Intro and guest introduction

What you don't want to do is sit on your chair all day and watch TV. We said potatoes were good earlier, but we don' want it to be the couch potato. As I drink this, nice refreshing Coca-Cola to increase my…

Please drink water. Well, you know, as we are doctors and we always say, do as you say not do what we do, so cheers. Welcome everyone to this episode of the Jaffordcast.

I am your host, Dr. Mark Papadakis. Nobody particularly special, just another fucking ER doctor. So this Episode, I'm here with my old med school bestie, dr.

Nina Shah, who's going to talk to us about nutrition and most importantly, leukembic. Something many of you are all either taking or at least very familiar with.

so let's bring her in here. Nina, hello, how you doing? Good and how are you, Mark? Very, very good. You too. It's been a long time. Yeah, definitely.

So Nina Shaw here, she's internal medicine trained. She went to Toro College of Osteopathic Medicine just like yours truly. We graduated the same class and she did her residency training in Largo Medical Center in Florida where she now still resides.

How are things going down there? Well, we're gearing up for hurricane season, so we'll see how this year treats us. That's right. but overall doing really well.

I guess, you know, I'm a Florida girl, so I had to stay back in Florida. So you're, your internal medicine trained, but you are in an office setting. You don't do any hospitalists or hospital work.

Is that correct? That's correct. I thought about doing a mix of both hospital and primary care outpatient and then realized that it is just full time.

You have to be present in the office full-time. It's really hard to go back and forth because inevitably something happens and I need to back in office or, you know, something would be pulling me away and wouldn't really be able to give my full attention to it.

So I do fulltime out patient Monday through Friday and calls. Nice. And what, you're managed care. So what is, what's managed-care mean? So it's based on, it is a model where patients are electing to choose this insurance, where the whole primary goal is to keep the patient as healthy as possible, which I think should be the basis of everything we do as doctors.

Sounds like what we should do. All across the board. Our job is to try to take care of everything as their primary care physician. Be their jack of all, expert of none is what I like to call myself and be their urgent care, be there emergency care.

If there's an issue, then I can try and get them in as soon as possible. It's not the same day than the next day. And if it's something that they're having an acute stroke or a heart attack, I'll send them your way.

Sure. Can you, so, um, do you manage things like lacerations or it like abscesses in your office or is that something you still refer out? So absolutely, it's something that is dependent on the doctor's own comfort and training.

I absolutely have no problem doing certain abscesses. Of course, if there's a certain size or certain area that's more concerning, I would send out. Absolutely, try to do things within the scope of my practice and my training, but if they're something's that not within my scope practice or training sure I'm gonna send them to the right people because ultimately it gonna keep them more healthy than me trying to things that I am not capable of doing.

And it's funny because we see, I've been seeing a lot more the last, you know, 10, even 20 years where primary care physicians are referring out more and more.

Yes. I mean, we're talking when my parents were obviously younger. You know they came from a generation where your primary-care doctor saw you in the hospital.

They admitted you to the hospitals, they said, hey you need to go to hospital, and I'll admit you. And they rounded in to hospitals. And then obviously saw patients during the day in their office as well.

So that they really were their primary physician. Obviously, you know, 30, 40 years later, we've gone away from that model. Is that similar? I mean, are you kind of like a hybrid of that?

So it's it. It's actually the model that I initially went into med school thinking I was going to follow, follow my patients in the hospital because that's what I always planned on being.

But I do try to do what i can in The Office. If they're having knee pain and they want an injection, I'm not going either prefer them directly to ortho.

I can take care of a knee injection. iI can Take care Of some small lacerations. Ii can. Take. Care. Of certain things that can be done in. The office doesn't have to be.

Done just because someone has the orthopedic surgery training. Do you find that your patients go to the ER less than other models? Is there any kind of data that shows that would be the case?

I don't know the exact numbers or anything and while this model of medicine does want us to help keep the patients out of the er, it doesn't not allow them to go.

Okay, so they don't need my permission to go to the ER. There is no consequence to them to Go to The ER, it's not like the insurance company says, Oh, you went to Er, we're going to drop you.

It's nothing like that. it doesn't reflect badly on me. However, if they go the emergency room because they have had right leg pain that started two hours ago, That is something that they possibly could have been seen by me in the office.

I have diagnosed DVDs. Also, I've diagnosed cellulitis. And those are things that I can do. They can go to the radiology center, get the reports that same day and get people started on the proper medications if that's the case.

I don't always have to send them out to the emergency room unless there's a transportation issue and I can't see the patient. A lot of patients do like the fact that this is kind of their one-stop shop.

Managed care and primary care workflow

They like that they can come to me because it's easier to get in to see me than it is to give the specialist because they are even more in demand than I am.

It is easier. That's a lot of why people go to the emergency room, why they go the ER, because they can't get into the specialists in time. They can get in to get their pain medications in-time.

Yet, it's easier to see me or I can at least lay eyes on them and say, hey, let's get this plan going. I'm going to start you on this. You can follow up with that doctor at that time or, I could take care of this, manage your blood pressure.

