From 350 Pounds To A National Movement: The Real Fix For Obesity Transcript

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Introduction and Dr. Trow's Background

This is Doctor Talks, real talk from real doctors on the issues that matter to you most. Today we're joined by Dr. Trow, who is, you know, one of my favorite guys in this space, like super passionate about what he does and really cuts through the bull, you know, in a way like nobody else.

And I really respect that because sometimes you just got to hear it blunt. And the thing is that he's had a great backstory, which we'll get into, but really had a huge amount of success to treating patients, because that's where the rubber hits the road.

And this is always one of my pet peeves, too, and I'm sure you agree, Tro, is that you get all these guys who are like academics, or they say, oh, it's all about cutting calories.

Look, I proved it with my energy balance equation. Therefore it should work. And if it doesn't work, it's your own damn fault, right? And it's like putting the blame on patients.

And you know what it's like to be on that side of things. And you know what it's like to be, you know, in medical school and learning about, hey, it's all about calories, all about calories.

But this is where it's like, you got to treat the patients because when stuff doesn't work, You have to say it doesn't work and find something that does.

That's being a doctor. It's not just repeating the same old stuff that we were taught that everybody knew didn't work. And that's where I really love what you've done with your weight loss clinic, you know, helping, you know, hundreds or thousands of people, your results, you know, which I'd love for you to go into what you've published.

Just draw dropping, right? And of course, weight loss is just such a huge part of longevity and good health. So why don't you take us through your story?

Like when you were in medical school and when you were struggling with your own weight problems. Cause I think that's really important. Yeah. Well, thanks, Jason.

First of all, you are an inspiration, actually the people. The plain talking blunt, say it how it is. I definitely learned from a good mentor and somebody who's always been good to me and gracious to me.

So, and you know, I've read all your books. I still recommend your books to this day. And I think, you know, having the courage and the vision to execute on the things that you've done, I think, you know, that it gives us a leg to stand on.

So, you know, and there's so many that came before both of us. So. You know, going back to Atkins and Nokes and Fedke and Nina Ty Schultz and Eric Westman.

But yeah. So I appreciate, I appreciate, I love being here. Happy to, happy to be here. My own story starts really when I started to experience obesity at age four.

I remember going to a supermarket and running away from my mom and running to the ice cream aisle. And literally opening up boxes of ice cream and eating them as a four year old, right?

So in the middle of the supermarket, that's where my journey started. I was unknowingly had all the quote unquote obesity genes. And I also had a thyroid issue that would go basically undiagnosed.

So I had all of the quote unquote causes of obesity genetics and, and a thyroid issue. So. At age 13, I was the current weight I am now, which is around 200 pounds, sat in a office with a doctor who took care of my family.

And he made me wait in the waiting room for two hours and then put me on a scale and said, I'm fat like my family and go count calories. Right? This is literally what he told me.

And he didn't know this. Like I have a like nearly photo, at least when it comes to numbers, like a nearly photographic memory. And I had memorized every nutrition label on every cereal box.

I knew the calories of everything, right? It wasn't my, the knowledge of calories that I needed at the time. And, but that really, that was the moment where I was like, I'm going to be a doctor.

It was this, this anger that I had at this guy who was like, Go learn about calories that renew it. So that's when my sort of origin story started. Of course, you mentioned going to medical school, gaining 10 pounds a year, becoming a, you know, going through residency, getting 10 pounds a year, board certified internal medicine, chief resident, you know, and ultimately getting obesity certification, obesity board certification.

Early Obesity Struggles and Medical Training

And I was a 350 pounds doctor. And same thing in the Yale system, I'm told. You know, go and, you know, why don't you count your calories? Cardiologists would say you should lower your fat.

Endocrinologists would say you should be an energy balance. And nobody once said, well, let's figure out what's driving your eating. Are you hungry? You know, nobody once said that.

Nobody once said, you understand what foods satiate you, what foods keep you full. Do you understand, you know, that fasting may actually decrease your hunger?

Right. And nobody said that. So ultimately it didn't come from the medical community. My inspiration to sort of learn more. It came from my wife who said, are you going to be alive?

Can you go figure this out? You scored on the 90th percentile on your board exam. You're not dumb. You're a smart doctor. Go for, you're the chief resident, go figure this out.

