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Dr. Bret Scher: Welcome back to the DietDoctor podcast, with Doctor Bret Scher. Today it is my pleasure to be joined by Dr. Robert Cywes. Now, if you haven't heard Dr. Cywes speak, you're in for a treat. He is such a knowledgeable and passionate individual and that clearly comes through in this interview. He is a board-certified surgeon doing bariatric and weight loss surgery, both in adults and in children, and he has a tremendous amount of training and experience in this field.

He actually started in South Africa, getting his MD and his PhD, working with the esteemed Prof. Noakes during his carbohydrate days. Then he came to the United States to train in pediatric surgery, went to Canada to get further training in adult surgery and now has been here in the United States practicing for years in a very busy weight loss surgery practice.

But he's probably one of the most unique weight loss surgeons you're going to meet because, there's an old saying, "If you go to a barber, you get a haircut." If you go to a surgeon, you get a surgery... Not so with Dr. Cywes. He wants to evaluate everybody to see what he can do before doing weight loss surgery, using weight loss surgery as either a bridge or a last resort and focusing more on life style, specifically focusing on low-carb, high fat nutrition.

He's a big proponent of carbohydrate as an additive substance that is causing more problems than any other addictions that are out there and he talks a lot about that and makes a very compelling case for why we need to think of carbohydrates as addictive in certain populations. So, I really hope you enjoy this interview. His passion, his enthusiasm and his knowledge really comes through in this interview. So, without further ado here's Dr. Robert Cywes.

Dr. Robert Cywes, thank you so much for joining me on the DietDoctor podcast.

Dr. Robert Cywes: Thank you. It's great to be here after all the good work you guys are doing.

Bret: Well, thank you, it's truly a pleasure to talk to you because you're definitely one of the most unique surgeons that I've heard speak. You talk about, emotional attachments, about the psychological side of things and you talk about doing what you

can do to not operate on people, which I got to imagine it's going to get you kicked out of the surgical community at some point if you keep this up.

Tell us how you got down this road, from being a bariatric weight loss surgeon to then focusing on the lifestyle to prevent the need for surgery in some people or to use it as an adjunct with surgery.

Robert: Thanks, I think the value of what I do, and really can all be summarized in two words, pattern recognition. And I think as physician's in general we have lost our curiosity, and we believe the facts and we believe-- and we are not open, we don't open our minds to... hmm, maybe these facts aren't quite as factual as they should be.

One of the values of being a bariatric surgeon is we have a very high-volume practice and we started seeing certain patterns of patients all along and one of the myths about bariatric surgery, is that it's forever... It isn't. Everybody loses weight, everybody loses a massive amount of weight when you first do the surgery for the first to two three years, but the effective durability of weight loss it's like a very powerful diet.

It doesn't last very long, beyond two to three years, because it ultimately is a form of comfortable starvation. It's a form of intentional caloric reduction. But if patients preserve the reason why they became fat in the first place then they will figure out ways around that surgery and most of those patients regain their weight.

There's an incredibly high weight regain, whether it's partial or complete and most bariatric surgeons conveniently ignore that aspect, which we focused on very heavily, or alternatively, probably even worse, they can't eat enough and when they eat the wrong types of foods they become malnourished and those are the two things we're battling with our population, over time.

So, I looked at this group and I looked at the group that was successful and those that weren't and we looked at the changes that they made and that helped us to step backwards and figure out, okay what are the driving forces behind causing obesity? You see the way that surgery works is-- the way I look at obesity is a little bit like a polluted river.

You can go down to the river's edge every day and take the crap out, and if you've got a big net and a lot of helpers you can take a lot of that crap out... that's surgery. But until you shut the factory down, that's putting the crap into the river, you're always going to have a polluted river.

Bret: Right.

Robert: So, more and more, with that pattern recognition concept, we started looking at... okay, what are the common threads, the common pathways with these patients, in terms of why they are eating in excess? And the first thing we found out is that-- and I'll put this statement out pretty boldly and I'm 100% confident about this, it is impossible to become fat from eating food, it is impossible to become fat from eating food.

That doesn't make sense, but if you step back a little bit and think, okay we've been a species for a very long time, what we eat is not trying to kill us, it never has. So, there must be something else that we've introduced into our food system under the label of food that actually isn't food. And more and more as I interviewed my patients, I found that about 80-90% of the calories that they consume was this particular substance and it was ubiquitous.

I've never met a fat person or a type 2 diabetic that wasn't dominant in terms of their consumption, both in terms of quantity and frequency of this particular substance. And as I looked at the substance and put it into the context of my research I found that it was one particular category that we introduced into our food system altruistically in the 1950s and '60s, but very erroneously and we haven't been able to let go, and that substance is obviously carbohydrates, sugar and starch.

And what we found is that our patients developed this out of control relationship with carbs and that they eat almost in the same pattern, as which smokers smoke. So, we stepped back and we looked at that and we looked at our patients from a variety of different perspectives and what we found is that again, ubiquitously every type 2 diabetic, every obese patient has either a deficient or a dysfunctional way in which they handle their emotions.

So what we found, and as you-- as we again step back and look at some of the recent history of this, in the 1950s, physicians, Ancel Keyes is the dominant one, but physicians became concerned with people having heart attacks and strokes. At that time we had no idea that it was related to smoking, obviously from the '70s and '80s we know that absolutely now.

However, we were concerned and we did autopsies on patients, we found this build-up of fat, clogging their blood vessels with cholesterol and fat. So, we did the simplistic but plausible thing... aha, it must be the fat that we're eating that is clogging our blood vessels. That's a hypothesis and you know what? 70 years later, after billions of dollars spent, is still a hypothesis.

Bret: Right, but it's a hypothesis that's become so prevalent in our society that has been promoted as fact and yet they don't have the science to back it up. And because

of that we've seen the rise in processed foods and low-fat carbohydrate foods which has stimulated this obesity epidemic that you seem to have correctly identified through your patients.

