Paleo Solution - 408

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Robb: Hey, folks, six listeners can't be wrong. Another edition of the Paleo Solution podcast. I really had a fun time today. I got to talk to Dr. Emory Liscord. She is the assistant medical director at the Department of Emergency Medicine Maine General Medical Center. She has a really fascinating story battling with some health issues from a diet that was not matched to her physiology despite being a medical student and a marathon runner.

She's just right in the front line of where current healthcare situation is. I believe she quoted about 90% of the things that she sees as an emergency room physician, they're preventable. But that prevention involves a massive number of issues ranging from our food system to social processes. We dug into a lot of this stuff. I don't know that we got to a concrete answer on anything other than, holy smokes, this is a complex topic. But really had a great time talking with Dr. Liscord. I think that you will enjoy it too.

Hey, Doc, are you there?

Emory: I am here, Robb.

Robb: Cool. Dr. Liscord is with me. We had a minor technical issues which have resulted in a hardwire Ethernet connection and sitting Indian style in your basement, it sounds like.

Emory: Exactly. It's fantastic. Love it.

Robb: Doc, thank you for coming on the show. Thanks for navigating the little technical difficulties that we had getting going. You shot me an email recently.

Emory: Yes, I did.

Robb: And made an introduction. Can you tell the listeners about yourself? I covered some of this in the introduction but it would be great to get a little bit more of your background.

Emory: Absolutely. So, I'm an emergency medicine physician. I graduated from Dartmouth Medical School and did my emergency medicine training at Boston Medical Center. I was looking for the craziest busiest ER in all of New England and that's where I landed. The reason that I reached out to you, Robb, is because

I left Boston and I moved to a rural area in Maine and just started to pay attention to what I was seeing in the emergency department which really was quite different from what I expected to be treating when I went into that specialty. I'll tell you -- go ahead.

Robb: No. You go ahead.

Emory: Yeah. It's wild. I would say, probably 80% to 90% of what I see in the emergency department is 100% preventable by lifestyle modifications. I just, through my own health journey, and I'm happy to talk about this or not, but I started running marathons in medical school. As a lean marathon runner I was diagnosed with pre-diabetes.

Somebody who was not in medicine gave me the Primal Blueprint. That was one of my first introduction to this world. I've just have gone down the rabbit hole ever since and just really frustrated with my own profession, the healthcare system, and the lack of resources that I'm seeing that my patients have here in Central Maine. My husband and I started a health advocacy group and we teach classes in the community and I'm trying to teach other physicians about healthier way of living. That's my background.

Robb: That's amazing. We get a lot of questions around career path. I definitely want to hear more about your own health journey but why did you choose emergency medicine? A lot of folks, they'll fire an email and they're like, "Hey, I want to make a difference. Should I do this? Should I do that?" Without knowing the person. How are you wired up and why did emergency medicine appeal to you?

Emory: Right. I mean, I think I would say I'm a bit of an adrenaline junkie.

Robb: Shocker.

Emory: So, let's just put that. We'll put that out there. But the other thing was, in medicine, you make a decision.

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It's do you like taking care of people who are mostly well or do you like taking care of people who are ill? If that makes sense, critically ill, acutely ill? I found that I thought I'd be a family doc. I went into medicine with family docs in my family and I assumed that's what I would do. But I found that it was just -- I felt the visits were short. People weren't making a change. They weren't getting better.

An ER for me was very tangible. Somebody comes in, they have a dislocated shoulder, boom. I can put that back in. Someone's in a car accident, I can stabilize them. Somebody has a heart attack -- The thing is that, and this comes out of the military really, is that medicine is fantastic if you want to live to tomorrow. We really got it down. I mean, emergency medicine is really good.

But the chronic stuff, as you know, is just we are failing and flailing and people are getting sicker. And so I liked that being able to tangibly make a difference in that moment but what I'm realizing is I make right now with my practice every day, it's like I see people and, yeah, I can stabilize them when they have their heart attack or their stroke but they're back in a couple weeks later with something related and it's just the more medicines people are on the sicker they're getting. It's so frustrating.

Robb: It is. I remember doing my undergrad. I worked as a pharmacy tech. Folks would come in, they'd be older, maybe mid 60s, late 60s. Oftentimes they would comment, "Well, this is my first prescription." Almost like a badge of honor. They typically were reasonably lean, reasonably healthy. They were just this interesting demographic of older folks coming in, first prescription. And then son of a gun if it wasn't like now it's two, three, four, and it seemed like the wheels fell off.

On lunch breaks, I'd talk to the pharmacists. I'm like, "Hey, do you notice this trend?" And they're like, "Yeah." And it's just one of those things where we would talk about it a little bit but we didn't really know what to do. This was five, six years or maybe even longer than that, before any of this ancestral health stuff got on my radar. But even at that point--

Emory: People were starting to realize. I mean, if you think about it, we went from, "Okay, let's put statins in the water," to, "Oops, it causes diabetes in 40% of women." Oops. Basically, we have a philosophy with our work which is less is more. The less you put -- You do not need a pill, a supplement, a shake. You don't need anything. You actually need to take a lot of stuff away, in terms if you want to see better health, and that includes prescribed medications.

