Introducing Dr. Akshita Mehta + Dr. Divya Kurian Transcript

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Podcast intro and host introductions

Welcome to the Dive into Health MD podcast. I'm Divya, an emergency physician. And I am Akshita, a radiologist. We're here to talk about medicine and whatever else we're curious about.

As a disclaimer, we do our best to stay up to date, but science moves fast, and so we always leave room to evolve our thinking. All right, let's dive in.

So for the first episode, We wanted to meet the hosts and introduce each other. You are up first. What's the 30 second version of who you are and what you do?

I am an ER doc, primarily. I have a fellowship in administration. So I do a lot of hospital stuff that nobody wants to do basically. And I'm also board certified in lifestyle medicine, which is maybe the opposite of emergency medicine in a of ways, but it focuses on how to use your lifestyle to be healthy.

Awesome. When did you first think, yeah, I'm doing medicine and why? I don't know if you know this, but I am brown. No, of course I have brown and of my parents are very happy that I m a doctor, But I' m from New Jersey.

And in Jersey, there's this weird thing where they were really, really desperate for EMTs at one point.

Divya's path into emergency medicine

So you can be an EMT at 15 and a half. I think is the cutoff. And for some reason, me and my friends in high school were like, yeah, we want to be EMTs.

We think that's cool. Honestly, the rest is history from there. So I became an EMT. Then I become a type of paramedic called EMC critical care, which is like a step down from parameic.

I went to med school and then I specialized in emergency medicine and here I am. Nice. Why emergency? Did you consider anything else? I think this is maybe a stereotype of emergency medicine, though, that we're those kids in med school that were happy in every rotation and could have easily done any rotation, and when we were on that rotation we are like, yeah, I'm definitely doing this!

And then when you sit down and look at your scope of everything you've done in medical school, you're like wait, what field covers everything? emergency, and that's kind of how I ended up.

Plus I guess I should have seen it written in the stars, given I started off my career as an EMT. Yeah, I feel like you were talking about cardiology for a while too.

Oh yeah, exactly! I went all over the place. I applied to internal medicine actually, i don't know if you remember that, then I really liked PEDs, they really like OB, considered psych for hot second, even considered surgery for second.

Like I did everything! Oh, anesthesia! Anesthesia was my other real intense be an anesthesiologist. What do people get most wrong about your job? That it's the pit.

Have you seen the show? No, I'm not sure of medical shows. I saw like a soccer is not me for a little bit a couple of couple seasons and then that is literally only one and I was like I get enough of this medicine crap in my life.

Like I have no interest in adding this to my TV regimen. Well, the pit, it came out kind of recently and it's actually really good. It's really accurate.

Emergency medicine misconceptions and superpowers

The main thing, main two things that I cannot, I couldn't even fully watch the show because the entire time I was watching it, i would be sitting there like trying to memorize everything that the patient said and all of the things they did and ordered because in my brain I needed to go back and write notes which they never show in the Yeah, no, there's no one writes a singular note in that entire show.

And the other thing is like every, it's each episode is an hour in the emergency room. and so like there is crazy stuff happening back to back, to, back and back.

So now people have been coming up to me and being like, is your job that crazy? And I'm like. Yes, actually it is all accurate, but I don't get all of that in one shift.

Like maybe that one hour is my entire shift, one crazy thing happens. Not back to back, but yeah, writing notes is a pretty integral part of the day. So very convenient that they left that out.

But man, there were so much that was inaccurate about Grey's Anatomy. Those residents were like the ER docs plus the surgeons plus every other subspecialty, they absolutely no sense.

That's why the page is so good. It's actually accurate and it shows actual hospital dynamics and our code words and stuff. Nice, okay. I'm kind of the answer to this one, but I want to see if you say what I think you're going to say.

What is your actual superpower at work? What are you unusually good at? Probably efficiency. Okay, that's not what we're gonna say, what were you going say?

For context, Akshita has been my CT scan reader mentor. And she spent an enormous amount of hours trying to teach me how to find that appendix and I still can't find it.

I do. Actually, did I tell you this? I have a reputation now as the person that reads their own scans and like people come up to me and ask me for advice on how to read the scan.

And I'm like, who do you, what? And then I was like oh wait, yeah, I just kind of sometimes do know what I am talking about. Yeah, you told me that. That's why I thought that was going to be your superpower, that you were like the eating radiologist.