Don't need to be the cardiologist. Manage your COPD. Do not need the pulmonologist I can take care of that." Now, if you needed a cath, I'm going to send you to the heart center.

I am not doing your caths. Things like that. That is where we try to take our things in the office. If someone comes to me with an uncontrolled diabetes with A1C of 10, and Im not throwing them to an endocrinologist, then I will see what their medications are, how I could fix that, what the insulin regimen is, whatever it is.

We evaluate that in office and try and manage it that way, rather than throwing it to every specialist. Now, do you take call for just your own patients, you cover your partner's patients?

How does that tend to work? Especially if they're so well managed by you guys, is there a lot of communication between you, guys? Or is it just, no, I'm on call from my patients 24-7?

So we do have a call service. I work with my partner and he has another office actually that he is primarily out of. And so the two offices, we basically cover each other so we're not on call 24 seven, but someone always is on-call.

So God forbid at 2 a.m. our patients are like, I don't know if I should be taking my blood pressure medication again or if should go into the emergency room because I'm having a headache and my vision's a little blurry and I think I might be having chest pain or shortness of breath or are you having panic attack?

Whatever it may be, then someone's there to either talk them off the ledge or tell them, hey, yes, go to the emergency room. I'm going to bring this up, not in the agenda, by the way, we're talking about something else, but how does this differ from a direct primary care model?

So the fee-for-service model where patients have the ability to go to whatever doctor they want. The other part of managed care, and I'm going to just kind of hit on this really quickly so it makes sense, is that whenever the patients want to to a specialist or if we feel like we need to take them to that specialist, it has to come be approved by their primary care physician.

That's the managed-care model, which is an entirely separate topic. We could even get into that more in detail, but I won't. But they have to be approved by me.

That being said, if the patient prefers a model where they can click, I want to go to the endocrinologist. I wanna go the bone specialist because you're not trained with bones.

You don't know what you are talking about. If they wanna to a go model, where pick and choose the doctors that they see, then that's the fee-for-service model.

go to the doctor. The doctor can take care of them or the Doctor can say, oh no, this is beyond my scope. I'm going to send you to cardiology to manage your blood pressure.

Are you owned by a hospital system or is it just a, you were privately owned group? So there's a group that I work for and it's got multiple different offices throughout the Tri County area.

I just have one little office in that company. Your small potatoes, is that what you're telling me? We're small potatos here, but we're good. I see a larger trend where primary care physicians are being bought up by hospital groups.

And in the Northeast here I mean, we were talking like Jefferson, Penn, you know, all these major players are basically taking their own docs in-house, basically self-referring and your independent docs are becoming fewer and far between.

So I'm kind of curious if that's been, if, that is what your guys are or if it's actually just, no, private group that has been avoiding the hospital systems.

No, we are a private. It's a very large group, but we're not hospital-owned or based or anything like that. We do have hospitals who will go within the company who cover our patients if they go to the hospitals.

But we aren't part of the system itself and they don't own us. So the crux of this episode is going to be, there's a lot

of discussion lately about wellness, nutrition.

The Department of Health and Human Services, the director, is a big wellness individual. And I made a video recently, an episode recently about him. But the main issue where we want to talk about is nutrition, namely starting on weight loss regimens and specifically ozembic.

Now, you with this model obviously take a lot more ownership in your patients than other models do, which is nice to hear. How comfortable and do you start patients on weight loss regimen yourself?

Do you consult with a nutritionist? How does that all start to happen if it does at all? So we do have an obesity epidemic in this country and obesity is not just adults who I deal with here in Florida, which is a lot of geriatric patients.

It's across the board. We see it in kids. Now we're seeing it and adolescents. we are seeing more and more, especially with, you know, even though we have all this healthy foods that people are saying are healthy, there's also a of overindulgence.

And so part of starting people on a train of weight loss is to educate them about, what is it? Weight loss as not a, quick fix. It's not a snap your fingers and it's gonna happen.

There's no a miracle pill or an injection that's going to work for you. A lot of patients say that they can't exercise you to X, Y, and Z whether it is a bad back or you know disability they have you no half their leg is missing for whatever veteran service that the thankfully did for us.

However, it's not, a lot of times we see it, people just want to have that quick fix where I just wanna be on the medication for a month until my daughter's wedding.

I wanna look good in this dress. It's NOT a quick-fix. And that's one of the things I always have to start with when it comes to these medications. Because all these medication, no matter what medication you're on, whether it is for the good of your heart, good for your lungs, whatever it it.

Every single thing comes with side effects and anyone who says otherwise is just fooling themselves. Well, or they're actually trying to sell you something for cash that doesn't actually do anything that advertises.

So either one, really. Now, have you gotten, do you get a lot of training and education residency about nutrition, especially going into internal medicine?

And I preface that by saying in emergency medicine, Obviously, that wasn't our focus of our training. So we didn't get nearly as much as someone as a nutritionist, but we still got some of it in medical school.

That was a part of education. But do you get more? How did that look for you in training? So in Training, we did get like a dedicated course or rotation with a Nutritionist.

