Podcast Introduction and Guest Welcome

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When they stop, They stop working and the body will adapt to theoretically. Hopefully we're looking at the data, Right? They take it. It long leaves the party for five half-life, drug is gone, but the residual effect is potentially a lifetime, which is fascinating.

Yeah. Fascinating, and that is from a pharmacological pharmacist's perspective. It's like, okay, we'll get receptors or whatever, but one dose impacts for a lifetime.

Never before have we seen anything like that outside of antibiotics and cancer medicine. That is going to break open some of our already existing moles of thinking about how we interact with medicines.

We are here to challenge the status quo. We're curious about the connectivity and complexity between diverse fields of knowledge as a relief to consciousness, chronic illness, mental health, resilience, and beyond.

Learning more about art and science of healing, or listening to stories of extraordinary healing. You're in the right place. Let's dive in. Welcome to the Two Curious MDs podcast today.

I'm your host, Dr. Surya Raman. And today I have Nick Nowak, PharmD, who's here to chat about all things, molecules and clinical pathways. So I'll just start with our Introduction to the podcast.

At The Two Curious MDs, we believe that curiosity fuels discovery, and in medicine, it's the key to transformation. We explore the frontiers of healing through narrative medicine integrative therapies, psychedelics, patient-centered care.

Hosted by myself and Dr. Alia Ahmed, this podcast challenges the boundaries of traditional medicine uncovering the untold stories, ethical dilemmas, groundbreaking research shaping the future of healthcare.

Join the journey because medicine is more than science. It's a story. Welcome, Nick. Yeah, absolutely. Well, thank you so much for having me. Truly an honor.

Absolutely. Wonderful. So my name is Nick Nowak. I'm a pharmacist by training originally from the Midwest with Disco in St. Louis and I've always taken a very like patient centered approach to care, which right immediately out of school, I started in compounding pharmacy and that truly shaped my lens of the world and how to practice medicine.

So with compound, it was a lot at the state level and federal level in how those interact. And then also in this like off label space, as far as like everything from a compound pharmacy is not FDA approved and more of like an integrated medicine type approach.

I've founded a few companies, which I'm sure we'll touch on during this. And specifically my professional entry to the psychedelic space was through a company called MECA, we have since sunset it, but we built out a nationwide ketamine provider network and also a national protocol to layer onto that as well.

So now it's my time to this intersection of health tech and psychedelics. Beautiful. Yeah. I mean, you're a clinician first, a board certified pharmacist.

You've worked for the US Air Force, like you mentioned, the 503A compounding and then digital health. And then you are on the board of the Pearl Institute in Western Northern Carolina.

Then you support business development for SoundSelf and advise founders across the mental health frontier. So you bring a rare lens to our conversation today.

Nick Nowaku2019s Background in Pharmacy and Compounding

that bridges these ancient healing compounds with this kind of unglamorous part of the regulatory compliance and, you know, the systems that we have to work through.

So I'm really excited to kind hear your perspective on what you're noticing from this really unique seat you have, in this field. How did your career bend towards the mental health frontier?

And what does sitting in so many seats at once let you see? There's lots to unpack there. So as mentioned from like the compounding, the interplay of state and federal has always been kind of a center point.

There has been this regulatory complexity and I feel like that is the linchpin to unlock these other modalities. And so when I think of this space is if we move forward medical, then there may be other use cases as well as far as like spiritual or retreats in others.

But first we have to go medical and really take like a rigorous pathway. Loosely it was this integrative mental, physical health that parlayed into the integritive mental health.

I feel like a lot of our payer structure, which we've previously built a third party administrator, is like this fairly reductionist approach of NDC number, CPT codes, and not really thinking about set and setting any soft touch points.

Which as a pharmacist, it's kind of weird to talk about because we just dispense pills, right? Nothing more than that. Being sarcastic on that, but so really getting into these like soft, like softer areas of deep interest and immensely valuable to the space.

Absolutely. Seeing what nobody else can see, right? Especially when you look at the full lay of the land. What do you understand about these medicines, especially ketamine and psychedelics, that physicians and therapists do think tend to miss?

It's this blended perspective. So I take this clinician forward and regulatory forward approach. And this can be a broad generalization, but I think conventional prescribers who come into Spravato first likely, they tend to have missed like the set and setting components.

I've seen a lot of reports of patients squirting effectively, ketamine up their nose, playing on their phones, order things from Amazon, and they go home and like, who's responsible for this?

Who's the responsible? It's just weird. Like what is happening there? But over time, there's this trend of like they realize the power of this medicine and then they do start to go in towards whether it be like comfort and more of it's like set in setting type.

Yeah. We've talked about this a little bit, Prime Day, right? It was so funny when you, cause you found it, I think on Reddit and then you posted it on LinkedIn and I'm reading it going, wow.

