Diet Doctor Podcast

with Dr. Ariel Ortiz, Dr. Meredith Sweeney and Karlijn Burridge, PA-C

Episode 74

Dr. Bret Scher: Welcome back to the Diet Doctor podcast. I'm your host, Dr. Bret Scher. Today we're talking about all things weight loss with a pretty strong focus on bariatric surgery and weight loss surgery, and talking about where it fits in into the scheme of weight loss interventions.

We'll talk about lifestyle, of course, nutrition, exercise, behavior modifications, we're going to talk about medications and their use and we're going to focus on weight loss surgery. We're going to hear from two expert surgeons, as well as a physician assistant expert who deals more with the patients on a one-on-one basis, and some of the lifestyle and sort of emotional and behavioral aspects.

Now, weight loss surgery has really changed quite a bit in my years as a physician. And as you'll hear me talk in the beginning, it was a huge procedure with huge risks. And that really has come down quite a bit. But let's be honest, it's still an invasive procedure, it's still mostly an irreversible procedure.

So if you're going to go through with that, you want to make sure you've gone through the process that you're psychologically ready, that your lifestyle is ready, do adjust to the surgery and continue your success afterwards. And you want to make sure you're working with a team that focuses in a multidisciplinary way to help you through the whole process.

So I hope you enjoy this compilation between Dr. Ortiz, Dr. Sweeney, and physician assistant Burridge, each with their own perspective, each with their own background and expertise, but all of them motivated, and dedicated, and passionate about helping people achieve safe and healthy weight loss.

Here's Dr. Ariel Ortiz. Now, Dr. Ortiz really is in a way a pioneer of weight loss surgery. He's been doing it for over 25 years. And he's trained many of the surgeons and he's gone through sort of the multiple iterations of the way the surgery itself has technically changed over time.

And as you'll hear, he's really started to incorporate himself as more of taking care of the patient, pre-op during the operation and long-term post op just not operate and be done. And that's such an important part. You can find him at obesitycontrolcenter.com. He's also a pioneer in medical tourism, his practice is based in Mexico, and people fly from all over different countries to come see him and to be treated by him.

So I think he's got a wealth of knowledge. And it'll be interesting to hear his perspective as well. So Dr. Ortiz, you've been doing this weight loss surgery for over 25 years now. And when I think

back, you know, for me 25 years ago, going through medical school, and then through residency, weight loss surgery, sort of had this stigma of like the last resort and this incredibly risky procedure that you really didn't want your patients to do.

But if they had to, you sort of relented, and that was from sort of my perspective from the medical side. But now when you look at it, things have changed quite a bit. So if you can give us a little bit of a snapshot of what things were like for you starting out 25 years ago, and how they've changed for now in terms of sort of safety and efficacy and the indications for weight loss surgery.

Dr. Ariel Ortiz: Thanks, Bret. Well, what's happened is that back then, weight loss surgery was not as, let's say, popular, but the disease wasn't as popular as well. I mean, really, people didn't understand that obesity was a health problem, and it was causing additional problems that had the comorbidities. So it wasn't as... there wasn't as high of a demand for the procedure that there is now.

And what's happened over time, like anything, there was a learning curve. So when we're talking about 25 years ago, well, there was this obesity epidemic that was starting, but it wasn't heard on the mainstream, media, etc. And on the other hand, weight loss surgery was just in its infancy, weight loss surgery had started way before that, but it wasn't until the laparoscopic approach or the keyhole surgery, making it a lot less invasive, permitted patients to actually look at it as an option.

And yes, I agree with you. It was seen as a last resort. But as we perfected the procedures, then we started seeing it like, holy moly, these patients have metabolic syndrome. And three weeks later, we're seeing all these diseases like their diabetes, hypertension resolve, in this shortest three weeks.

We've got something good here... and that's when the title change from weight loss surgery or bariatric surgery to bariatric and metabolic surgery. And probably one of the most important things is that, and we discussed this, you and me, about how back then when it all started, there was a very high risk of complication, even mortality, when surgery was being performed back then, because there wasn't the expertise there.

So it was quoted up to one out of 25 could have a potential risk of death. So that was a very high gamble, a very high price to pay.

Bret: Yeah, that's for sure. And so one out of 25, back when you started, and then now what would you say the risk of mortality is based on your experience and what you think the literature represents.

Ariel: Less than 1%, the literature all across the world says less than 1%. But it's been a dramatic change on what we do and how we do it. So weight loss surgery was a couple of procedures. Now there's over 10 different procedures. We use as minimally invasive techniques as possible.

Now, robotics is coming into play. So there's additional technology, there's better training for those that are actually performing the procedures. And there's something else which is extremely important. It's not just now surgery, it's surgery plus something else.

Bret: Yeah. So that's a great point surgery plus something else. So what is that something else?

Ariel: For us, it's been this growth in 25 years. Back then I would receive a patient, "Hello, Doc, it's good to see you." "I'm going to do your surgery, I'm going to make your stomach smaller, and

then I'm going to see you recover and say goodbye." And that was that. And as surgeons, that was our training, I mean, the only time we want to see you again is when you bring a new patient over.

But you don't want to see the patient again, because oh, Lord forbid, it's a complication. But we learned that the surgery is a tool. And as a tool, it's got to have an instruction manual. And as these years passed by, we learned that patients not only have an addiction to food, they have certain addictions to carbs, there's a metabolic response to the surgery.

And it's beautiful, but it can revert back to pathology or disease if they don't do the right thing. So that's when we started thinking, what are the right things? What are we going to recommend to these patients. And it's interesting that we started over 10 years ago, to give our patients a pre-surgery diet. And this pre-surgery diet was not based on low calories. It was based on low carbs.

Why? Because low calorie diet is basically so difficult to maintain. The impact is there. But most patients, especially obese patients, aren't going to do it because they're tired of dieting. So what do we do? We said, All right, we're gonna protein, fat and fiber, the PFF. And that's what we gave our patients before surgery.

And one of the most interesting findings was that during those two, three weeks prior to surgery, where we gave our patients protein, fat and fiber, and restricted, obviously, the amount of intake, but it was mostly therapeutic carb restriction, we found out that the livers would arrive in a very healthy status. In other words, we would do a surgery.

And the livers were like, hey, doesn't look like pate. That's good, because I have to peek under the liver to do the procedure. But parallel with this, I found out that these patients were coming back and telling us well, you know what, I'm not using my blood sugar medicine anymore, because I started getting low blood sugar after the first week of doing this, or my blood pressure, I was getting dizzy, and I went to the doc and we had it suspended.

And this is, you know, in a window of two to three weeks before the surgery, before I even had touched the patient. So I said we're on to something. So that's how it started.

Bret: Yeah, that makes a lot of sense. And it seems like a lot of the weight loss programs before surgery, though, are these like shakes, get off food and take these hypocaloric shakes. So you took the different approach still have real food but make it low carb? And then what about after the surgery? You try and keep your patients on a similar diet after the surgery, or is it you're cured, Go back to eating what you want to eat?

