Introduction to Thyroid and Obesity Medicine

Hi, I'm doctor Kelly Halderman. I'm a former medical physician and author of The Thyroid Debacle. I'm now devoting my life to education, research and biotech because I realize we need educated people to bring us cutting edge information, especially when we find ourselves with a diagnosis such as hypothyroidism.

When I was practicing allopathic medicine, I myself became very sick, bedridden with what would be diagnosed as Lyme and mold infections. Along my health journey, I was also diagnosed with Hashimoto's thyroiditis, a condition I was told that could only be managed with medication.

Well, I'm here to tell you that there is more than medication to help you, as you will learn through my powerful interviews with several functional medicine practitioners.

There are tools that will help empower you to take charge of your health. Join me today as I interview leading doctors, naturopathic specialists to uncover the most useful health insights for you.

This podcast has been launched in collaboration with Doctor Talks. Visit them today at Doctor talks.com. Backslash Calendar to learn more about their upcoming summits.

Hi everyone. This is Doctor Kelly Halderman. Welcome back to Doctor Talks where we're focusing on thyroid health. And we have an expert guest who is amazing.

And she is an expert in obesity medicine. And she's also a physician entrepreneur. Welcome, doctor. Catherine Saunders. Thank you, Doctor Kelly. I'm excited to be here.

Yeah, I'm really excited to have you here. Everyone's talking about obesity right now with Mozambique and, you know, Real Housewives and what is going on with this.

And so I think this audience at the US who struggle with thyroid disease, you know, some of us do get into situations where we're dealing with obesity.

And so I'm really excited to talk with you specifically about this because you're an expert. So tell us about how you got to practice in this field. What made you choose obesity medicine?

And tell us about your clinic and what you're doing right now. Sure. Thank you for asking. Happy to share my story. So I, did my training in internal medicine at Weill Cornell Medicine.

And when I was practicing internal medicine in primary care, I just could not believe how many weight related comorbidities I was treating with multiple medications.

Dr. Saunders' Path into Obesity Medicine

And I didn't have the tools or the resources to address the underlying cause of many of my patients medical problems, which was there under overweight or obesity.

And so at Weill Cornell, I came across Doctor Lou Irani. He gave a talk when I was in medical school that I thought was just so interesting. He is my, my, my mentor and our co-founder of our company.

He's one of the pioneers of this whole field of medicine and has really devoted his career, to developing treatment strategies to treat obesity. Starting in the 80s, you know, people thought he was crazy, and he persevered.

And now this field of medicine is just absolutely blowing up. But I know who he was from medical school from a

lecture he gave. And then during my residency, I started to work with him in my, you know, residency practice.

We had, a weight management elective of, I, did all of that. And then we, started a fellowship at, at Weill Cornell in obesity medicine. So I was the first clinical fellow in obesity medicine, basically training with him and the other physicians at the Comprehensive Weight Control Center at Cornell.

For a year before I joined the faculty there. And it just fell. It still does feel like such a luxury to me. To be able to help people, become healthier, reach their health goals, resolve or improve their weight related health conditions by helping them, through diet, exercise and, you know, medical approaches to weight management.

Great. And we're going to get into every facet of that, which is going to be really interesting. But let's start off with getting granular on the term obesity.

What is obesity? Great question. Because it's it's really, debated right now the best way to, you know, assess people's weight and people's metabolic health.

You know, we still use body mass index or BMI, which is a ratio of height to weight to categorize obesity. Just because it's cheap, it's easy. Literally all you need is height and weight.

There are many, many, many problems with body mass index that I'm happy to get into. But we define obesity as body mass index over 30. And so that doesn't take into account, you know, fat versus muscle mass.

It doesn't take into account different cultures, different societal differences. But that's kind of a crude way to, kind of risk stratify. Okay. So you you did say there are some pitfalls to BMI and you mentioned a few.

Anything else? I mean, it is a crude measurement. Indeed. And it really is not a true reflection of body composition. So can you comment on that. And then, do you use any other tools to better characterize obesity.

Yeah. So, you know, obviously when we look at a patient, we don't just look at their body mass index. We look at all of their weight related health complications.

We look at a large panel of labs, we look at their family history. We look at so many different factors that are affecting patients weight. So we take into account everything that's going on that affects weight in any way.

The standard of care in this field is, is really going towards more thinking about, you know, body composition and sort of ratio of, of fat to lean muscle mass.