But what's interesting is how do you use the weight loss surgery to either help people get over that carbohydrate addiction or do you try and use it as a last resort, where does it fit into your--?

Robert: It, it really depends on the patient, and it depends on the conditions of the patient. So, the first thing that we have to have is-- and let me just back up for one second, what we found is briefly in one sentence, we became lipophobic as a society, we removed fat and we went from 5% to about 60% recommended carbs in our diet. That's like saying hey you know what, water is really bad for you. You have to drink whiskey with every meal.

Not everybody's going to become an alcoholic, but it certainly raises the standard, and the question was who is becoming that alcoholic? So, the first thing we do now in our practice is we identify patients from two different perspectives: The first group is obesity the primary issue, and typically for most people if you're 15, 20, 30, if you're an adolescent, a child, if you're in your 20's or 30's, it's the dominant issue with them is obesity-- yes they are... it's impossible to be heavy and healthy.

So, there are health issues occurring and some of them have profound health issues, but around the late 30 to 40 years and certainly 40's, 50's and 60's, obesity takes second place and what prioritizes that are some of the health issues, cardio vascular issues, diabetogenic issues, maybe polycystic ovarian syndrome, we focus more and more on the health issues.

And the way we make our decision about the timing of intervention I believe that 100% of patients need a shot at a cognitive behavioral carbohydrate addiction program first and foremost. Every one of them, is an expert at failing conventional weight loss programs. They've tried it all, lost some weight, they've failed the calories in, calories out methodology.

Bret: Right. People, don't come to you as a first step, they come to you after they've tried the liquid diets, after they've tried counting the calories, after they've tried the point system with Weightwatchers... they've done all that by the time they get to you.

Robert: And they've spent thousands of dollars and the only thing they've lost is the weight out of their back pocket, you're absolutely right. So the first thing is are they primarily here for obesity or are they a brittle diabetic that's now having to go on insulin? That modifies my ideology because we have time that we can spend with

someone who is just trying to lose weight on the conservative side, because the slope of the weight loss curve doesn't matter.

When you're a brittle cardiac patient, as you know, or if you're a brittle diabetic, we want results pretty quickly, and absolutely the surgery is the single best form of intentional caloric reduction. So we'll move those patients into the surgical category more quickly.

The other thing is that if someone is not willing or able to really initiate the type of dietary approach and has a roadblock to the understanding of what we're doing I'd be more reluctant to do surgery on them, because the surgery will work for a little while, but it's going to fail. So, that is the paradigm with which we look at for surgery, but there's something else that we look at that's very important, and that is what is the cause of their emotional dysfunction. We divide our patients into two very distinct categories.

The first category are permissive patients, and this is not their fault. Nobody choses to become fat, it's our responsibility to address it, but nobody chooses it, and what we've found as we've looked at pattern recognition is there's a certain sub-group of patients, around half, maybe just less than half, that come from a familial background where there really is no structure.

So, let me give you a couple of sentences on this. In order to build an effective emotion management system or skill, you need to put effort into something and the return of the investment in effort is a wonderful sense of well-being, a sense of pride that elevates your self-esteem and self-confidence and then you're willing to put more and more things in. Why is that important, because when you are putting effort into something over time, the first thing is, that effort, that thing that you do, is a wonderful endorphin activator.

And the endorphin system is one that we use to help us to relax periodically, to help our brains to function effectively throughout the day, but also to handle large amounts of stress, anxiety or depression, and almost all the patients that come in to our office say, "Oh, I'm a stress eater." Yeah, of course, you are. So, the first group of people are folks who kind of should put the effort in to develop these skillsets, but they divert. They have a Nike problem... they just don't do it.

So, for example, "You know what, Johnny? I really want you to eat some broccoli today, it's healthy for you." "Oh, okay Mom, I'll eat the broccoli, but you know what? "There's pizza in the fridge. I'm going to eat the pizza tonight. And then tomorrow, I promise you, I'll eat all the broccoli," or "you know what, I've got a Math test tomorrow, "I'm going to study really hard for this, but there's a cool show on TV, "and

I'm going to watch that and then, and then after the TV show, well, I know my Math pretty well, I'll get a C this time and next week I'll get an A."

So there's all the intent to do the right thing, there's all the intent to put effort into stuff, but they never ever transition into a-- intent into effort, therefore they do not build up self-esteem and self- confidence. And it's so much easier for those patients with no structure in their lives to triangulate to some inanimate readily available thing, whether that's nicotine, alcohol or what's now ubiquitously available carbohydrates.

Bret: Which hits the endorphin system....

Robert: Absolutely.

Bret: That's where they get their endorphin high. So, I've heard you say before, we eat carbohydrates, not for food, not for nourishment, but for endorphins.

Robert: Right, so when I said earlier on that food doesn't make us fat... Food has a very, very powerful biologic feedback mechanism that prevents us from overeating. If I put a big steak in front of myself... I may be very hungry, I'll eat a certain amount, as soon as my satiety system kicks in, I stop eating steak and I cannot 10 minutes later or 5 minutes later eat more, but I sure as hell can eat some ice-cream or some chocolate or chips or... I am not eating, I am relaxing, I'm doing crystal meth, and that's that methodology.

So on the one side you have the group of patients who have no structure, they are the permissive or hedonistic group of patients and it's a parenting style. The issue with those patients is try as they might-- they just don't have the skills to put the effort it, and that group of patients we can often take down the surgery road a little bit faster, or a little bit quicker, because they're going to keep tripping over their own two feet.

On the other side of the equation we've got exactly the opposite. We've got the authoritarian families. An authoritarian family is very rigid, overly structured. So that they are willing and able to tolerate the austerity of putting a lot of effort into things, but instead of feeling the pride and the pleasure of the accomplishment of effort, what's happened is they've set some ridiculous standard, some ridiculous goal or result that there is no way they can achieve.

