Bariatric Surgery Versus GLP-1s: The Real Talk on Weight Loss That Works | Dr. Alexa Roth Transcript

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Podcast Introduction and Guest Welcome

Welcome to the Doctors Making a Difference podcast where we help physicians to be empowered with the tools they need to successful in medicine, in finance and in life.

Join us as we highlight doctors and other professionals around the world who are making a difference. It's not very often that I get to record an episode with a physician that's part of my own referral network.

Today, Dr. Alexa Roth is going to join us. She is a very accomplished bariatric surgeon and weight loss specialist, does a fantastic job with patients that have referred to her.

So I can vouch for the success that she has had both as a surgeon. and as a professional, helping many patients lose weight and have lifelong meaningful weight loss.

I've appreciated her activity, her social media outreach, all the important things she's done to try to help patients in this space. And I'm very excited to welcome Dr.

Roth today, and I know you'll enjoy this episode. So today we are privileged to have Dr Alexa Roth with us. Dr Roth, would you mind introducing yourself to our audience?

Absolutely, and thank you so much for having me. So I'm Alexa Roth and I am a bariatric surgeon and also a board certified obesity medicine specialist.

And I run a comprehensive weight management program here in Idaho with kind of medical and surgical focus, both. I've been here for five years. Our program is a center of excellence now, which is an accomplishment that we're very proud of and glad to be here.

Oh, thank you. We were talking a little bit before we hit record. Most of the people who listen to this are physicians and they're going to understand your journey of how you became a physician and what you did.

Talk us through for a minute. How did you choose bariatric surgery?

Dr. Roth's Background and Path to Bariatric Surgery

You know, you go from a pre-med student to being a surgeon to saying, I think I want to do bariatrics because that's a unique path and something people are talking about a lot right now with all the GLP-1 medications and you're an expert on weight loss and I'd like to hear a little bit about your journey how you decided to go that path.

They always say in health care I mean go do the specialty of the people that you kind of get along with the best and i think that had a lot to do with it for me.

My parents are both in medicine they're both cardiologists so growing up of course I thought I would do some internal medicine special cardiology yeah I did some research in endocrinology, I think I had it before medical school, and so I came in very kind of internal medicine heavy.

I hated anatomy, smelled terrible. And I just was like, surgery is the last thing I'm ever going to want to do. So as a student, of course, i put it as the first rotation because you know, you're going you want to just get it out of the way.

And I still remember the first case I ever scrubbed into and it was like a Nissan redo on some kid. It was 10 hours

long and I just stood there the whole time and was I think I have to do surgery.

My atypical reaction, right? But in a prior life, I did a lot of sports. I was a competitive athlete. Swimming at a very high level. Race triathlons nationally.

Somehow that focus that I used to have for sports going to translate into surgery very, very well because it requires all dedication and focus. That was how I kind of became a general surgeon, at least a residency in general surgery.

From there on out, I had wonderful mentors in bariatric surgery, and again, it was not the thing that I thought I would do. I though I was going to be like a trauma surgeon or a transplant surgeon and you put those livers in people in the middle of the night, you know, something kind high-paced and exciting.

After a few years of that in residency, I just got really tired of like wounds and people dying and emergencies and all of these. The surgeries were just very hard on the patients and the outcomes were not always good.

And there was a bariatric surgeon where I did residency who said, you know, You're really good laparoscopically and you could really do this. And I want you to think about it.

She trained me and I just fell in love with the specialty. I mean, not even intending to, but you see these very complicated operations where you literally reroute someone's entire GI tract using incisions the size of pinky fingernails and they go home in 18 hours.

What other specialty does that? And then even better, the patients love it. They're happy. You're so happy they come back, they see you every year forever and you see their whole life change and your see your whole family change.

And it's just like, patient satisfaction rate is like a hundred percent. I mean, it is so unusual. to have someone who wasn't somehow satisfied with what you did for them.

