Revolutionizing Obesity Care: From Myths to Medical Breakthroughs Transcript

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Introduction and Guest Background

Welcome to a special Heartline Echoes episode where we revisit some of the most impactful conversations from Heartline changemaking in healthcare. This rerun isn't just a replay.

It's an opportunity to reflect, reconnect, and reignite the ideas that continue to shape the future of healthcare. Whether you're hearing this for the first time or returning for some fresh insights, let's dive back into this powerful discussion.

Enjoy! Welcome to Heartline, Changemaking in Healthcare. I'm your host, Dr. Andrea Austin, a board-certified emergency physician, physician development coach, and educator.

After years on the front lines, I've learned that real change in healthcare starts within. Each episode invites you to explore the inner work that unlocks clarity and bold leadership, because healing systems through changemaking begins with following our heartlines.

So I'm very excited to have Dr. Catherine Saunders with me today. She is co-founder and executive vice president of IntelliHealth. She's a clinical assistant professor of medicine at Weill Cornell Medicine.

She's a physician entrepreneur and leading expert in obesity medicine. She's on the cutting edge of effective and compassionate obesity treatment. She practices at IntelliHealth's clinical services affiliate, Flight Medical, and she teaches at Weill Cornell Medicine.

She received her undergraduate degree Phi Beta Kappa Summa Cum Laude from Dartmouth College and her medical degree from Weill Cornell Medical College, where she became a member of the Alpha Omega Alpha Honor Medical Society.

She completed her internship residency training in internal medicine at New York Presbyterian Hospital. in Weill Cornell Medicine, where she served as the ambulatory chief resident.

She was the first clinical fellow in obesity medicine at the Comprehensive Weight Control Center at Weill Cornell Medicine. She is a diplomat of the American Board of Internal Medicine and the American Board of Obesity Medicine.

She hosts the Weight Matters podcast with Dr. Louis Arone, She regularly speaks at international conferences and she publishes extensively on obesity medicine and weight management.

She also makes frequent guest appearances on a variety of podcasts and radio shows and we're so happy to have her on our show. She also has recent awards and recognitions, including Women at Well Investor Competition, Brown Brothers Harriman 22 Women to Watch in 2022, and MediCo Lifetop 30 Influencers Transforming Wellness in 2023. I am so excited to have you on the show.

You've got just an amazing list of accomplishments and in a very important area of obesity medicine. Thank you so much for having me. I'm really excited to be here.

The first question we ask our guests frequently is, why did you choose medicine? So growing up, I was just curious about many different things. And in high school, I liked most of my classes.

So when I got to college, I didn't really know what I wanted to do. But my two freshman roommates actually were both pre-med. And I just thought it was so fascinating seeing what they were doing.

So I ended up doing a women in science internship and then transitioning over to pre-med. And it really was because of my freshman roommates in college that I started to pursue medicine.

So very grateful that I happened to be paired up with them. So your specialty now is obesity medicine and it's been fairly well published that medical school curriculum has historically ignored obesity and oftentimes our medical school curriculums is a systems-based approach and avoided more of a comprehensive or integrative look at diseases like obesity What do you think the largest myth around obesity is that doctors are responsible for propagating?

Great question because there's so much misinformation about obesity. So my mentor, Dr. Louis Arone, has been at Weill Cornell for several decades. And from the time he finished his fellowship, went into obesity medicine.

People thought he was crazy for years and years and years and didn't understand what he was doing. You know, he really persevered and kept proving people wrong.

When he gave a talk to my medical school class talking about how obesity is a disease, obesity is a complex chronic disease, and how he was working on medical treatments to cure obesity and to treat obesity, it really just blew my mind because in my medical school experience until then, We'd never really talked about obesity and learned anything about nutrition.

And so this idea that obesity is a disease, we now have a lot of scientific evidence proving that. And I'm happy to get into any detail of that. That would be helpful.

But this is something where many health care providers still think of obesity as a lifestyle problem and still, you know, tell their patients, oh, just eat less, exercise more, just you know, go and lose weight and don't really talk about it as the disease that it is.

And that requires medical intervention for most people to be able to treat successfully. So a lot of our listeners interact with patients in the acute setting.

Probably the biggest group of listeners are emergency medicine physicians. And, you know, a lot of times people are honestly coming to emergency departments with chronic diseases.

They're not acute presentations.