Because we have this mental block, you know, every physician says, oh yeah, I'm going to wait until the medicine is in the REMS. And then when it's in, the rems, that means it safe and all we to do is just stick to the Rems.

That's the end of where our thinking stops. But then we're talking about the experience being so different. to so central to how this medicine is doing its work.

And, you know, part of what we've learned as clinicians is absolutely it's about who's in the room with you, what the rooms looks like, What it smells like what it sounds like.

What's, how long can you stay before you recover? Like those soft touch pieces are not something that people in medicine design for because we're really busy designing kind of like yeah, the ACD codes and the NDC.

And so it's a really rare perspective to hold that you do. Can you tell me a little bit about how you arrived at that perspective? I think just pragmatic perspective on medicine, and I've always practiced conventional medicine quite a bit.

So I have had many years in emergency medicine. You mentioned I was a contractor at the airport, so I in the ICU most of that time, which is when we have the best emergency medical care in world, no doubt about that in my mind.

But I've always seen people struggling with these mental health disorders and we put them in a room on a high stress situation and not really take care of the whole person.

It was just, is their blood pressure okay? Are they safe? Put them into the VHU for 48 to 72 hours and get them out and hopefully things work out. That was just like, it's just a mess.

And speaking with like many therapists, many patients, any clinicians nationwide, It's always like what is going to have durability of outcomes? Not just, you mentioned REMS, which is focused on safety primarily.

Yeah. Sure we can check the blood pressure, but that doesn't necessarily show healing. Yeah, and for us to think that, oh, we've done that and so our work here is done is that dangerous place, right?

You describe your work as building at the edges of what healthcare is willing to try. What is something at that edge right now that genuinely excites you and something that scares you?

I don't know about the scary part. I'm a relentless optimist. Really? I'm pushing your edge then.

Why Psychedelics Require a Different Clinical Lens

Well, it comes down to like a big miss right now is credentialing and specifically when it come to set and setting. So Pearl, so I am on the board at Pearl which is a nonprofit in Western North Carolina.

They were an MDMA expanded access site. Kim and Raymond leadership there. Incredible, beautiful people. They just have like this space. You walk in, it feels like a home.

It feels welcoming. And for, especially someone with a mental health struggle, to go into a space like that rather than busy clinic, white walls, and just like, well, like how we think of modern medicine, there are very different truths to hold.

Yeah. And so, and then to take that one further, we have this AI network coming forward. So a lot of my network is our tech founders and just founders builder type personas.

One of those is Soundself, which the key focus there and there are other practices that use it, but it's Fervato REMS criteria. It's like, can we take this immersive technology unit and fit it within this two hour REMs criteria?

So people aren't playing on their phones or anything from Amazon. They would have two hours. And then really it's focused on breathwork at a baseline is like training someone to do breath work.

It is self-driven by the individual. I don't know of another company that has built like this. We have Spotify playlists, we have music, but when the individuals actually driving it has a synesthesia element of classes for lights.

There's audio and a vibroacoustic that it really gets into these deeper states. That is definitely at the edge and very high interest and truly phenomenal, amazing.

But how do we explain that to people? It's always a constant battle and struggle. It is so novel, but it's so incredible. Yeah. And that is something you're right.

There's a scary part to that, right? Because when a drug gets developed and it starts to get implemented and people are starting to look at how to fit it into their already existing clinical pathways, What you're describing is about safety.

It's about when you are doing breath work and you within yourself and can kind of just let go at that deeper level. You've got to have an understanding that I'm safe, I am okay.

I don't have to be monitoring constantly for my time up, right? When is the next patient going to come? Because unfortunately in healthcare, we don' have spaces where that is even thought about.

Maybe in the OR a little bit, you know, as people are going in for scary procedures or something like that, maybe in some of those team-based care situations.

But I feel like when we talk about ketamine, we're talking about an interventional procedure, right? And so how to kind of hold it as a procedure versus an outpatient visit where you're just there for a long time.

Right? So we've talked about that where it's like a frame shift in the paradigm. Let's move on to, I'm going to borrow a bit from Michael Pollan's book, you know, how to change your mind.

I always ask people journeying into this space, even like for me, myself, Dr. Emmett, when we first went from pediatrics to like integrative care and then psychedelic care, we realized that we were changing.

Like our perspectives were changed. So the journey into the space usually forces people to fundamentally unlearn old paradigms. What is a core assumption or truth that you held earlier in your career about pharmacology or mental health treatment that the psychedelic Renaissance completely upended for you?

I've always held like both worlds as I learned a tremendous amount. But even when I was in pharmacy school, it was like one modality, but I'd never actually like dissuade like the alternative, the healing art.

It's always been adventurous. I'm never, I have been more and more into those as, as been in this space because of my peers and these absolutely brilliant people around me.

But I mean, specifically in the psychedelic space, it's less about the molecule, right? So when I think about conventionally prescribed meds, oncology med being different, antibiotics being difference, most medications are like when an individual is on them, they're working.

