people to donate earlier in life when they're relatively healthy in a pre-planned way, the outcomes for patients could be better. So there might be a ethical balance that says that if we put all the pieces together, the scale, at least, potentially tips. You're absolutely right. We'd have to do some surveys and that sort of-

Zeke Emanuel: This is a totally utilitarian question. Does paying actually increase the supply without other negative consequences? That's the question. You and I can sit here and pontificate about it, or mostly the people at the University of Chicago Economics Department who push this hard can pontificate about it. But it's

really an empirical question. We won't know until we test it and I'm happy to test it if we rigorously study it and we don't just, again, be ideological about it. Before we do that, I would suggest we try one or two other things that are, you might say, less controversial and might also increase the supply.

Robert Pearl: Let me pose another ethical question, which is, early in this last pandemic, as vaccines were being developed, we might have been able to bring them to the marketplace two, three months earlier had we been willing to administer them to individuals and then challenge them with the virus. This is an approach that was used in other countries. It was not used in the United States. What are your views as a bioethicist on this question?

Zeke Emanuel: Well, that's another question where I think it's pretty clearly a utilitarian question, which is, is this actually going to get us to the answers we need faster? How well it protects people? How long that protection is? What the optimal sequence is? I am not 100% sure having looked at this multiple times that in fact the challenge studies, given the difficulty of raising the virus, getting the exact right dose to expose people to. It's not trivial and that that would've helped speed things along. If it wouldn't have helped speed things along, you shouldn't have done it. You should have just done a randomized control trial.

Zeke Emanuel: And early on, frankly, Robbie, getting tens or hundreds of thousands of people to take the vaccine and study them was easy. That wasn't a problem. It was our inability or our bad clinical research infrastructure in the United States that did not allow us to do these tests easy and promptly. I think that's a much bigger issue, frankly, than the ethical issue of challenge studies.

Robert Pearl: What else went wrong during the COVID period?

Zeke Emanuel: Just about everything. The CDC testing. But I think if I had to point out the biggest problem is we did not use this opportunity to make structural institutional changes that would last long after the end of COVID. Let me give you just three of them. I've already mentioned the clinical research. If you look at the clinical research that the United States produced, we did a horrible job of generating clinical research. Besides the randomized control trial of Moderna vaccine, we were not at the forefront of generating clinical research data, large scale randomized control trials that answered major questions. The British were way ahead of us, answered more questions faster than we did. We do not have a very good clinical research infrastructure for rapidly answering pragmatic questions, and we have long asked narrow questions with lots of inclusion and exclusion criteria that make it hard to enroll people.

Zeke Emanuel: We still don't today, as a consequence, know the optimal timing of doses, when the first one and the second one should happen. What about mixing and matching them? We don't really know the durability of the vaccines, not just in terms of antibody response, but also in terms of B Cell and T Cell response. We did not set up an infrastructure so that every week we could enroll people and test out different antivirals or immune modulators to see if they worked well,

and we missed that opportunity. We did not revise our clinical research infrastructure. And the best example of the crap we produced was convalescent plasma, where we had scores, if not hundreds of trials at every institution doing something slightly different so it wasn't a large randomized trial across the country with standards so we could pool all the data. We had myriad individual trials that were slightly different so you couldn't actually pool the data and it was terrible.

Zeke Emanuel: And the NIH didn't revise how it approaches institutions to participate. Second, we could have made major changes in indoor air quality, which we know is extremely relevant, not just to COVID but the flu, to other respiratory illnesses, as well as asthma. So upgrading all HVAC systems, putting in HEPA filters where you can't upgrade them. Changing the rules. Creating standards and grading systems for commercial and public buildings. We could have done that. We should have done that. We didn't do it and we had money for it, especially in the education sphere, but also the public building sphere. And I think that's, again, a hugely important missed opportunity. And third, we know that our data was terrible. Nothing reliable and timely, near real time, produced in the United States on COVID.

Zeke Emanuel: We were relying on Britain and Israel, sometimes Denmark, South Africa. As my grandmother would say, "That's a shanda." That is a terrible place for us to be. We have not fixed that. Yes, we have put an analytics branch at CDC, but the analysis is only good as the data. We haven't compelled states to report data, to report it electronically, report it in real time, compelled health systems to do the same. And it's a bad mistake. Another missed opportunity in my humble opinion, and we didn't fix the infrastructure and institutionalized reform there. Three big areas where this terrible COVID pandemic came and went and we didn't fix the systems around it. And I can go on and on and on and on. Wastewater testing is another area.