Obesity as a Chronic Disease

And I do have to move really quickly even though they're coming to me with a complex problem like hypertension or their knee pain and which now I think obesity is definitely part of their presentation.

And so I'm trying to think, you know, sometimes my advice to residents is just do no harm during that interaction. So what would be your advice for an emergency medicine physician that maybe at best has five minutes to talk with a patient?

They honestly might be that patient's only touch point for three to six months because that's how long it's taking to get into primary care. What would you advise them to say during that interaction that would at least set that patient up to not distrust the medical community and not do harm about potentially opening their mind to how obesity might be affecting their health?

Yeah, that's a great question. This is very tricky because you're right, so many people have really limited interaction with the medical community, and maybe they've had bad interactions, especially if they have obesity.

They've definitely encountered weight bias, weight stigma, and discrimination. So maybe that's one of the reasons why they avoid medical interactions.

We now know that there are at least 200 weight-related comorbidities. Literally, so almost every comorbidity you can think of can be improved or resolved with weight loss.

So many of the presentations that you encounter in the emergency room, I mean, hypertensive emergency, you mentioned knee pain, stroke, heart attack. So many different presentations are associated with weight.

It's a little challenging. Many of these patients have probably been told by doctors in the past, oh, just eat less, exercise more, or just go off and lose weight.

And they've probably tried over and over and over. But because of the way our bodies really fight weight loss, I explained to my patients that we've been evolved to be very good at not starving.

And so these patients who are presenting to the emergency room with an emergency have probably tried in the past to go on different diets and either they don't lose weight or they do, but then they regain the weight.

So many people give up after trying that over and over and over. So it's first just important to recognize that people are coming to a medical encounter with a variety of different backgrounds and a variety of preconceived notions and a variety of experiences.

I would say that weight can be a very touchy subject. So thinking about vocabulary, saying, you know, excess weight or weight instead of fat or obese.

is something to start with if it's appropriate to bring it up at all. You know, I would say in those five minutes, if you feel like it's appropriate to just kind of add in and, you know, especially if you develop good rapport with the patient, what I would do is maybe ask permission.

You know, you could say if this is appropriate or if you don't mind my bringing it up. Would you be comfortable talking about your weight for 30 seconds of your five minutes?" And the patient is open to that.

You can just say, you know, I'm sure you've tried many times to lose weight and, you know, they might have already lost 100 pounds. So you can't assume that they're at their high weight.

You know, you can't make any assumption about where they're coming from, but you can just bring it up gently, ask permission and ask, I guess, I would just really offer resources.

You can say, you know, I know about this great practice or this great doctor or this great company that specializes in weight management because we now understand that this is actually a chronic health condition that requires medical treatment for most people.

And I just want to throw this out as a resource. If you ignore this, that's fine. But, you know, maybe just very, very, very gently offer resources in a very appropriate way.

I love that. I love like asking permission. That's a great tip and I think that translates into a lot of different things because then, you know, patients might say, yeah, I don't want to have that conversation today.

We're fine. Right. Exactly. Yeah, and I think that gets back to medical school. We were at least introduced, at least my medical school, we talked about motivational interviewing, and it sounded fine.

And it really rang true to me, because I gained some weight during COVID. And there was just a point that I went through where I was like, I don't want to talk about this.

And it was interesting that my prior gynecologist had an interest in obesity medicine. It's one of her niches. It's listed on her bio. And it was probably a year into the pandemic.

And I think I had just gotten vaccinated. I'm an ER doc. It was super stressful. And she was like, we're not going to

talk about that today. We'll talk about it when you're ready.

And I was like, thank you, because I just can't. I do not have the capacity right now to even think about this. I understand I'm overeating, but I don't know what else to do right now.

How to Talk About Weight in Acute Care

And it really was a good empathy building for me that people aren't ready until they're ready. And I'm interested in your perspective, because are you mainly interacting with patients that in some way are, quote, ready because they've walked into your clinic that is for obesity medicine.

You know, you're asking permission shop but just resonates. That's a great opportunity. We actually tried to do a quality improvement project when I was a fellow trying to speak with patients who were on the cardiac step down unit after having had a myocardial infarction.

So after they were recovering and out of the kind of acute phase, and it just was a hard time to capture people in the hospital. On one hand, you might think that if somebody has kind of a health scare, that might be an appropriate time.