I'm actually doing a fellowship in obesity medicine which I really like that, the Obesity Medicine Association. This is western medicine but they have really -- They have Stephen Phinney, Jeff Volek, Jason Fung are all lecturing at these obesity medicine conferences. They're on the cutting edge of nutrition. I've said to my husband in the emergency room I don't think I've ever in the -- how long have I been doing this? Eight, ten years. I never have seen an obese person over the age 80 because you just don't live that long when you have so much weight.

Robb: Right. That totally makes sense. Hey, let's dig in a little bit more about your health situation because, again, if we went to maybe the more mainstream dietetics scene, the Alan Aragons of the world, it's basically eat more or less whatever you want, just watch the amount. And if you exercise, all is right in the world.

Emory: Right. Exactly.

Robb: You're super well-educated. Dartmouth is arguably one of the best medical schools in the world so, clearly, you are smart. And you had the gumption to do both medical school and embark on marathon training. I could probably make an argument that lurking in the background of all that, there was some sleep deprivation and some hyper vigilant state that was probably contributing to this, but how did you, as a young smart medical student, develop pre-diabetes through the process of embarking on marathon training?

Emory: I know. Isn't it wild? Well, I mean, I'm not really sure but I'll tell you that nobody in my family has diabetes. Everybody is pretty lean so it doesn't run in my family because I'm sure genetics, I believe that genetics does play a role, not completely. I had started getting into running as, I would say, productive procrastination.

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It was the one time I didn't feel guilty for not studying, was when I was out for a run. But I fueled with gels, crackers. I mean, I was the low fat high carb. Popcorn, I would eat two bags of popcorn for a meal. I mean, this was what we did. This is endurance training. And then when I was in residency I actually got pregnant in residency -- that's not stressful -- and then I was diagnosed.

My hemoglobin A1C was a lot higher than I would expect. That's when I started looking at ancestral health. Once I cut my carbohydrates down a little bit -- it wasn't even ketogenic. We're talking down to 100-150. I normalized my hemoglobin A1C and I started to just feel a whole lot better. This is what really clicked for me. Ever since then I haven't looked back. My son is six now, so that was six years ago.

Since then I sort of -- I'm still running. I actually used to work the medical tent at the marathon in Boston and I took care of some of the bombing victims during the Boston marathon bombing. I always made this goal that I wanted to run the Boston marathon. But I didn't really want to raise money so I wanted to qualify. But I didn't want to get diabetes so how do you run, how do you train for a marathon and not get diabetes eating all this high carb stuff?

That's when I got really into the more fat-adapted running, the ketogenic athlete type, working towards low carb running. It was great. I qualified for Boston. I ran Boston and fueled on fat. It was great.

Robb: That's awesome. I love that you mentioned that you didn't have to go into the extreme ketogenic world. It's so funny. Keto is amazing. It's such an underutilized tool. But the world has become this thing where it's either keto or you're eating Kitavan level of carbs and there's no middle ground.

Emory: People are too dogmatic and you get into trouble. I'm super interested in epigenetics and genetics and one thing I've realized is probably related to our genetics but people have different genetic polymorphisms that maybe they don't metabolize saturated very well. Maybe they do better on a high carb or at least, I would say, never eating processed food. I think that's one thing we can all agree on.

I think being dogmatic, you come into a lot of problems with that. I think keto is extraordinarily powerful for people who have metabolic disease but I also think that eating a sweet potato when you're training for a marathon is okay and you shouldn't have to beat yourself up about that.

Robb: Well, and it's funny, you established the crazy thing. Let's look back to what Atkins recommended ages ago. Let's really ratchet carbs down, get the metabolic syndrome reversed and now let's titrate you up, focusing mainly on whole unprocessed foods to a point where you're able to maintain weight and general metabolic health? Are you generally feeling well? If we tip over that, then let's just reel it back in.

That just seems like a very reasonable approach. It's very customizable too. We don't know exactly where you are on that spectrum. We don't know where you will finish when everything is said and done, again, because of genetic and epigenetic considerations. But within that, we can really dial this whole story up and down. You propose that and it's like madness.

Emory: Yeah. I think also something that I'd been super interested in just over the summer is the idea of being more seasonal and I'm learning that you're more insulin sensitive in the summers. Everything is on a circadian rhythm. We've learned that from the work of Satchin Panda who you probably have read about. Maybe in the summertime when you're picking blueberries, you can eat some blueberries. It's okay.

But in the winter months when we didn't have access to a lot of starchy vegetables and whatnot, maybe we are eating more fat and meat and I think that's also, once you're metabolically flexible, that is definitely a nice way to be

able to enjoy the seasons and not be so dogmatic. But I do think that -- and I know you guys have the Keto Masterclass. I was just reading about it on your website. I think that's awesome.

Actually, we're doing grand rounds on the ketogenic diet in October this year, which is I don't know if you're familiar with what grand rounds is but this is the whole hospital, all the physicians in the hospital are invited and they do a lecture on a topic. I'm really excited about it. I'm a little nervous about what my cardiology colleagues are going to say. I got to know the lipid stuff at the back of my hand.

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Robb: That's amazing. Do you know who is speaking at that event? It's a multi-series event usually, right?

Emory: No. So, grand rounds is every week and all hospitals hold grand rounds and it's just on different topics and all specialties are invited. One of my colleagues, Dr. Madore, is a functional medicine physician in the area and we've teamed up trying to make change in our community. He invited me to help him with that. We're really excited about that.

Robb: That's awesome. I will forward you a bunch of papers I received from Bill Cromwell who's the developer of the LPIR Score and all that NMR technology.