I didn' have that. I don't even remember if that was even an opportunity for us in our option. But of course, it was a lot of on the job or I went to a seminar or we, you know, listen to lecture.

And of, course just reading on our own. I always tell my patients listen, the key to weight loss is scientifically proven really simple calories in has to be less than calories calories out.

So you burn more calories than you take in. If you're following that you are saying that your eating you know the healthy low carb low sugar low fat whatever it might be whatever diet lifestyle change I like to recommend lifestyle changes sustainable lifestyle that is you have done and it's not working for you whatever maybe maybe you on.

Chronic steroid therapy which is making you gain the weight because you keep getting the munchies with the prednisone Because you can't be off the daily predness on because of your PMR or your really severe asthma

Whatever it may be.

Those are the cases where I find myself saying. Okay, I'm hearing you. I am listening I see your diabetes is getting worse because your on the Prednis zone I See your weight's getting worst because on a Predna zone, but without the predator zone your breathing's through there Can I say shit?

Oh, yeah. Oh yeah readings for shit. Mm-hmm So that being said, how do you handle that? I have had patients who have to be started on medications for that reason, because they have exercise-induced asthma.

Their asthma is bad for any other reason. Cold- induced asthma, they cannot be without their inhalers. They cannot handle it without the prednisone because their lungs tighten up that much.

And I think that's a component of the conversation that has been missing, where it's not just a question of, okay, eat less and exercise and you'll be good.

That's great for your 20-some-year-old person who's in college or who is out of college and trying to lose at freshman 15. Patients who also have chronic illnesses that may or may not have stemmed from their weight issues before but are largely due to other factors and so how do you tell that COPD or asthma patient go exercise when they have the exercise-induced asthma as you said and they need medication for that but by the way their asthma medication makes the heart rate increase a little bit.

It becomes a bit uncomfortable and they stop prematurely or whatever the case may be. But, and not to mention, there are patients who don't have access to food that is necessarily in their best interest to lose weight too.

It's cheaper to go to your local fast food and McDonald's, let's say, than it is to stay at home and cook. Yeah, absolutely. That's something that we see a lot of, I think, across the country.

Financial constraints that my patients will have, whether it's to get their medications, which also is another topic on hand, or that they're just not able to make the food because of some disability, rather they can't cook, they don't know how to cook.

How are you supposed to prepare, you know, a grilled chicken with steamed broccoli if you don t know the first step to take or you can t afford the fresh groceries versus the frozen dinners that are easy able to be popped into the microwave, which might have the fat, the sodium, and everything that you don't want to on a diet, even if you're doing the lean cuisine.

I forget what else was out there now. Look, I'm a fan of Marie Callender's products.

Nutrition, obesity, and lifestyle counseling

They're fettuccine alfredo, they're roasted turkey, whatever it is. That is my midnight 1am meal when I come home after a shift. It's loaded with sodium.

And I literally just had a nephrologist on here not too long ago. talking about blood pressure where they say, yeah, you've got to limit your daily intake of sodium to less than 350 milligrams, or your single serving, I should say less then 350 mg if you want actual ideal blood pressures.

And how are you supposed to do that when most of our processed foods have added sodium, added sugar, all this kind of stuff? And it's funny that you say that because the processed foods are the ones that are cheap.

Those are affordable, they are shelf stable, and they can be lasting longer. So if you have transportation issues, you're going to gravitate towards those things that last longer and are easy to make.

And that's what we come across a lot in the primary care setting where, oh doc, I don't have a car. How am I supposed to get my groceries? I can't afford to have them delivered.

They jack up the prices on the delivery services. There's a whole lot of moving parts to this. When do we say, okay, you know what? Yes. You you're you ready for Ozambique because just like I said earlier, everything has side effects.

Ozumbique is not not immune to that by any means. Now, Ozembic is a medication that basically was marketed initially for people with diabetes who have struggled with weight, but also, you know, A1C issues, things like that.

And it just so happened that the people taking Ozmbic found weight loss to happen as more of a side effect, I think, as opposed to a true, like, hey, take ozimac to help lose weight.

This was like, hey take, oazimic to your diabetes. Oh, by the way, now I'm losing weight and I think people got wind of this. And now suddenly over the span of, I guess like what, two, three years, it really just blew up in the medical and the influencer community now.

A hundred percent. It's actually very similar to, let's talk about sildenafil, you know, the little blue pill that the gentlemen really like to get. That actually started out as a cardiac medication and they noticed if they start taking more and more that they were having some sustained erections.

And we're talking now, Sudentafil is a generic name for Viagra. So he's absolutely right. We all of a sudden are taking Sudenafill, Viaga for hair loss.

And all sudden the wife and the girlfriend and mistress, who knows, is suddenly very, very happy that they're on this medication for her loss of all things.

They're getting some better side effects. So they take more and more, and then they feel like, oh, okay, that's happening more. The similar concept to Ozempic.

Ozmpic was originally, you know, directed to have help with the diabetes. And of course, a lot of the diabetic patients are overweight. They are carrying the extra weight, which is why they ended up in the diabetics range, or maybe it was a familial component to it.