Ariel: Well, it's evolved. And here's the thing. I didn't do it on my own. I'm a surgeon and as a surgeon, I'm a technician. I'm a handyman, let's call it and we are different. So I have a group of really good thinkers, my nutritionists, especially my lead nutritionist that's always doing these observations and always asking herself are we doing it right?

So she questions stuff. She looks at the mainstream way of nutrition and then she questions these approaches. And that's how we came up with the wait a minute if it's working before surgery, let's use it after surgery. So our three main goals now are to decarb a patient, detox a patient, and replenish their good bacteria. Why is this? Well, because as we look at science, there's tattletale signs that, yes, insulin is very high.

And if you stimulate insulin, it becomes high and then you become resistant to it. And then you'd be... you have metabolic syndrome. So we said, all right, let's not stimulate it. So the surgery itself does this, but for how long? And we're not willing to chance it simply because patients can revert... 30% of my patients have metabolic disease, like diabetes, or hypertension.

And most of them have at least one marker of metabolic syndrome, because excess weight obesity, excess fat is a marker for metabolic syndrome. So these patients after the surgery, well, the most important thing is that you not only want to give them a good quality of life, you want to give them kind of almost a guarantee that they're not going to progress in their disease, but revert the disease.

So surgery in a matter of weeks, and these are studies that are well published, changes the patterns of patterns of ghrelin and leptin, and all the peptides, intestinal peptides that are associated to insulin secretion, sensitivity, etc. That happens in a matter of weeks. But for how long was my question, because I've received patients that come back two years down the road that didn't do what they were supposed to do, and now they're diabetic again.

And now if you've already done a surgery now, what do you do? What additional surgery do you do? Those are the challenges we see today? So basically, to answer the question, yes, we started using the same approach after, which is to decarb a patient, in other words, restrict the amount of exorbitant carbs that we eat in a regular fashion as Americans, a standard American diet, move away from the standard American diet.

Number two, I really do believe that there's also research that supports that the way that agro industry in the food industry produces food has an impact on the toxicity of food, pesticides, herbicides, fungicides, chemical fertilizers, plastics, plus other numerous toxins in our body. And last but not least, I believe in wholly... in that we poorly understand the living organism within a living organism, which is our microbiota, the intestinal bacteria, are there for some reason, and it's been studied constantly.

The complexities are incredible. But you want a healthy microbiota, how do you do that? Well, have a healthy soil because we've killed the microbiota in the soil as well. And those are the things that as we progress in science, I'm feeding to my patients almost on a daily basis of video program that they get three minutes a day, because we're we don't know everything. But we know some stuff now. And it's very exciting.

Bret: So this is a lot of interesting talk to hear coming from a surgeon. And the old joke is, you talk like this, you're going to get your surgeon card revoked, because this is not how surgeons are supposed to talk, right? Like that's the old stereotype. Now, do you find that that really is an old stereotype and things are moving in this direction more?

And it's becoming more common for surgeons to think this way? Or do you think it's still the exception that a surgeon or a surgery practice thinks in this way?

Ariel: I have to say that, you and I, because we've been in the same side of science, have been criticized for thinking a certain way that is now going mainstream. So all those low carbers, high fatters... the toxicity, all that stuff. It's like, Oh, that's just... And now it's starting to have this presence in mainstream media and information, accessible to anyone.

With surgeons, I find that we're basically starting to attract attention. And I believe that the phenomenon has to happen to many of us, it happened to us. In other words, to me, my cholesterol

was creeping up, my LDL was going down, my HbA1c was going up. And I'm like, "What the hell, I don't even have diabetes in my family. What's going on?"

And it had to be me who lived through it to say, I dramatically changed my health status. I can do that for my patients. And of course, I was already doing it. So I just extended it even further.

I believe that there's going to be more and more interest simply because surgeons are going to experiment themselves, not just because they're finding it in the literature. I really want to start publishing these incredible numbers that we've had experienced cutting carbs on our pre op and our post op and the low risk of returning to disease like hypertension, diabetes.

Bret: Now, when you look at the landscape of weight loss interventions, and you can see surgery, you can see lifestyle and you can see medications. Do you see the three of them as working together? Or do you think maybe you don't need surgery, you just need lifestyle medications, or you don't need medications, you just need surgery... Like how do you see the interplay between those three factions?

Ariel: I gotta say that when you look at the statistics of metabolic syndrome, well, first of all, when you see that very few people are actually adults are metabolically fit, then you say, well, a lot of people could benefit from metabolic syndrome treatment. And one of the metabolic syndrome treatments is weight loss surgery. It's the most effective one, simply because it really does change your metabolism through hormonal changes that are associated to surgical changes during the procedure.

Having said that, I've had patients that with simple intervention, from 60 units of insulin a day, they became hypoglycemic to a point that they stop using insulin seven days after. This was somebody that was completely diseased and you can change their life, we just cut their carbs, and they were non-diabetic in seven days. So there's science to both of these things.

Now, when is it applicable to do a major surgical procedure to someone that can benefit simply from therapeutics that are non-surgical? That's where the question is. But I have to tell you, there's factors that are involved, somebody who is definitely not going to change their lifestyle, or may not have the ability to change simply because of how they work where they live.

Somebody who already has a very high risk of developing complications of vascular... you know, that really well cardiovascular disease, neurological disease, renal disease, those patients immediately benefit from a weight loss procedure, and they benefit from it in a matter of weeks. Like I said, it takes two to three weeks for those hormonal patterns to change.

And then there's those that simply say, I want the quick route, or I want to have the whole spectrum of things, I will do the change of lifestyle, I will do medication if needed, which medication is not needed, I have to say. And last but not least, I'll do the surgery. And I have patients that are 25 BMI, but their body fat is 32.

And they have a history of... and I'll do their surgery, simply because they don't have to prove to me that one year from now or two years from now they're going to be above 30 BMI.

Bret: Interesting. That's interesting, because that last patient you just described as someone who based on any insurance protocol would never be considered a candidate. So you're saying I see potential to help this person? And it makes sense because, you know, like you said, it's becoming called metabolic surgery.

It's not just about the BMI, it's about the metabolic health as well. Now, you mentioned the change in the hormones that happened, the hunger hormones and the satiety hormones. But are there other factors as well that help with the rapid change in metabolic health? Is it just you can eat so much food? So it's the caloric restriction? Is it that you're not absorbing as much? What other factors do you think are involved?

Ariel: It depends on the surgery, but I have to tell you from my practice, I've done 24,000 surgeries in the past 25 years. And that's why the gray hair, right. And I've learned many things, one of the most important things that I've got it easy because patients preselect themselves to my program. So all my patients look online, they look at my program, and they like it.

And they know that they're going to have to go to two to three weeks pre-surgical preparation, by detoxing their liver by decarbing their food intake, like I just explained, and then once they're prepped, they travel for surgery, they come in, we do weight loss surgery, we're in Mexico, we're a center that resides in Mexico and our patients are international from the US, Canada and other parts of the world.