So it was kind of the combination of, the actual surgery part of it, which I really did enjoy, but then also just the long-term relationship that which you get with patients and bariatrics is so special and very much like primary care.

You develop these long relationships with people and you know a lot about them and, you just don't really get that in other aspect of surgery. It was all those reasons.

That is interesting. Yeah, like you said, it's a unique thing because the commitment to lose weight is for people with the disease, obesity, they are in that probably for the rest of their lives in one form or another.

So that's really an interesting perspective on it. Why that is kind of your primary care, internal medicine roots, kind reflects back to that. Well, and ironically, the other thing that I really liked as a student was psychiatry, go figure.

It was almost, you would see these people in the hospital, they're going to medicate them and kind of talk through some stuff with them. And it wasn't anything that I ever thought I could do like in seriousness.

But there is honestly a lot of psychology in bariatrics and a of the psych meds you end up getting pretty familiar with because your patients are on them, and you have to tinker with things sometimes.

It's just a nice marriage of multiple different specialties, but you still have the surgery aspect of it and technically it's pretty advanced. Oh yeah.

Well, one of the things that I'm excited about on this particular interview, we have a lot of guests, people that they haven't met or people who are in different specialties around the United States, but you're in my network.

How Bariatric Care Differs from Other Specialties

Like I refer patients to you and so I am excited that i'm talking to someone that's in our own referral network, you have shared several patients over the years and really enjoyed that interaction, our patients love it.

Yeah. I think that for bariatrics, and I just say I'm an obesity medicine specialist. I don't know, a weight loss doctor sounds a little trashy, but definitely a Weight Management Specialist, an Obesity Specialists.

And I that many patients, the first time they come to this office, they don t really know what to expect. What they walk out of it with, if it's me or if its one of the PAs or our dietitian, their finally in a place that understands their story and understands the disease process.

And there are so many physicians out there that just don't get weight. And they say, well, you just need to diet more, or you need exercise more. You're eating too much, and you're not exercising enough.

They dont understand that some patients really need live in a major calorie deficit indefinitely, that it's not possible without surgery or medication or some combination of those things to get a hold of their disease process.

Patients are used to being told that they're lying, they are told theyre lazy, this is their fault. That's the messaging that we have here. And I think it feels good for people to finally have a spot that they can have that conversation with someone who actually understands their story.

And, you know, I'm not heavy, it doesn't run in my family, but it's my whole professional practice. It's common that that's the experience with us. I mean, most weight management practices.

I would say it's too bad in some ways that that's the message our patients have received. I come across that all the time as a primary care doctor. People have heard that message again and again, and many of them have genetic obesity.

That's not something that they have really done to get it. And that is what I try to frame for people and say, you actually have a disease and of course you need to eat carefully and build your muscles and all that kind of stuff.

But if you're talking about the disease, obesity, it's really important to treat it because if we don't treat, you will have tons of downstream effects.

And I wish there were fewer social implications and less of the negativity that seems to surround that disease. But it is really like life-changing for people when they go to someone like what you are saying and they get not a message of looking down at somebody telling them how to change, but as a peer, a colleague or a friend saying, well, I can help you.

Of course, there's so many different reasons for the obesity epidemic, right? And everyone wants to say, oh, it's inactivity, It's this, its that. I mean, many things, but I think genetics, epigenetics and the food environment that we have are like number one, number two and number three.

And so you're a child growing up in poverty with food scarcity and a family that all suffers from obesity and metabolic syndrome. Well, I mean, what's going to happen?

A lot of my patients have struggled with weight since childhood and that's not something that you can really control. So. The one thing that I have noticed with the whole GLP-1 revolution, I've been part of that.

I mean, a big proponent of these medications in the right circumstances. And I think what that has done, it's made obesity as a disease more approachable for a lot of people.

And more and more people who were unwilling to address weight or unwilling, to recognize that maybe they did actually want to work on weight loss or maybe did have a problem are now coming out because these things are so mainstream now.