But if they're acutely in the hospital, that can be a different story. So I would say everyone is different and figuring out what motivates people and when to bring this up in an appropriate way makes a lot of sense.

So we're fortunate in that when patients present to me, they're generally motivated to talk about it and they know that we practice medical weight treatment.

And they've either come from their primary care doctor, another subspecialist, or family or friends who are our patients and have done well, or whatever the story is.

Most people kind of know what the conversation is going to be like, but every once in a while we do have patients who come to us because somebody pushed them to come and they don't really want to be there.

And then it just depends. I spend a lot of time just educating. and trying to relate to them. So we do a very comprehensive evaluation and I try to pick apart every factor in their weight history and their medical history that has led to weight gain and every barrier that prevented weight loss and then explain to them You know why obesity is a chronic health condition and what has made it easier for them to gain weight and harder to lose weight and sometimes that can really resonate with them if you know we identify likely undiagnosed sleep apnea or if we talk about some of their medications that have led to weight gain or.

you know, different lifestyle factors. And then once you kind of get into the details with someone and they're like, oh yeah, this makes a lot of sense.

And wow, I didn't realize that this wasn't just a matter of willpower and this wasn't just about what I'm eating and how much I'm exercising. And this is something bigger than all of that.

That often is the key to getting through to them, but everybody is different and it takes some time to, you know, develop rapport, listen to them and figure out how to get through to each patient.

So I have to ask just some common medications that maybe our listeners are taking. Does birth control cause weight gain? So different kinds of birth control, maybe more or less weight promoting in general.

I'll preface what I'm going to say about any medication with weight regulation is very complex and there's so much heterogeneity, there's so much variability.

So when you talk about any intervention or any medication, We can talk about average numbers or generally if it's weight promoting or not, but everybody's really different.

So it's important to think about either your story or your patient's story or whoever we're talking about. Timing wise, does it make sense that you started birth control and then start gaining or not?

In general, the more progesterone-focused birth control methods tend to be more weight gaining. So the ones that may be the worst are like the Nexplanon, anything that's an implant or anything that's more progesterone-focused.

The combination pills tend to be more weight neutral. The one that's the most weight neutral, I would say, is the copper IUD because it doesn't have any hormones and any kind of barrier birth control.

But if someone starts birth control and notices weight gain because of the birth control, I definitely would take that seriously. Interesting. I'm looking at the screen, but you have the IntelliHealth logo in the background.

What is IntelliHealth? Yeah, so I just going back to my background and kind of how we got into this, I did my fellowship in obesity medicine and then I joined the faculty practice at the Comprehensive Weight Control Center at Weill Cornell Medicine with Dr.

Arone. I practiced there for several years as faculty and then in 2019 my husband had been trying to convince me for years and years and years to start a company.

And finally, in 2019, I was like, okay, let's do this. Basically, his background is more entrepreneurial and in finance. And from the beginning, when I became interested in obesity medicine, he was just struck by the massive supply demand mismatch that there are millions of people in this country.

who are eligible for medical weight intervention. And at the time, as a first fellow at Weill Cornell Medicine, one of the first obesity medicine fellows in the whole country, and even now, you know, I think the number's up to 120. There are about 7,000 who have taken and passed the obesity boards.

but there are very few physicians who are really specialty trained to provide a very high level of obesity care. And so in 2019, my husband and I teamed up with Dr.

Arone to start IntelliHealth to really scale and democratize access to the kind of care that we deliver. And so we have a software program and an app that trains providers and supports providers and then We also have clinical services where we deliver care directly.

It's called Flight. So we have Evolve as our software platform and Flight is our clinical services. So our listeners, if they wanted to learn more about how to interact with their patients that have weight gain or obesity, they could use your platform.

Absolutely. We generally work with larger health systems. We can work with providers on a one-off basis. But yes, the way our program is designed is to really train providers without doing a full fellowship in what obesity is, how we evaluate patients with obesity, how we treat obesity, which medications we use.

And then we have all of the clinical decision support, medication decision support to guide them along the way with really personalized treatment for each patient.

That's amazing. And you mentioned about bringing this to patients as well. I deal a lot with patients that are having difficulty accessing care. Could they reach out to IntelliHealth directly?

Is there like telemedicine services? I'm out in California and I believe you're in New York. Yeah, exactly. So yes, we originally started with our software, but then had so many requests to provide the medical care ourselves.