Robert Pearl: Let's go back to another ethical question. In my book, Uncaring: How the Culture of Medicine Kills Doctors & Patients, I wrote about physician-assisted suicide. This is one of the most controversial areas of medicine. What are your thoughts on whether the traditional rules and norms need to be changed?

Zeke Emanuel: Well, I've written about this. I've studied this for the last 25 years. I was, if not the very first American empirical researcher and commentator on this area, one of the first small group of people. I did a lot of surveys and interviews of patients who were terminally ill and cancer patients and oncologists about this. And my view is the same. First of all, I would bet almost everyone listening to this podcast thinks, "Well, the kinds of patients who really want euthanasia-assisted suicide, they're patients in excruciating pain," and that's wrong. That is not the patients who want suicide or euthanasia at the end of life. That is just simply empirically false. And that image was very important to lots of legal cases. I think, again, we have the wrong image in our head.

Zeke Emanuel: It turns out that the people who are interested in assisted suicide and euthanasia are interested because of psychological distress. Depression, hopelessness, fears about loss of autonomy and other things. Our usual way of treating psychological distress is not, "Here's a few pills for suicide." We usually say, "You need some help psychologically and we're going to provide that help to you." I have been against legalizing assisted suicide and euthanasia for a very long time precisely because of that. I do not think it's the answer to a question that is very relevant. First of all, it's not the answer to the question, "How do we improve our end-of-life care?" for two overwhelming reasons. The first is, not many people will use this even when legalized. Even in Oregon where it's been legalized for over 20 years, or permitted for over 20 years, less than 1% of people who die use it.

Zeke Emanuel: So just not a way of addressing a problem. You still have 99% of people who aren't interested in assisted suicide or euthanasia, who are still dying, and you need to improve their end-of-life care experience. So the idea that we'll solve the end-of-life care problem by legalizing assisted suicide and euthanasia, that's another pipe dream that has been foisted on the American public by advocates. Second, as I've mentioned, it's not addressing the problem that really drives people, which is psychological distress and control. Third, it really is a case that we do have a slippery slope that the more comfortable people are, the more we use this, even in cases where it may not be legal or it's pushing the limits. We've seen this in the Netherlands and Belgium where it's unremitting suffering.

Zeke Emanuel: Well, it's now expanded to psychological suffering becomes a legitimate reason. It's adults, and now it's become, "Well, we can do adolescents and children into the single digits." So you really do... And, by the way, the numbers that use it increase. It really is the case that there is a slippery slope, and the idea that there isn't, is people not really taking seriously the data. And finally, people think this is fast, painless and flawless way of dying. And again, the data don't show that. There are complications. There are problems. The Oregon data tries to hide those problems and they don't separate them out. But the fact is that when you look at it and when the Dutch have looked at it, that there are some serious problems.

Robert Pearl: One last question. You wrote many years ago about how you personally would see your medical care differently once you reach the age, I think it was, of 70.

Zeke Emanuel: No 75.

Robert Pearl: 75. How have your views on that subject changed since that time?

Zeke Emanuel: They really haven't changed. Human beings are on a spectrum or a bell-shaped curve or some kind of curve, where some people are cognitively intact, are physically intact well after 75. Most of us are not outliers like that. Most of us are solidly in the middle. And what you see is in the middle. The rate of Alzheimer's goes up at 75. It's like this small case of people with early Alzheimer's, and then it shoots up after 75 and really high so that by 80, 85 you

have roughly between, depending on the study, a third and half the population has dementia. Physical ailments, everyone's like, "I'm going to continue physically fine and then fall off a cliff." Turns out, that's not the way life has been going for most people. The disability, the inability to do activities of daily life has actually somewhat increased recently.

Zeke Emanuel: The other thing is, for many of us, even if we're mentally clear, we become a little mentally ossified, by which I mean, the intellectual plasticity of people, the ability to learn new things, the ability to think new thoughts rather than repeat what we've said over and over again in the past, I think... Well, not I think, we know goes down. I mean, in the brain it's a Darwinian selection for neural connections, the areas you use over and over again get stronger. The areas you don't use that much atrophy, which is why it's hard for most people to learn new languages older in life or how to play an instrument older in life. And as a consequence, you're basically doing a lot of the same old stuff. And if you look at people, there are only a few people and they are outliers, and somehow they must have some mechanism of keeping mental plasticity going. Their genetics are different than most of us.