Emory: Awesome. That would be super helpful.

Robb: Yeah. He's an amazing guy. I want to ask this question but I don't want it to be super leading.

Emory: Okay.

Robb: Where are the problems in the current healthcare, sick care system?

Emory: Oh, yes. I love this subject.

Robb: If you were to delineate five points or ten points or whatever, where would we tackle this? I mean, it could literally start anywhere from food production or whatever you want to jump into.

Emory: Yes. First, I would say defining what I run into in my community. So, my kids are -- One is at daycare and one started kindergarten. I will tell you that this has been a struggle for me. I have been trying to get them to serve food that is

unprocessed and real food at the daycare and the school. I just got the lunch list and it's like Mac and Cheese for lunch and crackers for a snack.

What I think the problem is, because I've gone to some of the administrators in these organizations, and the problem is they get federal funding so they have to follow the "USDA guidelines." Now, personally, I think that the USDA guidelines are pretty general. You don't have to serve processed carbohydrates. You could serve some sweet potato or something like that.

But the problem is, I think, following the USDA guidelines and that's at a federal level. And then the other problem is just the money, just the cost. I live in farmland so I think there are creative ways to get around that, partnering with local farmers and whatnot. But it takes organization and I think that organizations are just so resistant to change.

That's at a local kind of organizational level. These are problems we've run into. But from a physician, this is the biggest challenge. I have a lot of colleagues who, because I associate with people who are familiar with this stuff, I have friends, a lot of physician friends who practice intermittent fasting, time-restricted feeding, a lot of them are intermittently ketogenic, they're aware of this, but I've talked to them about their practice with their patients and their fears lie in the fact that the American Diabetes Association, the American Heart Association have these guidelines.

They worry medically legally. Once you have an MD or a DO next to your name, if you say something different from a guideline, someone could come back and hold you accountable legally. Physicians, even though they might know this stuff, they feel like their hands are somewhat tied because they're supposed to follow these guidelines and their practices are monitored. Does that make sense?

Robb: Absolutely, absolutely, yeah.

Emory: It's almost weird because my husband is a personal trainer and does some health coaching with his clients and it's--

Robb: He almost has more latitude than you.

Emory: He has way more, in fact, to the point where I'm like, no, I can't even have a one on one meeting with someone because then if somebody can say I'm their physician they can say what I say as medical advice. Even if you have every disclaimer in the world, it doesn't protect you. And so I think where we really need to make change is at the more institutional level but, unfortunately, as you probably know, within these governing bodies in medicine are conflicts of interests.

You can't really find them easily but if you go on the American Heart Association, the American Dietetic Association, when you start looking, you start to see that they get some of their funding from parts of the food industry or the pharmaceutical industry. It's just really hard to compete with big business. I can't compete with the Coke brothers. I can't.

I don't know how to do that. I think I'm feeling right now like I'm going to approach this from a local level. I'm really going to start getting involved with the school board, getting involved with local because I feel like that seems more approachable to me but I do believe we need help at the federal level as well.

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Robb: Yeah. It's so interesting and such a morass. I seem like a crazy person because for ages I've been talking about the subsidies that are generating this junk food catastrophe. If you look back when Richard Nixon was getting reelected in 1971, I think, he needed a conservative voting base to support him and they had largely disbanded the farm subsidies programs that were enacted during World War II but they were still on the book. They were still there. There was still a template.

They just ramped that up. He got his voting base. And then there were a couple years -- I was born in 1972 and I vaguely remember this period of time where the news pieces would talk about these warehouses of food just rotting and spoiling. So then they had to figure out what to do with this stuff. That's when high fructose corn syrup was developed and all this other stuff.

Parallel to that was this fear of fat, fear of animal based fat, and this emergence of this super cheap seed oils that could be hydrogenated. So, it was just this perfect storm. But you've got that subsidies part on the one hand. You have the collusion part maybe at the upper end. CrossFit is interesting in that they're the only entity that has a global reach that has been talking about the collusion between basically like Coke or, let's call it Big Sugar, and the influence that they had on things like the Affordable Care Act.

There was this provision of exercise as medicine. The basic line item was, hey, we need to get people to exercise more. We're going to government subsidize coaches and personal trainers to exercise these people but you will not comment on the qualitative nature of their diet and, oh, by the way, they can have up to six servings sugared sodas a day and that's fine. I threw this on my Facebook page the other day and people lost their minds.

Emory: I know. I mean, I just -- we have a Facebook page as well and I just posted an article about just the history of the vegetable oil industry and where that comes

from and it's just you reading, "Ew." I mean, and it's everywhere and it's so -- It feels overwhelming although I have to feel hopeful because at least in the field of western medicine, like I said, this fellowship, people ask me what are you going to do with this fellowship? I mean, you're an emergency medicine doctor. You're going to do weight loss counseling in the ER? Probably not.

But what I do want to do is I want to get those, that accreditation so that I can now go to talk to physicians where I am a clinical professor at the University of New England in Maine and so I can speak to medical students and teach in the community. It feels overwhelming.

Robb: It is in a way. I think that your point about starting at the grassroots level is really the only way this is going to happen. It's really fascinating to me. Our clinic here in Reno, we have worked with police, military and fire. We did a two-year pilot study that--

Emory: I heard about that. That's awesome.

Robb: It saved the City of Reno $22million, 33 to one return on investment.