So no matter how much effort they put in, they're always falling short of that goal, always falling short of that result, and the very fabric of the thing they're doing for pleasure, for emotional relaxation, for endorphin release, creates a lot of anxiety and stress because they're never good enough and they're never ever getting praise, they're never getting made to feel positive and powerful.

So, it's very erosive to their self-esteem and self-confidence and those people triangulate again to some inanimate thing that makes them feel good that is not judgmental. And the example there is, "Johnny, you've got to eat this broccoli, it's good for you." "Oh Mom, okay," and he sits down and 20 minutes later he's wrestled that broccoli down. "Look Mom, I finished." "Well that took you long enough."

Never quite good enough, or you know what... "Look Mom, I studied really hard and I got an A in my Math test and I came second in the class." "Who came first and what question did you get wrong?" So, the whole mentality is not good enough and then you find something that ubiquitously just makes you feel better. So, just to extend that theory, if you've got a second... I'll share this little anecdote with you.

Two people have knee surgery, and what happens is the first woman is really good, she's accomplished, she works hard, she's got a great life, she plays tennis, she goes to church, she's got a great family. The knee surgery doctor prescribed Percocet for three weeks and after five days her knee pain is gone. She gets back to her life, she throws the Percocet away.

The second woman, very accomplished-- and doesn't have to be a woman, it can be a guy, but the second person, very accomplished, hard-working, very productive, but is so busy working that she has no time for rest and relaxation.

So, she's bottled up, without knowing it, she's bottled up all this emotional stress and tension and then along comes the doctor after he knee surgery and gives her three weeks of Percocet, and she takes the Percocet, that's very effective for knee pain but for the first time in her life she just develops this tranquil feeling from the drug that just relaxes her for the first time and she feels in control of her life for the first time ever. And it's kind of a vicarious association.

So, after the knee paid is gone, she continues to use the Percocet, not for the knee pain but modify this emotional stress and tension, because she got a deficient emotion management system, but the problem is then she needs more. So, she goes from three to four or eight to 10 to 12 to 30 or 40, but she's absolutely fine.

And then along comes the government-- and she's been tranquil and absolutely fine, functional, not perfectly functional, but doing fine, for 10 years. Along comes the government and says this opiate crisis is terrible. Laudable, I agree with that. Doctor goes to jail, drug companies get sanctioned, but they fail to ask is why is this woman taking this Percocet?

Bret: Right.

Robert: And when they take the drug away from her, she got nothing, she got no emotion management tools. So, what do they do, suicide rates goes up, alcoholism rates go up and heroin addiction comes in, now we've got an opiate crisis? Well, why I'm telling this story is because the exact same thing happened with obesity. In the 1950s, less than 5% of our diet was carbohydrates.

By 1977, it was entrenched in the food pyramid at 60%, so what happens is little baby, little Johnny, little Jilly, whatever their name is, as a child is told this food is so healthy for you, and at two to five years of age, they don't have-- because they come from a permissive or authoritarian family, they haven't started developing effective emotion management skills. So, not only is this orange juice, this apple juice or this Cheetos or Cheerios or Goldfish healthy for them, so called because of the food pyramid, we know differently but they're getting a high from it and they develop an attachment.

And as they get to become teenagers, a little bit is not enough... It's available everywhere, so they develop this out of control relationship with carbohydrates to help them to deal with their emotional management. Now along comes you with your keto diet or me with my surgery, which is more dramatic, and in one day, we kill their best friend.

And the challenge with that is it plunges these patients into anxiety, stress and depression, because all they wanted to do was lose weight. And maybe they're losing weight, but they realize that's not the be-all and end-all, I've lost my best friend. So, if you as a physician, are not also making the patients aware of the fact that that's going to happen, and help them to develop the skills and the tools that they need to mitigate against that, they'll either go back to eating carbs, like a lot of people after smoking cessation, or they find another drug.

And a lot of the bypass patients, a lot of the bariatric patients find opioids, because they are given that, or they do suicide, they do alcohol, they find another outlet.

Bret: I think that's such a great point to talk about a little bit more, because there is this risk of being in an echo chamber in a low-carb world, that the people who are doing great and succeeding are the ones flooding the online chat rooms are the ones that are doing the podcasts, are the ones that are promoting the message, but the real question is, who is not doing so well and why and what can we do about it?

Because those are the ones that we need to reach. So, it sounds like your primary message is filling that emotional need when you get rid of those carbohydrates, which a lot of people don't talk about and don't think about. So, is that one of the first discussions you have with a patient when you talk about the ketogenic diet? Not what

you should eat, not how many carbs, but what you're going to do instead, when you get rid of that endorphin high?

Robert: Yes, so first of all, we absolutely don't use the word diet. A diet is something you do for quick weight loss, you can go to Oprah or Doctor Oz for that. This is a lifestyle change, and so the very first discussion we have is as we explain to them, why they became heavy in the first place. And that they need to reduce calories, but that is vicarious.

The human body can do that very effectively, you've just got to reawaken those systems, but we really talk about the fact that, the reason that they became heavy in the first place is because of a deficient emotion management system. And anytime you get rid of any drug, you need to replace the positive parts about it. So, the first discussion we have is get people out of the dietary calories in, calories out philosophy and get them into understanding that this is a substance abuse problem and it needs a cognitive behavioral approach.

So, it's removal and replacement. And the value of removing carbohydrates, you see the problem with carbohydrates, because they are a drug, and because they are a recent drug in humans, there is no feedback control. So, there's very tight feedback control when you drink water. We've been drinking water as a species forever, so when you're thirsty you have no idea how much you're going to drink.

You start drinking because your brain says you're thirsty and very quickly, at some point your body says, enough my thirst is quenched, and you automatically stop drinking. You don't overdrink, although you could, but there's no incentive...

Bret: -You don't crave more water once your thirst is quenched.