And so there are companies that are looking more at body composition and their scales now that, you know, measure body composition. And many people argue that that's a better way to, take a look at, metabolic health.

You know, a quick, easy, dirty way is to measure waist circumference. When I was in person. Now I'm all virtual, but when I was in person, I used to actually, use, a waist circumference, you know, tape measure to measure my patients waist circumference.

Defining Obesity and BMI Limitations

Because we know that abdominal obesity or visceral obesity, that fat in people's midsection, that that's the severely around, our abdominal organs, that's the more dangerous fat that we're concerned about.

And so when we measure waist circumference, that gives us a good idea. So for women over 35in and for men over 40 is where we start to get concerned. Okay. Interesting.

So it seems that obesity isn't just a symptom, but it's a disease in of itself. So why is it a disease. And you sort of do allude to this too. So let's go a little bit deeper on that.

And that again why is obesity a disease. Great question. This is something that, you know, many people and even many health care providers, don't know as much about obesity because we don't learn about it.

During medical training. This is changing, which is a great thing. But, you know, we understand that obesity is a disease because there really are distinct path of physiological and distinct hormonal changes.

When people gain weight, what happens is that there actually, changes that happen in the area of the brain, the hypothalamus, which is sort of our energy regulatory center.

And so with excess weight, there's actually swelling or inflammation that doesn't allow feedback signals to get through from our fat cells, from our stomachs, from our gut.

Telling our brain how full we are and how much fat we're storing. And so when you start gaining weight, many people will say, I just feel like I'm more hungry than I used to be.

I feel like I'm thinking about food more. These are real physiological changes that happen that actually caused this feed forward mechanism. So when you gain weight, you tend to gain more weight and more weight and more weight because of these distinct physiological changes that happen with excess weight.

So it sounds like you're saying that the old adage of eat less, exercise more might not be exactly the key. When we're looking at a disease, when we're looking at a disease of obesity, with the physiological changes you just mentioned, it seems that that information would be very outdated.

And so you as an obesity expert, you know, describing those changes, I'm sure a lot of people can resonate with that and that, you know, they're eating a lettuce, the salad, you know, once or twice a day.

But there's still so, you know, they're gaining weight on their appetites. Disregulated. And that's that's very interesting because I think that we sometimes think that our bodies are broken and that there's something wrong with us.

But this goes down to the the molecular level of, you know, what's happening in the brain, what's happening, you know, that's causing those changes. So it's it's very interesting.

So what you're doing in your clinic then is medically treating obesity. And so, can you give us insight into that? Sure. Just to kind of take a step back and explain why eat less, exercise more does not work.

You know, it's it's amazing how, you know, when when, you know, providers don't understand how obesity works. Many of our patients will tell us that they've seen a million doctors who said, oh, just eat less, let's exercise more, just go off and lose weight.

Why Obesity Is a Disease

And it doesn't work for most people. For some people, they can eat less, exercise more, and they will gain weight and keep it off. That is a smaller percentage of people.

But for most people, what happens when anyone goes on any given dietary strategy is that our bodies basically go into this anti starvation mode where our bodies don't want to starve.

So if you start eating fewer calories, if you do any sort of, you know, regimen or program to lose weight, you end up getting more hungry. You think about food more, your metabolic rate slows down as you lose weight.

You actually burn fewer calories at a lower weight than a higher weight. And this is all part of a phenomenon that we call metabolic adaptation or adaptive thermogenesis.

And this is why by the time most people come to see us, most people come for, you know, medical weight

intervention. They've lost and gained and lost and gained many, many, many times, because their body is anti starvation, responses keep pushing their weight back up and each time this happens it can get harder and harder to lose weight until somebody's body can be really, really refractory to to weight loss.

Yeah. And all this psychological stress that goes along with it I'm sure you see patients that are very scarred. I mean they're doing everything they can.

Their lives are revolving around counting calories and in trying to lose weight and it's probably just really a nightmare. And for you to come in and really explain this, that adaptation, it makes so much sense.

It makes so much sense that, you know, even with the cell danger response. You talk a lot about that. Our bodies are very intelligent and they're doing things to protect us.

And, and so this kind of sounds like an adaptation where when you start to lessen your calories, that's really what your body's doing to protect you. And so when you see patients are they are the majority in that category where they've done so much of that back and forth, back and forth that they're they're really, you know, in a different situation.

And if so, you know, even if that's not your majority are you still able to help those people? Yeah. Good question. So, by the time most people see us, they've tried on their own at least a couple of times.