So that's why we launched our clinical services, telemedicine practice, which is called flight. We are in the next few months, we'll be in most states in the country, different providers are a group of different medical licenses, but at least one has a California license, providers can absolutely refer their patients to flight and they can, patients can go to joinflight.com and fill out a form to request an appointment and if they're eligible for medical weight

management and were licensed in their state, we're happy to treat them.

And does flight accept insurance or is it all like direct payment?

Birth Control, Weight, and IntelliHealth

Yeah, so, you know, because obesity is a chronic disease that requires long-term treatment, you know, meaning you can't just stop a medication when you lose weight because that would be like stopping an anti-hypertensive or an anti-diabetic agent when your numbers look okay.

We're talking about long-term treatment. Our mission at the company is to improve access to care. So we want this to be affordable and doable. So we're currently in network with four payers.

We take many insurances. So yes, our whole goal is to make this accessible. That's amazing. So I have to ask about GLP-1. Some of our listeners may know, some may not.

So glucagon-like peptide-1 It's definitely been in the media. Maybe you've heard of some celebrities that are taking GLP-1. There's certainly a lot of different weight loss clinics that offer it.

So I think this is important to cover because maybe some of our listeners have been curious about trying it for themselves and maybe some of them are thinking about referring patients.

So what is GLP-1 and what are your thoughts on its current popularity in America? Yeah, so it's actually been around for a long time. It just recently gained popularity among many people who can afford it or are taking it, some appropriately, some not appropriately.

GLP-1 is a gut hormone that we produce in our bodies. It increases after we eat. It tells our brains that we're full, that we've eaten, and it makes us feel less hungry.

It makes us feel full faster. It makes us stay full for longer. And so it was developed as a diabetes medication first, actually. It's an insulin sensitizer.

It was developed as a diabetes medication, and it was found to be associated with very significant weight loss. Some of the older versions that were around Victoza, when I started practicing, Tosa is a daily GLP-1 that's FDA approved for diabetes.

In 2014, the weight version of the daily Victoza called Sexcinda, also a daily version, higher dosages, FDA approved for weight. It was approved in 2014 for obesity.

And so we've been using Sexcinda on label since 2014. Ozempic is the latest craze. The difference between Vixx and Sexcinda and some of the other options out there and Ozempic is that Ozempic is weekly.

So Patients really prefer doing an injection once a week instead of every day. Ozempic came out in 2018, and so we've been using it for weight, either on label if our patients also have diabetes or off label if we're using it among patients who don't have diabetes.

And so we've been using it since 2018. suddenly got really popular now, I believe because of the approval of Wegovi, which is the same as the Victoza-Saxenda relationship.

Wegovi is the obesity version of Ozempic. So we use all of these agents and they're important tools in our armamentarium. They have not been studied among patients who have a lower BMI and don't have diabetes.

So they're being used very frequently among patients who, you know, may not be appropriate. So you hear about all these crazy side effects. And again, if they're used in patients who have a very low BMI who don't have a medical indication for these agents, it's a little bit of unchartered territories.

There will be more side effects, most likely, especially if they're prescribed inappropriately. And so all of the craziness in the media is. frustrating for us as physicians in this field because it's led to many shortages and it's been harder for us to get them for our patients for whom these are clinically indicated.

Hi everyone, it's Dr. Andrea Austin. If you've been feeling stretched thin or wondering who you've become in the middle of practicing medicine, Recalibrate might be exactly what you need.

This program creates identity level transformation for doctors because every single participant still practices clinical medicine, yet many have reshaped their careers, their schedules, and their sense of purpose through what they've learned here.

I'm very excited to be co-facilitating the 2026 cohort with the incredible Cherie Johnson, and we've redesigned the program to fit real physician lives.

There are two-hour group sessions twice a month from January 29th through July 2nd, every other Thursday from 3 to 5 p.m. We only have a few spots left and if you've been wanting to work with me individually, this will be the only way you can do it through spring of 2025. Yes, my personal coaching practice is fully booked and I'll only be taking on new clients if you're in the Recalibrate program.

If you want to take your growth even deeper, you can also register for the Heart of Medicine, our once-in-a-lifetime immersive conference in Australia, a perfect capstone to the Recalibrate journey.

It's unlike any professional event you've ever attended, and I'm really excited for the listeners of this podcast to join me in Australia. Learn more and register at coachingfordoctors.net.au.