You guys need patience. So cool. could influence that on you. Also Neil, our friend, I got him to actually put indications when he orders radiology scans.

Yeah. And I would like to say that's a superpower. What is the hardest part of your job that outsiders don't see? That's the hard question to answer because it's, it would say the emotional weight of everything that you're trying to see and handle, but it is not in the moment.

Like you'll see a really tough case that is really sad. you know, horrible trauma or some horrible diagnosis of cancer. But then in the next second, you have to walk into a totally different patient with a whole different complaint and then have forgotten in a sense that what you just experienced.

And I think that rapid switching is really hard. Though I don't know. I that maybe most people know that about the ER, maybe? I bet a lot of people don' t think about it.

So let's follow up. Do you debrief at all? Or do you get any of that?

Hard parts of ER work and patient expectations

Yes and no. For example, if someone dies, we all do pause and do like a moment of silence. Or if we have a really tough, medically complex case, I'll try to debrief it in that we'll talk about really quickly what went wrong, what

happened.

I do think as a resident or a med student, you have more time like that. As an attending, You don't have choice. You have to see the next patient. You have to, yeah.

You don't really have a choice in the matter anymore. And to be honest, the hospital system probably doesn't care about you that much anymore, so they don' t give you the time anymore to debrief and take psychological breaks.

What do you wish every patient knew before coming in? I think people don t understand what an emergency room is. Unfortunately, most people come in hoping for an answer, and I will say the vast, vast majority of the times I cannot give you an answer.

Most people are looking in, you know, they're coming in with, say, chest pain, something simple. Well, I can't say chest is simple, but something straightforward.

And they are like, what is causing my chest and fix it? And neither of those things am I often actually doing. Usually I'm giving maybe a pain medication to band-aid over the pain for a little bit, and I am ruling out emergency things.

And then the rest is up for your primary doctor typically or specialist or outpatient team to figure out. And I don't think people understand that. So they often leave feeling really unhappy with their ER visit, not understanding that this is fundamentally the role of the ER.

I also hear this thing that patients will say is like, they did nothing for me. What they're not understand is on the back end, we've ordered a ton of studies.

We've order a tone of imaging. But to them, it feels like we did nothing because we are not able to tell them what it is and fix it. Yeah. But you're making sure that the emergent critical things are exactly.

And then if they're going home, going to be stable. Which is huge and not always straightforward and always easy to do depending on the person. So yeah, that's cool.

What do you wish every doctor knew about your specialty? The same thing. I cannot tell you how often outside care people, SNFs, even like actual other ERs will send people to the ER being like, do something.

And we're like what do you mean? So yeah, really the same that the year's role is purely to rule out emergencies. Sometimes we get lucky and we can make a diagnosis.

So that's the rare case, not the rule. What do want this podcast to be and what you want it not to?

Why the podcast exists and what it should be

For me, I miss what we had in med school, which was a forced way of formalizing talking and while learning simultaneously. Like, friendships are interesting, especially as you get older, in that it's hard to keep in touch with people, even the people that are your best friends, because you'll call them up and you're like, what's new with you?

And you know, like chit chat a little bit about stuff and then you kind of fall out of touch and call each other again a month later. And I think the one nice thing about training and being in school is that you are forced to be with each other because you're studying together or you know, trying to figure something out and teaching each and I really want this to more of a between us way to keep that kind of spirit alive.

How much time do you think we spent together in med school? How many time did we not spend together? Okay, that's fair. What topics are you excited to argue about?

argue about whole body MRIs. I am here to argue with you. What's your we're not giving advice line for listeners in

your own words. And there's actually an art, not a science.

It is a practice. Honestly, you cannot give advice without knowing the background of that specific case. Yeah, I mean, it is helpful to talk about to provide education and to works in physiology, common disease processes, but to take any kind of direct guidance or, you know, advice is not possible unless you have a specific relationship.

Yeah, and arguably dangerous. What's one non-medical thing that makes you interesting? Can I answer this for you? Yeah. This has to be a part of the video component though.

You have that i think makes you incredibly interesting. are you outing me? i am, yes, absolutely. this is this book that you have written, so i'm assuming this was like an empty journal or i m sure it was, right?

Akshita's radiology background and lifestyle medicine

and as we have been learning about wine and then you will have gone way above and beyond and studied way more than i have, but you had filled out an entire like journal hand written with an index about everything related to wine.