And then I turned to literature, 300 diet books, you know, I read through a thousand, maybe original articles. And what I found out was a lot of what you've been talking about for years, which is a lot of our nutrition and medical information is co-opted by industry.

And this has come out over the last 10 years to the global energy balance network and the conflicts they have. The JAMA article you posted about very recently talking about the billion dollars of conflicts.

So anyway, but you can read through that if you actually read the literature. And when you read the literature, it's just low carb and intermittent fasting are powerful.

And in fact, they're more powerful than low fat approaches. And they're even more powerful than calorie counting approaches. So if you look at the interventional data, calorie counting is literally the worst way you can approach weight loss.

Then like it's sort of low fat and the optimal is really, you know, a low carb and intermittent fasting approach in my interpretation of literature and, and very much so for metabolic syndrome.

So that was it. I had never eaten a steak at that point. I had never, I had never cooked a steak. I went through stints of being very strict sort of calorie counting and even being vegetarian for a bit.

And what I found was that for me, addressing hunger and addressing the metabolic syndrome was critical. And I

applied those principles to a practice. So seven years ago, I started a nationwide practice.

Well, we started in New York, but we've since expanded to 50 states. three doctors, four health coaches, a personal trainer. And we leverage remote monitoring using, you know, continuous blood glucose monitors, ketone meters, body composition scales, blood pressure cuffs, even Holter monitors, sleep studies.

We can all do this remotely. We have a nationwide network of imaging centers to get calcium scores and to get labs done. And we've helped. 2000 patients lose and get this, you'd be proud about this, almost 100,000 pounds in our clinic.

And my mission is clear to be the medical practice that I didn't have and to actually, to actually make a difference. And we've published our results, as you mentioned, and we have two year results in submission with 15.5% weight loss at two years in a large cohort of patients.

And this is without, you know, we're weight loss medication neutral, meaning we do not prescribe them. We do not prescribe as many as we discontinue. So meaning that our weight loss results are literally world-class.

in my opinion, and I'm biased. And we've also published our- Well, I think that, I think it's pretty clear, right? 15.5%. I mean, that's better than almost anything out there, right?

So it's not, it's not your bias. It's, it speaks for itself. I mean, that's, that's crazy. We published in our original cohort our, we calculated the 10 year, you know, atherosclerotic cardiovascular risk index on our cohort of patients before and after.

And before our program, they came in at about a 9.5% 10-year cardiovascular risk. And after our program, the risk was, you know, just under six, about 5.75%. Meaning we reduced the 10-year cardiovascular risk using the most widely accepted AHA, ACC, cardiovascular risk estimation tool.

We reduced the risk of cardiovascular disease by 44%. And in this course, and so when we published this data, we also published the cost savings and. Sorry.

We also published the cost savings, which was about anywhere from two to $4,000 per year in just prescription, prescription costs. So depending on the cohort, you know, the very sick cohorts up to $4,000 a year we're saving.

in prescription, deperscription costs and in the sort of less sick cohorts, about 2000 per year. Uh, and in that, the, those papers, one was published and one is in submitted.

Building a Low-Carb Weight Loss Practice

So we're pending publication. So yeah, I'm, you know, I've lost 150 pounds and kept it off almost a decade now. And, and I'm applying the principles that, you know, I've learned from all the luminaries, including yourself.

We published even a, and I'm going to pause here after this. You know, so many of the endocrinologists out there were so doubtful of the results. You know, we published in and just had a med school, med student sort of seeing what's going on in our clinic.

She's like, I have to publish this. You know, we showed that we lowered A1C in a cohort of patients when she was just visiting our clinic from an A1C of average, you know, 11.5 to 6.5 with just low carb and intermittent fasting.

So, so that's my goal is to basically be the practice I wish I had. It's to make people like you and Eric Westman and Nia Teichels and you know, Tim Noakes all proud and, and in a way that you can, you know, say that, you know, exemplify all the principles that we all talk about.

So that's, that's the goal. Yeah. That's amazing. I mean, that's, that's, I mean, it's just crazy good. These results, like, I can't emphasize enough, like lowering your risk of a heart attack or stroke by like 44%, virtually no

intervention or medicine.

can actually do that, right? 15.5% of weight loss. I mean, maybe you get that with super high doses of Ozempic and stuff, right? But with a lot of side effects.

