Introduction to Dr. Joel Kahn

Welcome back to the conversation. Today I have the esteemed Dr. Joel Kahn. Hi, Dr. Kahn, welcome. Esteemed, esteemed. Because I had so much steamed spinach.

You got it. Oh, that's the one. Well, in my mind, very esteemed you. Let's introduce you to our audience. I don't know how anyone watching doesn't know you, but you're a cardiologist.

Triple Board certified in internal medicine, cardiovascular medicine and interventional cardiology. You're also a clinical professor of medicine, and you're known as America's Healthy Heart, Doc.

And viewers can actually find you working still at your Center for Cardiac Longevity in Michigan. And I have to tell you that my journey to you occurred several years ago after you did a podcast with James Maskell.

Evolution of Medicine. Right. And I heard that podcast. And your interview was the thing that opened my eyes to possibility that there was something beyond what we're doing in Western medicine.

So you are a huge impact in why I'm sitting here right now hosting a summit, why I am doing what I do. So thank you so much for the impact your. Yeah that that was a real special evening and I'm glad it made an impact on you and I hope a lot of other people will do that again right now.

I hope. Yes. Yes. Okay. So we're talking mitochondria today. You are the expert on this summit about heart and heart health. So we're going to get into, you know, what's important here about mitochondria and why this is so important for heart health.

So could you start with sharing? You know, let let's talk a little bit about statistics and what's going on with people in their heart health. Yeah. And, you know, they have to be repeated because they're so shocking.

I mean, we get dragged down by various health concerns. We got a big financial crisis going on. We've obviously had the pandemic. We always have cancer issues and, you know, horrible.

But still, more people will die this day, this month, this year from cardiovascular disease, the whole umbrella of heart and blood vessel related illnesses than any other.

And the last statistics I saw were about 20, 22. About 700,000 Americans a year die of cardiovascular disease just ahead of cancer. But it's been that way for 105 years.

We're number one. We're number one. You know, it's not a title you really want. And COVID got close a couple of years ago, but it's dropped back off, thank goodness.

And some shocking numbers. And I don't like really memorize this, but a thousand people a day drop dead suddenly. And, you know, it's sad if you're an older person with congestive heart failure and you're slowly dwindling in the families around you.

Heart Disease Statistics and Sudden Death Risk

But to kiss a loved one or a father or a mother or a sibling, a parent goodbye and never talk to them again because a thousand people a day drop dead of cardiovascular disease.

That's called sudden cardiac death. You know, and it seems like lately we read about that a bit more actors, musicians, athletes, it's in the headlines a bit more.

And they may actually be a bit more post-pandemic. Some of it is controversial, post-pandemic, bad lifestyle choices. COVID itself may have some impact on their blood vessels through spike protein damage.

That's the viral illness. COVID. And of course, there's controversy about the vaccines and damaged arteries. I won't go down that path because we'll get shut down and they won't let us talk anymore. But that's that's the issue.

And, you know, and I just want to pose a question, and I think I posed the question sort of in that James Maskell conversation of a couple of years ago.

You know, you're getting to be 40 or 45 and you have a standard doctor or a functional medicine doctor. And they mention things like a health checkup, like maybe a mammogram, or you don't believe in them and you get a third MG or you get a colonoscopy, you get a collagen.

I challenge you to say who's been told by their primary care doc and maybe even their function that check your heart, check your mitochondria in your heart because you're statistically more likely to drop dead.

And there's sort of an assumption that that doesn't exist, that we have a breast cancer screening program and a cervical cancer screening program and a prostate cancer screening program and a colon cancer screening program.

But you just go through life. And the problem is heart disease slowly develops in those that it develops until the day that it can be, you know, suddenly tragic, either a heart attack, emergency room or death.

If it reliably gave us years of warning, we could listen carefully for those clues. And maybe the most reliable one in guys is erectile dysfunction. And erectile dysfunction may be three or four year warning period before there actually might be heart symptoms.

Heart attack. It's not as clear that there's such a clue in women. It might be fatigue and back pain and palpitations. But the bottom line this all messages or the next few minutes that we're conversing, let's talk about, you know, this amazing burden of heart disease, the impact it has on heart function, which relates to mitochondria, because mitochondria drive the heart, make the heart function and, you know, early detection be as aggressive.

