Diet Doctor Podcast
with Dr. Sandra Palavecino
Episode 60

Dr. Bret Scher: Welcome back to the Diet Doctor podcast. I'm your host, Dr. Bret Scher. Today I'm joined by Dr. Sandra Palavecino. Now, Dr. Palavecino works in a small town in Seaford Delaware, but she is originally from Venezuela. She got her medical degree at the University of Venezuela.

And completed her training, was practicing doctor in Venezuela, but then moved to the United States where she had to redo her residency, which is just part of the rules for foreign graduates coming into the US, where she did her internal medicine residency again at University of Connecticut and as you'll hear, she then got interested in obesity medicine so she's now board-certified in both internal medicine and obesity medicine, and she's the director of the medical weight loss program at Tidal Health in Seaford Delaware.

And she has a great perspective on this because as obesity medicine specialist and as the director of the medical weight loss clinic, she needs to know all the tools available for weight loss. So whether that's medications, whether that's very low-calorie meal replacements and of course what diets are going to work best and how to work best with bariatric surgeons to get the most benefit out of what they're doing both pre- and post-operatively. So she understands the whole picture.

And I think that's so important both from a science perspective of knowing what works, but knowing also what works with the patients and the behavioral changes that need to happen. And that's where I really like her perspective, she talks a lot about behavior management and those are certainly things that we do not learn at medical school, that we do not learn in residency.

So to hear her talk about that as sort of the prime intervention that she does with her patients I think is so important and I really hope you can take away some nuggets about what that means. What that might mean for you individually, what that may mean for physicians and as you'll hear me conclude at the end of the interview, this is the physician people need to work with.

If you really want to lose weight and you want to work with a weight loss specialist, this is the type of approach and philosophy I think so many physicians should have and I hope it gives you hope that you can have that approach, whether it's with her or with others who think like her. They're out there.

And if you're not getting this type of detailed approach and thoughtful approach, maybe it's time to start searching for someone who can give that to you. So, with that, I hope you enjoy this interview with Dr. Sandra Palavecino.

Dr. Sandra Palavecino, thank you so much for joining me on the Diet Doctor podcast today.

Dr. Sandra Palavecino: Bret, thank you for the invitation.

Bret: Yeah, it's my pleasure. So, as I mentioned in the introduction, you are board-certified both in internal medicine and in obesity medicine and you are the director of the medical weight loss program. So, you spend all day helping people lose weight and maintain that weight loss.

So, I want to talk about the specifics, but I am curious about how you got to this point in your career. In your training, were you always interested in focusing on weight loss? And how did that happen? Give us a little background about how you got to this point.

Sandra: Well, my medical career started a long time ago. In my country, right after school you go to medical school. So at the beginning my interest was more in infectious disease, tropical medicine. I did work in the Amazon jungle with malaria.

That was my most interest. And so I moved to Connecticut, where there is no tropical medicine going on... But, doing my training as a resident for the internal medicine program, they did have a small rotation through a weight loss clinic, which was very interesting. And when I moved and started working here in Delaware I saw the big need of something else besides the regular advice to my patients for weight loss and that's what I got really interested; so, I will say there was about 2012, 2013.

Bret: So, I am curious about the cultural differences just in terms of obesity and lifestyle... when you were in Venezuela was that you weren't as focused on it because you were doing tropical medicine or was it simply... it was obesity and metabolic disease simply not as prevalent so it wasn't as obvious?

Sandra: Definitely not as prevalent... Back then I remember... the country I live in, doesn't exist anymore, but back then even with all the inner wealth that we had I don't think obesity was a focus at all for us as doctors, so that could also be part of our education that is missing. We wasn't really never a focus.

Over there, you know, I did a very tough internal medicine program back home, very complicated patients, a four level hospital and it was very interesting in all points of view, but obesity was definitely not in the top of anybody's mind at that point.

Bret: Yeah, that must've been a little bit of culture shock then. You come to the United States and all of a sudden everywhere you turn the majority of your patients are suffering from overweight or obesity, metabolic dysfunction... Did it take you little time to sort of say, wait a second, this isn't right, something's wrong here. What can I do differently? Like what was your progression like there?