And so that is a change that I've seen. I think even compared to five or 10 years ago, a lot of people are coming in now with a little bit of a different understanding than they before, before these meds were so common.

If you see that in your practice with your primary care patients, I do. I think what I've observed and a lot of people have observed the same thing, that patients are recognizing that all the cardiac disease, the ends and strokes and heart attacks and all these issues are heavily related to metabolic disease and metabolic diseases heavily relate to obesity.

And so I think people are making that connection increasingly as the public becomes more aware of it. And then there are medications and surgeries that have really helped.

It seems like people were more willing to accept that than they ever were before. So I thinks it's good, but there's a lot of education with all of these different treatment options that needs to happen.

Yeah, educate us just a little bit.

Patient-Centered Weight Loss Treatment Options

Again, you know, if you're talking to mostly physicians, how do you approach that when somebody comes in? Because I think, at least when I went to medical school, that was the model we were given is you've just got to eat less and exercise more.

There's really not much else for you. And there was a bit of guilt and shame and all that kind of stuff built into that, which is frustrating because that's not very helpful in medicine at all.

How do approach it out? Like typically when someone comes and says, look, I've struggled with obesity. for decades and I've tried all the white lies things and i've been on Weight Watchers and nothing seems to work for me.

How do you approach that conversation with a patient? Yeah, so I tend to be very objective in the way that I approach this and just you know as a physician if you're approaching someone with diabetes I mean if their A1c is 6.5 versus 12. 5 you are going to have a different kind of algorithm there for how you care for them.

Of course, we take a pick-pick page in history and all of that and what have they tried and have not tried. But my general approach is to go off of what the patient's goals are and then to describe the different treatments that we have and where that would put them and the pros and cons are.

And then when the patients are able to make their own decision about the direction that they go with their care, they tend to stick to the plan a lot better than if it's something that I just say, well, this is right for you and I'll see you in six months when you're ready for your procedure.

So when it comes to weight loss treatments, there's a spectrum of options and lifestyle diet and exercise is essential for other treatments to work, but in and of itself, it tends to not be very effective.

And that's data, national data. Thousands and thousands of people that they've studied in NIH trials. So if you go on a low calorie diet, you get a gym membership and you do that for a year, You'll probably lose five to 7% of your body weight and then you're going to plateau and Then you are going get frustrated and it's not going be well sustained between two to five years.

So most of that weight is then regained. And that's the story of all of our patients that struggle with obesity where they're constantly dieting, they can't stick to it, or on a different exercise plan that falls off.

So in and of itself, that is never really a thing that I recommend alone because they are seeing me and obviously they have a goal of more weight loss than five to seven pounds of their body weight.

So the next step up from that is medications. And when it comes to meds, of course, the cost, side effects, insurance coverage, tolerance, I mean, these are all the concerns with medications, but depending on the medication, most patients can accomplish between 5 and 22% of their total body weight loss.

So if their weight-loss goal is 30 pounds and they weigh 200 pounds, medications make sense. That sounds like a good fit for that patient, depending their coverage of So the caveats with the meds are that like all medications for chronic disease, medications work when you're taking them.

They do not work. When you are not taking. And all of the lifestyle in the world will not replace a terzepatide 15 milligram prescription, right? Right.

So many patients are very excited at the possibility of medications for their weight but upon learning all of these other requirements you know that this does have to be more or less a lifelong prescription and it would be chronic therapy and all these costs associated that Usually there's a little less enthusiasm about that direction for patients with larger weight loss goals.

No, not everybody. And I do prescriptions for a lot of people and we never even get to surgery, but that's typically my conversation with meds and it just depends on the patient and kind of their coverage.

And then the last option for weight management is surgery. And surgery is the most effective option that we have. Total body weight loss is typically between 20% would be like an under responder all the way up to 40%. I've even had 50% before with certain procedures.