Whatever it may be, we have noticed that if you lose weight your diabetes can get better. You're off a lotta the medications, maybe you get off the insulin.

Hey, doc, I'd much rather take a once weekly injection than having to stick myself with insulin three or four times a day, whatever the regimen may be.

I would rather have to take that than have Metformin and Glypozidin. They think it's the catch-all ones all. However, because of all this weight loss explosion that happened with it, people, especially like the celebrities, would lose 40 pounds in a very short amount of time and everyone's like, I want to look like that now.

Oh yeah, they were really overweight and now they're, you know, skinny minis, whatever you want call them. And now it just skyrocketed to the point where the people who actually were supposed to get the Ozempic are not able to.

It is really expensive. That makes it another difficulty to There's been discussion lately about insurance plans for this year, even in my hospital system, where they're not going to cover Ozemic or they are not gonna cover it completely.

So now it's becoming more expensive to use it, assuming you're using it for pure weight loss and not associated with diabetes. And to be clear, we're talking about diabetes type 2, your insulin resistance.

Diabetes type 1s, you know, need insulin no matter what. Sorry guys. To be fair, the majority of type 1 diabetics are skinnier, so they don't really need the weight loss.

I dont really don t find my type one diabeics running towards Ozempic, but I do have lots of Type 2 diabetics and I have a lot of patients who are non-diabetic who want Ozmpic.

Mark, you kind of asked me about it earlier in this conversation. What do we do for the patients, who can't handle vigorous exercise? But I'm going to define that again.

Vigorous exercises is not the same for me as it would be for for a man or for bodybuilder or a long, you know, triathlete or somebody. Vigorous exercise for them might be running 50 miles.

You asked me to run 50, I'm going to be on the floor. The vigorous excercise for me might like a spin class or something. I could go ride a bike for 45 minutes and I feel really good.

I'm getting my heart pumping, but vigorous exercise is dependent on the patients or the person's physical capabilities. If your heart rate can get up to that 150 with the exercise, you're probably in that moderate vigourous exercise range already.

What works to get me up there is not going to be the same thing that works for a triathlete. They're going run a lot longer for that. Yeah. And we also, you know, the old adage and we talked about another episode is 10,000 steps a day, right?

But, 10 thousand steps of day sounds great. If that's all I need, it's not. It depends upon your body type and if you are severely overweight with chronic disease and you can only manage 5, 000 steps today, great, You're still putting some kind of stress and some, your burning something in your to help get that working again.

For somebody like me, I'd probably need more than 10.000 Steps a Day to get my heart rate up because it just, It's my metabolism. Maybe I need 20,000 steps or 10,00 steps plus, like you said, a spin class if I'm going to really want to do exercise.

I think I heard it in one of your previous episodes, too. It is about the moderate exercise, you want average about 150 minutes per week, which can be done in five 30-minute sessions, depending on what you like, or three 50-minutes sessions or however you wanted to be it up.

Patients who do 20 minutes a day, they'll do 10 minutes in the morning and 10 in evening and they do it every single day. That's about 140 minutes in a week, that's almost there.

So it really depends on how you want to do it, but when my patients say that they can't do for very long, I say break it up. Do five minutes before breakfast, do five before lunch, five after dinner, and then go for an evening walk around the block with your dog.

So is there a stepwise program that you have with your patients? Do you recognize immediately, you know what, your somebody that's going to benefit from being started on Zembec immediately?

Or do you try to say, let's try regimen, lets give it a week, four weeks, two months, whatever the case is. So I'm gonna say that there's not really a set program that my patients have to go through.

Everything is really case by case depending on what the patient is going through, depending what they've tried, and depending how long they have been struggling with this.

And of course depending their comorbidities to see if they even qualify for Ozempic. Is the risk worth it? So you talk about comorbidities and risk. Um, that's something that, I mean, there's also discussed about side effects of what, what comorbitities do you look for specifically when looking for Zembek to starting on Zembik?

So obviously you want to see, Hey, do they have diabetes? Is this one person who actually I would have thought about starting someone on a Zempik. If they don't have diabetes, it's really hard pressed for me to say, yes, I'm going to start you on ozempic.

You have to have a significant amount of like heart disease, lung issues that would be worsened by your excess BMI or your elevated Bmi body mass index, however you want to To be able to say yes, I'm going to start you on it.

However, the side effects are such they're great. I've heard podcasts of people who did great with Ozempic and they lost the weight. And I also heard the opposite where you don't hear these very often where people were on the Ozmpic but they didn't lose the way.

In fact, they couldn't handle the almost stun to GI system that they had. The way that ozempic decreases your appetite is by slowing down your gut mobility and how food actually is digested, your entire digestive system is slowed down.

But by doing that, yes, you decrease one's appetite, but you can also make it extremely painful. difficult for when you don't get the nutrition you need on a daily basis because you're just not hungry because nothing is moving.