You may also email me at andrea at andreaaustinmd.com for more information. Yeah, that was so helpful. It really highlights a trend. You know, what happens a lot in America is we want a quick fix.

And this seems like a quick fix. Yeah, exactly. And this is not a quick fix. This is absolutely not a quick fix. I mean, similar to any medication for a chronic disease.

Again, if you stop an antihypertensive, you expect your blood pressure to go up.

GLP-1 Medications and Weight Loss

If you stop a diabetes medication, you expect your glucose to go up. For our patients who've lost weight and are maintaining weight, if they stop their medication, they expect or they know that their weight is going to go back up.

So same exact idea here because weight regulation works that way and obesity is a chronic disease. So for our patients who are taking these medications, and they're keeping off 100 pounds, they're really motivated to continue the medication and they know that this is a long term thing and the risk benefit profile is really favorable.

But if someone takes this medication to lose five pounds, it's expensive, if it's not getting covered, it's probably not. If they're not meeting indication, they're likely gonna stop it at some point, then they're just gonna regain the weight.

So that's interesting to me. You say that, you know, obesity is a chronic disease. So let's say somebody was 100 pounds overweight, they lose 100 pounds and you track their calories.

So are you saying like even if they ate the same like what's supposed to be supporting their basal metabolic rate that they'd still end up gaining weight potentially?

So what happens is, as we lose weight, you know, again, the way I explain this by patients is that our bodies have been evolved to be very good at starving.

So we literally have these anti-starvation responses. So think about you or your friends or your family or patients

who've gone on any diet. At a certain point, you get more hungry, you think about food more, your metabolic rate slows down, you actually even burn fewer calories at a low weight compared to a high rate.

So if you're not on a medication that fights this hunger, that fights these cravings, that potentially fights the metabolic adaptation, then you're going to get more hungry, think about food more, and start eating more.

And so that is just sort of the natural course of what happens with any dietary intervention where you don't have a medical treatment to actually fight your body's anti-starvation response.

So I see it's twofold. There really is this change in your metabolic rate to try to hold on to the weight because that's how we've been evolutionarily built.

And then you are hungrier. So it's usually both for people. They're eating more and they're holding on to more calories. Yeah, so all of these gastrointestinal hormones adjust in a way that basically tells your brain that you are more hungry and you don't feel full.

There's so many metabolic changes and there's so many pathways that are involved here that really just work to push somebody's weight back up to, you know, what we call their kind of metabolic or their fat set point.

At Cornell, are you doing any type of genetic testing? Does genetic testing have a role in obesity medicine right now? Great question. It's very exciting.

There's a company, Rhythm Pharmaceuticals, that is developing treatment options for mutations associated with obesity. So they have one medication that is FDA approved and they have trials ongoing.

When we see patients who have a history of childhood obesity, like age two, not just people developing obesity in their 20s, and a body mass index over 40 at their highest, There are a couple of other different criteria, but we've been sending for genetic testing because there's so much more that we're learning right now.

So that's an exciting area. One of the other things that we're doing with IntelliHealth is just we have algorithms that basically take into account characteristics of each patient and then generate a set of recommendations for the patient and for the provider and generate our medication decision support.

So consider these medications, consider these with caution, don't use these medications. And as we get more data, we're noticing trends in terms of, you know, this isn't something that's like on the manufacturer label or, you know, whatever it is.

But these are trends that we're noticing more real time before we have a study proving this, where we can have that adjust our algorithms to really refine our treatment strategy.

So right now we use our best clinical judgment. We don't really have genetic tests saying, you know, use this medication, don't use this medication that are really proven yet.

But, you know, with our large data set, really kind of phenotype out obesity. So we can identify these trends. And then when a patient presents who has these characteristics, we can say per our huge database, this medication is most likely to be the most effective for you.

Is there a role for surgical gastric bypass? Because I will tell you my experience and I think the interesting thing that we always have to remember is Certainly for those of us that work in the emergency department, we have a very skewed view of everything because we're seeing complications, right?

But my experience seeing surgical gastric bypass patients is they gain back a lot of weight. And unfortunately, I see a lot of people that have chronic pain associated with it and They don't absorb nutrients well, and they get all sorts of different complications.

After seeing it through the ER lens, I would never want one, but is that something that's still recommended by obesity medicine specialists in certain situations?