But I mean, those are results that are just off the charts. Amazing, right? And the thing is, you know, it comes back to sort of the principles. And this is where I think I've always felt a little bit betrayed by the sort of academic sort of medicine medical school teaching sort of thing because it's all about calories as you said and yet you know everybody sort of says oh well you just have to count calories that's all it is but if you look at the actual data there's actually zero long term trials.

And they've been done, right? The Women's Health Initiative, there's tons of trials that have said, Oh, cut 500 calories. People cut 500 calories in a low fat diet, they eat less fat and so on.

And they don't lose weight. So it's very clear that just focusing in on calories, and of course, the traditional strategy was cutting fat, is actually guaranteed to fail.

That's what the evidence shows. But more than that, that's what the real life evidence shows. We've all done it, and it doesn't work. So why do we keep saying it's true, it's true, it's true?

And this is what you've always been getting at, which is we're not saying that it's like calories is the wrong thing to look at. you have to look at what's driving the calories, right?

You have to get to that deeper level of understanding, right? Sort of like, I always say about alcohol. Well, you can say alcoholism is alcohol in minus alcohol out, right?

That's obvious. So it's all about alcohol. Well, if you're suffering from post-traumatic stress disorder, which is causing you to drink alcohol, you can't just say, just drink less alcohol.

That's the stupidest advice you can hear, but yet when you apply, you have to treat the PTSD. If you apply the exact same logic to calories, if you have depression, ultra processed foods, refined carbohydrates, which is driving your calories, because they're not making you full.

Nobody ever says, eat fewer carbs, eat less processed foods. They just say, it's all about calories, but it's the exact same flawed logic. And that's what always gets to me.

It's like how bad that, one, how bad the advice is, but two, also how bad the logic is behind that advice. It actually makes zero sense. Like it makes no sense at all, the strategies that we use.

So what's the core You know, you've obviously had great success with yourself, which is amazing. And also with your patients. So what are the sort of core principles that you use in your clinic?

Because you're not the only one who's had success. Dr. David Unwin has had tremendous success with his, with using the same principles. Um, so maybe what are those key principles in that you use in your clinic?

Yeah. So, so I want to emphasize that I'm going to talk about that. And Dr. David Unwin is another mentor of mine. We worked together on this paper that submitted.

So, which I was, you know, so glad that he, you know, was able to serve as a mentor on that paper and, and guide it because he truly is a champion, uh, just like yourself.

And, but let's come back to this, the silliness of calories. I think, you know, you brought up the example of alcohol. Like to think about it this way, I think is the easiest way.

It's not just the calories make you eat more calories, which they absolutely do. When we have calories from

carbohydrates, you even calorie controlled, you will develop metabolic syndrome.

Right. And we know this calorie control. You will develop fatty liver calorie control. You will have glycemic excursions, which make people gain weight and get hungrier.

Right. So, and this is calorie controlled data. So. The, the idea that the calories can make you want more calories. I think that's also, you know, now becoming well understood and more understood, particularly through the lens of those blood sugar roller coasters.

When you're, when your brain is seeing the hypoglycemia and the setting of high insulin, it's like on fire for food and everybody knows it. You just have, you know, some Chinese food.

And then three hours later, you're loving the leftovers. And the reason why you love the leftovers is that. blood sugar vacuum your brain is seeing. And the same is true with cold pizza.

You know, everybody loves cold pizza three or four hours later for a reason, right? Our body is, our brain has been primed to eat more and our body is preferentially storing energy.

But then the other side is true. And your, your issue with alcohol, like the way you brought it up, I think is, is the case in point. If you had a thousand calories of steak, you know, an hour later, two hours later, three hours later, You know, you may be going on a hike.

Why Calories Alone Fail

You may be the next day. Certainly you feel great. Right. If you had a thousand calories of alcohol, how much energy expenditure will that lead to? I mean, you'd be out cold, you know, and the next day you're hungover, not interested in going hiking.

Right. So the calories not only determine the calories in, they also determine the calories out. And I think this is, this is the problem with calories.

When you focus on calories. It's like trying to get to the answer without doing the work, right? And the work is how do these calories affect your body?