Emory: And we need this because money talks and people are not going to make change unless you can prove that it's actually going to be cost effective.

Robb: Right. But within our current reimbursement model, none of the incentives are really aligned to make this stuff work. One thing that's been changing recently, and this might be something that you look into as far as folks to reach out to, the self insured captives are the first entities that are realizing that they have maybe an eight to ten year window before they're effectively bankrupt.

This is true virtually across the board in all westernized societies, maybe 15 years or something. But when you overlay population increase with healthcare increase, there is -- it's an exponentially increasing story, all kinds of other collateral damage with that, amputations and dialysis and all that stuff. It's basically going to bankrupt societies.

Emory: Yes, it is.

Robb: People will say, "Well, socialize the medicine, and do this and do that." That doesn't change the curve on this at all. Gosh. Again, I want to ask this but I don't want to do too leading of a question here, but what do you see as being the problematic features of the insurance system as it stands right now with regards to healthcare? How is it contributing to this problem?

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Emory: Right. Well, I'm a little radical. I sort of am more of a socialized medicine person. I feel like we need to focus on preventative care and, frankly, I'd like to take the middle man out of things, insurance companies and billers and coders and all that stuff. I'll tell you, my mom was over in Scotland a couple of years ago and she had some chest pain. My mom is healthy, has really no medical problems, doesn't take some vitamin. But she's an older woman who had chest pains.

She goes to the emergency room in Scotland she gets worked up and gets her cardiac work up or whatever. She gets discharged. She goes, "Where's the billing department so I can pay my bill?" And they were like, "What?" They don't even have a department. There's no billers. There's no coders. All that money that hospitals spend on that middle man stuff is just gone. It's not a cost for them.

I'm a little more extreme in the sense that I feel that we need to focus on lifestyle and prevention. The pharmaceutical companies, people make a lot of money when we're sick because the food industry makes a lot of money, the pharmaceuticals company. It's just like war. People say they don't want war but there's some people who make a lot of money when we go to war. And the same is true for when people are really sick. I'm a little more radical, probably than you expected.

Robb: No, it's interesting. I tend to be more in this libertarian market-oriented camp. Some of my thought, and it's all crazy stuff, but I would love it if there were five American medical associations. Each one of them could plant a flag and go around and say, "We're the high carb, low fat vegan camp. Here's where we go. Hey, here's the ancestral health camp and here's this camp and here's that camp."

And then have them compete against each other. A fascinating fact. I don't think that that's really necessarily going to happen. But there is some interesting stuff. If you look at the cost of Lasik eye surgery over the course of time, it's followed this thing called Moore's law where it's basically gotten much, much better and much less expensive over the course of time. And there's no reimbursement for it at all. It's all elective care. It's out of your pocket.

Singapore has a really interesting system where it is a State-mandated healthcare system. They run the whole thing via health savings account. If you're poor then the State puts money into an account but you basically then are in charge of where you put your healthcare dollars and everything is completely transparent. Like you go into a Chinese food restaurant and you've got the menu of options and what have you, and this is by no means perfect but they're spending what they produce. I lean towards this kind of market-centric innovations.

Emory: Right. I see what you mean. That's super interesting. I guess, the only thing that – I mean, you said the government would put money into health savings account for people who can't afford it. A lot of the folks that I take care of in the emergency room, the bulk of people are people who are struggling financially. They don't have the money to spend on gym membership or a health coach or this or that and so I just worry about – and they don't have access to healthy food even though we live in farmland.

They might not have money to put in gas to drive to a farm. That sort of thing. And so I do tend to feel – I worry about that segment of population that just is really doesn't really have anything extra when it comes HSAs. That's the only problem with HSAs. And we have an HSA. I like that because we're healthy and we can choose what to use it for. But I could see it being an issue if somebody has nothing or somebody gets something terrible that happens and it's a huge cost.

Robb: Right. And that's how they set these things up. They have a catastrophic plan and then they use the HSA for more the discretionary stuff day to day.

Emory: But, I guess, people have more power and more decision making around their own healthcare which is really nice.

Robb: The challenge, and this is the thing that I always try to figure out of balance with is we want these nets so that people don't just augur completely into a mountainside with this net.

Emory: Right. You need the nets because, otherwise, it's more expensive for society. And that's what I see. People use the ER. People use the ER all the time for their regular care because they don't, they can't afford the office visit for their primary care doctor. You know what I mean? So they use the ER, which is more expensive, but they don't technically -- I have to see everybody who comes through the door which is what I like about my job. But that means people are using it inappropriately.

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Robb: Right. But the danger that sometimes emerges with these programs is the safety net becomes a noose that they can't get out of sometimes generationally. The Singapore model is interesting where these HSAs, let's say somebody they've been unemployed, they're getting some governmental assistance, they're putting this money in their HSA account. When they get a job that pays much better, that money goes with them so they're not losing that. For some folks, if they get destitute enough, they end up having a low middle income based around

subsidies, basically, and they might need to earn $70,000 a year to match the degree of governmental expenditures that they get. That's sometimes a monumental hurdle to get the person out of that scene. Some of the nervousness that I have too is the government hasn't really been making good decisions around the dietary recommendations.

Emory: I agree with you. I totally agree with you. I like the idea of thinking out of the box, actually. I mean, I'm not by no means expert on health policy but before I went to medical school I did some research for a physician down in Rhode Island who in his small town of Scituate, Rhode Island, they were piloting something called population based primary care where everyone in this geographical area paid in and they had access to their local doc.