But you sound like it's unique to wine. I just like writing things. And maybe that's what's so unique about me. Like I really like stationary. Stationary?

I think you like learning. Well, I also, yeah, also really liked learning Well that is all my questions for you. Okay. So let's start with what is your 32nd version of who you are and what you do?

Okay, so I am also a doctor. We met in med school. I went into radiology and then further self-specialized in neuro-radiology. So professionally, that is what I do.

I am also married and have two kids. And then starting this company, died in health and really kind of stemming from just seeing a ton of chronic disease.

In med school, I was obviously in the hospital and in clinics and dealing with patients who were varying levels of sick. But then as a radiologist, seeing it day in and day out constantly.

So when you're practicing medicine clinically and you in front of patients, there's only so many patients that you can see in a day. And depending on what you are doing, that might be like 15 in clinic or 20 in clinical or 30 or something like that.

When you practice radiology, That number multiplies and I can hundreds of scans potentially in the day, so the amount of disease that I was seeing going from clinical medicine to radiological training was so much more.

inundated and I mean, almost like, like what you were saying in emergency, it's almost, It's a clean roulette. Every time you open a case, if I close a, case another one just kind of pops open and you have no idea what it is going to be.

It could be a fully normal case. it could a massive brain tumor or pancreatic cancer or something absolutely terrible. And you just, you never really know what your in for and it can sometimes be, a little bit of a surprise and kind, of heartbreaking.

and then very similarly, close the case and report it and oftentimes, If it bad, call the doctor and tell them what's going on. And then you just open the next one, you keep going and you do this day in and day out.

And so there was just this, uh, yeah, kind of string of. of chronic disease day in and day out. And so we've been for our own health learning, things that we can do to try and stay healthy.

But then maybe one day being able to teach this to other people. Maybe you kind of covered this with that answer,

but one question that often got when we were at the Lifestyle Medicine Conference was, you're a radiologist.

You don't see patients. Why the heck are you getting a board certification in lifestyle medicine? Yeah, so yeah, there was definitely this point where I was like, man, you know, early career, am I really just going to talk about the same disease processes over and over again for the next like 40 years?

Like, is there anything that we can do to try and prevent some of this or just play a different role in medicine? And so you and I did a board certification in lifestyle medicine, and we went to the conference, which is part of getting that certification.

And I am sure I'm the only radiologist there and got this question all the time, like what are you doing here? Are you going take this back to your patients?

This makes no sense. And at the time, I mean, had no idea, but I ended up getting really interested in food. And learning a lot about food and food quality and how to find quality food products and help vastly different food, products on the shelves are in grocery stores.

Um, and so that's kind of where it started and then started building a docu-series and. But also was still very interested in all other aspects of health, like sleep, which I've had issues with and movement and exercise and a whole bunch of factors.

And then, so, that where Simon Health came from. What is something that you're still bad at?

Learning radiology, humility, and missed findings

A lot of things. I think that's the beauty. There's always room to go up with everything. I mean, medicine is endless. One of the coolest and most humbling parts about being a doctor is experience is definitely the one thing that you can't trump.

You can read every book under the sun, but the experience I really think is what makes you a good doctor. But even doctors who have been practicing for decades often see something new.

See something that they don't know. And when I was choosing radiology, someone mentioned this to me and they were like, if you're going to go into this field, be prepared to be humbled.

You will never know what is on the next scan every single time. Every single day that he practices, he still says that you find something new. And he was like in his fifties.

Um, and that's entirely true. I saw something this morning already that I had just never seen before. It was a weird orgal mass that looked very strange on MR compared to CT.

and it's really humbling. you can try really hard, but there's nothing seamless. I mean, and in that line, is there a particular miss or a particularly like common thing that you're the most worried about missing?

Most worried. I think it's the thing you don't know. That's something that we learn through training, which I feel like is almost one of the more beneficial things.

You get to this point in medical training where you gain a little bit of confidence and you know, like, oh, I know things I can take care of patients.

treat ammonia and heart failure and then you keep going and you're like, I know nothing. Because the thing that's scariest and the think that I'm gonna miss is the things that i don't know.

Yeah, so true. I feel this every day in the ER constantly. And that the challenge of the ego when you see someone who I so confident about something or so competent that they're not going to miss something.