You're then now malnourished, you have vitamin deficiencies, You are not getting the nutrients you needed, your protein starts to go down and you are going to lose muscle mass.

you may not lose weight, but you will replace it with fat. Your not going have the energy to work out. How are you supposed to build that proper protein in the muscle in order to get that healthy weight that you want?

You don´t want to just lose the weight you wanna lose fat not the muscles because otherwise how are supposed do your daily activities? Yeah, and that's a very good point.

The recommendation is interesting, I had to look this up myself, the protein recommendation for men to not just build but maintain your current body mass.

I have it up here, 0.36 to 0,45 grams per pound of body weight. So if you're someone who, let's say, for argument's sake, weighs 200 pounds, you need about 100 grams-ish of protein per day to maintain your current muscle.

I'm not talking about your building or whatever. Just the actual muscle that you have. And if don't get that, now suddenly you're dropping, and for women it is a little bit less.

So yeah, for woman it's a bit little less, we're saying 1.2 to 2.0 grams per kilogram of body weight, so obviously the conversion factor is little different, but it still the same idea.

So now you have somebody with, like you said, a gut that's completely slowed down. They're not able to absorb any, not even just absorb the nutrients, get the nutrition where they need to go because they're vomiting.

I've seen more and more cases of people coming to the ER lately with nausea and vomiting, stomach pains, you know, things of that sort, diarrhea. And we're now asking their history of what medication are you taking?

Ozempic uses, dosing, and side effects

And it's starting to come in with more more as saying, oh, I'm on ozambique, and A week ago, two weeks ago a month ago and now all of a sudden their body's starting to have this reaction to it.

Yeah. And people will say that they're on Ozempic for some time and not realize that some people are being titrated to their doses and that, they went to a higher dose and all the sudden they are having difficulty with it and they were like, no, that doesn't make sense.

I've tolerated this already. They don't want to blame the Ozmpic. Well, because for them so far, it's been a miracle drug. You know, this is a thing that has helped me lose weight finally, so therefore if I go off of this, I'm gonna do the whole V-shaped recovery in terms of weight gain and they don't want that and I completely understand that.

And you mentioned titration. Do you titrate the medication up or do you have like a fixed dose that you start people

on? How does that, how does dosing work for you?

So it's not, again, there's nothing fixed. I would start them on the lowest once a week and probably see them again in one, two, three months, depending on both their schedule and how much we're trying to see then lose prior to that.

Now, after three or four, six months if I'm not seeing any changes and we've titrated them, I must start talking about taking them off of it because they're obviously not getting that benefit and there is no point in taking a medication that will stunt their GI system that way.

If I start them on it, we're getting a little bit, were not quite there yet, I might after three months or a month or two increase it. I may say, hey, take double the dose.

We're going to change your dose to double it and titrate it up to the point where they can potentially get that without having the side effects. And I do it really slowly because a lot of my patients have other issues going on that already cause gut issues, that are already caused nausea, vomiting and I have to make sure it's not the ozempic that's doing that because again, these side-effects can be really confounding and confusing because they're really nonspecific.

Have you had guidance from the drug manufacturer about how often to follow up or how much you titrate here and there? So no, not directly just based on reading up on the medications and stuff.

I haven't really had the titrait too high. Generally not had to do that more than once or twice. And then we kind of find a steady state. A lot of patients get to their goal weight and then they're staying there.

But again, if they've gotten to the goal, wait, take them off automatically or something like that, they're going to regain all that weight right back.

Some people are like, I'm just on this for life and I am accepting it. And some people like I only want to be on it and then try to maintain. Now that I have lost the 50 pounds, maybe I can get back into the gym.

Maybe I kind of go out for a run again. I maybe have the ability now. My athletic ability will be even better and i can do it on my own now and maintain it my on.

There is a catch 22 about that. We'll see if it works. So that's interesting because what I'm hearing is basically there's two types of patients. Your one patient you're saying, okay, you aren't going to be on noxemic because you are functionally and physically unable to perform the workouts needed and the exercise needed to lose weight.

So therefore let's kickstart you so you can be at a level where you start to actually exercise and work out and then eventually you won't need the medication anymore.

versus the people who, if you drop it or take it away, everything's going to come right back again. But is that a function of their socioeconomic status?

Can they not afford healthier food where they're eating more and more processed, dense, you know, sodium dense foods, or is it an issue of self-control?

So it's probably a combo for my population of patients. A lot of them do have the fixed income. They're retired, they're working on, you know, whatever retirement fund they have had left or somebody else's retirement from their late husband or whatever it might be.

So for that side, it I don't want to say 90%, but it's a very high amount of patients who have that fixed income. So obviously finances are always going to be a little bit on the tight side.

Eating healthy, while some of them get assistance from the insurance company a couple of times a month or a

week, they get a lot extra to buy those healthier foods.

It's not always gonna be the case. They're not gonna always be able to stick with that. so eating healthy is difficult just purely because healthier food costs more.

And that was gonna be part of my other question too, which is do they get assistance to purchase food? Like right now, at least as we're talking, there's budgetary proposals going through the federal government that talk about reducing SNAP benefits, reducing a lot of these benefits for the working poor and lower income families, where they relied on them, ideally relied them to purchased healthier options, but obviously, that might be rolled back a little bit.