They have weight loss surgery, and my weight loss surgery is not a very invasive procedure. I just make their stomach smaller. And it's called a gastric sleeve. And we've improved upon the technique, but ultimately, it's a very basic principle. We make their stomach smaller, patients eat less. And of course, there's a calorie restriction associated to that. But the difference is that this calorie restriction is induced by the surgery.

It's not something voluntary, so it's not like they can go and number two, their hunger diminishes because of these changes in hormones. And sometimes they tell me, "Doc, sometimes I forget to eat it. And now you're doing intermittent fasting. So, we've got calorie restriction, we've got intermittent fasting.

And of course, we add to that the carb restriction, especially processed food restriction, then that gives us a nice scenario where the patients are actually losing weight because of a number of things, not just depending on the tool. But those would be the mechanisms. And last but not least, it's the psychological preparation of a patient that knows that it's going to undergo some dramatic physical changes, and metabolic changes and health changes.

And they know what to expect. So as they lose weight, and they don't have any hunger, they're like just expecting the weight loss. And they're proactive with everything versus being reactive when you're just on a diet.

Bret: So you mentioned the surgery that you do predominantly as the gastric sleeve. Now, there are other types of surgeries, there are many different types of surgeries, there are balloons that people inflate, there's the traditional gastric bypass surgery, they're sort of the older diversion surgeries. If someone's looking to decide what is the surgery that I want, that's going to help me the most the best, you know, benefit to risk ratio, how do you help guide that patient to make that decision?

Ariel: I'm very biased, because I've done so many, so many procedures that are very... the least invasive procedure with such good results. But I'm always going to tell them, "Look, go for the easiest, the best bang for your buck, the easiest procedure", because the proof is in the pudding, right?

And the pudding is this. If I do so many procedures, and they don't fail? Why would I go to a more

aggressive procedure? But to answer your question without bias, if we put a graphic, on the one side, you have the very least invasive procedures like a gastric sleeve or gastric band that has kind of fallen out of popularity. And then you have the most aggressive procedures, like the biliopancreatic diversion, it's even difficult to say, can you imagine?

So on the one extreme end of things, the lesser the invasiveness of the procedure and complexity of the procedure, the lesser the risk of complications and mortalities. But the less weight and weight loss it produces, or aggressive or life threatening a complication could be and the more side effects, you're going to have the procedure but the more weight loss you're going to have.

So those are the gamma of different procedures you have on the one end and on the other end. And the question would be what the patient wants? Well, many of the patients say, "I don't care, I want the most amount of weight loss." All right, cool, then get the most aggressive procedure. And that's what most people know. I would add to that, what do you want to lose? It's not about how much weight you want to lose... what do you want to lose?

Because if you want to lose skin, muscle mass, hair, maybe a tooth or two, yeah, go for the most aggressive procedure, because some of these procedures are dramatically malnourishing. But if you want to lose body fat, oh, go for a less aggressive procedure. Because the difference between weight loss percentage, the amount of weight you're going to lose between the most aggressive and the least aggressive, is around 10 to 15%.

For somebody that's got to lose 100 pounds, that's 15... 10 to 15 pounds difference. And like I said, you might lose more weight on a more aggressive procedure. But it's not necessarily fat, you're losing lean mass, and you don't look as good. So those are the things I would tell a patient before they decide on what procedure to have.

Bret: It's interesting that you brought up body composition, because that is such a hot topic. Because you're absolutely right. You don't want to just lose weight regardless, you want to lose the fat mass and try and maintain the lean body mass. So do you find that the surgery itself makes a difference? And I guess, you give them specific advice for their post-surgical lifestyle that will help maximize the lean body mass and keep off the fat mass.

Ariel: The end is really important. I give them the procedure and plus the program. So the procedure is I'm going to give you the least amount of procedure for the best amount of weight loss. And that's why I don't do aggressive procedures. They're not in my regular armamentarium. I start off with a restrictive procedure that restricts the amount of food you can eat, the gastric sleeve.

And when I do that, I don't find patients malnourished. I get to see what... Why? Because they can eat. They can eat a lot less but they can eat. Most of them are going to reach around 65%, 70% of their excess weight loss goal. In other words, they've got 100 pounds to lose, they're gonna lose 75.

In fact, our numbers are a little bit better than the average. Why? Because we do put them on a program. But this program can't be something that's just oh, here's the booklet, and go on your way. We actually take time to send them a video a day on every step during their post-surgical journey. Why is this important?

Because everybody is going to go through certain changes, certain phases after weight loss surgery, and it's all starts with a lot of liquid loss, water redistributes, then you start seeing a good amount of body weight loss and fat loss, then you're going to start seeing a little bit of malnour-

ishment in many patients, and they're having lean mass loss.

And some patients have issue with hair loss, etc, their fingernails brittle, all these signs. So every single step has to be addressed and preemptively treated before it becomes a problem, then you're going to see patients talk, "I'm in a stall." And that can happen that two months, three months, but they're happy.

And we learned this many years ago that the stall really is about weight, because the scale doesn't change. But the body fat composition is dramatically changing. So these patients are saying, Doc, you know what? I'm not losing weight. But I lost three sizes these past couple of weeks. Yes, exactly. Fat weighs a lot less than muscle mass.

So all these things are... basically we leverage this knowledge, so patients can start getting excited and then proactively start getting involved. And then that's when you start getting resistance training. It's become a science. And it's very exciting. I have to say that I'm moving away from just being a surgeon to being more involved in all these different facets of these life transforming therapies that we're blessed to be able to give.

Bret: Yeah, that's encouraging, because that's what it takes for long term success. No question. Now, what do you see as the future of weight loss and metabolic surgery? And where is it going to fit in terms of, you know, where doctors, non-surgeons, think about when they're trying to help their patients? Where do you think it's going to fit in their armamentarium of things to do and how's it going to change in the future?

Ariel: So surgery is becoming more accessible, there's more surgeons doing it, it's more standardized. And even though it has really good results, it has a less ideal scenario where we're having a lot of, I don't want to say complications, but a lot of recurrences. And that's where revision surgery comes into play. So 10 years ago, we used to do all just weight loss surgery on first time patients. Now 30% of my practice is revision surgery.

So we're kind of recycling some of our patients. Where do I see the future, I see the future, really concentrating on what's causing the problem and not how to treat it. Just recently, a week or two weeks ago, there was this published paper on a new drug, that helps dramatically lose weight. Now, that's very promising.

Maybe in 1020 years from now, surgery's not going to be needed, hopefully. But for the time being, I see it as something that's much safer than it's ever been much more effective. And that can be used in conjunction with programs that are already there to give ideal and long lasting results, durable results. The problem with surgery and surgeons is that we're isolated. As surgeons, we're doing the surgery, we talk to the patient.