And this I listen to your introduction. I mean, I try to avoid excessive Western medicine. A lot of what I do with patients is reassure me you don't have heart disease.

You don't need those prescription drugs. You just need a lifestyle. And some of it is really application of very high tech western medicine. And that's where we're talking about here, early detection of heart disease.

So we got to drop these numbers. They're just tragic numbers. You know, what impacted me when I listen to that interview all those years ago was your discussion about how you are an interventional cardiologist and you did a lot of procedures, put a lot of stents into people, and then you came to this realization that that wasn't the solution and that there were other ways to help save people's lives.

And that wasn't working. And that's when my eyes opened big and I went, What this a cardiologist is saying we should be doing less procedures and doing more lifestyle things.

So I've given up doing what are very lucrative procedures, gastro zation and stents to focus solely on usually lower paying preventive strategies. But it's the right thing to do.

And frankly, it's a wide open field. There's lots of cardiologists doing procedures and there's sadly a very small percentage that are talking. You know, as I say, hashtag, prevent, not stent.

Why don't you never get heart disease or why don't you find out about it so early that it never becomes a serious problem? These are very doable. They're actually not elite or expensive concepts either.

And just to tie it in, you know, we'll have a healthy heart with healthy mind. Let's just take mitochondria for a minute because I do want to give justice to it.

If we've got that, we don't think about it. We're all busy with our life. We've got this gorgeous heart beating 60, 70 times a minute, over 100,000 times a day.

It's beating and it requires tremendous energy. I mean, just we pump this little tiny little muscle the size a little bigger than a tennis ball, you know, pumps over five gallons a minute of blood through the body, like a torrent all the way up to the brain, all the way down to the toes.

We've got to get it all the way back up to the lungs to pick up oxygen. It takes tremendous energy. And we've also learned it doesn't just take energy to contract and push the blood through the body.

It actually the heart has to relax and let the blood fill back up for the next cycle. That takes energy to it's energy. It's energy. It's energy. And I believe the statement is correct that there's more mitochondria Purcell in the heart than any other organ in the body.

I know the brain is pretty close and I don't want to absolutely say that the heart is overtaking the brain. But given the intense muscular activity of the heart, I think it is the heart's number one for mitochondrial density and it requires lots of blood flow.

And we're talking here about early detection of heart disease. We want healthy heart muscle and healthy mitochondria. You need healthy blood vessels, big blood vessels.

And there's also the small ones called microvascular circulation. You want to keep them all healthy and you want to have the right nutrients. So your mitochondria work and you know, these single most scientifically backed supplement in the literature, not all kinds of it is actually coenzyme Q10.

Mitochondria and Heart Energy

A recent giant meta analysis of almost a million subjects found that if we used coenzyme Q10, sometimes called Coke, Q10, sometimes called ubiquitin now.

But mitochondrial support for the heart and other muscles, but it's easy is primarily for the heart lowers blood pressure, lowers cholesterol a bit, takes away palpitations, is great for migraines.

Many other uses for CoQ10, you actually can reduce cardiovascular death by about a third and many vitamins. We don't have that data people joke about vitamins are expensive urine and standard.

Doctors and cardiologists often tell patients you don't need that long list of supplements. You got coenzyme Q10 on there. You got better mitochondria back than previously.

And you know, I do consult on a lot of patients with shortness of breath, actual congestive heart failure, sometimes hearts that have been weakened by previous heart attacks or blood pressure and that's a mitochondrial disaster.

And we have so much to offer there. That's some of the most biochemical kind of game plan. How can I support your heart's mitochondrial pathway? Part of it is eliminating toxins, things like heavy metals and estas IEDs and or again, or phosphates and just a super, super clean lifestyle and heavy metals particularly.

It's very easy, you know, for a there's there's again, it's not new agents in our cardiology literature that an accumulation of cadmium, lead mercury within the heart itself can cause serious disease and is very common and can be very lethal and can be measured and can be, you know, work to detoxify and eliminate.

It's certainly not a standard part of medicine, but it's important. And I urge everybody, get that done, get some heavy metal testing. We live in 2023 where we're in polluted area and get your mitochondria working better by

eliminating toxins and then you can create this whole mitochondrial support with coenzyme Q10 and ribose and taurine and sometimes magnesium and l-carnitine.