But insurance potentially can help offset some of that cost too, it sounds like. So yeah, of course it depends on the insurance company and their policies.

And I'm not really privy to each and every single fine line, but there are certain patients with certain comorbidities in the interest companies that I take that do get a bit of benefit and a lot of assistance from them.

I don't remember if it's a weekly or monthly thing. to help them afford those healthier groceries and they are directed towards only those healthier groceries.

I think they can't just go buy some ice cream with it or something. And that was going to be my question as well. Is there limits to what they could spend this on?

And it sounds like there are, you know, ideally if you're going to say here's money for healthy food, they can't just spend it on gummy worms or something like that, or a Snickers bar.

No, this is designed to help you buy that head of lettuce or these herbs and that breast of chicken. Now, I want to circle back to something because we talk about follow-up.

You said, you know, if you follow up in one to three months, your titrating things, You work, as we talked about earlier, a managed care model. So you have the resources and the capacity to actively manage and followup on these patients.

But I see patients when they come in to me, they're not be able to see their primary care doctor and like, six months or something, you know, it's okay, my doctor put me on this and I'll see in six or eight months, or whatever the case is.

Is this a medication that people should be actively followed up on in the short term or is it just, how does that work here? So I personally don't think it should be six months, 12 months.

You started on any patient I started a new medication on. I usually do not see them. because things can happen and sometimes the patients don't know how to convey that.

It's my job as their primary care physician to figure out how things are doing. Sometimes they dont know to how convey, Hey, I'm getting dizzy. I don t realize that my Losartan might be too high of a dose and my blood pressure is taking. Yes, and that's how you wind up in the ER because suddenly you're 8 o'clock at night getting out from your chair, you feel dizzy and say, well, am I feeling dizzy?

Yeah, fall on your head. Exactly. Yeah. And I say, well, your blood pressure was 80 over 50, here's some fluids, go home, follow up with your doctor. Then it's like, I can't.

I have another appointment scheduled in four months. So now I'm left with the task of do I reduce somebody's blood-pressure medication? Was this a one-off occurrence too?

And that's part of the issue that you know, emergency physician has, which is, okay, your blood pressure was really

high for this visit or really low for that visit.

It's better now, but I don't know if it was the medication that was maybe doing it. I didn't if there's something, you're body is just changing because you haven't seen your doctor in a year and now this medication is working too well on you.

Who knows? I'm glad that you said that. In our model, whenever a patient goes to the hospital, whether it's the ER or they were actually admitted, we have a time that's set by the insurance companies that we need to follow up with them in office.

So for ER visits, you'd like to see them within, let's say, seven days. For hospitals, a little bit longer to them because they might be a bit more complicated, might need more records from the hospitals which is an entirely other issue.

Yeah, that is. That's a pain in the ass. I had a patient go to the emergency room today, I'm getting her in my office tomorrow. Now is that space in My schedule, though.

Okay, that was my next question. Is that built in? Good. Try to build in, you know, maybe one or two, some days, three spaces where I can get those same days and where i can Get the person who says that they can't breathe and they think they have might have a COPD exacerbation.

Well, let me listen to your lungs. If you're wheezing, I'm going to get you on a breathing treatment here in the office. I'll give you the steroids in your office, get on your prednisone, and get your antibiotics if you need it, then I will get it on our way and follow up in three or four days.

Does your office have ancillary staff like a respiratory or a diet or as somebody aside from just you guys, obviously, is there staff that you can call on a moment's notice and have the patient, you know, hook the patients up to?

Like, how does that all work? So, no, I don't have a Respiratory Therapist, like, a dedicated Resipatory therapist or nutritionist or anything like that, but my nurses are trained to be able to give them the, the Albuterol, or the Duaneb treatment.

They're trained to be able to do basic injections. If it's something a little bit more difficult and we can't do it in the office, then I try to get them to the resources that we have within the company.

That's nice. We have infusion centers that sometimes I can give people fluids in. I've done that before. That was a little bit more difficult, but we did it.

Yeah. It's impressive. The reason why I asked is because when I was students, now I rotated with a pulmonary critical care physician who also had a primary care position.

So he would see patients in the hospital, usually in mornings he'd round. But then he also took care of many of those same patients after the fact. He had dedicated respiratory therapists who would be able to hook somebody up to a nebulizer, you know, give somebody prednisone, things like that in real time, which did save patients a trip to the ER in many ways.

In your group, do you find that you are more liberal in giving Ozembic and starting patients on Ozmbic or a little bit more conservative when starting them on Rozembik?

How do kind of fall in the gradient, if you would say? That's actually a really easy question for me. I'm definitely more on the conservative side of things.

You don't use it, you're gonna lose it. So if I don' make them, if i tell them hey yeah you can have the electric scooter, You dont need to walk, they're never gonna get up again.

They're going to be on their ass. I've seen it with 50 year olds, I seen with 60 year old, i've see it the 70 year. Now we get to 80s and 90s, we're talking something different.