It was primary care so it didn't cover catastrophic but it's a grassroots way of dealing with lapses in healthcare coverage. It's just another thinking out of the box thing to do. You get a nice group of people. They know each other personally and they're just invested in their community and in their neighbor. Because the truth is, people do want their neighbors to be healthy but it's hard when it's this huge corporation and it doesn't feel so personal.

Robb: Right. It's interesting. I've been tinkering off and on with a book on this topic for seven years. Before World War II, all of the healthcare in the United States looked largely like what you just described. People tended to carry a catastrophic plan. That was mainly cash and carry but also a ton of these things that look Medi-Shares where people would group aggregate around their church or different civil organizations and stuff like that.

The interesting back story with the changes around World War II, there was a wage freeze in the States because it was looked upon as gauche that people might get paid more than these deployed GIs shot and blown up and everything. They froze wages. As with all this stuff, you try to control one thing and then something else pops up. What the company started doing was incentivizing benefits packages.

They said, "Hey, what if we give you free healthcare?" This was the beginning of this third party payer system. The third party payer system didn't really exist prior to the end of World War II and then over the course of time it's just grown and it has supplanted virtually all -- Again, other than plastic surgery and things like Lasik, the selective medical interventions, most of medicine now nests under this third party payer system, which is just really a bleak system.

If you're the doctor, I'm the patient and somebody else is paying for it, the payer really wants to screw you over. They don't want to pay you anything. They have a whole algorithm where like one-third of claims they just don't pay out right

and you've got to follow up on them and hopefully you don't – And me, if I'm paying into this kitty, I don't really care what the ultimate cost is. As the medical provider--

Emory: That's so fascinating. I didn't know that history.

Robb: Yeah. And then as the medical provider, whether it's a hospital or a private practice doctor, if those even exist anymore, they have to constantly continue to ratchet their cost up to absorb the shenanigans on the part of the third party payer. If we bought tomatoes or cars this way, it would be absolute chaos. Yeah, it's interesting. But this is some of the stuff that I think is really worth having conversations around. It's so big and so complex that we definitely need to just kick this stuff around.

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I think people are willing to do a lot of experimentation. This is some of the stuff that was -- I would love if the federal government said, "Okay, all 50 of you states, you guys are going to do some experiments. Tinker with this for five years. And then we're going to look at best practices and we're going to make best practice recommendations across the board."

This is actually what happened under Bill Clinton with his Welfare Reform Act. Instead of them assuming that they had an answer, they actually take it back to the States and they had 50 different reaction vessels trying to go through this. Some of the attempts were absolute disasters. You couldn't imagine that people thought these were good ideas. And then other things were really good. There were some work programs and creating some skin in the game and incentives. I guess, it would make me happy, and I think it would get much more traction as far as finding legit solutions if we had multiple experiments going on instead of just this one mega experiment.

Emory: Yeah, I agree. One of the reasons that my husband and I moved to Maine was for that. We felt Boston, Massachusetts just was -- It's big. It's busy. There's just a lot of people. But Maine, it's really -- you definitely have access to your local politicians. You have access to local -- You can get involved in a way that it's harder to do on a national level or on a bigger state.

When it comes to healthcare, I'd been feeling out how can I get involved? What do I really want? Who can I talk to? Because I live literally a stone's throw to the State house. As a physician, I definitely am trying to feel out but I don't know. I'm sort of like -- I think this conversation is so interesting. I don't know. These conversations are so important to have because I'm not sure what would be the best. I don't know what I want to go fight for.

Robb: It's interesting, the work that we've done with the Farm-to-Consumer Legal Defense Fund, which they are a nonprofit legal entity that basically like when the Feds go and try to shutdown an Amish dairy because they're selling raw milk, these are the people that basically intervene on their behalf.

Emory: That's fantastic.

Robb: Amazing people. They said something that's really interesting. Emails don't matter. Letters have a little bit of influence. But if ten or 12 people call a representative and call them and articulate a point and this representative hears this point, phone calls and in person stuff really does matter. It really does influence things.

You wouldn't think that it would but what they've mentioned, they've been in these down to the wire situations where they're trying to get bills passed to legalize the sale and even possession of raw dairy and some stuff like that. The phone calls have ten or 12 people ended up swinging the thing such that the representatives bought in on them. I think that we do really underestimate the power that we could have if we even had a few folks call or show up in person to the public representatives.

Emory: Yeah. And I've heard that about the email thing. I remember hearing that. Because you can always generate all these emails from bots or whatever. Obviously, my technical stuff is a little lacking. I know that it's harder. So, yeah, showing up in person. Yeah, it's a big problem.

Robb: It is. We're doing some work with the Chickasaw Nation and just a dramatically insulin resistant population facing some really dire healthcare costs in the foreseeable future. After getting back from hanging out with them for a full week out in Oklahoma, what was fascinating is talking to the doctors, talking to the health coaches that they have. There was a profound sense of the need to provide skin in the game for the participants in their programs. The lack of incentives for people to be bought into this they feel is actually at root cause to the current problem that they have.

Emory: So, what incentives are they talking about?

Robb: Both financial and social. With my NDA, that's as deep as I could go into it. It's fascinating though because it starts looking very marketized and they're still -- the charter of these folks is to provide the utmost service to the people of the Chickasaw nation but what's fascinating is they are fully in recognition that their current model, which is incredibly generous but requires no real buy in with regards to dietary choices and exercise and everything.