But as surgeons, we're never gonna ask them. So how are you eating? That's the work of the nutritionist. So in the United States and many parts of the world you have a multidisciplinary team, and I don't screw around with your end of the business and you don't screw around with my... doing all the surgery, but they're not getting involved with the patient, the day to day struggles.

And when I see these webinars online and conferences, and they're all debating if they should talk more, or suture more, or cut less or reroute differently, but nobody's talking about this aspect, which is about the quality of life. So you've got the really aggressive surgeons like well, "We cut from here to there and then if you eat an enchilada you go to the bathroom or you crap the enchilada, and you're gonna do really well.

And you're like, but wait a minute, these patients are suffering. They've lost all their hair, their skin quality is terrible, they look like they're dead. They don't care. It's about the numbers. It's about how much weight did you lose and what is the most aggressive procedure I can do and how big of a surgeon I am.

And we got to move away from that. You're treating people. People that have already lost hope and they're looking for hope in something and then suddenly now you add to them a new set of problems instead of resolving the problems they already had.

So I believe, I'd like to see in the medical field in the surgical field, a little bit more of compassion, and a little bit of more interworking between departments, between the nutrition team and between the surgical team. Weight loss surgeons need to learn more about nutrition, and more about their patients and more about what they have to go through. It's not just about doing surgery.

Bret: Next, let's hear from Dr. Meredith Sweeney. Now, Dr. Sweeney did a bariatric surgery fellowship in Louisville, Kentucky, where she now practices and has been doing bariatric surgery for the past seven years. You can find her at Dr.Meredithsweeney.com. That's Dr.MeredithSweeney.com. And what you'll hear from her is that she's really got this wonderful approach, again, about taking care of the patient from start to finish.

And finish means a lifelong of care of lifestyle interventions, of addressing the emotions, of addressing addiction, not just operating, although she knows plenty about the operations, but really addressing all these other aspects, which is really sort of the future of bariatric surgery and weight loss surgery.

So let's hear more from Meredith Sweeney. So Dr. Sweeney, we've heard a little bit about how weight loss surgery has changed over the years and the decades. And based on that having been doing weight loss surgery for the past seven years, you've sort of, you know, come on the tail end of that. So what is your perception on how weight loss surgery now is significantly different from how it was say, when you were in medical school or when you were maybe first learning about this?

Dr. Meredith Sweeney: That's a great question. And as you alluded to, I've been in practice for a relatively short period of time. So the way that I was trained during my fellowship is exactly the things that we do today. And I didn't practice very at the bariatric surgery if 30 years ago when gastric bypass technique and things were open, were quite different. And they were usually big, laparotomy surgeries.

And then the sleeve gastrectomy, you know, the sleeve is kind of the newer kid on the block. And we've really only been doing that for less than a decade. And then the lap bands, those were kind of falling out of favor as I was finishing my fellowship. And certainly we don't do too many of those now.

Bret: Yeah. So when it comes to the balance of maximum benefit versus minimum risk is are all signs pointing towards the gastric sleeve at this point?

Meredith: It's pretty clear that direction, yes. And then you have to look at the long term outcomes, of course, of who's keeping the weight off and who's having these long term success because that that you might find a little bit of a variability in sleeve patients versus gastric bypass patients.

So we have a very careful discussion with patients upfront before we choose which surgery we're going to pursue to make sure that is well aligned with how what we think is going to give them obviously, the minimal risk of the surgery itself. And potential long term complications, we want to minimize those. But we also want to look at the big picture, we want to get these people healthy.

Bret: So what are some of the main risks or concerns that a patient needs to be aware of when they're considering gastric bypass surgery or gastric sleeve surgery?

Meredith: So there's obviously the operative risks, the risks, you know, you're sewing, you're sewing things back together in a different anatomy or you're cutting in the case of the sleeve, you're cutting and stapling across the entire length of the stomach and removing the big portion of stomach so they're left with just this tiny sleeve shaped stomach.

So there's risks of problems that those connections at those staple lines, you know, those risks can last anywhere from a few weeks, but then you do have potential long term complications, things like ulcers, scar tissue from surgery itself, causing issues down the road, hernias, of course, since we are making incisions and going into the abdomen... Long term we start to talk about the weight regain.

And that is a discussion that we have up front with patients like surgery is not an easy choice. It's not the easy way out. Our patients that are successful, they work very hard to change their diet and lifestyle and make those permanent changes.

Bret: Give us an idea of what's involved for the patient for the you know, time to prepare, time for surgery, time for recovery to get back to real life, what how do you advise patients to think about that process?

Meredith: So it is you know, mentally obviously, the patient has to be in a place where they are ready to make these changes and to make the surgery successful. So you know, that's obviously very individualized that can take years for some people, it can take decades for others to get to that point where... and we hear the same thing over and over again, you know, I've tried everything else to lose weight.

I put more back on... you know, it's the stories. We all hear about these conventional dieting techniques. So once a patient has mentally gotten to that point where they're ready, they're committed to one take on the slight risk that surgery has, because the surgeries are very safe now pretty low risk, pretty successful overall.

But once they've made that decision, and they're committed, and they're committed to making lifelong diet and lifestyle modifications to use the tool that surgery is to its utmost success, then it takes anywhere from a few months to get them through the process of the paperwork and the preoperative clearances, the surgery itself, they usually take one to two hours, my patients, on average, go home the next day, and they're back to work within one to two weeks.

You know, if patients have a very active job, or it involves heavy lifting, then they're going to be, you know, on the longer end of that, but my patients that sit in front of the computer all day they're back to work within a week usually.

Bret: So out of the hospital in one day, back to work within a week or two. I mean, I remember back from my med school days, that was totally different.

Meredith: Totally different.

Bret: I mean, they're slightly different. So that's quite a sort of benchmark in terms of how the surgery has progressed and how surgeons have improved and the techniques have improved. And the post-operative care is improved as well, I'm sure all of that is intertwined into getting the patient out of the hospital and back to their lives sooner.

Meredith: Absolutely. So multifactorial, the way that bariatric surgery has evolved. And for the better.

Bret: Now you referred to the risk of weight gain, that is one of the, you know, probably the individual's biggest concern and you know, the so called "failure of surgery". What do you see as the biggest factors impacting someone's risk of regaining weight?

Meredith: So I tell patients that their preoperative exams... this is before we've even set foot into the operating room, I tell them that they have on average about two to three years where this surgery is going to be helping them significantly with portion control, with hunger suppression, but eventually your body kind of gets used to that new anatomy.

And after three or four or five years, they no longer have that intense change that the surgery provided for them up front. So I tell them, they have that time period, however long it is for that particular patient, whether it's two years, three years, to retrain their brain and to develop healthy lifestyle choices that they are going to be able to continue for the rest of their life.

They have to establish a healthy emotional relationship with food during that timeframe when the surgery is significantly helping them and be able to carry on that new life and that new relationship with food. Because when we see the patient start to fall off and the weight start to come back up, It is almost always because their relationship with food has gotten unhealthy.