When they stop, the stop working and the body will adapt to and body won't adapt. These are ideally, theoretically, hopefully, we're looking at the data, right?

They take it, it long leaves a body, four or five half-lives, the drug is gone, but the residual effect is potentially a lifetime, which is fascinating.

Fascinating. And that is from a pharmacological pharmacist's perspective. It's like, okay, will get receptors or whatever. But one dose impacts for a life time.

Never before have we seen anything like that outside of antibiotics and cancer medicine. Right. Like that is going to break open some of our already existing moles of thinking about how we interact with medicines.

A medicine that's only taken once or twice and has lasting results versus a medicine you take every day. And I

think that where the attraction for a lot of patients is towards this kind of therapy, because nobody wants to be taking medicines for decades at a time.

I that that a shift that being driven by market dynamics as well. there's a friction between this ancient healing tradition and this modern industrial medicine.

And we're kind of at this bridge here where we are just building the roads to where those two things can touch. So what do you see? You know, the discussion is also about the state of the psychedelic space in 2026. As we know year to year upon year, we face so much change and so many different things that we can only speak about this moment, right?

Exactly. Give me your perspective about where we find ourselves in 26, what we've just been through, What's the energy building for this next stage, you know?

Do we look at regulatory, do we like at commercialization, Do you look care delivery? I'm happy to go down any of those paths. You know, I think start with the regulatory because that's going to drive it all, right?

That's gonna tell us what's available and what not. And then we can go into, yeah, what are some of the models that you see maybe succeeding or kind of leading the way in meeting those regulatory parameters?

So from a regulatory perspective, the current administration is obviously very forward from the psychedelic perspective.

Set, Setting, and Care Delivery Challenges

So we had the executive order earlier this year, and that seems to have unlocked a lot of momentum. Unfortunately, it seems that one half has high interest right now.

Historically, I view this as a bipartisan ecosystem that we're very involved in. I hope that holds to be true over the arc of time. And so the executive order and then state by state changes.

So Oregon, Colorado, New Mexico, I know there's dozens more out there, lots of them being pushed through and really just finding these like wedges forward for whether it be research forward, so Oregon's more wellness, and Colorado's is more.

Yeah, and then the models of care. So what I find fascinating there is these iterations. Oregon could have iterations, Colorado iterated off of that, New Mexico iterating off both of those states.

And iterations and also care delivery. Like how many hours? What safety? Would you conventionally prescribe psychotropic meds? How do those interact with these and bring the old world a new one?

We're able to figure it out as opposed to waiting for federal permission to be rescheduled from any schedule one substance to either FDA approved or natural medicine pathways.

Yeah, absolutely. And so as we're kind of blending these two, I'm also coming upon this question of like, who are the patients? You know, you mentioned bipartisan.

There's a real push from the VA to now open up funding for psilocybin research, for example. and as well as we're singing a lot of research going towards Ibogaine.

I'm really curious, I am asking everybody I know, because Ibocaine is probably the least known, but also the most, Hamilton Morris called it, the kind of puzzling psychedelic.

It doesn't act like any other, and it has the longest duration of action. Can you tell me what you think about Ibobaine in this kind-of field? So my understanding, my very limited understanding from a purely chemical structure

standpoint is that it has multiple pathways and it's very hard to narrow down from purely a receptor, singular receptor standpoint.

And one of my close friends does quite a bit of legal research on that. He's really interesting. Just out of left field. So Brian Hubbard will, because he's always traveling, we'll come to Asheville.

We have two bigger events every year and one to the biggest year on, like, whether it be Texas or these other state pathways coming through. And I think a lot of it is it doesn't have preconceived connotations.

I think if there's a push towards psilocybin or LSD or something that has some preconceived connotations, I don't think it would have wedged forward. But it's also the most complex.

We're going to have cardiologists there, we're gonna have therapists and psychiatrists, like the more complex to get through from a care delivery standpoint.

And I guess if we can figure that out, then everything else is easy. One of the only psychedelics that have true physiological risk, albeit lower, and we could give magnesium, there's pathways, but it's real.

And we're still doing some research there. I've met people who have had lived experiences from a cardio toxicity standpoint. So it is real, Absolutely.

That's that worry, right? It's like there is enthusiasm because yeah, it' s more acceptable because you're right. It doesn't come with the cultural baggage.

And then, you know, just the kind of recognizing that, yeah, Ibogaine can get your heart rate down to like the 20s. And so an ICU setting is what you have to recreate to be able to support somebody through this, right?

You have be to able have medications on board and the specialists on-board. So yeah. We are taking probably primarily veterans. We're sending them internationally to receive Ibogaine, we being collectively, right?

And then they're shipped on a plane home in a couple of days without any type of aftercare follow-up. And like, what if their world just got turned upside down and they are going back into the same setting where hopefully maybe praying that they have a supportive home life and people understand what they've been going through.