Robert: But if you're drinking alcohol, alcohol has no negative feedback, it's a positive feedback system; water for nutrition, alcohol for pleasure or for endorphins. So, you have to set a very specific limit on how much alcohol you're going to drink. If you don't, you'll drink until you pass out or get drunk and if you do that repeatedly you become an alcoholic. You don't do that with water, because there is no feedback regulation, okay.

So, when it comes to carbohydrates, exactly the same situation exists. Carbohydrates are a drug that's primarily consumed for pleasure, for the endorphin value, they're not nutritionally necessary. We will not die if we stop eating carbohydrates and there is no negative feedback when it comes to carbohydrates. So, the reason we stop eating, is because of the portion we selected to eat.

So, our brains, when we're are hungry, decide how much food we need, or the restaurant puts food in front of us, and because we can override any minor satiety signals, because carbohydrates have no feedback, we're able to eat a massive amount of carbohydrates. And we overdo it and that's part of the whole weight gain thing, to get that high. When you're eating fat, and this is why it is called a LCHF, a low carb high fat diet.

The human body has been consuming fat, since we existed, whether we were herbivores, or carnivores, fat has become the thing that enters our blood stream. Remember, cellulose in a gorilla gets turned into fatty acids as absorption, not sugar, you can make a gorilla diabetic. Be that as it may, we have always had fat as a resource, and therefore the human body has a very powerful, robust, sophisticated system of negative feedback when it comes to fat.

Let's just use one word called leptin. So, as you eat your meal, a little bit of fat goes into your blood stream, gets into the fat cells, as the fat cells start to take up fat, they say, whoa, I'm getting fat here, we need to block this, and they release a hormone called leptin. Leptin after about five to 10 minutes goes to your brain, and says, boom, I'm done. You do not need to a focus portion control, the human body does that for you, and as soon as that leptin begins to rise, I'm full, I'm done, and if you overdo it, you get a little bit queasy.

So, you learn, maybe earlier on in a ketogenic diet or a high fat diet, you override a little bit because that's your format, but if you learn to eat sequentially, which is another critically important part of what we teach our patients, instead of deciding how much you're going to eat depending on the portion, take that same portion and put it in the middle of the table and go back and forth eating tiny amounts.

And what will happen is as leptin becomes activated, especially if that food has a high fat content, you'll say hey, I've been back two or three times, I'm full, and you'll recognize feedback signals for the first time in your life.

Bret: Okay, so it has to be a conscious decision to go get the food and bring it to you, rather than having it there, because then you get the psychological of... ah it's there, I don't want to waste it, I might as well eat it, it's in front of me. So, the psychology can override that leptin response, to some degree.

Robert: Correct. First of all, if it's a high carbohydrate low fat meal, which is the standard American diet, there is no leptin response. So you can finish whatever's in front of you and the question is, when do you finish? And you typically finish when your plate is empty. If you're going back and forth, number one psychologically, you've

got an empty plate in front of you, but you then have to make a decision, whether you need more based on how you feel, not how much you intended to eat.

So, eating carbohydrates is by intent, whereas eating fat, ultimately, if you understand that relationship and you eat sequentially, is by feedback fullness, therefore you never have to decide how much you are going to eat. This whole concept of intentional caloric reduction or portion control, and every CICO diet is based on some magically pseudo-scientific story that ultimately comes down to a very sophisticated, caloric restriction.

It's a formula of caloric restriction, whether it's Nutrisystem or Weightwatchers, the body cannot sustain that... you know why? Because that's called starvation. There are times when my body needs a huge amount and there are times when it needs almost nothing and I've got to connect back with my feedback pathways and once you do, it's impossible to get fat from eating food.

Bret: From real food....

Robert: Real food. Food, food by definition is something our body needs for its nutritional value. But drug by definition is something we consume for pleasure. It is not necessary for human survival. I don't know about you, but I certainly don't need heroin, except maybe on Monday's.

Those are things we don't need, okay, and thirdly... excess can cause harm. And with food, because of the feedback systems, it's very rare for us to get into harm's way. So, this whole concept that fat causes us to become fat is by definition erroneous.

Bret: Yeah, so when you're-- when you're helping somebody, does it have to be low-carb enough to be into ketosis? Is there something about ketosis that you think helps with the weight loss, helps with the long-term success, or is it just low-carb enough that you're focusing on vegetables rather than pasta and processed foods and breads? Is there a difference in the carbohydrates and can you see the people success with 100g of carbohydrates if it's from the right carbohydrates, or is it 20g of carbs ketogenic lifestyle?

Robert: There's two questions there. The first thing we spoke about a little while ago was portions, the amount that we eat at one time. The second issue is the driving force behind snacking. Okay, so first and foremost a snack is always an emotion event, it is never a nutrition event, and a snack by definition is stuff we consume for our emotions, that contain calories.

Bret: Right, if you're snacking it, usually means you're not getting in enough fat or calories with your meal or protein possibly, you're not getting enough with your meals

if you're feeling hungry, or it's the routine of I'm just used to having something to put into my mouth.

Robert: I don't think it's a lack of calories. If a lack of nutrition, call that a meal, but a snack is something we use like a smoker smokes. About every 20 minutes, the human brain needs to relax and the endorphin system is in charge of that relaxation. What we do defines us, the dominant thing we do defines us, so the smokers always every 20-30 minutes, are looking for an opportunity to go and have a cigarette.

The obese or type 2 diabetic are always looking for a snack and they surround themselves with easy access. So a little bite here, a little bite there, and we get, oh no, no that's different, that's like saying I only smoke five cigarettes a day, but if you walk behind them it's twenty cigarettes. Same thing with the frequency... so, the first issue there is when you're snacking on carbohydrates, and that's what a snack usually is for most people that are not trying to change, it's an endorphin event not a nutrition event.