Again, they're using it for stress management, they're using it for coping Coronavirus, has everyone coming back to my office and I'm like a broken record in the office, you know, people that had surgery 2018 whatever. And, you know, stressful certainly global pandemics have caused people to go off the deep end and go back to bad habits. And so we have those who are having a lot of those discussions right now.

Bret: So you mentioned patients coming back to see you who had surgery three, four or five years ago. I mean, to come back to see your surgeon is usually a pretty rare thing. You only come back to your surgeon when you want more surgery. So what are you doing different to help support these patients if you're not re operating on them?

Meredith: So this is where my passion for a low carb ketogenic lifestyle shines through. These patients, you're right, they don't need another surgery, they need someone to talk to and they need someone to educate them on the changes that they'd need to make now in order to get back to that successful weight that they were probably once at.

You know, in different bariatric surgery practices that may look different, ours is set up with we don't we only have two dieticians on staff, but a dietitian or a health coach could be perfectly capable to be in this role as well. It doesn't have to be the surgeon because like you said there's no further surgery to offer them usually.

But this is where I kind of differ from some other bariatric surgeons and that I truly believe in a low carb ketogenic lifestyle. And I sit and I talk with people for, you know, at length about teaching them what it means, what it can do for their body, how to implement it, how to get started and

how to be successful long term.

Bret: So do you think if someone gets the advice after their surgery, just eat everything in moderation, and you'll be fine because you've got the surgery and now it's just gonna work and you're gonna be able to do things much easier. Can that work for some people? Or is that just a recipe for failure?

Meredith: I think in general, it's a recipe for failure. You know, we can't make any absolutes. There's probably a percentage of people that that is going to work for. But overall, the majority, you know, if you've gotten to a weight of 400, at 400 pounds and you're considering surgery, you have an emotional unhealthy relationship with food. That's the bottom line. And so you have to address that, and talk with patients about that through the whole process before surgery during you know, that perioperative period, and then certainly follow up after surgery.

Bret: Right? You're not operating on their brain, you're not operating on their emotions, those things don't change when you operate on their gut.

Meredith: That is perfect. I say this all the time. I'm like, I can't fix this. I can rearrange things down here, but I can't do this. And truth be told, of course, I'm not a trained psychiatrist, psychologist, therapist. And so it's a very complex issue to deal with and to talk with patients about.

Bret: Yeah, and probably something I'm guessing you didn't learn much about in your surgery training, is it?

Meredith: Certainly not.

Bret: Yeah.

Meredith: And the nutrition piece as well. We don't touch on that during fellowship, during training. You get a little bit during medical school. But that was, of course, the old Food Pyramid and everything in moderation and three meals a day, two snacks in between, it just doesn't work.

Bret: Yes. Do you think this is the new paradigm for greater success with weight loss surgery is these multidisciplinary practices, that really address the emotions, really addressed the nutrition and the surgery is maybe just a small part of it?

Meredith: Absolutely. As the surgeon, I'm just a technician, I am one little piece in the wheel of a bariatric patient's success. They need the dietary counseling, they need the mental health aspect. And of course, all the clinical things that go along with that. But it has to be a multi-pronged program to get people the success that they need.

Bret: If a patient comes to you for the very first time, and they're not convinced they want surgery, they want advice about how to proceed. And you walk through them, you walk through with them the options of surgery, of lifestyle, of medications, either individually or all combined. How do you sort of help them see that as the progression and the benefits in the different indications?

Meredith: Honestly, by the time most patients see me. that discussion has been had by their primary care doctor. But if I were to be in that position, well, we'll say that, I would... of course in medicine, we want to try the least invasive, the safest routes first. And for me, I would educate them on a low carb lifestyle, like a ketogenic perhaps lifestyle, and take that and see what they can do with that.

And then if weight loss medications need to be introduced temporarily, to see if that can give them some success, or maybe give them that, that springboard that they need, then certainly that's an option that's safer than surgery as well.

Bret: Yeah. So, I mean, do you still think of surgery as sort of like the last ditch effort? Or do you think of it as something that can kickstart and be used, you know, in combination with other measurements. Or a little bit of both, I guess?

Meredith: A little bit of both? It is a last ditch effort. But and I'm not trying to put myself out of business here because obviously, I'm not in the operating room, making a paycheck. I do think that patients should, you know, obese populations should really be educated on what we know now, what you know, not what we were taught as children, but what we know now about the science of food, and the highly processed, highly addicting refined carbohydrates, and give them that information, empower them with that information, and see if they can make those changes on their own.

You know, personally, I saw my husband lose 70 pounds on a ketogenic diet, and he's not even in medicine. He's the one that introduced it to me in 2018. And so I jumped in on the science side of it and bandwagon because I'm a scientist at the end of the day. And then I started reading, you know, he just he ate bacon and eggs and steak and drops like 70 pounds. I started listening to all the podcasts, I started following people like Dr. Bret Scher, that... reading the books, but listening to the Jason Fung, and the Dr. Tro's.

Bret: And, yeah, so what have you noticed change in your surgery practice since 2018, when you started implementing low carb?

Meredith: It's so cool. It's night and day between in the way that I talk with patients now, before surgery and after surgery, because I have such a deeper knowledge of food and its addictive tendencies and the "bad foods, you know", and that everything in moderation doesn't work for our obese population, they've basically used... they've proven to us that that does not work in traditional diets.

And low calorie and low fat diets don't work. You know, we have this page that everyone has to fill out in their bariatric paperwork and towards the end and it has to do with insurance approval for surgery, but they have to list diets that they tried in the past. And it makes me laugh every time because everyone has checked that low calorie, low fat works.

Yes, try that. Try that. Well, we know it doesn't work for the majority of people, certainly the obese population. And so the way that I talk to patients since 2018, and since I started to get passionate about this education endeavor in terms of low carb and keto lifestyles, it's definitely had a positive impact on my patient outcomes. And it's definitely changed those day to day conversations with them significantly.

Bret: In your surgical practice, what have you noticed in terms of the speed and efficacy of metabolic benefits? Because we talk a lot about weight loss, but also one of the most important things is how they respond metabolically with their blood sugar, their triglycerides, their blood pressure, what have you noticed about the speed and efficacy of that?

Meredith: I love that question, because that's one of the most exciting things that I get to see and I get to like actually measure with lab tests. But I'll tell you, first of all, within the last year and a half, I put all of my patients on what we call a liver shrinking diet before surgery. So they get

this page, our dietitians instruct them. If you're one of Dr. Sweeney's patients you're going to do this for two, maybe four weeks before surgery, and that the time period depends on how much central obesity that they have.

But it's a ketogenic diet, it's removed all the processed food. That's what the liver shrinking diet is, as you know, it shrinks fat around the midsection, and it's probably the most effective diet that you can do to shrink the midsection and me as a surgeon, since that's where I'm operating, I need that to shrink as much as possible before surgery. But what patients are finding is that they're getting off of their diabetes medicines, their blood sugars are stabilizing even before they walk into the operating room. And we send people home on fewer medications one day after surgery.