And maybe they can lose weight. But as you said, you know, each time they regain weight. And so what we do during our initial visit is to explain the physiology or explain the pathophysiology and really educate patients about how this is a disease.

This is not a lifestyle problem. This is not a matter of willpower. And there are reasons why they're it's been really impossible for them to lose weight and keep it off.

So going back to your previous question, we got a little bit, sidetracked. But you know, how we approach patients and how we help them lose weight medically.

And if we can help these patients. Yes. What we do when we see a patient is a very, very, very comprehensive evaluation. We look at a series of labs, we ask tons of questions about their weight, history, their medical history, everything going on that affects weight.

And the purpose of this is to identify every factor leading to weight gain, identify every barrier preventing weight loss. So that we can come up with a comprehensive treatment plan that addresses each of those factors systematically, so that we can really get this to work, because if we miss something big that's going on, you know, it's not a one size fits all approach.

Like, sure, you can give every single person an expensive, you know, medication that can work, but if you miss the fact that they're on for other medications that are weight promoting, that they're doing night shift and their circadian rhythm is off, that they have undiagnosed sleep apnea, that, there are other lifestyle dietary factors, that are really roadblocks.

It's going to be hard to make as much progress, and it's going to be hard to, you know, make as much sustained progress. Yeah, I can absolutely see that happening.

And when we really don't go deep, like you said, there's so much that's missed.

Metabolic Adaptation and Weight Regain

And that reminds me of the paradigm for for treating hypothyroidism, looking at the TSH in the T4, there's so much more to it. It's much more nuanced than that.

And when we really look at the global picture of the cellular or hypothyroidism that is happening and all the root causes, all the y's, all the cellular stress, we can start to really knock that stress off.

And start to really bring that person back to a more of a homeostatic state than an allostatic state. So I did have a question. Do you employ the use of genetics at all?

Do you find that helpful at all in your evaluation? So I definitely do a family history. And that kind of feeds into my education. So, you know, most of our patients have a family history of obesity and or diabetes.

And so I use that to explain how that can make people more susceptible to weight gain. And just as, as an explanation of why everything is going on and talking about kind of the combination of genes and environment and how everything, you know, has a role, we're just not quite there yet in terms of, you know, you can't just go to a genetic test and have it, you know, give you, a comprehensive treatment plan.

There's a lot of research going on right now. And I think that, you know, in the next decade or so, we'll be in a different place. But, you know, we don't really do genetic testing as as part of our work up at this point.

Yeah, I ask because there's a lot of genetic testing out there that promises to analyze your genetics. You're 23 and me or what not your your your data, your raw data, and come up with the perfect diet plan for for you and that you're going to lose weight on this diet plan.

And I think I agree with you, Doctor Sanders. We're so early in our understanding. You know, I do, I do obviously think family history is one of the most important things genetically you can really do.

But looking at genes like FTO and things, I think people get lost in the weeds and they start to try and do things that, you know, really, they're maybe gimmicky.

But they're really not rooted in science, and in clinical medicine. And, and so, you know, speaking speaking of clinical medicine, did you want to go into how you, how you medically treat obesity?

Sure, sure. So, you know, the cornerstone is still kind of optimizing lifestyle. So we talk to every single patient about, you know, dietary strategy about physical activity, about behavioral modification.

And, you know, when I first meet with someone, if all of that seems really different from what they're already doing and they want to try with, you know, that first and see how far they can get, I'm all for that.

But most people, as I said, have, you know, tried so many things and they've lost and they gain. So most you know, of our patients, we do end up, you know, using a medication the first time that we need them.

If you take a look at the FDA criteria for anti-obesity medications, it's, what we were talking about before a body mass index of 30 or above. So in the obesity range, or 27, which is in the overweight range with at least one weight related, comorbidity.

And so our expertise, is in pharmacotherapy for obesity. So the anti-obesity medications and how to pick, you know which one for which patient or which combination for which patient, how to be extremely strategic about prescribing these very responsibly and appropriately and safely so that people can tolerate them, that they work for people, and they kind of fit into the whole treatment plan.

Yeah. I actually, saw a quick video of Chelsea Handler, and she was describing that she was prescribed ozempic. Now, she probably doesn't have a BMI anywhere near 27, but she was prescribed this drug, anti-obesity drug.