And there's all these other wonderful prescription drugs for people with advanced cardiac disease and heart failure. But usually my role is to bring in a bit of the natural and layer and on top of the standard.

I can't I can't discount all the advances that have happened. But so I just wanted to, you know, spend 5 minutes on mitochondria because the heart is a mitochondrial organ.

And it's just something that talked about a lot when you go visit your internist or your family doctor or your cardiologist. Yes. So I would love if we can have a discussion, if you would, about cholesterol. Yeah.

So could you could you let us know? I mean, I feel like there's a lot of conflicting information out there about cholesterol and what's the what is the good number?

I can remember back when I started practicing medicine 20 years ago, the you know, the level of LDL that was acceptable was around 130. Now it's around 100.

I prescribe more statins than probably any other drug. And I would love to know what your thought is on this. I get people asking me all the time, how do I do this naturally?

What's really dangerous, what's really safe? And and also, can you talk about what is the important thing about cholesterol? And are we doing damage by lowering cholesterol too much?

Yeah, and I'll give you my spin on it. But it's a spin from a lot of patient care and a lot of research and writing and learning. In fact, I was listening to a 45 minute lecture on this topic just before I signed on.

The Zoom had a little break between patients cholesterol. Wouldn't matter if there wasn't some evidence that in some people, cholesterol accumulates in blood vessels in the lining of blood vessels.

Then they'll feel them in the into my blood vessels. And cholesterol can be part of the pathology that narrows blood vessels and causes symptoms like shortness of breath or angina, chest pain or cholesterol could be part of the syndrome that causes heart attacks, strokes and death.

There's no question. The pathologist told us, you know, over 100 years ago, if you have a clogged artery in the leg and a brain and a heart, part of the chemistry of that garbage in the artery is the chemical cholesterol.

I mean, there isn't sugar in arteries. It absolutely has excess. Sugar in the diet is a factor in poor health, including developing clogged arteries. It's taking a while to get to that conclusion, but there's absolutely cholesterol in the arteries.

And the only question is, is the level in the blood related to what's in the artery wall? Is the level in the diet related towards an area? Well, these have been very, very tough questions over the years so that our liver makes cholesterol.

Is that good? It's absolutely good. We absolutely need glass drugs to support our hormones and our sex hormones and our cortisol and our vitamin D, we all know that.

Are there are some people that is there any really question that in some people, cholesterol damages, arteries? There is not. There's a type of scientific analysis called MRI, Mendelian randomization.

There are people born from birth that's redundant that make a little more cholesterol than the average public. And there are people due to genetics snips and there are people that are born that make just a little bit less cholesterol than the average in the public.

And because that difference starts at birth, it's true. Your whole life, by the time you look at them at age 40 or 50, the amount of heart attacks, strokes, death is dramatically different.

There's really no controversy that and I keep emphasizing in some people an elevated predominantly LDL cholesterol. It can lead arteries to become disease, leading to what we call strokes, heart attacks, bypass stents and think the challenges were so different biologically.

My favorite word in the last five years is precision medicine or irony. Get a second favorite word, personalized medicine. And this is the challenge and this is what has become so hard.

You mentioned we got two people, relatively similar, 45 years old. One has an LDL of 130 LDL cholesterol and one has an LDL cholesterol. One in 30, they may be dramatically different in how their arteries are.

And the current medical model is they're both going to get ten milligrams of Atorvastatin, Lipitor, hopefully after 3 to 6 months of some diet, exercise, weight loss, lifestyle recommendations, but probably not.

But they can be very different. So one of the biggest and most important messages, please, everybody just write this down, is that people that don't have atherosclerosis scientifically don't need prescription medicine for cholesterol.

I have patients in my practice. This may sound radical and I'm a statin prescriber and I'm a cholesterol believer, but if you have a heart calcium scan done, $75 to $99 test and it comes back zero and you're about 45 or 48 or 51 years old.

The science is overwhelming. You do not benefit from prescription drugs and you can allow the LDL cholesterol to stay elevated. There was a recent study in 2023 called the Western Denmark Heart Registry.