So for patients with larger weight-loss goals, by the numbers, this is going to be a better intervention. Then I talk about the pros and cons of procedures and the lifestyle changes that are necessary and all that stuff.

after hearing kind of these three different options, patients can usually identify where they're going to fit. And they say, I know I'm a hundred pounds overweight, and you're telling me that I don't have coverage for any of this GLP-1s and that would only get me 70 pounds.

So it sounds like a procedure would be a good fit, or it could be, well, if I have type 2 diabetes and my BMI is 34, it might sound like I might have some coverage of GLPs.

Based on that conversation, that's the direction I'd like to go. I say great, let's get you going. It's very individual. The other thing to consider is that this is not an isolated treatment.

It's not like you say, I only want this one thing or I want that one. All of these treatments work very well together and many GLP-1 patients after a few years do decide they want a procedure.

And many patients who have surgery still benefit from a GLP-1 or other weight management medication on the tail end. And I prescribed Fentermine before GLPs became a thing.

I mean, it's cheap. It works decently well. No long-term data that says that it is bad. That's like an OMA recommendation. you can get it for 15 bucks a month.

And if that helps us with 10 to 15 pounds of weight recidivism treatment, I mean, great. So I really do believe in using all of the tools. When you look at the disease process of obesity, this is going to be there for the individual's entire life and different treatments may make better sense at different times.

And maybe it's meds for 10 years and then a procedure and some more med or a procedures and med in 15 to 20. I mean, I don't know. Everybody's life is different.

So doing the obesity medicine part of the practice was also very important to me because then I can give people everything. We can talk about all the different treatment options and not just one.

This reflects like kind of a national conversation that needs to happen. And because obesity is so common and so many people experience obesity in their lives, and because it's so tied to negative health outcomes down the road, I think it is important that we kind reframe so everybody, when they go to their primary care physician or wherever they, they really need to have a conversation like that.

to say, where are you at? What's important to you? And what are the things that you can do? Rather than saying, well, just count your calories and exercise, we should talk about the lifestyle, the type of food that your consuming, talk your family history.

And it's almost like obesity in some cases has become so common, that we've stopped talking about it. We just talk the diseases that come from it, but obesity really does drive a lot of cardiovascular disease in general.

And so I love your approach. I think it's patient centered, it outcome focused, and it is real. Instead of saying we're going to do this one thing for six months, you're talking about a lifetime of change.

One of the hardest things to see, I have a lot of patients that come from all over, from Wyoming and Montana and other parts of Idaho and someone comes in and they're 400 pounds and their BMI is 64. And they say, well, we did phentermine for three months and my primary doctor said, if that didn't work, i would have to come see you.

Okay, let's talk about something else then, but having an understanding of just the relative efficacy of all of these treatments, I think is so important because if someone comes in with an A1C at 12.5, you put them on met for it.

I mean, no, they're getting like insulin and the whole thing. And those are the people that you really have to treat kind of more aggressively. So. think that as all of the weight management terror becomes more common I think a lot of people are gonna just become more familiar with this stuff but I Think the last thing to say with weight loss is that the best treatment is the thing that The patient is gonna do and stick to and There is absolutely no sense in doing procedures for people that aren't going to use them or for aren' interested in using them and there's no since in giving medications to people but aren''t going too also focus on the lifestyle that has to come with the medications.

And so I think the patient choice is important and their understanding of what's required of them for these things to work is also very important, and always try to incorporate that.

Yeah, I agree. One of the things we've come across or probably you do the same is insurance coverage on the various things, whether it be medications or procedures.

We've had people fly to Tijuana to go get their weight loss surgery and then they come back and it's not that the surgery went poorly, but they have no support system for potential complications and some terrible disasters.

Insurance Coverage, Costs, and Medical Tourism

It kind of breaks my heart when I see people just feel like they're so desperate that they have to take these steps that are really not going to give them the outcomes they want, because there's not a long-term support network like what you have described.

This is a really important thing to talk about, coverage for this type of stuff. And it starts when they are born, like, what kind of things are modeled as a family, and what type food do we eat, in what types of social situations we engage in.