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That's not going to fix anything. They've rolled out various initiatives and they've been -- They've mainly been getting the people who already ate well and went to the gym.

Emory: Yeah, I know. I think having the -- What we found around here is that having conversations in your community is probably makes the biggest difference. I work in an ER. Everyone is unhealthy. I work shift works. So does everybody else. There's always junk food around in the ER because people are stressed. They stress eat. I mean, it's like the worst.

I just started doing time-restricted feeding a couple of years ago and that's where I started the conversation. I just started being honest about -- People would ask, "What do you do for health?" And I always thought people would think I'm crazy if I'm like, "Yeah, I don't eat breakfast." But I just started having conversations and now going to the ER and everyone is like, "Hey, are you ready to break your fast yet? Yeah, I'm just going to get some eggs downstairs."

It's normalized it in an environment where that was totally abnormal a year ago. And I really -- That's then probably just having these conversations and educating people about -- I mean, I think educating people about actually their physiology and hormones and getting a little more science-y is really helpful. If people have that kind -- if they're able to understand that, which a lot of people are.

Robb: I don't know if you know Mark Cucuzzella but he's a VA system doc, rural West Virginia, low carber, marathoner. The guy has run some marathon, like 30 years in a row or something like that, an amazing guy. But he deals with a very rural population and he'll have folks show up in the emergency room with a blood sugar of 500 and they're doing 200 units of insulin a day or something.

He shows them a sheet of green foods, yellow foods and red foods and he'll go through and say, okay, what on this green list will you eat for breakfast? Boom, boom, boom, here's breakfast. What will you eat for lunch? Boom, boom, boom. One or two things on the yellow list, nothing from the red list. And he's getting some really remarkable results with that.

He makes himself super accessible and he -- Circling this back to early in the conversation and the risk exposure, what he is recommending are whole unprocessed foods. He monitors their meds closely. And then at the end of the day, if somebody were to ask him, "How can you justify what you're doing?" Their meds go down and their lab values improve.

Emory: Exactly. I have a very good friend who does some admin but also practices medicine in the VA system in Maine. She's a primary care doc. What she tells her vets is, basically, if a caveman couldn't have eaten it then you shouldn't. If you have to open it, if you have to open a package, you shouldn't be eating it. She gets a lot of -- that's been huge. The other thing is she'll have people, if they have an iPhone, get MyFitnessPal and she just says just 100 carbohydrates a day. If you can log stuff and just start to notice where stuff is.

She's got vets coming in going, "Hey, Doc, I'm off my insulin. I lost 50 pounds." It's so powerful. It's like she's actually asking them to do less, take something away, not add something and they're getting better health. I'm so excited about this. Sometimes we'll talk to people about this on my overnight shifts when it's a little slow, somebody is saying they have back pain and I'm like, "Honestly, you need to lose 50 pounds."

This one woman who I talked to about this, she had chronic abdominal pain. This was months and months ago. I had suggested, "Hey, you should read this book called the Obesity Code," or talking to her a little bit about insulin and stuff. She came back for some sort or muscular skeletal thing a couple of months later and told the PA who saw her, "Oh, yeah, I've lost 40 pounds. My husband has lost 60." Just from my small conversation. That was probably like 20 minutes long. That was a motivated person who was obviously interested in learning about it. It's pretty crazy. It's not that complicated.

Robb: No, it's not. It's really not. No. It's incredible. I just have to share this story with you. Because I have some questions. But we were talking some folks who have a beautiful hospital, hospital system, and they were recognizing the food that we have in the vending machines and the cafeteria, 90% of it is junk. We're going to totally revamp this thing. They went to like -- the snacks were basically fruit and jerky, more or less.

Emory: I love it.

Robb: Yeah, which was amazing.

Emory: This was a public school?

Robb: No, this was a hospital.

[0:45:00]

Emory: Oh, the hospital.

Robb: Privately-owned hospital. Okay. So, here's the situation. All of the junk food, sodas, all that stuff had been removed. The employees don't have access to it, the patrons, the people that would go in and out. What do you think happens after that?

Emory: To the health of the employees?

Robb: Just in general, what happens? I knew immediately. They told me that they did this and I knew exactly what happened.

Emory: I don't know.

Robb: I said, "One of your staff members started bringing sodas and snacks and selling them." And they did. There was a nurse in the ICU. They named her Nurse Snickers. She would go to Costco and buy a flat of Snickers and then she would dispense these things from her desk to the staff. They did give it to very many patients. Some of the patients caught wind and she would give it to them instead of selling it to them.

And then there was another individual that would basically smuggle in a flat of soda and then they would go track this guy down. This is a little bit of my circle back, again, where if people don't understand economics and markets they are doomed to find solutions. Because it was very well-intentioned but they didn't have any leverage over the next step to this thing. Whenever you create a police state, a prohibition type situation then you create a black market almost inevitably. You've got to be really crafty about how you align incentives around all that stuff.

Emory: Right. I think you need buy in from everyone involved. I do some administrative time at the hospital and I had a meeting with this wellness committee because I'm trying to do, bring them in and do health coaching during the shifts for the nurses that work 12 hours, which is crazy. We were talking about, okay, when it's a bad day at the hospital, what does admin do? They go out and buy pizzas.