The second thing is that when you're eating carbohydrates, your blood sugar is continuously fluctuating, and as your blood sugar goes up, whether that's two M&M's or a whole pizza, insulin gets produced and insulin drives your blood sugar down, when your blood sugar goes down, you get hungry.

So, the problem with a high carbohydrate diet, is that you're perpetually hungry, and that is why their advice is turned from one or two meals per day and I talk about the post food pyramid diet. They are now recommending six to eight meals a day, small meals a day, that is not the way human beings are designed to eat.

Bret: Right, so it's out of necessity that they eat a high carbohydrate diet.

Robert: Correct, so the cool part about this is that you don't have to do this intentionally. When you go into ketosis, you don't feel hungry, because your blood sugar and your insulin is very basal, it's flatlining. Now obviously you're going to get fat adapted? But when it's a flat line, you don't get those sugar highs and sugar lows.

At the same time, you still need as fat person, a type 2 diabetic, which is the same disease by the way, to put something in your mouth, like a smoker might use a piece of gum instead of a cigarette, to manage your emotional needs. And that's where we try to have patients develop a ritualistic relationship with something they can put in their mouth that doesn't contain calories. So, in my case that's a cup of coffee.

I don't drink the coffee, I sip on it throughout the day. After every patient in my office, go back... relax my brain, it's an emotional relaxation, let the stress tension of the last visit go, relax myself, have that little bit of coffee to trigger it and when I go

to my next patient, I'm totally on, they get the best of me. If I go patient to patient to patient, I'm building up the stress and tension, my brain's going to take a break and I'm going to lose focus.

So, understanding emotion management as it relates and interrelates to eating and drinking is critically important because what we've tried to do is introduce the carbohydrate addiction model, when you remove carbohydrates, we have to replace their role in our lives. One role is food nutrition, so we have to go back to eating for the nutritional value not the endorphin value and secondly, we've got to understand the emotion management effect that carbohydrates had to find a replacement.

Bret: It's a great point about the replacement and I think that's something that we don't talk enough about, whether it's going outside for a walk, whether it's just taking a minute to breath or meditate or be mindful or like you said the coffee.

What I find is a lot of people do like to use a drink as a substitute, which I think is great, unless it's coffee with heavy cream and MCT oil, because then the liquid calories are adding up, which could be a detriment or the caffeine is adding up if people are drinking the whole coffee and actually from a personal experience, when I'm working from home, I find myself snacking on the nuts, more than I should, so I started drinking more tea, and I noticed I was getting a little shaky from all the caffeine, so then I went to regular water, but regular water doesn't quire cut it, so I need something else, whether it's hot water or some of the flavored salter waters that are zero calories. Are these the types of recommendations you make?

Robert: Absolutely, so what we're looking to do is we understand that obese people, like smokers are very oral in terms of their relaxation technique... Some people can pray, some people go for a walk, some people can chat to other people, depends on how you're wired.

Obese and type 2 diabetics are primarily wired to put something in their mouths, so number one, the difference between a snack and a bridge, and a bridge is a term I coined, is that a bridge bridges across that moment of endorphin requirement without a caloric load. So instead of a coke, even a diet coke, is a perfect-- no but it's a hell of a lot better than the coke. So it's a segue across, but what the caffeine in the coffee does, is that it needs to give you an endorphin rush.

I find, that some people use water, but water long term doesn't satisfy the endorphin need. Now you can create a ritual around it, and I'm not going to knock that, but the other point you made is very valid. In people trying to reverse type 2 diabetes into remission or trying to lose weight, don't add extra calories to your-- even if it is or because it doesn't contain carbohydrates, all because it's keto, doesn't mean it's okay.

So, you said the cream and the MCT oil... when you're trying to lose weight, when you're trying to get rid of your diabetes, give your body that intermittent fast, where you're not consuming those calories. So, that's the group that's lowering their weight.

Once you've done that, if you look at all these skinny people in Hollywood who's looks are their living and they've adopted the ketogenic diet, which I absolutely love, because I think it's a healthy way to go, better than lettuce leaf eating, what the MCT oil and the cream does, those people are probably at a slight caloric deficit, because they were very aware of it. So what the MCT and the cream, or whatever it may be does, is it keeps them in ketosis, it keeps activating leptin and prevents them from eating.

So, it becomes easier to adopt an intermittent fasting pattern. And they're then getting little bits of calories, it will never make them fat, it won't, they don't need to retard their weight loss, they want to stay stable, so the maintenance phase, we introduce that to keep them where they are.

And remember a lot of my surgical patients are not able to eat a huge amount of calories at a time. So the way to kind of stop the weight loss on a ketogenic diet is to increase the little bits they have, never enough to cause weight gain but enough to modify weight loss.

Bret: Right, I think that's a great point because we do have to separate the different types of ketogenic lifestyle. There's a weight loss ketogenic lifestyle and then there's the Hollywood, Silicone valley or the people just trying to get high, chasing higher levels of BHB for the mental performance and they're not one in the same, so I think that was a great differentiation.

So, we went through a little bit of how you evaluate the patients that you see, sort of their psychological make-up in terms of who's going to go to surgery sooner or later, their background health challenges, who you're going to use surgery sooner or later.

Let's just say you start with the process with the ketogenic lifestyle and they're progressing but not as quickly as they would like, and then you're starting to think about surgery with them as an aid. Give us a little overview of the general different types of surgeries... and sort of what the potential risks are, long term for each kind.

So if somebody out there is thinking, "I've been doing this ketogenic diet and I've lost 50 pounds "but I've got another 100 to go, "would weight loss surgery be a beneficial bridge for me... what should I be thinking about?"

Robert: Absolutely, good question and I think that the first thing is, I'll never ever make a decision on behalf of the patient. I'll give them my opinion and my opinion is

based on the history we've have had with over 8,000 patients that we've operated on. So, we look at the range of procedures out there and there's devices and procedures, some of them are temporary, some are permanent.