Absolutely. So I think you're right. You probably see all the complications associated with bariatric surgery, but bariatric surgery is an amazing life-changing option for appropriately selected patients who are prepared well and followed up regularly after their surgery.

So if someone doesn't really understand what they're getting themselves into and you know, doesn't take the pre-op protocol seriously and then is lost to follow up, you know, and stops taking their vitamins and doesn't have their labs checked and that happens.

And then that can not be a great situation. But for patients for whom, you know, their BMI is very, very high and or they have multiple weight related medical conditions or they've tried and failed every option that we have in terms of our medications, it's all a risk benefit.

and my patients who ultimately ended up having surgery, the feedback that I always hear is, I wish that I had done it sooner.

Weight Regain, Genetics, and Bariatric Surgery

Because for some people, it's just nothing else is working, and that is the best option. And if done responsibly, can be absolutely amazing. So yes, of course, if you stop taking your vitamins, you stop having your labs checked, and you don't do your bariatric follow-up visits once a year, you know, there can be bad outcomes.

In terms of the surgical risk, you know, it's pretty low and most patients do pretty well. So we have many patients who come to us wanting surgery and then we optimize them medically before and then we follow them after.

In fact, in order to be considered a bariatric center of excellence now, Bariatric centers need to have a medical obesity specialist as part of their center because it really has to be a multidisciplinary approach here.

I see many patients who haven't achieved the weight loss they wanted or have regained after surgery, and there's so much we can do with medication after, even when that same medication didn't work before surgery, maybe even a fraction of a dose will be all they need to help them keep this weight off.

We work very, very, very collaboratively with surgeons and the two surgeries that are mostly done these days, the sleeve, the laparoscopic sleeve gastrectomy and the Roux-en-Y gastric bypass are amazing options for appropriate patients when done well.

I want to change the subject a little bit. I feel like this is such a great opportunity. I'm kind of selfishly using it for myself as a case study. So as an emergency physician and really any high stress profession, especially during the pandemic, the stress level was really, really high.

I'm also a veteran deployed to Iraq. So there's been a lot of different things in my life that have caused stress. The summer when I wanted to lose weight, part of that process for me was seeing a functional medicine physician.

And I had a lot of labs drawn and other ways of measuring. I had cortisol levels checked, salivary cortisol levels. And my cortisol level was like 1% of what it should be for my age and sex.

And so she diagnosed me with adrenal suppression and said that this was part of the reason that I was having trouble losing weight. I know this is a really complex question, but does stress cause weight gain?

Is that real? We hear about it all the time that the central obesity that we see is often the stress obesity. Is that real? What is your advice for patients when they come in and they maybe have a very stressful profession?

those stress absolutely can play a role, but weight regulation is really complex. And there's so many different

factors that can lead to weight gain. So when we evaluate patients, we do a very thorough weight history and medical history.

And what we do is identify all of these different factors. Stress may be one of them, but it's usually not the only thing. So if someone has a genetic susceptibility, if they have a family history of obesity, it means that they're much more likely to have an easier time gaining weight and a harder time losing weight.

And then with that genetic background, if you add to it, you know, medications that are weight promoting or stress or sleep apnea or insulin resistance or working night shifts or, you know, so many other lifestyle factors, it all creates kind of the perfect storm.

that just makes it really easy to gain. And then when you start gaining, it's easier to keep gaining and gaining and gaining. It's sort of this feed forward mechanism and it's harder to lose.

And so it is important to identify different factors and to try to catch the weight gain early as it sounds like you did or you've been doing because it's, you know, harder to lose once you've gained a lot of weight.

it's much better to kind of prevent the weight gain from happening if you can catch it early. So yes, stress can play a role, but I wouldn't say that if somebody has no other factors, just it's all relative.

Interesting. What haven't I asked you or what would you really like our audience to understand more about obesity? Yeah, so I think one of the most important things is just what we've been talking about, that obesity isn't just a lifestyle problem.

It's not a lack of willpower. There's actually a lot of science here and there are pathophysiological mechanisms that really strongly defend somebody's set point.

And so when you see patients, you know, any physician listening sees a patient just to have that understanding and to understand that everyone has had different experiences, especially with bias and weight stigma and discrimination and understand where people are coming from and, you know, not assume that they've never tried to lose weight or that they're at their highest weight and talk about this in a very kind of empathetic, compassionate way, asking permission.

and then understanding that there are resources. So we are very fortunate we haven't even gotten into this, but, you know, this is such an exciting time in this field right now where we have highly effective medications available and there are several more in the pipeline.