Pay attention to that and course correct, right? And then, you know, you hinted at the sort of, you know, this, this budgeting approach to obesity when really it's, it's, you know, needs comprehensive care, which is absolutely correct, you know, and, and you mentioned the pillars, which I think ties into this idea of comprehensive care.

You know, the baseline is lowering sugar, processed carbohydrates and processed fats. And if you do that, 70% of people don't need me. They can just download our free app and get that help.

And that's all there. And then they can, you know, do that on their own, or they can go to page four, which is also free from Dr. Westman, or they can just pick up a $5, you know, copy of your book and, and, you know, they can, the obesity code and they can get that.

And then, you know, once the hunger subsides, practicing that non hunger, right. And practicing that, you know, satiation that's basically, Hey, why don't you quit snacking and intermittent fast due to time restriction.

Right. And that's like the easiest next logical step, you know, and the people who run clinical trials and metabolic wards, they purposely design their trials to get around this.

If a, if a trial makes you naturally not hungry. Right? What's a way to counteract that? We'll bring them to a mess hall, give them three meals and two snacks.

Right? That's how you equalize and our good friends at the NIH who've done these trials, they know this. They're

not silly, you know, like they know what they're doing.

So the first order principle is actually nourish your body with things that will make you full for a long time. And then when you're full, practice not eating, stop snacking, pull back your last meal.

delay your first meal a little bit, you know, and that's the process of intermittent fasting. And I think, you know, the average American you've said this is eating 16 hours a day.

We need to make that fasting at least 16 to 18 hours. Most of the patients in my clinic are eating in a four hour window, you know, or less. And, and then, you know, then I think there's other pillars that we all sort of agree upon.

You know, movement is very critical, you know, excellent sleep. And this is, you know, absolutely. a huge miss in, in our entire population, you know, just one and a half hours extra of sleep.

Again, going back to how faulty calories are. If you sleep one and a half hours more a day, you will naturally eat 300 calories less a day. If you are awake one and a half hours more, you will naturally eat 100, 300 calories more per day and your ghrelin will be higher.

Right? Your fasting, ghrelin will be higher. The hormones that make you hungry, these hunger hormones are going to be off the charts. So not only, you know, are you miserable, you're also hungry and eating more.

Right? So again, sleep is another chink in calories armor. It's, it's, you know, it makes you eat less. It makes the calories in go down naturally. So sleep is another important pillar to pay attention to.

And then, you know, for the patients with really severe autoimmune disease or severe insulin resistance, you know, that's when we leverage sort of extended fasts.

And, you know, we, we, we grade those fasts, you know, we, we start with baby steps and we learn this from you and your clinic, um, you know, maybe one 36 to two 48 hour fast a week.

And then we titrate up depending on whatever's needed, but very, you know, most people can just heal with time restriction. you know, in special cases or very severe cases, you know, you can progress to prolonged fasting and, and particularly with autoimmune disease.

And I've seen, particularly with gut issues, I've had great success. I think the MMA fighter who, who had bad ulcerative colitis often credits you for introducing him to prolonged fast and healing his gut.

Yeah. So those are the basic pillars we use in our clinic. And we, we, the other, you know, most critical, you know, pieces Well, what are the things that prevent people if they experience a way of eating that brings them health?

Well, what are the things that takes them away from what they know is giving them health, what they know they should be doing? And that's really addressing mental health, stress, and food addiction.

And I think that that's, it's not a nutritional pillar. It's more, I'd say in the mental health paradigm, but helping our patients manage stress, manage their mental health.

and manage any food addiction and food relationship issues, I think is a key focus in our practice. And I really think I'd love to see the world start to embrace that more.

And one of the big leaders in that area is actually the Unwin family. Yeah, yeah, that's super important. Like I always think about food addiction because it's actually coming up on a lot of people's radars and so on in the context also of ultra processed foods, right?

Because they're sort of engineered to be highly addictive as well, right? So it's getting a lot more traction now but I always think about this paradigm that food addiction which is super interesting to me because it's like you have

food addictions which you know addictions are things you know are bad for you but you do it anyway right like smoking or whatever if you're addicted you you know it's bad for you you just do it anyway but if you have food addictions and that can happen it causes you to sort of eat a lot of stuff you shouldn't eat like you know cheetos or whatever And that's what's driving your calories.

So it's always like, well, if you know that the food addiction is driving, or if it's the emotional eating, or if it's the depression, which is driving your calories in calories out, which is driving your weight gain.