And we start with the least amount of help. So if somebody's tried many times and they're struggling to get going, but they are pretty authoritarian, they are pretty good at getting stuff done, they just can't put it altogether right away, that-- so for example someone who's tried and failed to quit smoking many times, I would have no problem writing them a prescription for Chantix.

In exactly the same way, an intragastric balloon, is a very useful temporary device. This is a balloon that occupies space in the stomach, fills you up with a very small amount of food so you only need to eat a small amount of food and you fill up and secondly it partially obstructs the outlet of the stomach, so it keeps food in there for a long time.

So, it takes the edge off the need to eat all the time, both psychologically as well as from a hunger perspective. And the balloon stays in there anywhere from six months to a year, and there are a couple of different balloons on the market, and what they do is, if you're working with it, you're able to break habits and form new ones.

One of the key things, I said before I don't use the word diet, because the end point of a diet is weight loss. The end point of our program is habit change, and it takes about 90 days to break a habit or create one, and then you want to consolidate it and the six to nine month time period that the balloon is in place, up to a year or so, allows patients, if they're effectively working this, to not only break those habits, but when they make mistakes, the mistakes are not punitive.

When you're on a diet and you make a mistake, you gain all the weight back and you have to start from zero again. With the surgery or the balloon it's kind of a stair step pattern, so you're losing weight really well and then you screw up, you have a Christmas party or whatever it is and you kind of level off, you don't gain the weight back.

You come in, we tweak your head a little bit, we can maybe make some tweaks, one balloon one balloon system, the old balloon system we can actually add another balloon, it's kind of the stair step pattern, during which time, you're losing weight, so you're seeing the success of that, which is an important metric.

But you're also transforming your way of life, your self-confidence, your self-esteem is growing and by the time those balloons come out, hopefully you've changed enough that you don't just go straight back.

Bret: Yes, what do you see when the balloon comes out, because now all of a sudden, the stomach has gone from a small effective size to all of a sudden, a much larger effective size. So does their hunger go up, does their craving for larger portions go up, once the balloons come out?

Robert: It depends on what the patient's done. There's a group of patients that come in, typically a wealthier Palm Beach patients, I know exactly what to do, I just need a tool. They will lose a bit of weight, figure a way around it and they fail miserably. That's called a wallet biopsy, it's a terrible way to go, because the only thing that lasts is the money they spent on the balloon.

That is the wrong thing and talk as I might-- we see that group of patients, we try to filter them out. The other group have transformed their way of life. The paradox is, even after the balloon has come in, they continue to lose weight and continue to get healthier, so that's the group we want to buy into this. The austerity happens with the help of the balloon.

The success phase is pleasurable, which is phase two, the first phase is the divorce and depravation, getting rid of the carbohydrates and not seeing progress, the balloon shortens that period. Once you get into the success phase, when you start to succeed, see results, you can leverage your success to do more, and we push them along that pathway.

So, that's what happens with our balloon system patients that really engage in the process, so they start a ketogenic diet and they use the balloon as a tool to help them. For patients that are either very, very sick or have a brittle cardiac or diabetic or other issues, maybe somebody who cannot deal with the PCOS, which is a sugar problem in the first place, or they're extremely heavy, now we're talking about your five, six, 700 pounders or people that have struggled and have really failed and finally people from a permissive background, that's where the more permanent surgeries help.

Understand that the effect of durability, of weight loss during that surgical time is no more than about three years, but as long as they follow up, I think of our office is AA for fat people, it's not a weight loss office, it really is that cognitive behavioral therapy program. Some just take a longer time to get it and practice it and make it part of their lives. So, that's where we select the surgery.

Now, in my opinion, I do not believe that the gastric bypass should ever be done, as a first line operation. The number of complications I see with it are enormous, I fix a lot of those, but they also have malabsorption complications. And if you're following a

ketogenic diet, in our program, it's a liability. I see them gaining weight back as much as others, and I see them become malnourished far more than other surgeries.

The operation of the day right now is the sleeve gastrectomy, which is a pure restrictive operation. So, what you eat, you get, there's really no metabolic problem with it, but you just don't feel very hungry.

Bret: So again it's basically shortening the size of the stomach.

Robert: So what we do is we turn the stomach into this big bag that can hold a huge amount of food and we turn it into a tube. It's taking a five lane highway and turning it into a one lane highway.

And because the traffic is slow along that highway, they eat a small amount, they feel full and they feel full for a long time. So, it's the most consistent form of weight loss. Obviously, if you eat ice-cream and Oreo cookies all day long, you'll still lose weight in the first six months but it will level off and you'll gain it back.

Bret: And it's not going to help your health.

Robert: Absolutely, so the health part of this is to also help with health parameters, and the paradox again is this, is that the single most effective treatment for type 2 diabetes is a gastric bypass. It cures-- not cures it, but it puts type 2 diabetes into remission, for a short period of time.

Bret: Even before the weight loss?

Robert: Even before the weight loss in the first few weeks their blood sugars normalize, the A1c's come way down. If, however the patients do not drastically change their relationship with carbs, it comes back. And an NIH paper that's just come out said they looked at over 50% of patients that had gastric bypass surgery for diabetes or were diabetic at the time, became diabetic again at five years, five to seven years.

So, you'll hear this about magic bullets and it's absolutely 100% true. Your diabetes goes away, but it comes back unless you do the ketogenic diet. But the sleeve has the same effect and it's even more powerful if the incentive is to augment a ketogenic way of life, rather than to replace the need to do anything.

Bret: So, if someone has tried and failed at multiple weight loss attempts and goes to see a bariatric surgeon and they say let's do the gastric bypass, would your recommendation be to say hold on, and ask them about the balloon, ask them about the sleeve, ask them about these other, I guess... you can say less drastic measures to start with?