But I think that it… As we talk about it as a nation, all this stuff has to come into play. What's covered and how does the patient respond to that?

And it's not a quick fix. It has be a lifetime commitment. So what comments do you have about the coverage and you address that with people? It's definitely an uphill battle in Idaho.

There are some states that are worse, so it could be worse. So there's other states are a lot better. I think that the coverage situation in any state typically lags like at least here around 15 years behind like what the data is suggesting.

And when you look at the finances of all of these treatments, which, you know, we're in it for the patients, of course, but we have to consider the cost of the treatments that we do.

The finances for these treatment are good, meaning that at least when we talk about weight loss procedures, they tend to pay for themselves in two years, sometimes three years.

the cost of the surgery versus the benefit to that patient and reduced medication usage, reduced hospitalization, reduce ear visits, or reduced doctor visits for all of their weight-related problems.

The surgeries are very, very fiscally sound things, actually. And I think I calculated, I mean, for most patients, they save at least $100,000 over the course of your life for the investment of surgery.

That's taking out what the surgeries cost, so there's a big benefit there. But coverage is still not there and we have all this data. Why is it not covered?

And that gets into kind of, you know, are the insurance companies covering people for more than two years? I don't have the answer for that either, but the insurances difficult to navigate for sure.

And so I always encourage people, if they want treatment, they don' have coverage. They need to go to their HR. they need a lobby. I think it's just going to take people appealing again and again, and people like me doing 600 doc-to-docs a year on various kind of treatment plans, but I think it will get better eventually.

And I mean, it has to, otherwise we're just not going to have treatments for weight. The medical tourism thing is a real problem in Idaho, and I that's because we have such a variable coverage environment here for surgery and then for other medications.

I would agree with you that this is not the patient's fault. I never fault people for wanting to take care of themselves. It's a failure of the health system.

When people have surgery outside the United States, it's very dangerous for them. As a surgeon, I take some pretty bad problems. They get on the plane in Tijuana, the airplane lands here, they come straight to the ER, we're working on them, but for the patients that don't have those technical problems, you know, They still have no support and then they don't know how to take care of the procedure and they can end up with nutritional problems and poor weight loss and weight regain or excessive weight lost and malnutrition and all the things that happen when you have a weight-loss procedure without appropriate support.

So, I think the more that we can do to make surgeries and medications more affordable and more accessible to people here, the less people are going to travel.

But until that happens, I can't say I blame them. I mean, people want to take care of themselves and I think they don't know the long-term implications of that.

Yeah, and as doctors, you see all the negative things that come through the ER and like, oh my goodness, what's going on? But it's like if we could just think about it.

I wish we could think about it systemically and that we had better coverage because I wouldn't recommend anybody to go do a surgery for a doctor that had no support, no matter what the surgery was.

You have to have the follow-up and training somebody in residency to do procedure, you could train them to it, but that's really not the most complicated part.

It's selecting the right patient and making sure that you have follow up and knowing how to manage the complications and, knowing to select patients that are more likely to complications versus not.

There's a whole bunch of training and support. And when we just fly in and do the procedure and fly out, even though you might be seeing a really qualified surgeon, you are not there to receive the support and care.

Anyway, it's just a tragedy in my mind. Yeah, no, It really is. There are some wonderful surgeons outside the US. That's not it at all. It's, not that our health system is so much better than everywhere else, but exactly as you said, if it is a support issue and all weight loss, including procedures, and involves lifelong care, And when you have the procedure done, it's not like getting your oil changed.

I mean, that's something you'd have to have some kind of ongoing follow-up for. So I hope to see a reduction in that trend. The next 10 years is going to be a big period of change in the way that we talk about weight and also the relative costs of all of these things.

And I'm hoping that can help with that situation, but I am right there with you. It's really sad when there's a not good outcome because in my mind, a preventable situation.

Maybe talk for just a second like what you just hinted as the relative cost. So say a person's on somaglutide or trisepatide and most of my patients don't want to hear that that's a long-term commitment.