And and she said that it kind of made her nauseous. So she started to have her friends come over so that she could inject her friends who are a little overweight and, you just, you know, you just really emphasize that you're very strategic, and you need a medical provider.

You need one who's very knowledgeable, like Doctor Sanders, to come in and really evaluate. And again, it's not just the medication. And that's what you're saying.

It's not just here's your medication and we have no other, you know, interventions or anything else, any other epigenetic advice and lifestyle factors like that.

You said. And so I appreciate that because I think people need to understand that that's not a miracle drug.

Comprehensive Evaluation and Medical Treatment

It's not something that, you know, that you really just order off the internet and that you can take yourself. And again, Ozempic, is there anything that I'm missing on?

It's also called Something blue Time. So anything else that I'm missing that you would want to cover about this? Because again, it is just so out in the open right now.

Yeah. So, Ozempic is actually the diabetes version of semaglutide. We Govi is the obesity version. So we Govi is the one that's FDA approved for obesity.

But yes, the the craze right now everyone's talking about Mozambique. But yes. No. So, you know, we treat, you know, people who who need it medically, who have been, you know, who meet the criteria for, you know, FDA approval of these medications.

These medications really have not been studied in populations, with a lower body mass index. So, you know, we prescribe according to guidelines and, you know, evidence based medicine.

And, that's what we do. What are some of the, side effects that a person may experience other than the weight loss that they want? You know, the side effects generally are not such a big problem when when we prescribe them, you know, appropriately and, you know, the way that we do.

It's when these medications are started at much higher dosages are used in, in people with much lower body weight. That you may get sort of an extreme, you know, reaction to them, what these medications are designed to do.

And let me just, you know, make a comment that this class of medication is just one of, you know, all of the agents in our armamentarium, these medications are, you know, some of the most effective.

And that's why there's so much interest in, it's been exciting to that. We have them. But everyone's gone nuts with these right now. But, you know, specifically talking about the GLP one agonist.

The way they work is that they mimic a hormone that we produced in our gut, that tells our brain and tells other organs in our body that we've eaten. And so your brain thinks that you've eaten, and so you feel full.

And so what I tell my patients is that, you know, being on a medication like this, especially for for people who, you know, have obesity or maybe they're on medication that's making them more hungry, or patients who have, you know, a lot of cravings or tendency to binge what this medication do does, is that it gives people back control.

It allows them to kind of regulate their hunger. So people will say that's like, oh my God. I just feel like my hunger feels normal now. And it's such a relief to not be starving all the time and not be thinking about food all the time and not, you know, I have to, like, stop myself from bingeing.

And so it really provides patients with this incredible, incredible relief where they feel significantly less hungry, they feel full faster, they stay full for longer.

And so it, it it's it's a really excellent tool for people who need it. But it needs to be done in a way, where it's part of

a whole to comprehensive treatment plan.

It has to be prescribed appropriately and adjusted according to what's needed and tolerated. And people need to learn how to eat differently on these medications.

Otherwise they're going to feel very, very sick. Right. And and since this is centered around, thyroid disease, I'd like to ask you about those people who come in and they have diagnosed hypothyroidism.

And I and I kind of want to know the percentage of people that, you know, if you could ballpark it, like, who does actually have hypothyroidism or who who, wasn't diagnosed.

But then you do all the labs and you can actually see it. And then should they have any concerns with their medication. And I'm sure that you probably work with other providers and prescribers, because as the weight comes off, our need for these other medication is like you started off talking about at the beginning, people are on all these medications and they're weight related.

So as they start coming out with these drugs, I'm sure that there is a lot of management. And that is a very important point to really drive home is that, you know, when you start regulating your blood sugar, you know, we have to be very cognizant of the blood sugar medications you may be on.

So again, back to my question would be with the hypothyroid community, can you just speak to to anyone who's on a medication who may just be wondering, like if they want to help, what would that look like?

Yeah. So definitely a, sizable percentage of our population has hypothyroidism. It's not the kind of thing generally where if someone has untreated hypothyroidism and we, you know, give them thyroid replacement, they're going to lose tons and tons of weight and, you know, you know, this as an endocrinologist and you know someone who treats thyroid, everyone always wants it to be your thyroid.

So there is that meme where the endocrinologist is like, it's not your thyroid, it's not your thyroid. So it's not always people's thyroid. But you brought up an excellent point.

When people lose weight, we have to be very diligent, about other medications that they're taking and improvement or resolution of other, weight related health complications.