If you don't use it, you'll lose it. So if you're not going to walk with the help with a walker, then why are we talking Ozempic? I'm not gonna give someone who's sitting on their butt all day Ozmpic.

I've talked to several people about this and there's a mindset that OzMPic is a shortcut. And for some people, it's the idea of you shouldn't need a short cut.

You should try X, Y, and Z first. Other people say, well, listen, we use cars to drive around our neighborhoods, which is technically a shortcut. So why not use Ozembic as a short cut to weight loss?

And I think what's missing this conversation is what we touched about, purpose, because if they don't learn healthy habits, if the can't access the right foods, they cannot exercise, then ideally you want them off medication.

The whole point of a lifestyle change is to not rely on medication and yet, Ozembig is one of those medications where it sounds like you may have to be on for quite a long time if not for life to maintain what benefit you have from it.

100%. Here's the thing about Ozempig is that even though it's marketed as a weight loss drug, it is marketed to be used in conjunction with healthy eating and exercise.

So if you're not doing that, I don't really see, maybe miraculously or luckily you'll have very very little intake, so yeah, obviously calories in is less than calories out.

So that might be the effect you get, but if you're not exercising, you are not following a healthy diet, your not going to get the maximum benefits from the Ozempic based on the studies that we have.

I have seen people say, oh, I'm on Ozmpic, they haven't lost a pound. Oh yeah, we celebrated, went and had a cheeseburger and some french fries and then we treated ourselves with a little chocolate cake.

Well, that sounds delicious. but it's not working with your diet. There is a discussion on my previous episode, one of my periods episodes about discipline.

And it was the idea that if you have the discipline, you won't need the medication. But if don't have discipline now you need a medication and ideally in an ideal world, the medications is there to help support you to get to where you'd need to be mentally and physically where that you no longer need it.

A hundred percent. People do look for the easy way. Oh, this is a surefire way. I'm going to do it. But again, it's all about the discipline. You have to combo it with the diet and exercise.

But, again nothing is going to be quick. Nothing is gonna be in three months. The studies have proven that this is over like a 12 month time frame which you could lose one to two pounds a month easily with a proper diet an exercise and it is a very slow weight loss but it a healthy weightloss because you are doing it the proper way.

Calories in is less than calories out. And we also have to add to that, it's also the type of calories we're eating. If you're going to say, well, I'm eating, you know, only a thousand calories a day.

Yes, but if you are getting most of your calories from heavily processed foods, that's different than eating a 1000 calories of, chicken breasts and pastas and, lean meats and vegetables.

Sure, where are your omega-3s with the fish? Where are their lean meats and proteins? where your vegetables, Where is your fiber? That's all going to keep things going, especially on ozempic.

You definitely want to make sure you're taking some fiber because again, some of the biggest side effects we see

on Ozempics, I talked about it earlier, the slow digestive system.

People get small bowel obstructions, which can kill you. people get pancreatitis, Which can Kill you! All these things are things that we have to monitor.

How's your stomach doing? Are you having nausea, vomiting? are you have normal bowel movements? Things like that, when I follow up with them in the office, those are some of the questions I'm going to ask them because those were some other side effects that we see in on ozempic.

And it's important also for those who are on OZMPIC to understand that if they're having persistent nausea and vomiting, severe abdominal pain, it very well could be an infection.

It could appendicitis. Sure. But if you come to the ER and I diagnose you with basically nothing, hey, we found nothing in our work of your pancreas and it's normal.

There's no obstruction. This is the medication that's doing this to you. And I think there needs to be greater understanding that this is a risk that you signed up for when you're on this type of medication.

It's not easy street. No, there's marketing, their social media influencers out there that will tell you it is, but it actually not. But that's what the thing is.

So influencers will create.

Follow-up, access, and closing remarks

That's their job is to create a, an enticing environment, whatever it is they're influencing you on, whether it's makeup or cooking or a book or medication or lifestyle.

Oh, you should try this meal. This, this recipe is really good. Maybe it. Is maybe they are going to spit it out as soon as the camera stops. You know, we don't know what happens on the back end.

We don' see the behind the scenes all the time. But the same thing is, is like I mentioned with the, I listened to a podcast, this is years ago at this point, where the patient had been on Ozempic, they lost nothing.

They were malnourished. they were the exact same weight and they had so much fatigue because they just didn't have the energy or strength to do anything.

Turns out their hemoglobin is probably low because they weren't getting the right B vitamins and all this and that. Yeah, and anemia is a thing with ozempic.

The nausea, the vomiting, diarrhea, that all causes dehydration. There goes your kidneys. When you have gallstones and then now you need to have a surgery to take that out, now after a surgery you want to be on ozempic, which I don't think is good idea because that causes more issues with your GI system.

And obviously there's, you know, I don't want to end the episode on all doom and gloom. There is a population out there that does benefit and will benefit from Ozembic.

But I think the take-home message to our patients is it's not a miracle cure. It's something that has to be used in conjunction. But it has to be heavily monitored, too.

You can't just take the shot, walk away from your doctor and say, okay, we'll see you in six months or see in a year. No, no, this is something that we have to keep very, very close watching you on.