Like we say that you're on this and at least for the foreseeable future, you might be on for decades at some dose or another. What's your experience as far as cost comparison of those who say someone needs to lose more than 30% of their body mass and they say, well, I don't want to do a surgery.

It seems like it's less costly because I can get compounded through zepatite at $200 a month or something like that. But what's the cost of comparison between someone that says I'm going to go do the surgery and kind of a one-time procedure versus someone who says, need to stay on a weekly medicine indefinitely.

The data here is like pretty powerful and this is not anything I have generated. This is stuff I've read and I guess repurposed for other people at times.

But the cost of performing a bariatric surgery and we'll start at the bottom, let's say a sleeve gastrectomy, that's a pretty straightforward procedure.

The cost to the hospital for those cases is typically $10,000, maybe $12,00. I want to say we get slightly more than that from Medicaid, but it's not like it is a particularly expensive procedure for state insurance plans and federal insurance to cover for.

If you were to put someone on brand GLP-1 and that, you know, it was Zempik or Wigovia or True Zepetide or whatever, they all run in the $1,200 to $1800 a month range.

Those procedures are the sleeve and then that therapy becomes cost equivalent at nine months. Really? Yes. Nine months of medication and you've paid for a bariatric surgery.

And then, you know, of course the cost of the medications continues to go up versus the surgery as a one-time investment that then generally over the life of that individual then saves them about the insurance companies and 75 to 120 thousand dollars depending on the patient.

And that's if we're going with the brand GLP-1. So there's really like no argument that would support better longevity of the medication, at least with current costs.

Now, the costs are coming down somewhat if you're getting these meds cash pay from the pharmacies themselves. And I mean like Lilly Direct and like Innovo have mail order pharmacy, usually in the realm of $300 to $500 a month.

Even at that point, I mean, if you do the math, let's say you're spending $300 a month for 12 months, that's $3,000. Do that for three years and you've paid for a bariatric surgery.

And that if that you going out of pocket.

Treating Obesity Earlier in Life

Then again, at three-years, you are going to hit that inflection point where you still paying for the meds, right, to maintain these results, but the surgery you not paying anymore.

So I think with the cost environment of these medications, even if getting a compound, These are not financially wise choices to make for many people if they would have a different alternative to manage weight with a procedure kind of for the overall outcome.

And nobody wants to think about the cost, but the truth of it is, I mean, We all pay for these medications with our taxes. Our own health system has to find a way to support treatment for obesity for everyone.

And I'm not saying that everybody needs surgery, but I am also not that saying everybody in the world needs to be on a GLP-1. At these prices, it's just not sustainable and I don't know how we can kind of shoulder that cost for everybody.

Over a third of the country is obese and that's a lot of very expensive medication that really has no like end point. So I dunno if that answers your question.

No, it's a nuanced discussion, but I think it is useful again for doctors who are listening to this or patients to have that conversation this day. Where do I fit on that spectrum?

What have I tried? How much weight do i need to lose? what's the relative cost now and what is my long-term cost? And then systemically, insurance companies need that conversations as well and say, for the right patient we should be covering this for sleeve gastrectomy for example.

For a lot of people, that's gonna be more cost effective and more effective for the actual outcomes. And other people they have a lower amount to lose and a moderate dose of GLP-1 is going to give them what they need.

Other people like you said, it's going be phentermine. They really just need a little bit and other do just really need to eat different and have different outcome because they just 5% weight loss and they're going achieve it.

I like this kind of systemic approach. It's not just one size fits all and then the cost part of it really is an important conversation with the individual.

But systemically, that's really important, especially if you're talking about a third of individuals in our country being overweight or obese. That's a tremendous number.

Very high. I mean, insulin is extremely expensive. Heart failure is sleep apnea is expensive, CPAPs are expensive. All of these things are inexpensive and so you have to kind of weigh the cost of that too, right, with the costs of the treatment.