Robert: You know, there's a little bit of bias, because any time any patient comes into me, they've already failed at everything else, and they want surgery. Their obsession is their weight, or maybe the diabetes and they want a cure for that. And I've got to sit down and actually hurt myself professionally or really fiscally, by stepping back and saying, "Whoa, hold your horses. It's not going to work the way you want it to work."

There is no magic, there are too many both surgeons and doctors that prescribe diets that are magic bullet doctors, "Do this and you magically lose..." and we invest in that magic. This is hard work, it's a lifelong process, and, so we have to step back and talk to the patients about this. My job is the surgery, all they have to do is show up. Their job is to transform how they handle their emotional needs, away from a drug called carbohydrates, toward things that they do.

That's a lifelong job and we have to partner together, but I've got to introduce them to that partnership. So, I know that the majority of people are antagonistic towards surgery and the odd thing is, so am I, but I recognize that there is a group of patients, where we've done absolutely everything, form the ketogenic change perspective that just can't make it happen, and that as I said, is like somebody's tired and tried to quit smoking.

Well, we very readily write that Chantix prescription, and I know it's the downside is not as much. I think that for people that are recalcitrant, that are struggling, that are putting the effort in, and we have to have that message in, it is an added tool that we can really help them, because ultimately as physicians, we want the patients, number one, not to die, and number two to be healthy.

And if we can mitigate against those two things, I believe we should use every tool we can, but we should do it sequentially, and a very, very small percentage of patients, actually need surgery. The majority of them can do that up front with other tools and things we can provide for them.

Bret: So, now let's shift for a second and talk about the long term sequence of this, you know the-- you see them, you do a sleeve or a balloon, they're losing weight, but they got 10, 20, 30 years to maintain this, and let's be honest, as easy as a lot of people like to say, a low-carb ketogenic lifestyle is, it's still not a straight line.

People are going to slip up, they're going to have mistakes, people are going to gain weight and fall off the wagon, so to speak. Depending on their personality type that may be the end for some people and they don't get it back and some people may jump right back in. How do you deal with people from an emotional side, to help them through those failing moments, or those weakened moments?

Robert: So, at the very first visit, we reinforce this all the time, we introduce the concept of failure. Not as a failure but as a passage to doing better, because everybody fails. Nobody quit smoking the first time, it's typically three to five attempts minimum, before they finally do, but every time you learn a lesson and the value of the surgery, as I said, is that stair step pattern. The only thing I chastise my patients for is, if they don't come through the door.

It's AA for fat people. Beyond that, we are number one never judgmental or critical. You have to throw that away. These patients have beaten into submission because they cheated, they're a screw up, they're a failure, they're terrible, they're-- that's what Weightwatchers does and what happens, they don't go back. When you're struggling, get your butt into our office. We're not going to kick you down, we're not going to push you down, we're going to help you back up, okay.

So, you know, part of the other problem with alcoholism, if you've been sober for a year and you go out on a bender, that's not so bad, not a problem. The problem lies in the fact that the next morning they don't say that was terrible, I've got to get back on track, they take three of four months before they can get back on track. So one alcoholic binge is not the problem, it's the problem with permission.

Once they grant themselves permission to drink, they can't stop, and it's exactly the same with our patients. So, the fundamental turning point of our practice is the word permission, and your whole being, your-- we have this incredibly sophisticated system of validation and trivialization and mitigation and minimization and rationalization the... I know I shouldn't be eating this cake or this pizza, but right now, for this very reason, I need my shot of heroin.

So, we help the patients to understand that the word is permission not quantity. The world, the diet world out there is always rewarding you with the very drug that made you fat. So, we build into that, a certain amount that you can have.

Bret: Right, there's an office party, there's a birthday party, go ahead and have your couple of—

Robert: Or you save up all your points at Weightwatchers to have some cheesecake. That's like celebrating a year of sobriety with a case of beer. So, it's a ludicrous concept. That's why the first thing we concentrate on is zero carbs, not an allowance. There are incidentals that we need to cater for.

The goal is to try and be as close to zero as possible, but you asked about failure... the next thing is this, we tell patients, you're going to make mistakes, it's never a bad thing. You try to create an environment where you don't have easy access to

carbohydrates, but when you make a mistake, the most important thing as I just gave the alcoholic's analogy is not the mistake itself, it's the recognition of the mistake.

And the time frame between making the mistake and recognizing that you've made it, is critical. So, we introduce, very early on, we reinforce, reinforce, reinforce, the concept of OAC; ownership, analysis, correction. Ownership is, "Hey I made a mistake, and I don't care if it's one M&M or the whole bag", because it's the word permission and in addiction management we can be very binary.

You either did, or you didn't. It doesn't matter how much alcohol someone drank, it's that first sip of beer that's the problem for the alcoholic, it's the first puff on that cigarette, the first snort of heroin, it's not how much. The diet world is filled with restriction. You can have a little bit, but you can't have a lot. Well, you can't tell an alcoholic that. Asking an alcoholic to count their drinks, or asking a fat person to watch their portions, it's like telling an alcoholic to watch their drinks, you can't do that.

So, the word permission governs everything. So, the first step is ownership, and it becomes much easier to recognize when you've made a mistake, if we have binary rules. Now we don transgress them from time to time, that's the mistake. The next question you want to do is go back, because you can't correct the mistake, okay, you can't correct the mistakes. So, the next questions is what were the circumstances?

How did I get myself into a position that I made that mistake? What was the overwhelming emotional issue or what was the proximity of me to the carbohydrates... and where did that come from? And the next time, I'm in the same situation, what tricks or tools can I do to make it different? And one of the things that we teach our patients, is they have lost the ability to make choices. In addiction we've lost the ability to make a choice, but we've retained the ability to make a decision.

A choice is when it's right in front of you, should I or shouldn't I, you're screwed. I can guarantee you if there's ice-cream in my fridge tonight, I will eat it, and I'll eat it all gone. But I can also guarantee you that I've made the decision that there is no ice-cream in my fridge. So, a decision is a pre-emptive thing. I know what I'm going to eat and how I'm going to eat, what the pattern is, what's going to happen at the table before I walk into a restaurant.