LDL cholesterol is over 190 with a calcium score. Zero did not result in an increased risk of any cardiovascular damage over about four years and part of the study and 16 years and the other part of the study it's not to encourage people to have a super high cholesterol, but it's to ask the question, do I have a super high cholesterol in clean arteries or do I have a super high cholesterol and I'm starting to develop the disease.

And there's two tests. One is an ultrasound of the carotid arteries. The best version is called the CMT Carotid Interval, medial thickness ultrasound, quick little test, no radiation.

You got no plaque. You probably don't need prescription therapy.

Cholesterol, Plaque, and Precision Testing

Work on your diet, eat a little more oatmeal, have a couple more ate a mommy, have a little ground flaxseed on your on your salad or something and get some gym time in.

But if you've got plaque and it says, you know you're 45 years old, but your arteries are like a 57 year old man or woman, you probably need to get a little bit more aggressive and then even probably a little better.

Is this heart calcium CT scan requires a prescription. Usually from a provider is less radiation than a mammogram, no injection, no needle. It's available at every hospital in the United States except for the smallest.

The smallest. And if you have an LDL cholesterol of 150, but you have a heart calcium CT scan of zero, even the very stodgy American Heart Association says you do not benefit from Lipitor and Crestor.

You benefit from concentrating on lifestyle and diet. So it's not such a simple black white. Yes, no, it's about precision medicine, but it's so easy and inexpensive to get these vascular tests and ask the intelligent question, why am I taking a drug if I don't have the disease?

We don't have a disease. You don't need a prescription drug if you have the disease. And we should be getting these heart tests either the harder to find carotid ultrasound or those simpler to obtain heart calcium cityscape.

Just like we think about a mammogram and a colonoscopy and a digital rectal and a cervical exam in a woman. This should be a routine part. It should be more important than all the others, because heart disease is so much more common and do it around age 40 or 45 and repeat it in five or seven years and sort it out.

Now I just want to go off a little bit, but the last trial is a risk factor for early heart attack, stroke and death. It's not the risk factor. There's many there's 20 I my mind always is blown off, you know, a little firework when I'm seeing a new patient.

What's their blood sugar, insulin resistance, what's their light bulb protein, the other cholesterol that about 20 or 25% of us can make in our liver and 75% of us can't make.

And that's how I explain to patients, 100% of us make LDL cholesterol and maybe 20 to 25 make two kinds of cholesterol. The other one is called lipoproteins.

And it can be very, very important in people simple little blood test. Everybody should have ones. And I said insulin resistance. What's your blood pressure?

Blood pressure is the big elephant in the room in so many people. What's your sleep status? What's your sleep apnea stars? Which inflammation status? TMO I won't go off on a tangent there.

Nitric oxide production, endothelial function. So you can have a high cholesterol in clean arteries because maybe all those other factors are in good shape and you can have a relatively modest LDL, even in a totally normal range LDL cholesterol and have abnormal vascular studies because maybe it's something else, maybe it's the lipoprotein.

So I don't want to make it too complex. It's actually pretty simple. You need about ten blood tests and one or both of these vascular imaging tests, and you're in a really precise precision place to know, am I in good shape?

Am I rotting? Do I need prescription drugs? Do I just the regular what's the plan? Well, I think this is really important. This so everyone watching right now, your time of investment and watching this summit is worth this 5 minutes that you just got from Dr.

Kahn, because here's what I know. Working in family medicine and internal medicine for two decades, not everyone knows who has a prescription pad. What you just said.

So what what many family practice doctors are doing is just looking at the cholesterol level and just gauging, well, you need a prescription based on this and they don't know what is.

I don't know if that's going to be something else can read. But just to tell you the frequency, I mean, I have a preprinted prescription pad. You should encourage your provider to have the same.

It's you know, there's no iodine injection. It's officially a C, D calcium scoring. There is a CPT code. That's what the insurance companies want. But this is self-pay.

Usually you pay 75 or $90 and get it done. I just wanted to point that out because. So. That's that's what primary care doctors should have and say, okay, here's your script for your colon as could be or your mammogram and here's your heart.

Calcium CD scan. And let's define if you're at risk or not, because there's a thousand people a day dropping dead. Most of them would have flunked that test big time.