And I'm not an economist. I never really was like a math person in school. So I stay pretty basic when it comes to the finances of all of this, but I think Making cost-effective choices as physicians allows us to help our health system sustain better.

And having somebody on a GLP-1 for 18 months and then having them not be able to afford it anymore and come off of it in the long run doesn't help anyone.

It actually makes the problem worse. Because every time someone loses weight, they tend to get metabolic

resistance. And then the next thing that you do, whether it's medication again or surgery again, tends to not work as well.

So I think starting with the most cost-effective treatments for that person that are going to make the sense is always a wise decision. Then having that be sustainable for them is very important.

So I'm a primary care doctor. What do we tell the parents of these kids? Because I saw a recent study that was something like 20 or 25% of high school seniors that were surveyed had pre-diabetes.

It was already in this place that are already overweight and already headed down that metabolic pathway. And I thought another study showed that as you are when you're 18 years old, had like a 90% concordance with your metabolic status when your 30 years.

So how do we start earlier, like, you know, in the preschool years and elementary and high school to make people so that they don't fall into this metabolic pathway that leads to so much dysfunction through a life?

Yeah, I think in pediatric populations, this has been a huge push by the AAP and they came out with some guidelines two, three years ago that were some considered somewhat inflammatory.

I was like yeah. but very kind of pro-obesity treatment in younger children. I think that the food always has to come first and the fluid that age range, if you're six years old and your entire diet is comprised of hyper palatable ultra processed foods and it's all juice and snack foods, and pop tarts and fast food, well, yeah, that's like a breeding ground for metabolic syndrome by the time that child becomes a high school age student.

So working with families and nutritional education when the children are young, most important thing. And then when their taste buds develop appropriately and then they're 10 and they'll eat a variety of different foods, you know, the obesity thing tends to be less bad.

If the children are already at a point where they are in the Obesity range or they have problems like fatty liver when they were 14 years old or sleep apnea when 15 or 16 years.

These are people that need treatment and that doesn't mean surgery, although surgery does work well in adolescents. But many of the GLP ones have dropped their levels down at 16. I'd have to check it.

And I don't have too many really young kids, I have some adolescents in my program. The discussion of more aggressive weight treatment when people are younger.

The worse the weight gets, the harder it is to treat. And so if you have someone who was 250 in high school and five foot eight, treat them in High School.

Don't wait for them to be 350 by the time they're 30, and then they are 450 by time their 40, then their 500 by they time are 55. It's just going to get worse.

The lower weights are so much easier to treated than the person who walks in at 600 pounds and it's like, well, If we're lucky, we can get 200 off, but then you're still 400. I mean, that's just a harder category.

So starting with lifestyle, absolutely.

Social Media Education and Where to Find Dr. Roth

But then adding in treatments when necessary. The struggle of the pediatricians is that the family may be adverse to this and they may say, well, this person is just, you know, they're just full-figured.

If the whole family is heavy and this is the lifestyle that this family has always had, how are they going to help that kid? And that is a hard question.

And I don't know if I have the answer to that one. A lot of appointments. Yes, it's not just one thing. I tell parents, and I try to think this myself, if you want to be different than the average person, then you have to eat and exercise different from the other person.

And it has to start when you're little. It can't just be chicken nuggets and plop charts for, you know, three times a day because that's what the kids love.

But like you said, they develop the palate and they've developed a taste where they only want those kinds of things where if you don't serve that as your primary meal, a lot of times they'll develop a palate, and develop variety of food tastes.

It's hard to teach it for sure. I have some adolescent patients, ASMBS and AAP will endorse surgery down to age 10, actually, if the child is really severely obese.

But I've done a number of adolescents, 15, 16, 18. They've all done quite well with a supportive family, of course. Usually when they have surgery, the food choices in the whole house change and it becomes more plant forward and more lean protein forward.

And they don't do juice anymore. They don' do junk food anymore, they dont have snack food in a house anymore and its not uncommon for like the family to have a reset in their health.

that kind of the benefit of having that intervention. I have a lot of couples where it's a husband and wife, they have some children, all of a sudden both of them feel their weight is out of control.