There are some really great after care programs in Mexico as well as the US, but that should be a primary focus. Yeah, absolutely. For clinics to also be aware that there are patients out there who have gone to retreats in different countries and coming back.

And sometimes that is the need. It's not the needs for the medicine, it's actually the needed for wraparound care that we also need to provide. So as we're kind of talking about this, you know, say psilocybin gets approved in the next year.

Walk us through what actually happens the day after. Because we've made the point, the FDA approval doesn't mean insurance pays or patients can get it.

you know, light bulb goes off, what has to happen between an approval to someone actually being able to afford the treatment? Oh, goodness. Far too much.

Medicine will be approved. The DEA, I'm not going to quote days because I used to have these etched into my brain, will then have time to reschedule since it will no longer be a schedule one substance.

About half of the states automatically rescedule on the DEa res schedules. Other states will have independent votes. which is going to be a disaster from a commercialization standpoint, because it's schedule two, it was a schedule three, schedule what?

Like, what if different states have different options? And then there's the payer side. So like, okay, its approved, going through commercialisation, DEA reschedules it, manufacturing is gonna have to catch up on that, expect on it and have a surplus at some point.

And the RVUs and third party administrators are going have book this in and payer coverage. I really honestly think three to five years is where we'll finally be smooth sailing after approval.

We're excited to get over the line, but then there's lots of administrative tech processes that can work to push forward. It's good to keep it in mind because I think when we talk about timelines, we forget that there is so much that will move once we hit that mark.

And, you know, so do you feel like this is an inflection point in 26 or is it too early to say, are we getting ahead of ourselves a little bit? I think every year has been an inflection point.

But absolutely though, when I look at Compass Pathways, I'm going to guess, 200 sales roles have opened up for Compass pathway. It's like that is pure sign for commercialization and they're hiring medical science liaisons and there's signal on that.

Regulation, State Models, and the Psychedelic Landscape in 2026

They seem reasonably confident this gets submitted to the FDA that there will be. I do feel like we are at an infection point on, that front and then lots of building to do.

Yeah, lots of building, but I'm glad to hear that there's investment happening already and that that's a signal that we can look at. The National Psychedelic Workforce Registry, the NPWR, is attempted to establish the single system of record before, you know, all this approval starts happening.

Tell us a little bit about that. Jeremy Rudy with SAPA, and I am an advisor for SAP, I just Effectively, we're like trying to bring the groups together like, like what, what does, so there's, is there going to be realms?

And, um, I don't want to butcher this on his behalf either because he has given us a tremendous amount of thought, has talked to probably hundreds of individuals on how to actually structure, structure this.

But my next POV is for credentialing. So for pediatrics, you have a credential process. For pharmacy, I have credential and process, therapists have credentials and processes.

And how do we aggregate some of that together across disciplines? Because it's not going to be the same medical board because there's going be multiple boards.

And so we need to start wrangling education and training into there, and then also these different professional groups and does that future hold a registry?

I think something along those lines seems like it has to happen, not to be a friction point, but if the payers and the boards could go to a central entity in order to trust but verify that certain metrics are hit.

And then there's organizations like Brain Futures who I hope will bring forward some type of like training standards. Because right now, as we see in ketamine, some incredible ones, there's some not so incredible, and some are four hours, summer months.

And what are the base metrics on how to do that? And so I do see some parts starting to converge, but we don't know because we still don' have permission and approval and we're waiting on Resilient as well as Compass as soon as possible.

Right, and all of these trained, a number of hundreds, I think, probably the thousands of trained facilitators who've never been able to actually train with the medicine itself, who may have done some online trainings, but there's no

legal recourse to train the with medicine until it becomes legal.

There's a lot of people who are partially trained who need to kind of then be fully trained as you're talking about it. And I'm really interested because when we go to these trainings, we see that there's practitioners from all walks of the non-traditional healers.

There are not just, you know, people in the medical field, but there may be spiritual, trained. chaplains, therapists, of course, anesthesiologists, pediatricians, farm days.

You started a company, a community called the MindShift Collective that puts together very different corners, clinicians, founders, investors, researchers.

And I'm really curious as to, you know, who's at the table and who is being left out. Who do you think needs to be at the table? And what can emerge only because somebody from outside of this bubble was at table.

Like what question, what are the real questions that sometimes a person like that can ask that goes, that makes the rest of us go, oh, wow, we hadn't even thought about that.

Have you had that experience? Yeah, so specifically regards to MindShift Collective. Intentionally small, intentionally by referral only. So it's all very high trust individuals and very much just like passion and mission forward individuals who just want to do good work is how would some ever own up.

And who is that? They view us all as builders. You're a builder, I'm a Builder, we're all builders in the space. We're going into this new spiritual landscape.

And MindShift Collective, probably 160 plus organizations represented in there, a lot of leadership. But it comes from therapists and clinicians and CPAs and designers and marketers and web developers and pharmacists like me.