And we would have had years to get a stress test, evaluate the full spectrum. Like I said, of all these blood factors that are promote atherosclerosis and then institute a plan of hopefully mainly lifestyle and supplements, really cool

data, I'll just give a shout out.

I've been waiting for a study that Berberine, which is a very commonly used supplement in the integrated world, may reduce atherosclerosis atherosclerosis.

So the first human study with Berberine showing it helps shrink plaque came out. Wow. I'm surprised who funded that. There's no my. Kids. The Chinese comes from China because Berberine is part of traditional Chinese medicine.

It was a small study, but I just point out there's so much. So, Doc, why do I want to know if I have some black? I feel fine. I don't want bad news because there are simple things in natural things to do.

Burger my berberine aged garlic. I am a big fan of a supplement got picked not marginal which is French maritime pine bark but that's another topic you know that's they're all mitochondria too. Yes.

And so back to the mitochondria support. I mean, we're here people are here booing because they want to know how to improve their energy. And you and I know that if the heart is not functioning optimally, this is going to affect the way you experience energy throughout your day.

You're going to have less energy throughout the day. You're going to have slumps throughout the day. So so heart health is a really important part of this energy discussion.

So could you talk about what I mean? There's many directions we can go here in this conversation. We can talk about drugs that interfere with heart energy production.

We can talk about lifestyle that interferes with heart energy production. Why don't you decide? What do you want to where do you want to go? Since we brought up the topic of LDL cholesterol and statins, I mean, the point I'm making in the last 10 minutes is, you know, you prescribe statins.

I prescribed statins, drugs like Lipitor in Crestor. And in many cases, that's an absolutely appropriate thing. Somebody who's had bypass stents, somebody who has clearly identified a high amount of plaque they didn't know about.

But the CT scan or the crowded scan showed that statins may be necessary. But I'll talk to you about it. Absolutely fascinating. Two pathways your liver is making cholesterol, statins like Lipitor, statins like Crestor, you know, some of the most widely prescribed drugs in the world, not necessarily, you know, a conspiracy theory.

Most of these are generic, very inexpensive drugs. So it's not like big pharma making a ton of money they used to. 25 years ago, Lipitor was a major selling drug, but it's pennies in the generic world.

So I just want to I want to take the money out of it and stick with the science. But you take that little pill called Lipitor because your internist says your LDL cholesterol is 130 and your grandfather had a heart attack.

And he's worried about your she's worried about your other good intentions. They're missing the fact they should get that c.t scan first. There's this pathway called the ventilate pathway.

Nobody needs to remember that. And the drug, the Lipitor, the Crestor, partially blocks the pathway so you make less cholesterol. That's all right. What everybody forgot in my biochemistry class in medical school 40 plus years ago is there's another branch to that pathway.

It's like a fork in the road. The other branch is called the drug pathway. And I guarantee you this is all scientific and well-described, but you never hear about it.

Well, it turns out when you take Lipitor and you take Crestor, you're not only blocked the full of the pathway, so you make less cholesterol, you block the drug pathway.

What does that give pathway? It stands for Journal. Journal, there is a biochemical name for the G pathway makes CoQ10. And we just said CoQ10 is one of the most important mitochondrial support compounds.

Whether you make it because we do make it as humans or whether we take it as a supplement. So you're taking your lipids are thinking, I'm doing this because my primary care doctor tells me it's a good thing or I really need to because I've had bypass or stents, but we're robbing our body of the ability to make coenzyme Q10 and you're going to get tired and you're going to have less efficient mitochondrial function and you maybe even will have a slight drop off in cardiac efficiency.

There are some studies out there, not a lot that they actual function of the heart may be slightly less efficient on statins, that people with congestive heart failure who needs great mitochondria more than the hundreds and hundreds of thousand millions of people that have congestive heart failure.

And it's been shown if you take a person with congestive heart failure and put them on a Lipitor, they don't need you get no benefit. Maybe their arteries are clean, but you're actually causing mitochondrial damage, mitochondrial dysfunction.

And you may actually worse than their congestive heart failure. So this extra pathway not only makes coenzyme Q10, it actually helps promote protein production and, you know, the heart muscle has to keep making more protein repairing, restoring juvenile eating its structure.

And you actually have statins may impair it's called protein translation. And actually down that pathway is actually vitamin K to also advocate for vitamin K2.