GLP-1 Medications and Thyroid Considerations

Because there's some medications that people may be on, are weight based or dosed according to weight. For example, synthroid or, you know, thyroid replacement or different kinds of thyroid replacement.

That dose needs to be reduced as people lose weight. Otherwise they're going to, you know, their TSH is going to go so far down and they're going to be on way more replacement than they need for their body size.

So, you know, helping people lose weight is something that has to be done, in a really monitored way. And it has to be done, you know, in conjunction with, with people's other, specialists or primary care doctors.

Blood pressure is another great example. You know, one of the benefits of weight loss is that we can help people come off of other medications. So if we don't talk to our patients about the fact that, you know, their blood pressure may change as they lose weight, they could be walking around really dizzy, or they could fall when they go from sitting to standing or, lying down to sitting because this is something called orthostatic hypotension, where if your blood pressure is two treated and it's actually low, with positional changes that can manifest, or people can just feel really tired and dizzy and not really know why.

So, you know, this requires a lot of education and a lot of management checking labs, checking vitals. If people are really losing significantly and losing quickly.

Great. And, I also wanted to ask you about supplementation. There's a lot of, nutraceuticals that can, you know, quote unquote, rev up metabolism, CoQ10, PCU, acetyl carnitine.

Do you do routinely or do you selectively use any nutritional supplementation alongside of the other interventions? So we don't the way we practice is really evidenced based medicine and we really use, you know, FDA approved medications.

I was actually part of a group of physicians and PhDs from around the country who did a systematic review, which was a large undertaking, very large undertaking, that we published about a year or so ago, maybe two years ago.

Looking at supplements for weight loss. And we examined hundreds of studies, and published our findings. I can share that with you afterwards, that we will we will definitely link to that because I see people when I was practicing, I saw people with suitcases full of Garcinia like kidney bean extract.

And, it just was it was very puzzling because, they had a lot of supplements, but they still were struggling. So, I would love to, to link to that paper.

I mean, that's really what we need. We need that kind of evidence. We need that kind of information in people's hands so they can really make the right decisions and not waste their money there.

I say, but yeah, that was great. I'm so glad I asked you that question because again, there's so much marketing out there and, and again, the way that obesity is looked at, and treated is, is really rudimentary.

And to think that, like, you're going to take, you know, CoQ10 and you're suddenly going to ramp up your ATP production and it's kind of, it's kind of hogwash.

So I'm really glad to have that, that paper, linked. And then, you know, since we touched on supplementation, were there any other, medications that, you wanted to go into at all in regards to obesity?

Sure. So just to kind of, you know, finish the conversation and supplement. What we did find in our systematic review is that the the agents that we looked at were not associated with significant weight loss.

So generally, you know, we don't even see efficacy. But what's actually more concerning is that the supplement industry is just not regulated to the extent that it needs to be.

And so false claims can be made and there's no, oversight into what's in every pill. And so a lot of medications that are marketed for weight loss, may either just not work, or they may work, but if they do work, that's actually more concerning because you have to think about what's in them.

And oftentimes it is, medications that have been taken off the market or different versions of stimulants. So, you know, my mentor, Doctor Lou Roney, has a saying where, you know, if they don't work, it's probably not harmful, but whatever.

But if they do work, you know, think about, you know, how dangerous and you know, you shouldn't be taking them because it's probably something dangerous.

So when people come to me on supplements, I ask them, you know, have they been working? And if the answer is no, then recommend stopping. And if they do work, then, you know, I just talk about how it it may be an unsafe situation and that we have medications that have been studied for a long time and that have been, FDA approved.

So to your next question, other medications that we use, there are six main medications that are FDA approved for weight. We use all of these. And it really comes down to, you know, this is our expertise in figuring out what makes the most sense, in what order and which combination for different people.

And then, you know, depending on what's covered by insurance, which unfortunately, you know, affects some of

our decision making, sometimes we'll use agents in the same class or generic components of some of these combination medications.

If that's just, you know, a way to, to get what we need for our patients.

Supplements, Safety, and Evidence-Based Care

Okay. Great. Yeah. And I to go back to what we were talking about, supplementation. I'm sure a lot of the supplements at work could be in the stimulant category.

And I really worry about, the stimulants, and also some of the glandular, supplementation that's out there. You have thoughts on that too? Yes. I mean, I'm really not an expert in this, but I sometimes people come in and their TSH is like undetectable.