And so really it's like where we could all have a different lens and perspective and discuss to see how the others view. Because if I go talk to pharmacists, type a specific way that we view the world, and it can be like regulatory and pharmacology in that order.

And when I even talk with therapists, it is a nice blend and merger on that. Yeah. We are focused on more of the above ground medical side. And so there is a miss in regards to the other plurality of abuses.

Yeah, absolutely. That's one of kind of problems to solve is there's a lot of this knowledge that's locked away in the underground that We don't have real forums to bring it out.

How do you bring in that knowledge? Because we are using that. Knowledge like set and setting came up because of the underground practitioners. It's not something that, you know, the clinical practitioners and that's what I.

Right. And that's what I kind of see is, you know, there's this understanding of we're inside of a very comfortable psychedelic bubble most of the time.

It's slowly expanding in coastal markets, urban centers and academic hubs. What are the unique cultural, political and systemic challenges for areas where maybe psychedelics are far less culturally embedded, accepted or understood.

Like, you know, this country is vast. There are a plethora of different markets. And if we're going to roll this out, the story of how this healing occurs and all the people that can hold it in that way, what do you see as to how that may shape up?

I'm by no means a forefront expert there either. If I had met guys, I would think inner city urban areas are probably underrepresented, massively under-represented.

Pearl is a great example. I live in Asheville, North Carolina. Perl is in Waynesville North, which is Southern Appalachia, 30 more minutes into the mountain from a very small town.

And the fact that they were an MDMA expanded access site for the hollers of Southern Appalachia is like really, really fascinating. And considering that population, many people have lived in the same hollers for hundreds of years.

I'm a yank by birth. So I say this like, it's like. learning. And so for them to build that and to be successful there is a very interesting signal. I think they are a beacon of hope because larger cities, there's enough of a population this can exist, but to go into these rural, interesting, I know these areas are open to it.

So the stigma has changed. It's no longer the flower children and it's just mental health struggles. People need help. Everyone's Yeah. And so finding these like kind of grassroots already existing groups of individuals or communities that are like already kind open to it and then creating that center of excellence or a place where people can come to.

So we're in some of those discussions and fundamentally. We're in, this isn't like a pro pitch, but they do a lot of training and then with the extended access site and looking towards some other research is like, can we have that be a center of excellence where people come here, train, learn, startups can come, incubate, and they go out to the broader world.

Because if it's viable there, then it should be viable elsewhere. Yeah, and they just like so many trained individuals and trained WMA practitioners and just waiting for.

Absolutely.

Ibogaine, Safety, and Aftercare Needs

And, you know, this makes me think that we are at this moment of being able to think about the psychedelic kind of renaissance or these medicines really being able to go to the people who are the most vulnerable, the ones who have been the needy.

What kind challenges do you think that are going to come up? Because some of those vulnerable populations are homeless, addiction, traumatic brain injuries or PTSD and other mental health challenges.

And that's always been a difficult population to treat. Some of them are veterans. And I know the VA is kind of trying to wrap around and bring access, which is one piece of it.

But yeah, I mean, you know, the stigma of the flower children, and the sigma of 60s psychedelic kind history that we have in this country. seems like it hits us in the face every single day.

Like I'm, you know, I've had like a moment of kind of like coming out of the closet about just even using ketamine. And I was using Ketamine in this pediatric field for 10 years.

You know? And now I am like, why are you asking me this question? As if I m not the same person with the the expertise just applying that exact same range of, You touch on that scales.

Yeah. Yeah. So, because I've worked in emergency medicine for a number of years. And then when I think about ketamine for mental health, and if we were to go IV, right, you start at 0.5 mgs per kg, milligrams per kilogram.

I'm thinking of P, it's like this very vulnerable pediatric population, probably like asthmatic crisis, like, we give… Oncology. Right. Massive doses to them.

Yep. Yeah, way, like, I think up to eight milligrams per kilogram, double check me on that, but very high. And so, then the use is different and the perspective is, you know, the connotation is just right.

So, You know to me, from where I sit, and I can speak a little maybe to my perspective, that I was doing it as a procedure. A procedure means that you've got the respiratory therapist, your got a nurse, a parent, got your child, explain to the child what's going to happen.

It's either a painful long procedure or a procedure like an MRI where they have to be still and you can't expect a two-year-old to do that. Or it's in the emergency room where there's, you know, yeah, we're going to fix your femur and keep you awake, right?

What we love about ketamine and pediatrics is the kids are breathing on their own. You know, you can talk to them. You can actually interact with them and say, Hey, this is going to be okay.

Go to your happy place. Do you hear the waves? Do feel the wind? And so, yeah, we would start at 0.5 milligrams per kilogram. And we will continue with the doses to keep them optimized.

We will go for two, three, four hours sometimes. Yep. With ketamine and other medications, using a lot of ketamine and there was no addiction. There was not issue with all this like wraparound.