And I think it's a combination of that liver shrinking diet leading up to surgery. And then of course, the fact that they're on just zero sugar liquids for that first 24 hours after surgery before they go home. But we're stopping there Metformin, we're stopping their injected insulin, we're certainly stopping their diuretics. And so the metabolic effects are quick and they are profound.

Bret: Yeah, and I bet that's also something you weren't trained in your fellowship training, in the surgery fellowship training about stopping medications and backing off on medications, or is it?

Meredith: It's really not, you know, as an obesity surgeon, you have to become pretty well adapt to deal with diabetes medicines. Since diabetes and obesity go hand-in-hand, we really need to have specialized knowledge of those.

Bret: What do you see is the future of weight loss surgery and metabolic surgery? Where's it headed? What are you most excited about?

Meredith: I'm excited about getting this information that we're talking about here today out to the masses. I think that every bariatric program, from the dietitians to the physicians, to the nurses, need to know the effects that carbohydrates have on our patients and their ability to succeed long term, the effect that it has on their overall health and well-being and this information as opposed to everything in moderation, and it just lowers your calories because your stomach is now a fraction of the size. It needs to get out. And I'm excited to hopefully maybe play a role in that.

Bret: Do you think there's currently resistance and still going to be quite a bit of resistance to that message? Like I mean, think about your partners, the way they practice the other people in your geographic area and people across the United States, your surgeons, the way they practice, is there a lot of resistance to that message?

Meredith: I think it's too early to tell, I anticipate that there will be and that's... and I don't like to make gross generalizations, but surgeons as a breed... pretty set in their ways, right? And it's hard as a physician, maybe what you told patients, or what we told patients 10 years ago, when we didn't have this knowledge. Now we have to go back. And we have to say, "Oh, wait, that was actually probably not what I should have been telling them.

Here's what I need to be telling them because I have this knowledge now." So you're going to find doctors that won't want to take those steps back and kind of retrace their steps and stop and critically think well, maybe this wasn't the right thing all of on. And you know, you're gonna find that in any profession, but maybe a little bit more so in medicine.

Well, you clearly show the mentality and the intellectual curiosity and just the personality who wants to think more and is willing to go back and change things and wants to do more than just

to operate. And I think that's so important in a surgeon. You've got to be good in the operating room, no question, but to have this mentality and this way of approaching things, I just think is so important and so refreshing and sort of the new wave of surgeons and certainly for weight loss surgery.

Because it's not like taking out an appendix and you're done. It's a lifelong intervention which you have really taken to heart and made a personal sort of mission to help. So I think you've done a great job explaining now. Any last words or other things that you want to mention about this?

Meredith: I really love the way that you put that. That excites me, that invigorates me to keep moving forward and at the end of the day, our patients success is our barometer. And of course, we want our patients to be successful and for us in our profession that looks like patients regaining their health and losing their excess body weight.

And so for me, not only is it a personal mission, but it's very much directed towards my patients' long-term success. And I've personally benefited from it, you know, my whole family, maybe the toddler excluded.

My whole family, we don't talk about calories at the dinner table, we talk about how much sugar is in specific foods and my children are growing up at a dinner table that they realize that too much sugar is harmful to their health. So my whole family has become significantly healthier because of our own change. And so, yeah, personal standpoint, awesome, patient outcomes are incredible.

Bret: Well, now that we've heard from two experienced and thoughtful surgeons about their approach to bariatric surgery and weight loss in general. Now let's hear from Karlijn Burridge. Karlijn is a physician assistant specializing in obesity medicine, and a fellow of the Obesity Medicine Association.

She's also the president of PAs in obesity medicine, and the founder of Gaining Health. Gaining Health is helping healthcare providers start an obesity management program. And she recently wrote a book on the topic as well, which you can find on gaininghealth.com. So now for a slightly different perspective, someone who's sort of more in tune with dealing with the patients on a day to day basis. Let's see what Karlijn has to say about all this.

So Karlijn, as we've heard, in the introduction, you are a physician assistant specializing in obesity medicine, which means you are probably the person who has more of the day-to-day interactions with people as they're going through their weight loss journey, whether it's from bariatric surgery, or for other means of weight loss. So tell us what you have encountered in your experience as some of the biggest challenges that patients face as they're going through their bariatric surgery experience.

Karlijn Burridge: Yeah, so I think whether somebody is going through bariatric surgery, or even if they're doing a non-surgical obesity treatment route, one of the hardest things is for them to make behavior changes, you know.

Behavior change is difficult, changing how you eat and incorporating more physical activity, and all of those things, those are complex behaviors. And once somebody is kind of set in their ways, once they have their habits, that's a difficult thing to change. So those are definitely the biggest struggles. What I find also is that patients really need to take a look at their relationship with food, how they think about food, and helping them become aware of that, and helping them make

changes, you know, one step at a time is probably the biggest challenge, but also the most rewarding.

Bret: Yeah, and I think that's such a great point. Because let's face it, bariatric surgery can make anatomic changes in your body for how your body processes food, but it's not going to affect how you think about food or your relationship with food.

So a lot of people when they hear that, though, your relationship with food, they may not be able to really internalize that and understand that. So how do you sort of explain that to people who are having little trouble grasping it? And how do you explain it in a way that's going to help them make beneficial changes in that realm?

Karlijn: Yeah, so I think it starts with getting a good nutrition history from a patient. So really talking to them about, okay, let's go through maybe a 24 hour dietary recall where we talk about, okay, let's talk about yesterday, what did you have? What was the first thing that you ate or drank?

And what time was that? And then what was the next thing that you ate or drank? And so you can kind of go through a whole day with them, and then talk about some of those choices. And I asked them about some of their struggles and their barriers. We talked about is it hunger, some people do feel hungry all the time. And so it's really difficult for them to try to incorporate healthier eating changes, or eating less if they're hungry all the time.

So if the hunger is truly an issue, then the great thing is that we have tools for that. So we know that bariatric surgery is going to help reduce those hunger hormones and increase the satiety hormones. So surgery can help with appetite control. We know that medications can help with appetite control. So we have a whole bunch of FDA approved anti-obesity medications that can help with that. And we know that nutrition changes can help with appetite control.

Studies have shown us that our low carb and ketogenic diet can help, they also alter some of those appetite regulating hormones. And so we can talk about those various options with the patients, if that's what they're struggling with. For other patients, it's not necessarily hunger that they struggle with, but they struggle more with emotional eating.

They eat for reasons other than hunger. So then we need to investigate that do they eat? Is it a stress relieving tool for them? Do they use eating for that? Are they bored? Are they eating out of boredom? Are they eating out of habit? Because it's a certain time of day? Or, well, the kids are eating a snack so I eat with them or well we always have a snack while we're sitting on the couch watching TV. So really trying to figure out what those triggers are for people. And then you can put together a plan to help overcome those triggers.