How is it that people are so stupid as to say, just count your calories? you're so stupid I always think because it's the food addiction which is driving that you got to deal with the addiction why don't you say to a heroin addict just take less heroin you're welcome I just solved your addiction problem yet it's the same logic and that that's what boggles my mind these days is how stupid the whole thing is and how you can, you know, how fasting can, for example, break some of those addictions, you know, gut issues, leaky gut and so on.

I mean, prolonged fasting is actually a very interesting topic. just because I don't talk about it a lot because when you talk about it too much online, people will, you don't know who's going to take your advice and go way overboard who shouldn't be doing it, right?

So if it's in the medical practice, it's different, but there's actually just so much data and, you know, coming out there now.

Core Clinic Principles: Food, Fasting, Sleep, and Movement

And a lot of the data looks at these longer fasts and a lot of them are not full water fasts. Because I know Al Nutra has been doing a lot of data, but it's super interesting.

I'm telling you that some of the stuff they come out with, you know, some of the results are just sort of mind boggling and clinical practice. Like I have people like you mentioned, you know, the MMA fighter, Georges St-Pierre, who completely basically turned around his colitis.

I have tons of people who are talking about all these inflammatory autoimmune conditions that actually disappear. And there's data on these longer fast, because again, the body's saying, Hey, you know what, you know, nothing's coming in, we need to make sure that we're not, you know, keeping cells around that have no purpose.

So if you have an overimmune immune system that might, for example, start to bring those down and reduce some of that autoimmunity, that sort of inflammation.

So there's not a lot of data because they haven't done the studies, but it's just interesting because you hear a lot of anecdotal studies. Like we hear tons of it because we do, you know, with the fasting method, we have a lot of people who do it, but we have tons of people, especially like Hashimoto's thyroiditis, right?

I can't find any scientific data because nobody likes to look at these things. They like to treat it with drugs, but I hear tons of people who are like, Oh man, my, my Hashimoto's just went away, which is a type of autoimmune disease, of course.

So, so interesting. Add a little clarity there. There is actually data on it. So I'm, I've been fascinated with this topic really ever since hearing some of the stories from your clinic and people have credited a lot of these sort of miraculous changes.

There is actually a, a, interventional study comparing a low-fat to a low-carb diet in Hashimoto's thyroiditis. And I want to say it was almost 100 patients with MRI findings and antibodies pre and post.

And lo and behold, what did they find? Low-carb diets actually decreased antibodies statistically significantly higher than the high-carb diets, and they decreased edema and the thyroid on an MRI.

So, and what do the people on low-carb diets do? As we know, they spontaneously eat less frequently and typically, you know, so it's basically saying low-carb and time-restricted eating is an antidote to Hashimoto's.

It's an early study, right? But it's very convincing. And there's been some other studies with people doing carnivore and OMAD who reversed, you know, in a case series.

who reversed their inflammatory bowel disease. And this is biopsy proven, you know, reversals in their, in the bowel. And the question I've had is, you know, is there something in our sugar and grains?

You know, what's the biochemical, is there some exposure that's with, that's with the sugar and the grains that, you know, maybe a contaminant, maybe a, a pesticide.

You know, is it a combination of that and the known autophagy benefits that you commented on? Is it also that, and knowing that these ketotic diets, you know, decrease interleukin-6, decrease TNF-alpha, you know, you know, is it, is a combination of all these?

I don't think we know, but, you know, these are pretty miraculous results. And that trial was just published as a, as a trial in China. maybe three months ago or six months ago, which is absolutely fascinating.

The first study I've seen to reduce, to have an impact on autoimmune disease, ever. And same with the tweet you sent out, so you turned me on to this other study in the Interfast study.

It was me sending that paper. Oh, you tweeted it out. I have to look at the whole paper still because I can't get it. So this study came out, what, a month ago or something like that?

You tweeted it out, so I listened to it and it was mind blowing. Like to me, it was completely mind blowing because you know how people always say, oh, fasting burns your muscle.

I'm always like, no, it doesn't. But what was interesting was in this study, they randomized people. It was a small study, I granted that, but they randomized people to after a heart attack, a serious heart attack, because it's the elevation MI, right?