I think that's honestly like the person that scariest. Cause you're now. And I. Think back to my like most impressive attendings when I was training, it's the people that were like looking up stuff on Google or looking at stuff, on up to date or whatever.

Those were the. People that I thought were. The most. Impressive, not the ones that are running around just being like, I know the answer to this. Yeah.

Because you have to stay open minded and you. Have to always think about, well, what else? Because if you see a mess in the parietal gland and it looks the same as another mess that you've seen, then you're just going to call it that thing.

But if your not open to it being something else, you are never going realize that it actually was something. And we learn rules, like brain tumors sometimes are hard to see on noncompensate keys, which are ordered very frequently, but that's not a rule.

You can find them if look for them. They're hard and they're subtle sometimes, But, if know what to look or if have the experience, they are there. always being open-minded and always realizing that there's more to learn and there is just stuff that you haven't seen before.

Speaking of masses, what's your take on incidentalomas? I don't know if this is controversial. I mean, I think they're challenging to deal with. Okay, so what is incidentoloma?

What is that? That's when someone orders a scan and we find something that we weren't expecting. So someone ordered a CAT scan of the abdomen because they were suspicious for appendicitis.

Maybe someone comes into the ER and their abdomen is really hurting and the doctor thinks they might have appendicitis, reasonable to order a CAT scan of the abdomen to look.

And then I, as a radiologist, would read that scan. But what if I see a lesion in the kidney? Right? What if i see the lesions in pancreas? That's what's called an incidental loma.

Or oftentimes when we get a cat scan at the abdominal pelvis, we got a little bit of a lung basis.

Incidentalomas and the debate over whole-body MRI

What If I See a Nodule in The Lung? right? what do you do with that? And the challenge in medicine is, well, what are you doing with it? and ethically, once you see something, you kind of follow it until you figure it out, right?

You can't leave a potential lesion in someone that could theoretically turn into a tumor if we don't know exactly what it is and not do anything about it.

So what happens is we end up following these things and there's a lot of downsides to that. The downsizes are one, you're more often than not asking for more radiation down the line, and then the two is you are giving someone a ton of anxiety.

Right. It's never fun to say, Hey, you've got this little thing in your pancreas. I don't know what it is. You know, in six months, let's get another scan and see if it changes.

That's incredibly anxiety provoking for someone, which is tough to do, but you're not going to not do it. Right? You kind of end up having to follow these things until you get an answer.

And sometimes the best case, the, best thing to you is follow it for five or 10 years. Sometimes there are some. really slow-growing tumors, where you almost need like five or 10 years to decide, hey, I think this is benign, has not changed, now we can let go.

That's terrible to do to a patient. But if it's something also like a pancreatic lesion, you're not gonna biopsy that thing, right? It's not a safe place in most instances to biopsy.

Now, there are some lesions in a very specific part of the pancreas, like the pankreatic head, we could do like, a terrestrial biocines, maybe not that risky, but for a lot of things, it not worth it to see it.

So then you literally just scan it, So, I mean, don't think that there's a better answer. I think a lot of times the best answer is don' intervene, right?

Don't do an invasive procedure because there are risks of that. But the downside is a of anxiety, time and money and potential radiation. So that's not like good either, but this is why you don''t want to over image.

Yeah, because the, people want. scans of their body, right? It's almost like a reassuring thing. And then there is something called therapeutic skin, like something that we talked about where Um, especially in residency, we would call a clinician and say, Hey, look, I don't think the scans indicated, you know, based on your note or based what you're saying.

I think this person really needs, or I'm not going to be able to give you the answer. Based off of this. And a lot of times, it wasn't an emergency medicine physician.

Like, Look, this patient really wants a head CT. They don' want to leave until they get it just to make sure. and I mean, sometimes it happens where we just scan them even when it's not indicated.

That would just say the most that we could minimize that and scan when medically indicated we're going to reduce the amount of insulin along this that we find because the vast majority of those incidental things end up being nothing.

Well, this transitions us nicely into my next question, which is how do you feel about whole body MRI? Oh, okay. All right. So my take on whole-body MRI.

This may change over time, but today. Originally, I was way more against it because I've never read these, so I'll say that disclaimer. But originally, what I had heard when they first came out is that these were essentially not back-mass, at least a lot of them were.