But everybody I talked to is trying to lose weight and be healthy so why are we putting this right in front of people who potentially could have food addiction or have their own issues with this food? She said that in their department, in the wellness department, what happened is they really sat down as a group and it was kind of like group therapy. They talked about their struggles and said instead of admin telling them to do something, they as a department made the decision that they want to be a health conscious department.

So, it came from the employees, not from admin. That was really powerful for me because I think it really has to come from the employees. It can't come from

me waiving my finger and saying, "We're going to stop buying you pizza," you know what I mean? More like, let's have a conversation as a department what kind of department do we want to be?

Do we want to foster resilience and mindfulness and health? Or do we want to be all stressed out because our job is really stressful and it's made worse by some of these choices? That was really interesting to me when she said that. I hadn't thought of that because I was like, "Well, as the administrator, I'm going to come in and make everybody--" That doesn't work because you don't have buy in.

Robb: It's fascinating. It's fascinating. It's a thorny topic talking to people about aligning incentives and you sound like this heartless person.

Emory: Especially when you talk about food because there's so much emotion and guilt and shame. I really do believe that some people really struggle with food addiction and I think until we acknowledge that then it's going to be hard to change things at least for those folks. My husband and I say this all the time. If you have a family member who struggles with alcoholism, you're not going to see him at Thanksgiving and say, "Oh, have a beer. You've done so well over the past eight years. You can have one." Everybody knows that's sort of ridiculous and yet we do that to our friends and family members when it comes to food and sugar. "Oh, you've done so well. Just eat that cookie."

Robb: We did a survey of our followers and one of the primary challenge points that people have is what we broadly put under the bucket of social and it was that friends, family members, coworkers, fellow students, whatever their situation was, it's so interesting. We notice this ages ago but if you show up at work or school or what have you and you've got a bag of Doritos and a big soda and all this stuff, nobody says a damn thing.

But if you show up with chicken breast, an avocado and you've got iced tea with a little MCT oil in it, people will lose their minds. They'll tell you you're going to die on the spot and they will do their level best to derail you. It's like, "Hey, man, here's the bowl of peanut M&Ms."

Emory: Right. And part of that is their own stuff. People bring their own stuff and then always misery wants company. People worry that if you're eating healthy -- Because I've struggled with that. I mean, my parents raised me to be mindful of what we're eating.

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I remember comments from friends. It's like people think that I'm judging them for eating junk and I'm like, "Look, Dude, I'm just doing my own thing." But they get insecure about it. People who make unhealthy choices get insecure when they're around people who eat healthily and so if you can get someone to indulge with you, you feel better. There's so much stuff that people do with their own food. It's so unfortunate because it can be such a pleasure and such a wonderful thing eating good food.

Robb: Yeah. And to your addiction analogy, you really don't have to take cocaine or alcohol or what have you. You can really avoid that. But at some point you will eat again. Even if you do an extended fast.

Emory: Right. And it's around you all the time.

Robb: It's around you.

Emory: I actually went to the grocery store once. I was with my kids. When we're on the checkout line, there's a bunch of candy and I say to my kids that's not real food, we just don't eat that. That's not real food. And that's a bunch of chemicals. I went to the manager and I said, "Look, have you guys ever thought about getting rid of all this stuff in the aisles because it's really not fair to kids." He said, "Well, these big food companies pay for their slot." At the grocery store, which I didn't realize but I should have known. But, yeah, it was just like, "Oh, okay."

Robb: Yeah. And this, again, we're getting back into the incentives. The government should not be in the business of subsidizing sugar and processed seed oils. A Twinkie should not be cheaper than an apple. That's just, again, creating all these super misaligned incentives. Even in Mexico, they enacted a pretty frisky tax on sodas, which again, I would tackle it first from let's stop subsidizing this stuff.

The US government still both subsidizes and taxes tobacco which is like a foot on the brake and the gas pedal at the same time, absolutely befuddles me but whatever. But they did get a pretty significant change in consumption behavior like that, that punitive tax on the sodas. And there is a sweet spot there. It's interesting. If you make them too expensive out in the open market then you create a black market that will provide stuff cheaper.

Emory: Right. People get all, "I don't want somebody telling me what to eat." But I have to say we all pay for it in the end. And I say the same thing. We don't have a helmet law in Maine for motorcycles and I had this guy once who was transferred to Boston Medical Center who was in a really bad motorcycle accident. He was in New Hampshire so he wasn't wearing a helmet.

I said, "You crazy man, you weren't wearing your helmet? What were you thinking?" And he was like, "Well, I just figured that if I got in an accident, I'd rather just die." And I'm like, "But you won't die because that's how good medicine is. We'll keep you alive. You'll be in a nursing home. You'll have a peg to help you eat and all this stuff." And I'm like, "I know it's your right to not wear a helmet but you're going to pay for that."

Robb: Stuff like that. And this is some interesting stuff where to the degree -- Generally, insurance like that would be more catastrophic but if dude wants -- One, I think, I love riding motorcycles but I haven't done it for ages. Now that I have kids I probably never will other than maybe a dirt bike. But if you want to ride a motorcycle you should probably pay a pretty frisky premium just as a baseline because the likelihood of you costing a lot is fairly high. And if you're in one of those States -- Nevada is a State that doesn't have a helmet law, and you choose not to ride with a helmet, your premium each month should be like $5,000 for that.