And it's very clear that they're taking, you know, thyroid supplementation. They're also all of these like like adrenal fixes or, you know, adrenal cocktails that I don't even know what is in these.

But I would be very, very, very cautious of anything that's marketed for, for weight loss. That's a supplement. Yeah. Adrenal fatigue is is really out there.

I mean, there's a lot of people who talk about it and a lot of people who have protocols and supplements and things behind it. And so, you know, with adrenal fatigue, the main symptom being fatigue, are are your patients that are is obesity tied to fatigue is what actually, my question is, do you see that tiredness in it or do you think it's something else so multifactorial?

It really depends on sort of diet and sleep and stress and it's not, you know, it's there just so many, so many factors here. Sometimes when people lose a significant amount of weight, things just kind of slow down.

Your body kind of tries to hold on to every calorie possible. So fatigue can happen. Actually talking about, thyroid hormones, the level of T3 can actually go down with weight loss.

So, you know, again, I'm not in under chronology. This is something that I generally manage. But sometimes, you know, replacing the T3 can can help with that.

Okay, great. Well, there's anything else, you know, in regards to this topic that I, that I missed, now is your chance to educate, people who are listening to your to your brilliant, you know, evaluation and how you do things.

So for resources, if you have anything else, Thank you. Well, you know, there's, there's so many different topics I could talk about for hours and hours and hours, but I think that the most important thing for, for people to realize is that if they are having difficulty losing weight and keeping weight off, it is not your fault.

This is not a matter of willpower. There's so many factors involved here, and our bodies really make it so hard for people to lose weight and keep it off.

You know, if you've tried diet and exercise and you've lost and gain and lost and gained, and you're someone who may be eligible for medical weight intervention, there are obesity medicine, specialists around the country.

You know, there's definitely good medicine and then some more questionable medicine. But the American Board of Obesity Medicine, the credentialing organization has now credentialed almost 7000, 7000 physicians.

And so the numbers are slowly creeping up. But there's still, you know, massive supply demand mismatch between the millions of people who could benefit from medical weight intervention.

And the very few of us who know how to practice this at a very high level. And that's actually why we started our company to, to bridge the, the, the gap here, the supply demand mismatch.

So, we actually have our own clinical services, a telemedicine practice called flight. It's a flight. And so if people are interested, they can go to join flight.com again.

Join flight dot com. It's part of our bigger company and telehealth. And our mission is to scale and democratize access to, the kind of very high level care that we deliver.

That's wonderful. And is, is that for practitioners or just for patients? So we have two offerings. We have a software platform and an app called evolve.

And we work with health systems, and their own providers will use our platform and app to be trained in how to do this and to give them the clinical decision support to try to work with their patients.

Access to Obesity Medicine and Closing Remarks

And then, you know, there's the app for patients. But for us, we have sort of a full service, comprehensive solution. We work with employer groups and self-insured organizations, and we can do, you know, direct to consumer, to really provide all the care ourselves.

That's great. And so for your typical your internal medicine, family medicine physician, I know you are boarded in obesity medicine, but could they still work with you?

And if they don't have time to like, pursue the board certification? Is this kind of like, like you said, like the bridge? Yeah, absolutely. So, you know, when we work with large health systems, they're providers, you know, our, our users of our platform evolve, and the there's onboarding, you know, what is obesity?

You know, obesity specific evaluation, you know, lifestyle approaches, which medications we use, how you pick the right meds for the right people. Again, for each patient, we have the clinical decision support, medication decision support.

So, you know, the few of us who know how to do this can't treat everyone out there, you know, who has overweight and obesity and needs medical intervention.

So we really need primary care doctors and, you know, other specialists to to be doing some of this too. But it is specialized and it has to be done, you know, in a comprehensive way that's really responsible, and and thorough.

So, that's why we've created our, our program to train as many providers as possible. That's so excellent. I mean, necessity is the mother of invention.

And definitely we need more providers. We need we need a better understanding. And that's very admirable. So then for the patients side, the website and then any other social media, like if someone want to become a patient, is that all the same?

Going to, those websites. Yeah. So it's just joined flight.com and more information about our company and telehealth. We have a website as well. Okay, great.

Well, it has been a pleasure, doctor Sanders. You have enlightened us a lot about, a topic that's so important, and that we really need more education around, especially our practitioners.

So, thank you so much for what you're doing. And, thank you so much for your time today. Thank you so much for having me. Doctor Kelly, it's been a pleasure to chat with you about this today.