So very exciting. Just recently there, a scientist colleague of mine, Dr. Barry Tan, found a plant in the Amazon. It's a beautiful red plant. Looks like a pomegranate, almost called the Annatto plant.

And NATO, I think is spell it. And it's been used to make a very pure form of vitamin E, but he found that there was a little residue and it's actually pure.

Jaron neil jaron i alg.

Statins, CoQ10, and Mitochondrial Support

So anyways, in my clinic, if I have to put you on a statin, I'm putting you on coenzyme Q10 and now commercially available g g just support your mitochondria to support your coenzyme Q10 to support your protein.

Translation I source it out of a company in New Zealand. It's commercially available called Gigi Pure because they've just got it to the market in a very pure way anyways.

And that's just like one example. We think we're doing something good for a person with a statin and we're causing mitochondria real dysfunction, but we actually can remedy the mitochondrial dysfunction without stopping the stat.

If we need the stat, it's just using biochemistry more intelligently. So that's a fun little pathway. It is. And so, Dr. Kahn, why isn't every cardiologist in America practicing like you?

Oh, it takes time. I'll tell you, I just just thought of one other thing, because people you know, if you I'm not anti Lipitor, but if you open the package insert it'll tell you you may develop muscle pain and aching.

You may develop brain fog. It's as of right in there are cognitive impairment and it talks about blood sugar elevation. And it turns out this guy pathway, which we don't want to block, but we have to if we're using Lipitor, Crestor, if you restore the amount of G. G.

with this supplement, at least in animals, blood sugar elevations return to normal. So it's hopeful that we may now have a strategy to deal with people who go on a Lipitor.

They have no choice to be on because they really need it. But they notice that their, you know, their CD, their continuous glucose manager or their finger glucometer or their blood work shows that their blood sugar stabilization has actually deteriorated a bit.

You know, it's it's a slow and steady process. I mean, I've been on a 10 to 12 year OD course of a lot of expensive coursework, a lot of expensive meetings, a lot of reading.

And you can do I mean, they're doing good work. My colleagues are doing good work. But, you know, this idea of upgrading it and really, really bringing precision medicine to the bedside, as I say, I don't want to make it sound too difficult.

Yet about ten extra blood tests get one or two extra imaging studies like the higher calcium CT scan. You know, you're welcome to read any of my blogs or blogs I'm always talking about, you know, this science where the other two vitamins, they got very good reason reviews, whereas omega three fatty acids and folate along with coenzyme Q10.

But CoQ10 is the mitochondrial miracle, so we'll stick with that as being the most scientifically backed. Yeah. But so many. Perla has Mad Pharma. You know it and I know it.

Even though so much of what we've talked about our generic medicines there still is the sales representative come into the office with. They can't bring anything anymore but brochures.

But there's still dinner programs at steakhouse sizes and you know probably the biggest influences when you go to national meetings and you just see, you know, displays that cost hundreds of thousands of dollars, millions of dollars just to sell doctors on the idea that new, expensive drugs are totally safe and better.

And we should be very skeptical about all that. I find that, you know, as I get older and older, more and more offensive. Okay. All right. In the last few minutes that we that we have here, let's talk prevention, because you mentioned at the beginning of this talk that you see a lot of people in your clinic who you're telling them you don't need to go on drugs, you just need to continue on with healthy lifestyle.

So do you have a sense of statistically how many lives you're able to save and improve with the way that you practice? Cardiology? Yeah, if you start stirring the pot and again, we have recent and good science if you take it.

There was just again another study who happens to be again from Denmark, from Copenhagen, this time 10,000 people that they will put their hand on the Bible.

I don't have heart disease. I'm over 40. I feel fine. I don't have heart disease. And you do. One of these imaging studies turns out about 50% have heart disease they didn't know about.

So that's a lot. What I do in my clinic, I take 50% and I put them on to eat healthy exercise. See in a couple of year plan, you know, making sure their blood sugar and blood pressure are periodically monitored, but 50% have silent heart disease of from minimal amounts to about 10% of the pie.

10% of the 10,000 actually had pretty serious heart disease. They had no clue about it because we don't have a program. We don't have a mammogram of the heart, but we really do have a mammogram allowed.