STEMI. to intermittent fasting versus sort of regular diet. And the people who did the fasting, I think three times as many had an improved left ventricular ejection fraction, which is incredibly important to your overall survival in the future.

So your heart function, it means your heart is actually functioning better, your muscle. And that was just mind blowing to me because that was a huge, huge improvement in a completely different, because you know how medicine is, right?

You get, they go into these, oh, you should thin the blood. So then, you know, you get 10 drug companies who are like, oh, let's find other ways to thin the bladder.

cholesterol, oh, let's find other ways to do cholesterol. But this is a completely sort of paradigm changing thing that, hey, this intervention, which is intermittent fasting, it has a lot of different ways it might help.

It might help with insulin sensitivity, it might help with autophagy, it might help with healing, it might help with immunity, it might help with inflammation, so many different ways.

We don't know which way, but the point is that there's potentially a huge massive benefit here that we're not, we're not using for our patients, right?

And, and, you know, I agree with you, a lot of these things, people look at a lot of academics too, they're driving crazy, I tell you, but they look at it the wrong way, because they'll say something like, oh, well, you know, for say Hashimoto's or inflammatory bowel disease, there's no evidence that fasting helps.

So therefore you shouldn't do it. And I was thinking, are you stupid? Because that's completely the wrong way to look at it as a patient. As a patient, you should be saying, what's the downside if I do intermittent fasting?

I might get hungry for a little while, maybe, maybe not. But I might lose some weight. But really, it's not that, you know, as long as you have adequate stores of body fat, there's really very little risk as long as you do it intelligently and you get help and get medical supervision such as at your clinic.

What's the potential benefit? Hey, I might just cure the whole damn thing or my heart might be so much better for it or I might reverse my diabetes. So the risk benefit is like massively weighted towards doing an intervention such as fasting because the risk is so low and people have been fasting for thousands of years at least.

But the potential benefit, whether it's inflammatory bowel disease, thyroiditis or heart function, is is massive like on a scale that's beyond what you can imagine even from your own results right i mean you showed that right true you know reversing diabetes right from 11.5 to 6.5 that's insane like no drug will do that for you you might need to take four drugs to do that for you right you know so it's like people are always like oh there's no benefit i'm like you guys need to treat some patients because you're not doing your patients any good.

And if you practice clinical medicine, you'd know that. Because the way to look at it is as a patient, if this was my brother, sister, father, mother, would I tell them to do that?

100% yes. 110% yes. You should try it. If it does you no good, don't do it anymore. If you can't do it, find a way to do it so you can still get the benefits, right?

Whether you do sort of shorter fast or longer fast or get some help with the fast.

Fasting, Autoimmune Disease, and Heart Recovery

We talked about training wheels for the fasting, you know, at the fasting method. So whatever it is, but that's the way to look at it. And that's the way you're gonna actually help people, which is why I think, which is why I love what you're doing, which is really getting out there and helping people because that's why, you know, people can't touch you, Tro, because you get the results.

Like people are coming to you because you're telling them the truth and they know it. Like you go to the, these calorie counting doctors and they're like, you know, that stuff doesn't work.

Like you knew it as a doctor, I knew as a doctor. So why doesn't anybody tell them? I think it's important, you know, we're here. This is largely a fasting talk that inner fast MI trial was very interesting.

It actually came out earlier this year. And it was a single center study. They did it in 2020 to 2022. I think it was 50 patients and they did the intent to treat, they preregistered intent to treat.

They published a protocol in BMJ, like maybe in 2022. And then they published this paper in, I think it was circulation. And the interesting thing, what they did was they separated the arms into sort of calorie controlled post MI, which is a low fat diet.

And the other group was, you know, do a intermittent fasting, you know, it was 18 six, which was what they were using. So 18 hours fasted, six hours eating.

And then they followed up at four weeks at three months and at six months, looking at the ejection fraction of the heart, which is how good that heart is pumping at four weeks, you know, at three months and at six months.

And at every single time point, which is kind of crazy, you know, the intermittent fasting group had a higher ejection fraction when they started at the same, right?

Everything was randomized. It was, you know, the EFs were basically, the heart pump was equally impaired. On

average, the intermittent fasting group improved about 20, almost 20 points.

EF improved 20. And just for that listener, You know, the average improvement is like somewhere between five and 10, right? So this was significantly higher improvement.