If you look at the menu, it's crystal meth, crack, cocaine, marijuana, I mean how the hell do you stay away from carbohydrates? If you go into a store to buy stuff, and you look around, everything is just bombarding you with carbohydrates. If you make a list before hand, you've made a decision about what you're going to buy.

Are you absolutely going to stick to it? Probably, maybe not but at least you're more likely not to buy crap. If you don't have carbohydrates in your home, you can't have them. If you open the fridge and say should I drink a coke or a diet coke, you're screwed, okay. So, a large part of what we train our patients, is suing more addiction type methodology, to protect them from themselves, and that's the issue, because you can't control your environment, you've lost the capacity of choice.

Bret: So you've, we've talked a lot about addiction, and it's a great analogy that makes a lot of sense, but when you talk about legal definition of addiction or rules and regulations around addictive substances, are we ever going to get with carbohydrates, processed foods, sugar or is there just no chance, because of all the industry and the history and the culture that we've sort of embedded ourselves?

Robert: Well, I think the first challenge and I said this right at the beginning, is to separate carbohydrates from food. Absolutely food is non-addictive. It doesn't meet any of the addiction criteria. And you can't stop eating food. Carbohydrates, and Nicole Avena, I think's her name, has done some great work on this, but carbohydrates meet every one of the DSM five.

If you just substitute the word carbohydrate for the word nicotine, alcohol or heroin, it meets every single one of the broad spectrum of addictive substances, from the mental alteration, from the need to, from the destructive lifestyles, from every perspective, it meets those criteria, but we've got to use the word carbohydrate not food, that's the first thing. So, it absolutely meets all the addictive criteria.

The second thing on the nutritional side, it is not necessary for human survival. At least the consumption of carbohydrates. Here's the error. Carbohydrates are absolutely necessary for human survival, we have to have sugar in our blood stream, but we don't have to put them in our face. Our body is very well adept at making them. So, they are not an essential nutrient, and while there is a survival advantage from time to time, from a species perspective, consuming them in small amounts at intervals.

For example Gary Fettke does a great talk on fruit that used to be available seasonally for a month or two, to help us to fatten up before winter, survival advantage. Now it's ubiquitously available and we're fattening up all the time. So, you know, it's not maligning carbs, carbohydrates aren't bad, they're not the problem, it is our relationship with them that is.

And once you've lost control of that relationship, that's where the abstinence part comes in. Alcohol's not a problem. I drink alcohol, so do you, I think?

Bret: Yeah.

Robert: So, but it's not a problem for us. If it was, abstinence would be the corrective pathway, and so the issue is not the substance, the issue is the relationship, and it's that addictive relationship, and absolutely carbohydrates meet every form of the addiction description. They really don't meet any of the descriptions for essential nutrients.

The one other mistake we make, is the world out there quantifies carbohydrates based on the additives. So, an apple is very healthy, but a bowl of ice-cream isn't, but if you look at the carbohydrate content, it's about the same. So, if you look at a glass of red wine, very healthy, a lot of anti-oxidants. You look at a glass of whiskey, not so much. But a glass of red wine is healthier for me than a glass of whiskey.

But if you're an alcoholic, it doesn't matter, it's the alcohol content that's important, and that's what we don't understand. So, when I talk to my adolescents, I use the turd theory... it's kind of a cute little thing. Do you eat your dog's poop? Hell no! What happens if I ate your dog's--? If I took your dog's poop and I dressed it up really nicely and I made it look petty and I sprinkled a few nice things on it and made it smell good, would you eat it then? Hell no!

Well, that's what carbohydrates are for fat people for diabetics, carbohydrates are the turd, no matter how much you dress them up, they're still a turd. You can find the stuff you dressed them up with in other foods. You can find your nutrients, your fiber in other foods that are not carbohydrate dominant.

Bret: Right, and you know I think there's an important differentiation to make, you're talking about the subset of people who are obese and are addicted to carbohydrates, but just like the alcohol analogy, not everybody is going to have that same reaction and that same addiction. So, part of it is for the person to identify for themselves, if they fall into that category.

But the second is when they come to someone like you, to be able to go down that path first before jumping into a lifelong altering surgery, so I really appreciate that perspective, and hopefully more bariatric surgeons and weight loss physicians are going down that path, to address a lot of the emotional concerns, before jumping into a surgery, I think that's very refreshing.

Robert: Yeah, I think the surgery is so darn effective immediately and everybody just focuses on the immediate result.

Bret: Right, not the long term.

Robert: The first year is lovely, and that's the error. It's so darn powerful we don't think of the consequences, but isn't that why we eat carbohydrates? Because they're

so darn gratifying immediately. We don't think of the consequences, that's the issue. We've got to think long term.

Bret: Right, good analogy. Well, I want to thank you so much for taking the time to join me today. If people want to learn more about you, where can you direct them to go?

Robert: Well, I'm on Facebook and I'm on Instagram. It's Robert Cywes, C-Y-W-E-S, and it's an open forum, but it's nice to friend me. My website is www.obesityunderstood.com and we're becoming more and more focused on the diabetes side, so we're building our diabetes website. We're also doing a series of podcasts, which will be turned into a book form, looking at different chapters. I'm recording that right now with Doug Reynolds, from Low Carb USA, so we'll be producing that in the next little while.

And if I can put one plug in there, in terms of changing away from the diet philosophy calories in, calories out, I want to put a plug in for Zoe Harcombe's new book, The Diet Fix, big in the UK, it's available by order here in the US, and it really transforms our thinking on the principles of diet that we're so welded to and that we need to let go of.

Bret: Wonderful, thank you for that and I look forward to seeing the podcast series with Doug Reynolds from low carb USA. Thanks for taking the time.