It's called a heart, calcium CT scan. And those people you got to work hard on, I think we make a major influence there of anybody. Everybody knows somebody's grandpa had a heart attack.

Uncle Joe had a bypass. My mother had a stroke. Those diseases, those were identifiable ten years before they got sick. And for a lot of them, just I open their eyes that food is medicine.

They might leave here with a brochure, a book. I might tell them to watch forks over knives on YouTube. Something really simple. But it's the first time in their life they made a connection.

Prevention, Lifestyle, and Patient Advocacy

You know, I maybe should upgrade my food and the idea of standing desks and walking and motion in their life. And I spend so much time on sleep, sleep, sleep, because there's so much data now between poor sleep and arthroscopy, ptosis and early death and dementia.

So it's about 50% of the people I'm seeing really need my ongoing care and 10% of the pie really, really need my ongoing care that we and I think that's substantial.

I mean, if every doctor could identify 10% of their patient practice, they got 3000 people in a family practice, and they're going to really impact 300 to 3000 in terms of risk and stroke, a big number.

Then we can take that thousand people a day dropping dead. Maybe we only drop it to 700 and dropping that because we're impacted. But you know what a wonderful advance I would be.

It would be. Do you have a sense of how many stents are placed that are not needed that could have you know, the problem can be solved with if. I have the ability to comment on that as a very experienced and doctor.

And my role to patients is if you went to an E. R. and you got admitted overnight and they found you have a problem and they're talking about putting in a stent in a couple of weeks, you don't need a stent.

You need a lifestyle program. You need a doctor. Dean Ornish, heart disease reversal program or doctor Caldwell assist. And you got to work with somebody carefully who knows what they're doing.

If you're in an emergency room and you're having instability or in a corner carrying it and they're telling you you're too sick, you can't leave, you're having your stent tomorrow, you're having your bypass on Tuesday.

You probably need it and you shouldn't bucket. Although a few people I've done some really I intensity consults from people in a coronary carrying it by face time trying to show me their data and make a decision if they have any room for a second opinion, even though they're in.

But I do believe that the majority of these procedures, there's a world famous study published in about March of 2020 called the Ischemia, ISC H EMEA trial, 5000 people with very bad heart disease, but they were outpatients.

Do you have to rush to the cath, the stent, the bypass, or could you treat them with medication, diet and lifestyle? And at the end of three and a half years, there was no advantage to rushing the cath or bypass.

So the people that are well enough to be out considering their options should probably try and find a lifestyle oriented preventive cardiologist and work with them or other practitioner.

There just aren't many of us, and it frankly takes some serious companies to work with a patient when the rest of the world is saying bypass, bypass, you're going to drop dead.

And you just the reality, the science says very few of them are going to drop dead. I mean, I've never had anybody drop dead in that saying, thank God.

Thank you. Yeah. Well, on that note, I mean, I could keep asking you questions for the next hour, but we do need to wrap up. You know, what I'm hearing loud and clear from from you.

If I was a consumer of health care watching this interview, what I would be hearing is I get to be my own best advocate. I get to read Dr. Joel Kahn's blogs.

I get to research this, take notes from this interview and go back to my health provider and advocate for myself. Because, like Dr. Kohn just said, there aren't enough of him to go around to serve the millions of people in this country.

So so this is the big message here is advocate for yourself. Little. I don't need to sell books. I can have a, you know, a nice practice, but a little tiny book called Derek.

Don't Get Bonuses. I wrote that sort of outlines the self care program. Why do I got to get what tests to ask for? Why is a stress test not ideal compared to a CT scan?

Little simple book with a crazy title that exists? Don't get bonuses. But anyways, I know we touched one person. We did a great job. I think we touched a lot of people.

We did. And thankfully, if you go back to your primary care doctor or your cardiologist and you draw up, you know, Dr. Joel Kahn, America's cardiologist, I'm reading his book.

Could we, you know, do some of the stuff he's recommending? Thankfully, you have a good reputation in this country and people know who you are and respect you.

So namedrop, I would say thank you. Thank you. I had a good mom and dad. Yeah. Thank you so much. Dr. Khan, this is. Thank you. Yeah, it's wonderful. Summit. Thanks.

I want to thank you for your contribution as well to the world. Thank you so much for everything you do.