So we can really treat obesity now as a way of treating the underlying you know, condition that's leading to over 200 other weight-related conditions.

So in any specialty, it's important for providers to understand about obesity and understand that there are resources. So we all don't need to be treating this ourselves if we have busy practices focusing on other things because what provider has any capacity to take on one more thing.

And in fact, if you try to do this without having capacity, you know, it can lead to bad outcomes where if medications aren't titrated appropriately, patients have side effects or if patients stop their medication, they regain the weight.

So this area is really a subspecialty that requires a lot of education, it requires training. And so if providers have patients who could benefit from medical obesity treatment, you know, referring to physicians who have been board certified by the American Board of Obesity Medicine.

Our company, Flight Medical, can see patients if, you know, we're in those states and if insurance matches up, but understanding what the resources are and bringing up the conversation and matching patients with resources so that we really start to get a handle on this.

There's so many great pearls in this episode, and I'd love to have you back. And we didn't really even focus on your entrepreneurial journey and what that's been like.

Stress, Compassion, and Entrepreneurial Advice

But a lot of our listeners are thinking about opening their own medical practices. Maybe they're in the integrative space. They're doing something different than what they envisioned they would be doing when they went to medical school.

Any words of advice or encouragement for somebody? Because you're clearly doing something different. You are well down the entrepreneurial path. What's your advice for women out there that are thinking about it or maybe even feeling a little discouraged right now?

Yeah, it's a steep learning curve. Definitely a steep learning curve. But I think many people are overwhelmed about doing something different because they haven't had experience and they think that they have to do every aspect of it.

But if you find good partners and figure out a challenge that you feel passionately about, and want to take on in a bigger way than just seeing patients one by one.

There's so much room for disruption right now because our medical system is so broken. So I would encourage anybody to just have the confidence and go for it.

But don't feel like you need to take it all on yourself. Understand that there's gonna be a lot to learn. Find people to help you. Ask for a lot of help and do it.

I love that. And that really ties back to an episode that we did with Murdad Soleimani, who is also an entrepreneur, has his own clinic. We work together in the ER in Temecula.

And we have capacity to do a lot of really interesting things. And I think one of the limitations of medical training in the internship residency model is they teach you to be able to do everything yourself.

Maybe by the end, they've maybe started to tell you that it's okay to ask for help and work in teams, some specialties more than others. But if you want to do something entrepreneurial, there is no way you can do it by yourself.

Exactly. I mean, literally when I started my fellowship, my husband, who's more entrepreneurial than I am or used to be, he was pushing to do something and I kept saying, oh my gosh, you know, I have a practice or growing our family.

I don't want to do this right now. That sounds like a lot. And it took him years to convince me. And as the field started to take off, he was like, we really need to do this.

And I think part of it was my fear and my feeling like I did have to take it all on myself. And for a while I was kind of the main doctor writing the algorithms and on all the sales calls and all the fundraising calls and, you know, writing all of our content.

But then we got to a point where we could hire a team of providers and many, many, many people to help us. So I think understanding early, exactly as you said, that even though we're trained to take everything on ourselves, you can't here.

You absolutely can't and you need to ask for help and that's normal. I love it. Well, this has been an absolute joy. How can our listeners, can you just mention again, how can they connect with your companies, with you on social media, anything you'd like to promote?

Sure. So I'm on LinkedIn. If you look up Katherine Saunders on LinkedIn, you'll find me. In terms of our company, our IntelliHealth website is a great way to learn more about the company.

And then for patients, join flight, f-l-y-t-e dot com. Patients can find out more about our practice and request appointments. I love it. We'll be sure to have all of that in the show notes.

Well, this has been a really eye-opening episode for me, and it's given me a lot to reflect on being more compassionate to myself, being more compassionate to my patients.

And I use the word compassionate very deliberately, because compassion means empathy plus an action. And so having empathy for our patients and that action might be as simple as listening.

We don't always have to give advice and maybe that action is sharing a resource when we've asked permission if that's okay. So those were really the big pearls for me.

Great. Well, thank you so much for your excellent questions and great conversation. I really enjoyed being your guest today. Great. Well, we hope to have you back again soon.

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