So I feel like I was a little bit protected from the cultural stigma against ketamin until I actually stepped into mental health. Interesting. It's just like the stigma is kind of connected to changing your mind, changing you consciousness.

Like, okay to use it for your physical needs, but you use for it your mental needs because oh no, we can't go there. Yeah, interesting. Yeah. That's what it feels like.

Stigma is hard, but definitely more education of what are you doing? But this also touches on, and you started to touch on this, if I think of like where care delivery potentially is in the future, I'd think the surgery centers, the ambulatory surgery center are what a potential model will be.

Potentially attached to hospitals, right? I mean, that's like the closest check that we have as far as like a pathway for care, delivery. Yeah. For the safety, for the availability of staff.

I mean, the way that we work now in the Healing Center at Traumeins is you've got the nurses, you got medical assistants, and you have the physicians.

It's a multi-layer thing and we've go this really comfortable setting. As you said, it's so important for this setting to feel like a place where somebody can belong.

can somebody can come in and find just a normalization of like, oh, it's okay to do this because the story they're walking in with into the doors is I am beyond hope.

This is the last resort. I've tried everything. And so we are really trying to take that story and say, actually, there's more like you than not. Not only that, once you remove the kind of overlaying story in stigma, this is actually going to become standard of care really quickly, because why wait for treatment resistance?

If you knew that one medicine failed, if you're new from this person's genetics, that they're not going to process these medicines, why not go to what you know might work and actually have a permanent solution or a more long lasting solution?

So yes.

Approval, Rescheduling, and Commercialization Hurdles

So, and I think the VA does incredible work, but in the V. A. they have to fail four antidepressants. I've been unable to reproduce this data. And each region can have the national protocol.

So now I'm going to like purely pick on that. But to failed four takes probably at least a year, multiple years. Yeah. And then we're only talking about NDC-oriented medications.

We're not talking other yoga, meditation, going for a walk with a dog, getting a puppy, other things that may help on that front. And so the idea of here's a medicine, ketamine, which we have already available, it's super cheap, and it'll work or it won't.

But you'll know pretty quick. It's, it feels like it needs to be like further up the food chain of like uses as opposed to failing for, and then you could try this mysterious ketamine, which was FDA approved in 1970. Right.

And so if we could flip that, I think the same will happen. We touched on. Yeah. So when that's FDA approved, we're going to do the same thing. It's going be FDA-approved.

There's gonna be these prior authorizations. That would be extensive. These people are already suffering. We're gonna do all these things and then maybe hopefully there's a chance, probably a low chance to actually get access to it.

Right? From a clinician standpoint, to not use that fast-acting ketamine that you know will tell you within a session whether it'll work or not. To put that aside so that, you can go through a four to six week course of a medication that alters your brain chemistry and may or may not work while you're in depression.

And people are in depression, they're not able to take their medicines every day. They're unable to be good stewards of their own healing. So we're already kind of overburdening a person, you know, who's already maxed out.

Maxed-out, but we wait until they are suicidal and then it's okay. It's like, okay, now you're actively suicidal. Now we can use it. And that doesn't respect the autonomy, right?

That feels like just what we call bass-ackwards. Yeah, you said it, not me. Yeah. It's tangential, but I think important. You touched on antidepressants.

So, one of the companies I'm consulting with is Alture, which is focused on tapering and deep respiration. Absolutely brilliant, incredible humans. And me in pharmacy school, I didn't realize how difficult it was for some individuals to come off of psychotropic medication.

We could talk on this one for hours another day. The number of like stories, and I've looked at some of these Facebook groups are 40,000 people in there.

Like people are going outside of the medical system to try to figure it out. And I'm not anti antidepressants, but I do think if there's an on-rec we need an off-rem.

Yeah. There needs to be informed consent for what this looks like. These are all tools. Tools could break things, tools could fix things. We just need to use them more properly.

Yeah, and I feel like there's a lot of people who've been on these medications for 20, 30 years who are now hearing about these new medications that are coming online.

And number one, I fell like they come in with a sense of betrayal. You know, it's like I've never been in this medicine. It stopped working. I'm still taking it and nobody's, you know kind of giving me the next option.

because there's kind of like the sense that, oh, if you're in a holding pattern and if, you know, escalating to suicidality or hospitalization, that means you are okay.

You may be under-functioning in your life and really not happy, but we don't even have a way to deal with that. So we're just going to pretend that it doesn't exist.

Some people who are coming for deprescribing have been on these medications for so long that sometimes it's a months-long process, which is really difficult, right?

Yeah. Potentially years. Yeah, potentially years and I find that maybe there's a potential for ketamine there to help just alleviate some of those, you know, let's bring in a little bit of the science because I feel like we talked really big.

What is happening to the brain receptors? Like what's going on here when we're trying to deprescribe? I mean, functionally, the body's always trying to get to homeostasis.