If you think about an MRI, the way that happens in a medical setting, we image a very specific part of the body, depending on what you're looking at. It could be the knee, if you were looking for a miniscule tear, an ACL tear.

it could the head if your looking a stroke or something. And the reason that we do a specific body part is because there are these things called coils, which we need to put in close proximity to the part that you image in order to get enough resolution to make a diagnosis.

If someone wants a MRI of the entire spine that is a massive area to cover, it's three separate MRIs. We order MRI the cervical spine first, and then we do the thoracic spine, which is the middle spine.

And then the lumbar spine which the lower spine we don't have an MRI, but the whole spine is too large and the resolution won't be great. So when whole body MRI came out, at least from what I've heard, initially, if you're imaging the interior body, the resolutions wasn't diagnostic enough and I just, they kind of sounded like a skip.

Obviously, they've been out for quite a while. Technology changes really rapidly. And from what I've heard, the resolution is actually decent and you can find things.

But I think this ties into the incident alone thing. Right now, there's no guidelines for everyone to get these done because I at least in many cases, we are doing more harm than good.

And almost bidirectionally, someone may get false reassurance thinking that they got a whole body MRI, it was

negative, and then there's nothing going on with them, which you can't find everything on imaging.

And then the other way around, we might find like an incidental trauma and now a person's panicked and that ends up being like a benign lesion that would never turn into anything and you could have like died never knowing that you had this thing and would have never caused you worry and it would've never impacted you from a health perspective.

And there are unfortunately a lot of things, not a whole lot, but there's several things in the body that are like that, that do not harm you, do no kill you.

They just happen to be there in some people. And so that is my main argument against the whole bloody MRI, because I think a lotta people that also are inclined to get these may be a little bit more anxiety prone or worried, and that's why they're willing to spend so much money.

Teaching, parenting, and the podcast vision

So then if it comes back saying, hey, there is this thing in your pancreas, I don't know what it is. That's horrifying. Could be to some people. And I think in some instances, it's probably doing more harm than good.

Now, of course, there's always the argument out there, you know, someone had one and they found an actual kidney cancer. and I that's like the most common example I've seen.

Get a renal ultrasound, I don't know. Of course if you image everybody, You're going to find things. But I also think it feels like not the right answer to say that every single person should be getting these.

Pivoting a little bit. If you weren't going be a doctor, what would you be? I have no idea. I don't know. I think if I wasn't going to be a doctor, I'd think teaching.

And I like teaching, and I also really like learning and teaching and synthesizing information and finding a way to make other people understand it. So I have two kids now.

My oldest is four, so I've got little kids. It has been really fun finding ways to teach through play. Little kids all day is so cool, I think. And maybe it's such a dichotomy from being in the hospital, right?

They're so excited about everything, like a leaf could fly by and they're ecstatic. Everything is happy and sparkles and rainbows as opposed to the feeling sometimes of being at a hospital for a long time that maybe that's it.

But the energy of little kids is kind of magical. So maybe not. Finally. What do you want this podcast to be? I want it to fun. And I wanted it be a space where we can learn and where you learn together and hopefully have some really cool conversations with people from different walks of life doing really things.

Basically, like almost like a compilation of just people trying to make the world a better place. So like including doctors, but then a whole bunch of other people.

I think what's interesting about medical school is you get exposure to still need different types of doctors and so many different specialties. And once you become an attending, it can be a little bit more isolating.

I mean, I do talk to emergency medicine doctors probably the most, and I did occasionally talk primary care doctors, but these are not like extended conversations.

At least for me, It's like, Hey, your person has a stroke or they don't have a struggle or Hey you're, you know, like primary caregivers person. Incidentally, found this mess that you need to follow.

Um, but I don't get a lot of in depth conversations about what their practice is like. And the types of things that they're seeing in the problems that are running into.

So I think this would be a cool avenue for that. But I also even getting away from medicine because also learning, like, there are so many other things are impacted.

that impact our health. And so talking to farmers has been fascinating, talking with people in the food production industry has fascinating. I also want to talk to people from the finance world, and that's another huge part of the Dive in Health series, tying finance and health, because a lot of people make food and stressful and healthy decisions based off of financial reasons.

So yeah, I think in general, just a space for us to learn to fuck with a whole lot local people and grow ourselves. That's our show for today. Thanks for hanging out with us.

Reminder, this podcast is for entertainment and general education, not medical advice. If you've got a health issue, talk to your own clinician.