Bret: Yeah. So I'd imagine a number of people listening to this or maybe thinking, you know, check, check, check that that's me, you know, and that's why a lot of people struggle with weight because of the emotional components of food, how it fills a void for us, how we turn to it for comfort. So what are some of the quick tips you can give people on how to overcome that?

Karlijn: Yeah, I think the first step is becoming aware of it, right. So once they're aware of it, then we can talk about, okay, what time of the day or what particular circumstances seem to trigger it for you. So save it stress, save it stress eating, at the end of the day, somebody comes home, they've had a long day at work, all they want to do is just eat food, because it brings down their stress levels, and it helps them just calm down for the evening. You know, that's fairly common.

And so then you can talk about different strategies that can help them bring their stress levels down, right, so I like to work with the patient and have them write down a list of five to ten things that they can do instead of eating to help relieve their stress. So whether for some people might be, you know, just doing 10 minutes of meditation and there's some great meditation apps now that can help patients with that. Or it might be, you know, going for a brief walk after work to kind of wind down.

Or it might be that they have a hobby, or something else that they like to do that can keep them active, that kind of de-stresses them. So again, this can be very different for every person, but really working with them to help them figure out some different tools and strategies for stress management, rather than turning to food. So that's one example.

Bret: That's a great example. And I think that's really important for people to understand that all these other options exist, and that it's really the stress you're targeting. And the food is just one component of targeting that stress. But there are other, I guess, you could say healthier ways to target that stress.

Karlijn: Yeah, and I think that's also really important for patients who are about to undergo bariatric surgery, very important for them, because eating these types of foods is not going to be an option for them after surgery, they will hurt themselves, it's potentially very dangerous for them. So if they haven't learned how to control those emotions in other ways, that's actually really going to be dangerous for them. If it's a non-surgical patient, we can take a little bit more time and work on it.

But for surgical patients, if they have a band, or if they eat a lot of food or eat the wrong foods right after surgery, that can actually be dangerous and that's why it's important. Well, all bariatric surgery, patients have to go a psychological evaluation prior to surgery, which is one step of it. But what I usually encourage is for those patients who do struggle with emotional eating, that they really get some therapy around this and some professional help, because they need to have better control over this before they're ready for surgery.

Bret: So would you recommend somebody not have surgery, just link it don't have surgery until you've got control of this issue?

Karlijn: Absolutely. And in fact, we'll do that all the time. And I think that that's a sign of a really good surgical team, when they are willing to say, and the surgeon also is on board and is willing to say, you know, you're just not ready for surgery right now, we want you to be ready. And we want you to have long term success.

And that means dealing with some of these other issues first, because once you've had the surgery, there's going to be enough that you're dealing with after the surgery already, just from the changes that you have to make from the surgery itself. So that's not the time when we want to be dealing with these things, we need to deal with them ahead of time. And this is going to be a lifelong issue.

This is not something that we do temporarily and then after a couple months, you go back to your old ways. So patients really have to understand that this is a lifestyle change for the rest of your life. And that's why I think it's so important that the whole team is on board and that the patient understands that this is in their best interest.

Bret: You mentioned sort of the hallmarks of a good surgical team. And I would throw in there

that part of the hallmark would also be telling people, you know, you don't need surgery, or you don't need surgery yet, maybe there are other options. So how do you work with patients when they're considering surgery?

Maybe they're not committed to it yet, but they're considering it. How do you help them see their options? Whether it be surgery, or medications, or you know, lifestyle with nutrition and exercise and sleep and so forth? You know, how do they combine? How do they work independently? Sort of how do you walk them through that?

Karlijn: Yeah, so I see these patients a lot of the time because if they know they're gung ho, they're having surgery, they're usually going to the surgical team and they're prepping them and getting them ready for surgery. But it's a lot of patients who are maybe on the fence, they're not sure yet if they want to go that route. And that's where it's really nice to have a comprehensive obesity treatment program like the ones that I've worked in, where they have options. It's not like you know, it's this or nothing.

And I really think it's important that you meet the people where they are. So those patients would then come in and see me. And I would go over their various options with them. And then we try different things. So I usually like to start out with nutrition changes, and see how patients do with just the nutrition changes alone, because as we talked about, especially a low carb or ketogenic diet can really help them with that appetite regulation.

And even if they have like a carb addiction, right, we can help them with those types of things and see how they do. And some patients, that's all they need. And they just need that guidance, and that support and that accountability. And that's all they need. For other patients, if they try that, or they're really struggling with that they want to try these dietary changes, but they're either just too hungry, or there's other things that are impeding their success that we could potentially help with the medication.

Then we add a medication, so it's kind of stepwise. And then we see how they do with the medications. And even with that, you know, sometimes you don't find the right medication at your first go. So I kind of depending on what their symptoms are, depending on what type of hunger or emotional eating they struggle with, there's different medications that I might choose for one patient over another to start out, and then we see the response.

And we might have to try several medications. So once we go through that, and I usually tell people, let's try to give it six months or a year and see how you do. And then at the end of that year, then we can reevaluate and see where you are, how close you are to your health goals that you've set for yourself. I think it's very important that patients guide this and that they have their own goals. And then we can reevaluate and see how we're doing.

Bret: I like how you mentioned the stepwise approach. And of course, you know, medications can be part of that approach. They don't have to be. But recently, we've just had two sort of big studies about semaglutide, the GLP-1 agonist, which seems now poised to become the number one go-to medication for weight loss. Although it's expensive and doesn't have great insurance coverage necessarily, and it's an injection and, you know, has side effects of nausea, and in a number of patients, fortunately, not severe in most patients.

But I guess the point being, when you see a medication like semaglutide, and you know it's got great potential to help people, what do you see is the downside of using that medication for weight management?

Karlijn: Well, the downside is, of course, it's a medication, and there's cost associated with it. It's an injectable medication, too. And a lot of times patients come to us because they want to get off of the medications that they're on. And I'm a big believer in using as little medication as possible, and using medication only when we need to.

But that being said, if we've tried other things, if we've tried everything that we can think of that we can work on, and the patient is really still struggling, we know that obesity is a medical condition and that we should treat it if needed with medications. And so I think it's just really important to individualize the treatment and meet the patients where they are.

Some patients are definitely willing to do a low carb or ketogenic nutrition plan and understand that this is a lifestyle change. This isn't something that you do temporarily, and then you go back to your old ways, and they're willing to do that.

Other patients aren't, and so, you know, if they're not willing to do that, I don't say well, then I'm not going to work with you. I'm going to meet them where they are and say, okay, well, then in that case, maybe let's try medication, because I do find the medications, a lot of times really do help with that appetite regulation, which then makes it easier for patients to stick with their nutrition plan.

Bret: That's a good perspective. Well, so now you've moved on to an exciting new venture for you at Gaining Health, where you're helping healthcare practitioners develop an obesity management program. So what are some of the keys that you know, a doctor or nutritionist need to know about starting an obesity medicine program that will help them succeed?