Emory: But people sometimes don't have insurance. I mean, a lot of people don't have insurance that ride motorcycles.

Robb: Absolutely. But that's where you definitely have to start aligning incentives at some point. We can't just collectively deal with that stuff and just keep tapering over the problem.

Emory: Yeah, exactly.

Robb: That's fascinating.

Emory: So fascinating.

Robb: What are some of the -- So, clearly, you are trying to reach out to your local community, local governance, making inroads there. What do you see that looking like over maybe three to five years? What are the bright points that you've seen with that?

Emory: Right. That's such a good question because it's definitely something that I've been soul searching about as of late. I mean, I think where I'm going is -- My husband and I have a podcast for local Mainers, Simply Health ME and we do classes and I do -- I'm talking at the library about kid's nutrition, health.

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I think that as I get this obesity medicine training I'd like to branch out and maybe teach physicians in the area and then, of course, try to figure out how I

can make a change with the school board, just local level stuff. But I have to be honest. I have a five-year-old. I have a three-year-old. I work full time as a physician. It's a delicate balance as I'm sure you're quite aware of. It's like, okay, I'm really passionate about this but I also have to keep my sanity and keep my own health. I'm in the middle of doing a lot of soul searching about that very question.

Robb: That's awesome. Well, I mean, this is year 20 for me in this process. Honestly--

Emory: And it's probably ever changing.

Robb: It is ever changing and, honestly, we've made more progress in many ways than I ever thought that we would. I never thought I would live to see a venture capital backed ketogenic diet intervention like Virta.

Emory: I know. That is amazing to me.

Robb: It's amazing but then at the same time I'm seeing ever more of a tendency for folks to slide towards wanting to consolidate power within the government and make recommendations from that point and this is where like the big food -- If the stuff is all broken up, if we had 50 food and drug administrations at the State level, that's a lot more people that you need to buy off and cohort, coerce and everything versus one or a singular entity. The dominant story that's coming more and more from this government level dietary recommendation is very strong in that plant-based vegan approach which can have advantage to some people but this is--

Emory: But again, dogma is always bad. If you were stuck in one -- You have to recognize it depends on the person. That's one thing. I like low carb high fat. I like a keto approach. But you know what, I don't judge people who decide they want to go vegan or vegetarian. It might work for them. The problem is getting so divisive over this stuff. And really it all comes down to not eating processed food. I mean, that's what it all comes down to. There's actually an underlying commonality between all this stuff.

Robb: Right. That was the recent diet fits intervention where they had a healthy low carb group, a healthy high carb group, both groups lost virtually the same amount of weight but what was interesting is that both groups started off as what we would perceive as being these extremes and they had a tendency over time to drift to this middle ground and it's that middle ground that interestingly which is right square with the recommendations from the American Dietetics Association and what have you.

There was that learn program that was compared and the A to Z diet study, Atkins, Ornish, et cetera, and this learn thing is like -- This is going to sound terrible, but like every dietitian's wet dream. Do not have any commentary about food quality. Literally there was no commentary about food quality, just portion control, just only have a third of a Twinkie and all that stuff.

Not surprisingly, out of that dietary intervention, the learn protocol performed the worst. It performed a bit worse even than the Ornish intervention, which I'm not really a fan of. To your point, we have to pick something. It's either high carb, low fat or higher fat lower carb and we really have to stay out of the middle which is the snack aisle and the buffet and all the rest of that stuff.

Emory: Exactly. And you have to -- Also finding things that work for you outside of, obviously, processed food. My friend who works at the VA, her dietician is really anti-ketogenic and really into the veganism but she goes, "Look, I'm not going to get my vets to be vegan. That's just not going to happen, so let's move on."

Robb: Right.

Emory: My god, does that even make sense?

Robb: Right. Well, we definitely -- we have a ton of job security.

Emory: We do.

Robb: Our work is not going to go away anytime soon.

Emory: I say that almost every day.

Robb: Well, Doc, it's been so great chatting with you. I'm really honored you reached out to me. Can you let folks know where they can track you down on the interwebs to learn more about you?

Emory: Oh, sure, yeah. We have a website. I do some blog posts, my creative outlet, simplyhealthme.com. And then we have a podcast, Simply Health ME, for Maine, of course, and then a Facebook page under the same name. Yeah, we do talk a lot about Maine but it's general health stuff.

Robb: That's amazing. I think that that really is where all this stuff starts, is the individual passion and building those relationships.

[1:00:08]

When I've spoken publicly and people say, "Why haven't you gone to Congress or whatever?" I'm just like, "Are you kidding me?" If I'm able to get some traction, it's going to be at the local level. And then over the course of time we may get some push further up the food chain. But at the end of the day, we really just have to take some personal accountability and get in and fight these fights.

And again, it's interesting. These self-insured captives are really looking around closely at different wellness programs and wellness initiatives because they're on the hook for dealing with these costs and all of them have a very short run before they're effectively insolvent due to these healthcare costs. I think people are going to start asking some very pointed questions and start figuring out how to align the incentives to get better buy in this.

Emory: Yeah, I totally agree.

Robb: Well, Doc, it's been such an honor having you on the show and hopefully get to meet you in real life.

Emory: Yeah, it'd be great. Enjoy the rest of the day.

Robb: Thanks. You too. We'll talk to you soon.

Emory: All right, bye.

Robb: Bye.

[1:01:15] End of Audio