So, which is, you know, fascinating. We kind of expected this from the, you know, pharmacology data, right? The SGLT2 data, right? Supposing that the mechanism is the same, lowering the glucose, lowering the insulin and making some ketones.

But this was stellar. It was a small study, but again, post-MI, you know, fasting should not be withheld. We have, you know, eating, you know, some eating disorder data, which is a big concern, you know, when there's eating disorders.

We published some data actually that intermittent fasting and low carb improves food addiction symptoms. And there's some data now with the carnivore diet and anorexia, which is also a little bit controversial.

Um, and then, you know, we've talked about intermittent fasting in, in other states, particularly being looked at in certain cancers like glioblastoma, ovarian cancer.

And at the least, I think, you know, the, the important thing is being mindful that these patients are vulnerable and you don't want them to go and just not eat anything.

You want them to get nourished. So yes, I think the average doctor that's spending seven minutes shouldn't just go and recommend fasting. But in a comprehensive clinic that's really doing a good job, I think we are moving away from this idea that fasting shouldn't be done to actually, there's a lot more therapeutic potential than we first realized.

And actually, we shouldn't have blanket told everybody with cancer to go eat ice cream and bonbons and do whatever you want. Maybe that wasn't the best idea.

So I think these trials that you talked about more and more coming out. Again, it's very early, but it's enough that the guidelines should include intermittent fasting and low carb as something that shouldn't be avoided.

It should not be contraindicated. It's not contraindicated. It just needs to be done responsibly and carefully. I think the worst thing we all could do is, you know, take somebody who has intense weight stigma, intense anxiety, food avoidant behavior, very low BMI and maybe emphasize fasting in that part.

That's a vulnerable person. And just about anybody else, I think we can get their feet wet with intermittent fasting safely, especially if you're a doctor listening to this or a dietician listening to this, you can safely implement these into your practice right now.

And in fact, we've been doing this for seven years and we're publishing the results David Unwin, as you mentioned, called upon us to publish our, you know, clinical data, our observational data.

And that's what we're doing. And the results are stellar. So nobody's going to run a, you know, no pharma company is coming to sponsor a double blinded, you know, I don't know how you double blind a fasting trial, but you know, nobody's coming to do a huge trial with fasting.

You know, even getting these 50 patient studies done is a miracle. So these hints of data that are showing success in Hashimoto's, showing success in MI, showing success in diabetes, these are enough for the average dietician and the average physician to start promoting these in practice, especially if the nonsense calories recommendation didn't work.

If your blanket, you know, recommendation, the 2000 calories, didn't work, as Dr. Jason Fung says, stop being stupid and, you know, try a different approach.

It may, you know, you may be pleasantly surprised. The trials that are coming out now are sort of mind-blowingly good because, you know, the Interfast MI trial was that, but they also had an Interfast, which was a diabetes remission trial.

And it was like close to 50% of those people went into a drug free remission. which is sort of insane. Again, it's like results so good that they're practically unbelievable.

They're like 10 times better what you get with them than what you get with anything else. The early fasting trials. I remember this because this was sort of big a few years ago was they do these fasting trials.

And this is again, where you have people who have no idea what they're doing clinically trying to run a trial and they'd be like, Oh, on one day, we're going to have you eat, you know, 500 calories.

But then the next day, we're going to have you eat like double your calories. And I'm like, why the hell would you want that? So then these people are forcing themselves to eat.

Meanwhile, they're way overweight and their sugars are high. I'm like, What the hell? Like, what the hell is that? And then they're like, oh, well, there's no benefits.

Fasting doesn't work, right? So about four or five years ago, we had a rash of these trials. I was like, oh, fasting doesn't work. And it's like, now that you actually have a bunch of trials coming out of everywhere, really, that are just showing the benefits of this approach.

And now, thankfully, we're sort of getting past that point. But I just emphasize that all the trials are coming out now, 2023, 2024. they're almost all like not just positive, but like sort of super mind-blowingly positive about the benefits that you can get.

And it comes down to the fact that like you look at some of these diseases, you know, obesity we know is a high insulin state, you know, people who are overweight have a lot of insulin.

Well, insulin tells your body to store body fat. That's its job. If you have too much of it, you need to bring it down, which low carb and fasting does.