Karlijn: So I think it's really important to look at the big picture. So obesity is a different... we treat obesity differently than a lot of other medical conditions that healthcare providers might be used to treating in their office. So it's not where we just give somebody a pill, and we have a come-back in six months or you know, in a year, and that's all we do. You know, it's really obesity medicine is about using a comprehensive approach, where we're using nutrition, physical activity, those lifestyle behaviors, potentially pharmacotherapy or surgery.

But so it's important that you're addressing all of those pillars in order for somebody to be successful. And that also means that you need to follow up with patients regularly. So I usually see patients who after their initial visit I might have them come back in two weeks, and then maybe again in another two weeks, and then usually monthly after that for at least usually a year or so depending on the individual.

And then after that we still continue to see them regularly and maybe every three months or however often that patient needs. So it's really important when you're putting together a program that you have that vision in mind, and that you structure your practice in that way. So that's one of the most important things I think to start out.

Bret: I imagine a lot of physicians listening to this would be like a who's got the time for that, like, I can't do that. So it seems like to really be successful, the program has to be multidisciplinary and has to have, you know, PAs, nurse practitioners, our ends, nutrition is some combination of that, to do most of the work, is that sort of also what you recommend?

Karlijn: Yeah. So, again, there's a lot of variability in how you structure that program, I would say when you're first starting out, if you have a medical provider, be that a physician, a nurse practitioner, or a PA, who is well versed in comprehensive obesity management, that individual can do

a lot of that counseling early on.

So for physicians, they have the American Board of Obesity Medicine that they can get board certified through. For NPs and PAs, there's the certificate of advanced education and obesity management through the Obesity Medicine Association, which I was the chair of the committee when we created that certification. So that was a really exciting step for us that we have a certification as well, so that we can demonstrate our expertise in this field.

So somebody who's comprehensively trained in obesity management can initially be the one who does a lot of that counseling. And now those visits do tend to be a little bit longer, you know, maybe 30 minute visits for the follow-up visits.

So as long as you can fit that into your schedule and into your provider schedule, then it could be the provider that does it. But if you feel like you want to have shorter appointment times and you want to bring on additional staff, like a dietitian or a health coach or an exercise physiologist to do some of that, then that's of course an option too.

Bret: Yeah, you've mentioned exercise a couple times. And I know when it comes to weight loss, you know, you hear you can't outrun a bad diet, that, you know, exercise isn't the first pillar. Nutrition is the first pillar, but exercise can be an add-on.

But a lot of people who suffer from severe obesity, also are sort of uncomfortable doing physical activity. So how do you help them safely and comfortably work in physical activities as part of their weight loss program?

Karlijn: Yeah, so again, it really depends on where the person is starting out. Certainly, if they have severe obesity, I tell them, don't even worry about that part yet, let's get your nutrition down for making a lot of nutrition changes, let's do one thing at a time. Because you also don't want to overwhelm somebody by trying to change everything all at once.

So we know that their nutrition is going to have the biggest impact on their weight, and how they feel. And so a lot of times the patient will bring it up to me before I even bring it up to them. Once they've been making some of those nutrition changes, they've been able to have some weight loss success, their energy levels are feeling better.

They want to know, "All right, when can we start talking about, you know, some physical activity or exercise?" So that's always a great sign when the patient brings it up, because you want to make sure that they're ready to make those changes.

Bret: Yeah. And that's a common experience that I've seen. And I hear that the patient tells you when they're ready, which I think is a pretty cool standard to go by, to know when they're ready for sure.

Karlijn: Yeah. And so when they do express that readiness, then you just start really small, you want to make sure that you're setting them up for success, that you're putting together a physical activity prescription, if you will, that's guided by the patient. So what did they enjoy doing? What could they see themselves doing?

What are they able to do physically, and then just start small and build on that. And I really like referring to physical therapy for this as well, for some of those patients that may have some joint issues or back pain, or other physical limitations, that can be a great safe place to start with patients.

Bret: Well, I think that was a good walk through the sort of emotional behavioral side of weight loss, whether it's for with bariatric surgery, or lifestyle or medications. Any other last thoughts or guidance to give our listeners?

Karlijn: Well, just if you are a health care provider, and you are interested in learning more about how to start an obesity medicine program, I would encourage you to visit gaininghealth.com, that's what I'm doing right now is I'm really creating resources for providers to make it easier to facilitate that incorporation of obesity medicine into clinical practice. So you know, check out some of those resources because those can be very helpful to get started.

Bret: Well, that wraps up this episode focusing on weight loss surgery, but also other weight loss techniques in general. I think it's really interesting to get the perspective of the two different surgeons and then with Karlijn the physician assistant, dealing more with sort of the emotional and behavioral side of things, but one thing that's clear and I think all three of our experts agree with that surgery is not a quick fix and that's it. It's part of a comprehensive program.

And I really liked to hear them talking about that, about how it has to be multidisciplinary, and how you still have to focus on lifestyle. And let's face it, you know, any one of the three options, be it lifestyle, be it medications, or be at surgery can work on their own. And I sort of liked the way Karlijn went through the process, starting with lifestyle first, then going to medications if needed, and then going to surgery if needed over a long period of time. She used a year, but it could be any period of time.

And I really liked that that process. And I think that that really speaks to all the different options we have, and starting with the least invasive, the least worrisome, as long as there's no urgency, immediate urgency for the weight loss.

And that's sort of like what Dr. Ortiz was saying, if there's an urgency, then, you know, that's when you want to operate soon, but also start with the least invasive operation. And we can say the same thing, start with the least invasive intervention as well.

And then when it comes to lifestyle, right, this sort of like bucket of lifestyle, so many people say, "Oh, I've tried everything. I failed on my lifestyle interventions. You know, diet and exercises didn't work." That's when we have to say, "Well, what diet and what exercise, and what type of behavioral modifications?" Because of all they've been told is to eat less and move more.

And that didn't work. That doesn't mean they've tried lifestyle. And I think that's sort of a problem we fall into as healthcare practitioners, especially if we don't have the most a multidisciplinary team. If we're doing it on our own, as a clinician, we don't have the time and energy to devote to walking our patients through all the different options. And that's something that here at Diet Doctor, we hope to provide for the clinicians.

To give you the resources you need to help your patients try a low carb diet, try a ketogenic diet. Maybe it's the secret they need, maybe it's the lifestyle they need to see the benefit, maybe not. But until you've tried it, you don't know. And then the same can be true for medications, although obviously you don't want people on expensive medications with side effects for a long period of time.

But if it can be a short term fix to give them a kickstart to help them with their lifestyle changes, to help them see success and motivate them, then it certainly has a role. And then of course, bariatric surgery, as we've said, plays a role as well, for carefully selected patients, carefully monitored

and treated in a multidisciplinary approach.

So I hope this was helpful to help you sort of formulate whether you're an individual considering these options for weight loss or a clinician trying to figure out how to work all this into your practice. Hopefully this helps you see sort of the timeline, the process, and the different options. So thanks a lot for joining us on the Diet Doctor podcast.