And so when there is an exogenous substance, in this case, being a medicine, for me, it's caffeine, The brain is going to adapt to it where then when it is removed, that it it, It's already adapted to being in the system.

I do believe that there are some individuals where there's actually like, damage happening, especially as like exogenous substance for decades. There's damage and there's some patients who get in like a really difficult spot where if you go back up, it's really painful and you're suffering.

And if it goes down, people are suffering, so they just need to be like consistent and go down or not very slow for. Yeah. So I think there is lots of like adaptation.

I do think that there was like some damage in that. some damage in there too. Not to be hyperbolic and not phrasing, trying to feel very precise in that viewpoint and perspective.

Yeah. Well, you know, a lot of these psychedelics that bring up this idea of BDNF, right? Brain-derived naturopathic factor. It's connected to that neuroplasticity, which is that ability to grow new connections in various parts of the brain that really is the underlying mechanism for the longer standing changes that sometimes people can see.

And In that framework, what do you think these other medications were doing? Were they dampening BDNF? Do you know what they do to BdNf? Yeah, I don't have a clear perspective.

Credentialing, Training, and Workforce Infrastructure

on what was happening with BDNF in that setting. We've just opened up a whole new kind of way of viewing mental health, like healing from mental-health conditions.

Before it used to be about suppression of symptoms or just getting to control of what were behavioral affective states. versus now we're actually saying things like, you know, this will make you feel better for a little bit, but actually the underlying what's happening under the hood is a longer process where you can direct some of this into, the neuroplasticity through integration.

I love what Robin Carhart-Harris' kind of work shows us about like the energy system on the brain surface where The energy becomes less sticky for those ruminative pathways, right?

Where usually those reminid pathways were worked on through psychotherapy. It's like you do the medicine, you start to change your thought patterns and your processes.

You know, depending on what you're carrying and what the psychedelics seem to do is give us a boost in that, in the realm of psychotherapy, which is, oh, it's easier to change your, your ruminative pathways, the, cause the energy after each session kind of redistributes to where, Oh, there's more available to this new pathway.

Let's see what this has to. So we talk about things like easy reps, you know? Go out there and do something that you would have found challenging before, but now you want to build towards.

Go socialize. Yeah, go play with your dog. Go make a good meal for yourself. Something that really felt difficult. And I feel like there's no medicine that's allowed us to do that before.

Just build ourselves a new way of being so quickly and so kind of adaptive, right? So, all right. Any thoughts on that? A million thoughts, but in regards to our conversation, yeah, I mean, like fundamentally, where I think many of us are aligned is like, this is a really like a therapy accelerant.

There's that one medicine dose, really it's the integration and accelerating core that we're often, psychotherapy is great, right? It's called standard, it may take a year if we could extradite that when people are suffering and just.

Right. move forward. My hospitalist's heart loves the resource utilization part of this conversation. It's like, oh, then we can utilize our resources better if we're accelerating somebody's throughput, you know, and not to be so cold and, clinical about it.

But in this field, it matters, right? Like if you can get somebody out of the emergency room without making them wait 72 hours, Yes. Because they have acute SI.

That is a huge boon to this already kind of really, you know, overburdened system in frontline healthcare. Going forward, what's keeping you up? What really juices your brain?

Yeah. Okay. Rapid fire. What's the most overrated psychedelic? This comes from like a regulatory and clinical perspective. To say that. Not necessarily like the patient facing side.

That's fair to say. I feel like you have a practical and pragmatic side that always kind of filters what you're putting out there. And I love that because we have to be careful.

Absolutely. Because our words have lot of meaning here. Maybe the other side of it, most likely to overlooked psychedelic. Is there a psychedelics that we haven't kind brought into view when it comes to this?

Yeah, I think meth alone for the, and not an area of focus. I haven't been involved in any of those, the companies doing research. But I, think that'll be a very interesting molecule to watch come through.

Yeah. And not a deep well of knowledge, but just from a half-life and an outcome standpoint. shorter half-life aspect and really following some of the thought process of like the MTMA.

All right. Let's switch a little bit because you do have your fingers in lots of different pies here. So maybe we switch little about tech founders in mental health.

What's the single most common blind spot for tech founder's entering mental? Ooh, many of them aren't clinicians. And so I think they underestimate the entrenched perspectives in the overall healthcare space.

It's so hard to change anything in healthcare, it takes so long and we're so far behind. My way is just the way that things are done until I retire. So for tech founders who want to move fast and break things, quotes around that, right?

And then redundancies. There's a lot of AI redundancy companies. Where's the moat? What's going to happen in five years? Yeah. Yeah, we're not thinking beyond that five-year horizon.

Kind of very short-sighted. All right. So to our curious question, in the spirit of this show, what's a question you're still sitting with when you don't have a clean answer to yet about healing these medicines or the system that you were trying to change?

How we scale those. I'm perpetually thinking, do we want to scale it? Fundamentally. It's like, if we scale it, there's all of these parts, right?