They go through surgery together or they go though a GLP-1 kind pathway together and the whole family changes. All of sudden all the food choices are better and so that's the other benefit I guess of treating the adults is that for the children you have the ability to intervene early.

Thank you so much. I want to talk for a minute about your website and your social media outreach, because you're busy. You don't have time to do lots of social-media stuff.

None of us do. But our patients are getting so many outside influences from not necessarily evidence-based or medical sources. And so I really appreciate what you are doing to try to educate the public.

Instead of just having it be one little soundbite from some Instagram or YouTube influencer, Now it's coming from a board-certified bariatric surgeon.

Tell us just a little bit about your efforts in that regard to try to educate the public. I think that, as you said before we came on, I mean, people spend two to four hours a day on their phone on various social media platforms.

And I was on a plane and I'm sitting next to this lady and she was TikTok for literally five hours. Scrolling. Like, how are you still watching that? It was just like total garbage.

This is how people spent their time more and more. Nobody goes to the library anymore. Nobody reads books. nobody goes through presentations. They're just on social media.

And so I was seeing so much misinformation in my community here, even among providers here among patients here coming in with these kind of strange conceptions about all of these different treatments for weight.

and I think a lot of people in My profession have kind gone this direction. I felt like I had to contribute to that. Yeah. So my website, I think it's where if people are engaged by the social media, they can go to the website and they read about all of these different treatments and what is the actual data and who's a candidate for what.

And that's for people that are kind of really interested and want to learn more. With the Social Media stuff, i've learned a lot about it. I started doing about six months ago.

But I find that the most authentic content is actually the stuff that does the best. And it actually doesn't take very long. If you're a physician and you are in your car and your driving to work and want to talk about something that you see for 15 seconds, slap some captions on it, post it.

People will watch it! If your standing in you kitchen drinking coffee and just take a picture of that and put some text on the screen with something to educate, people will just watch that.

So it doesn' have to be all this highly polished content, that stuff actually doesn't do very well. It feels forced. When I say do well, I mean, you know, it gets good reach.

People are engaged. So I think that if it's something that you're completely not uninterested in, then well that's fine. But if there's an interest in engaging with the public, It's actually not that difficult and it is doable.

I spend maybe three hours a week total. And most of that is just kind of thinking of things to say or how should I structure this certain thing.

Podcast Closing and Disclaimer

Well, and I think it's important. It helps people engage with someone who's really looking at the data and trying to get best outcomes. And the social media thing has taken over so much time and so energy.

There's not a lot of credibility given to people who have actually gone through the schooling and work. So we need more physician voices in this space.

I appreciate what you're doing. My patients who we have shared have loved working with you and I have really enjoyed looking at some of the content you've created.

And I just want to say thank you for what your doing, it really does make a tremendous impact on our patients. Yeah, I love what I do and i love helping people.

I'm happy that we here can be a resource for our surrounding community and hopefully help educate everybody. That's the nice thing about social media, goes everywhere.

Absolutely. So tell folks where they can find your website or where can follow you on social media. It's pretty easy. I made them both the same. The website is www.drrothweightloss.com.

My old practice manager actually came up with that handle, so I just kind of rolled with it. And then on Instagram, I'm at DrRothWeightLoss, pretty Awesome.

Well, I encourage people to tune in and follow if you're a physician listening. Look into those resources. It's excellent to become educated about it.

If you are a patient listening, get educated. Information is power. And it's just awesome to connect with you, Dr. Ra. Thank you so much for taking the time to do that and I hope you keep in touch.

Yeah. Thanks, Doctor Crane. Thanks for tuning in to the Doctors Making a Difference podcast. And thank you for what you do to help your patients and your community.

Your work truly helps so many people. We produce this content to have the tools you need to stay in medicine and to highlight the amazing work being done by physicians around the world.

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See you next time.