If you have diabetes, we know your insulin levels are sky high. Well, if it's sky high, then you should bring it down. Like, that's not that hard to understand.

What's going to do that? Low carb intermittent fasting. Okay, that's not too hard to understand. have certain cancers. Again, cancers love insulin. Some of these cancers have six, seven, eight times the amount of insulin receptors compared to a normal cell.

They love it. What is it doing? It's dragging all the glucose into the cancer cell and letting it grow. Well, if you have low insulin, it's going to affect those cancer cells more than others.

So there's good reasons why these things might work. And again, maybe if you're a purist, you'll say, oh, let's wait 15 years until all the studies are done and everybody agrees.

Training Clinicians and Changing Metabolic Health Care

But you know what? If you're a patient, that 15 years could be too late for you, like much too late. I mean, 10 year risk of heart disease. I'd rather bring it down by 44% than risk having a heart attack in the next 10 years, stroke, these terrible diseases.

And if it does happen, I want an intervention that kind of keeps my heart muscle pumping well. So, you know, so much happening right now. And then, you know, thanks so much, Tro, for being here.

And thanks so much for contributing your expertise. And I love again, I love your passion online. I think it's the best, like your tweets and stuff, they're the best because yes, they get a rise out of people, but it makes people stop and think and listen, right?

And that's, you know, to me, I think the greatest thing you're doing out there, you're doing so much good. And you know, you're, you're challenging that orthodoxy and they need more people like you, like real doctors who have like, you know, really walked the walk.

It's amazing. Thank you so much, Tro. Yeah, it's absolute pleasure. And, you know, one, one parting guess word is, you know, we're trying to make those doctors now with the society of metabolic health practitioners and not-for-profit that's looking to train doctors and coaches and dietician on the powers of metabolic health and do it ethically and do it responsibly and evidence-based.

Um, and, you know, so my hope is it's not just, you know, Dr. Fung and Dr. Noakes and Dr. Fedke and Dr. Ty Schultz and Dr. Westman. And, you know, we, we train an army of doctors and coaches to, you know, in a way that's not for profit and truly philanthropic to, to change this because, you know, our metabolic health crisis is enormous, you know, with a 40% obesity rate, the diabetes rate that's out of control.

And the expense of the drugs, insulin and the pharmaceuticals are going to bankrupt us. And we really need to drive it home. That's not just, you know, a moral failure or discipline issue.

This is, you know, an epidemic hitting our pediatric population. You know, I described myself at four. By age eight, I was going to Weight Watchers with my mom and I was already obese and I had gynecomastia and everything.

You know, we have a pediatric obesity epidemic right now, fatty liver, diabetes. And so finding these solutions, you're absolutely right. We're, the trials are there.

We no longer need to wait, right? We should not wait. We know that the orthodoxy in medicine won't change. We have a lot of evidence around that, around the regulatory capture in our medical industry.

you know, including the MA and the AFP and the American Academy of Pediatrics, who I wrote an editorial about because their guidelines call for 25 blood tests and an imaging study to safely lower the carbohydrates of an adolescent with metabolic disease.

That is what their guidelines say. And yet their guidelines say, you know, you should not withhold bariatric surgery or ozempic or which is, and it does not talk about doing any blood tests or any imaging for those modalities.

So we are facing, you know, why am I bringing this up? I'm not to single out the pediatric organizations or any organizations, but the monumental effort it'll take to change these organizations may take decades.

We know that the original research that you and I are talking about will take at least 10 years to find their way into traditional guidelines, maybe longer.

And we are facing such an unprecedented calamity in our populations with the dual pandemics of obesity and diabetes that we can't wait. So I appreciate you having me on, giving me the time to talk about the importance of this.

And we have to do something. And you're absolutely right. If it was my mom or dad or brother or sister, what would we tell them to do? Start lowering your carbohydrates.

Stick to real foods. When you're not hungry, don't eat. And once in a while, do an extended fast and a responsible way. So thank you for having me. Yeah.

Thank you so much. And yeah, again, you can find a troll on his podcast, the low carb MD podcast, which is great. And also check out his, his Twitter feed and you know, his medical weight loss.

So thanks so much, Joe. Thank you for tuning in to Doctor Talks. We hope today's episode has enlightened and inspired you on your path to optimal health.

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