And you need to aware that if you start developing side effects, it isn't temporary. These are side-effects that are going to persist until either you change the amount that you're taking or go off it entirely.

Sure. And this medication, it's a once a week injection because it lasts a long time. So these medications, these side effects are something that's going to be present for a few more days to the full week.

Now, if you did have significant side-effects, I'll talk to you. We can decrease the dose. You did okay on this dose, you want to go back on that dose and see how you do and then see the weight loss goes.

do we take you off of it? In which case, I can either titrate you because we want to make sure that your appetite doesn't come raging back and then you regain all this weight, or we can take off because the side effects are too great and you just can't tolerate it.

We can do both sides of that. And it's what is take home for Ozempic is really case by case. I think some doctors are definitely more liberal with Ozmpic.

Hey, I can go either way. Definitely more on the conservative side. But yeah, have a patient. She's on therapy, chronic prednisone therapy. It's definitely making it hard for her to eat right.

Its definitely make her gain weight. Her sugars did go up with it. The OzMPic was actually perfect for here. So everything go down. Here weight went down, here sugars went up, her A1C went to 5.4. Talk to your doctor first.

Please, please talk to a doctor. Actually, I do want to touch on something. I have had patients who've come to me and said, oh, i got the Ozempic from this online company.

There are a lot of these freestanding companies I'm hearing about so much now. i don't know their names, all of them or anything like that. who is getting it from them, but there's no monitoring, there is no blood work, no follow-up.

You're doing well on this, let's go up on the dose. Hey, you haven't picked up your prescription in 30 days, do you want more? I don't get it, BUT that's really dangerous to me.

If you truly want to be on ozempic because you feel like you have no other option, please talk to your doctor. The ones who are following up with you on a regular basis.

Yes, there are some people who once every six months is the visit that they need, but if they're on Ozempic and we're starting them on one and they are not stable and steady on it yet, I'm going to bring you in a little bit sooner.

But that's my model. That's what I like to do. I'd like see my patients in the office because it keeps them out of the hospital. Like to say, Hey, you know what?

We're going see you back in three months. And I'll have you go up to my staff and make sure you get your card and your lab appointment. If you have any questions, please give us a call.

We do have someone on call if you don't get us during business hours. And I think that's your, your mention about finding medication, getting medication from a non provider or an offsite server.

So whatever the case is, that not new either. I mean, there's, I see ads for hims and hers and the availability of these medications that honestly need to be evaluated before they're started on because.

It goes back to just like I said with the Viagra. People were getting Viacra off these independent pharmacies or whatever they might be just because they wanted to have, you know, an active sex life.

And that's okay. We get that people want to an act of sex. However, they also didn't inform the people that they were on a nitroglycerin, which now they're passed out in your emergency room again.

And I give them nitro for whatever may be happening. Didn't know they were on this medication. And suddenly now they pass out in front of me and I'm like wondering what the heck did I do here?

Turns out it was a medication overdose. I just didn't realize it. Well, Nina, thank you very much for coming on. This was great. I loved it. We touched on the Ozambic, obviously.

Risk, benefit, side effect profile, but also we need to reinforce with all of our patients. And this isn't just you. People think this is a primary care problem, it's not.

Every single specialty has to, and to some extent does, reinforce the concept of healthy eating, healthy lifestyle management, And really discuss it with every single patient that comes their way.

Ortho can have a discussion, the same with emergency, primary and pulmonary too. It's kind of everybody's best interest for these patients to have these types of discussions and really take a look at their lifestyle and see what can be improved.

Yeah, it's a hundred percent a multidisciplinary fact there because lowering your weight can improve your heart disease. It can prove your diabetes. That's the endocrine side of things.

They can approve your lung function. I can improved your joint pain because your body's not carrying as much anymore. So there's so many things that yes, being obese or being overweight can worsen.

Same thing that all those specialists should be talking about. Should be mentioning to their patients, yeah, It's probably time to lose a little bit of weight.

These injections are only going to take you so far. Ladies and gentlemen, Dr. Nina Shah, thank you again for coming on. We'll have you back on here at some point in the future.

I'm sure we'll talk about some other crazy stuff happening. All right. That wraps up another episode of the Jaffer cast. Thanks again to Dr Nina Shaw for.

Coming on, here talking about ozembic, weight loss, nutrition plans, and a bonus managed care, which is a model not many of us have actually realized is out there.

Tune in again. we're going to talk more about other aspects of healthcare, including, hopefully soon, a first term menstrual vaginal bleeding. One of my former colleagues is going to be coming on talking about bleeding in the first trimester.

She's OB-GYN. And eventually we're going have content on a Praxia speech with a speech therapist and maybe revisit the idea of diet and nutrition from a dietician.

We'll see. But if you're interested in coming onto talk about the show or have ideas about this show, please email me at JafferCast at gmail.com. As with anything, don't take my word for it.

Please talk with your own doctor, do your research because at the end of the day, I'm just another fucking ER doctor. Make good choices, everybody. it.