Underground Knowledge, Access, and Vulnerable Populations

There's the third party administrators, the RVUs, credentialing and training and all these different molecules and

these drug companies. And how do we thoughtfully scale?

Do we want to? I don't know. What are the alternatives? So there is that scaling model where it's available everywhere. what's intermediate? Like, is there another way to do this?

I think back to our work at Meeko and I, think we are onto something really critical doing that, really a provider network. So there was self-selection, including Shawminds being part of that when it existed, of being very thoughtful as far as where care was delivered.

And then also credentialing, as for as set and setting. Google reviews, getting pictures, talking to them. So if a patient came to us, we had a level of steerage as far as where they may receive like the best and most optimal care for during that therapeutic alliance, obviously.

It's hard to do that at a large national level. Makes me think, where are we collecting this outcomes data? Yeah. Where's this going? We have so much.

Our center has thousands of, you know, outcomes, data from… Ozmind. OzMind is collecting outcomes. Yeah, okay. Their data is not being collected in anywhere.

There's the National Clearinghouse of Information, which would be amazing to make some of these decisions on. Yeah, it feels necessary, especially as MDMA comes through, I'm sure there'll be a post-approval safety and efficacy and durability.

Yeah, because I'm thinking the patient mix is so varied. You've got different ages, you've, all the aspects of like, is somebody postpartum, for example, or somebody metapausal.

Then you have, okay, PTSD. Okay, are we talking childhood trauma? Are we taking military trauma. Are we talking intercurrent trauma, intergenerational trauma or racialized trauma?

I mean, there's like lots of different, just so much variability in which patient would be a good fit for which kind of wraparound care and which molecule even.

Yeah. Well, some may be tangential, but on that point, realistically, if someone's going for Ibogaine, like I have this assumption, they're probably a veteran or they are like a professional sports player.

And why are they doing that? It's probably, a friend went and did it. So there are all these other modalities and there's all of these clinical trials, clinicaltrials.gov being a great resource for people.

But they were like, oh, my friend did that. That must be the right option. I'm going to go to Mexico and do this. It was like well, who's this source of truth?

Yeah, and your friend and you may not have the exact same issue. And that's where we get into trouble, right? Is people saying, well, I heard that ketamine worked really well for this person and it's not working for me in the same way.

So maybe there's something wrong with me or something's wrong the way I'm doing it. No, it's actually that you're different and you need to be approached differently.

And I think some of that comes out in the preparation phase. Like what we do at Shaw Minds is sometimes weeks long of therapy intake, psychiatry intake in addition to the medical intake.

Then you do the preparations. You really get to know the person. Lots of clinicians are doing it. We're adding oxytocin intranasally. for some of these PTSD patients, because there is a subset of patients with such severe PTSD and nervous system dysregulation, where if you put them into ketamine, they actually have pretty substantial, potentially retraumatizing experiences.

And that's where people can say, I had a bit bad experience with ketamine, and I never want to do that again. But then when you add something like oxytocin, which is kind of like backdooring MDMA in a little bit, Do you have any thoughts on that?

Have you seen other people doing it? I want to just get a little vibe check from you. Yeah, absolutely. So when I think of oxytocin, so it's non-addictive, it' non schedule, to bonding hormone, its short acting and available at compounding pharmacies nationwide.

It's an easy adjunct inclusion of like these PTSD patients. I don't know if you're starting off with lower caesandrine oxytocin or the same dose of noxytosin.

But yeah, from a risk profile standpoint, that's ultimately like ideal pharmacological agents. low risk addiction. If it helps, great. I don't see a downside in doing that, to be quite honest.

Thank you.

Ketamine, Deprescribing, and Oxytocin Adjuncts

When I do the research on this, I kind of check in every three months or so because this question will come up and I'll look at the evidence and there's more and more building as to like, yeah, there is actual kind use case of, you can use it with low dose ketamine or you could actually use with the psychotherapy alone as you're kind of starting to get connected, you know, where somebody might have so much defense that you need to work through.

So again, shortening those timelines is the piece there. This has been such a great conversation. Thank you so. Yeah. Always so fun to talk to you. Absolutely.

Anything else you'd like to kind of make sure you get out there before we close for today? No, not at all. Thank you so much for having me and I'm sure we'll be in touch soon.

I think our audience is quite a mix of patients who are looking for what the experts have to say about all of this new medicine. So it's really our honor to bring experienced professionals like yourself who're doing some of the really hard work of synthesizing new knowledge, synthesising new ways of seeing and being and doing and taking that from the boardroom to the clinical, you know, front lines.

And we need more of you, Nick. So if cloning technology gets there, please do so. Well, thank you so much and you have a good rest of your day and signing off for the Two Curious MDs podcast.

Thank you. Thanks for joining us on the two curious MD podcast, we hope today's episode inspired you to ask new questions and explore fresh perspectives.

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