Zeke Emanuel: They can't do new things. In addition to many things, I am a reader of history and a few semesters ago I taught a course on Ben Franklin. And Ben Franklin was one of these outliers. It's not that he was physically fit late into life. He got a little too well off and a little too much into the good food and not exercising. Young, he was incredibly physically fit. He used to be a fantastic champion swimmer, very strong. None of us think about him as a young man, but he was incredibly fit and he was an outlier. He came back to the United States after being the ambassador to France during the war at almost 80 years old. And he was still writing, still went to the Continental Congress at the age of 82, not the Continental, the Constitutional Convention at the age of 82, wrote some brilliant things, including parts of his autobiography after 80 years old.

Zeke Emanuel: He was a true outlier. Most of us aren't going to be like that. And you can see many of your peers, we slow down at 70. People retire, they end up being less creative. They're just not producing and contributing in the same way, and that's not the way I see my life. I don't want my children or other people to remember me in a particular way. I want to go out being very active, totally intellectually engaged, physically fit. And so that's 75. And, again, it's just playing the numbers.

Robert Pearl: Well, see-

Zeke Emanuel: And by the way, people have often said to me, "Oh, my aunt, she's 90 and completely mentally intact." When you look, for example, and again, we focus on things like Nobel Prize winners and authors because we have data on those people, I don't think there's anybody who's done their research that led to the Nobel Prize after 75 and maybe even after 70. Mostly those contributions are between the late 30s and early 40s. There are a few people slightly older. People win it after 75, but their contribution was decades before that.

Zeke Emanuel: Similarly on novels or poetry, it's a very rare person and you can probably count on two hands, maybe three hands the number of people who after 75 have made major contributions. Vivaldi's one. Sophocles is another. Ben Franklin is another, but they're pretty rare actually. And you say that your grandmother was completely intact, and maybe it's true. I have no way of knowing, but I can tell you, there's a good reason to be skeptical.

Jeremy Corr: All right. To piggyback off of what Robbie just asked you, and I'm going to ask this in a completely nonpartisan way, when we look at some of the age of our elected officials, many of whom are much older than 75, and some of them are even in their 80s such as Dianne Feinstein, Nancy Pelosi, or even here in Iowa, we have Chuck Grassley, and if you look at the presidential side, I believe Biden is 79 and Trump is 76. And assuming they're the nominees for the 2024 election, they would both be in their mid-80s by the time that presidential term ends. The American president is the most powerful person in the world where they need to make snap decisions, are in charge of the nuclear weapons and needing to be in peak mental condition is probably the most important qualification of the job. Do you think there should be a maximum age for elected officials? Or how should that be handled?

Zeke Emanuel: Nope, and I don't think precisely because I've been giving you the Ben Franklin example, which is, there are people who are outliers. There are people who are mentally fit, physically fit and can be outliers. And I think a severe age cutoff is wrong for precisely that reason. On the other hand, I have up close watched some politicians, and interestingly, not all the politicians you've actually mentioned who clearly were not mentally fit, and were in office, including the Senate, and showed signs of various kinds of dementia. Now, I didn't, as I say, showed signs of. I didn't examine them. I didn't have the ability to properly assess them, so I'm not going to say they were demented, but showed signs that were suggestive.

Zeke Emanuel: We know that Ronald Reagan was one of those characters where many people had suspicions that there was some kind of dementia lurking there. You couldn't make that diagnosis because people weren't able to examine him. We don't have his medical records from the Mayo Clinic open and available to the public to see what his doctors actually thought. So I don't think a hard and fast rule there is appropriate. But I do think that there are cases where our suspicions ought to be high and we should make sure that we're electing people who are mentally fit for the offices that they're running for.

Jeremy Corr: Just a quick follow up on that. How would we, say after they're in office, if there is a cognitive decline after that happens, after they've already been elected, then how would --

Zeke Emanuel: Well, fortunately for the presidency, we have a method. Isn't it the 25th Amendment? So we have a method for the presidency. Ironically, for Senate and Congress, we don't have a method.

Robert Pearl: Well, it's been a pleasure today. You are fascinating, and I think the listeners will have learned much. I can't wait to have you back on the show. Thanks so much for coming.

Zeke Emanuel: Okay.

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