Sandra: Absolutely. So, during training, you just focus on like finish your fellowship, even though this was-- my residence, sorry... even though this was my second time. But, you know, you follow the rules and you do it again and then I still thought I was going to go for infectious diseases afterwards, but then the opportunity came for us to move to Delaware and down here in southern Delaware, there is no teaching hospitals or places to further continue your education.

So, I love internal medicine, don't take me wrong, I said, let's do it... I'll do it hundred percent. And I was in practice and I have my "aha" moment like a lot of us, because I was helping these patients to-- I will be one of those doctors that will bring the obesity to the front for the conversation but

then, that was it... I had nothing else to give them.

Whatever I was telling them that we should be doing, this is what we should be eating... the next appointment, the next appointment, nothing is changing. The doctor is gaining a lot of weight, my labs are being abnormal, so I said there has to be something else.

So that's why I decided to investigate some more. I found the Obesity Medical Association lectures about how to get on board Some of and I know this is going to sound a little bit different, but I went to that conference and I met Dr. Andreas Eenfeldt and that was my "aha" moment. This is what I can do for my patients!

Bret: Oh, that's great. I'll make sure Andreas hears this; that he was the motivating factor. Well, that's fantastic.

Sandra: Well, I told him the next time I met with him that he was fantastic... You opened my eyes. I was there for like three, four days, and his conference was maybe an hour, but that changed me for real. I came back to Southern Delaware and tried to give these teachings to the people down here with all our challenges and it has worked great. It's been six years almost.

Bret: Wow! So, let's talk about some of those challenges. So, southern Delaware in a pretty rural environment, low socioeconomic class... You know, so much of the low-carb conversation kind of gravitates towards, you know, grass fed, nose to tail, high quality... But that type of discussion just can't even start, it's a nonstarter for low socioeconomic population, like you have.

So, it's a big set of hurdles I think you have from an education and compliant standpoint. So, what have you found is some of the biggest hurdles to people adopting low-carb and sticking with it. What do you see as some challenges?

Sandra: Well, first, the challenges, this is just to introduce you to what I see all day when I'm driving to work. It's a very rural area, there are farms... But basically the major economic factor here is the poultry and the poultry plant. So, when you see farms around here growing corn or other grains, is not really for human consumption.

Even though some of it gets to the population of the area, but it's basically to feed this poultry. And then that's kind of what I see here all the time. So even though it's a lower socioeconomic, there are very hard-working people that keep us fed and other parts of the country. So, one of the challenges they always have when they come visit me is that "I'm not going to lose weight because I've never been able to do it.

Because I live in southern Delaware." And I say, well think about this... you were not able to do it because we were not giving you the right advice. So, I get that challenge a little bit out of the way. Then they go, well, but here we don't have like whole foods, or, you know, these grand supermarkets that will sell you all these fresh things.

And I say, well here we are in a community that works with farms. So, you don't have whole foods, but you have all these little farm stands all over the place that you can just go and get fresh food. So that challenge is a little bit... Now, you have to like them and know how to prepare them, but at least we get that a little bit out of the way.

Other challenges, like yeah, but I don't have a chef... I don't live in California and I don't have a trainer... And I say, we can definitely use this weather and these nice beaches around here... we can go for walks. And then if you follow low-carb high-fat diets, you definitely don't need a chef.

Very simple recipes... we will make it happen for you. And then I think for me the biggest, biggest-- I am a very positive person, so I was trying to make them understand those are challenges, but not obstacles.

We will work with it. But I think my main challenge around here is the fact that many of my patients do have two or three jobs. One of the major employees here are like I said, the food processing plants, which have shift work and so is the hospital and the medical system which is the other big employer in the area.

So, shift work is the big thing; having two or three jobs and not taking this treatment of obesity as very seriously. They think they go to the cardiologist... for sure, they don't miss an appointment. But thinking about losing weight is not serious for them until I make it forefront. And then that's how we go.

Bret: So, it's just so interesting that with your population, since they sort of are agriculturally based and have knowledge about food production and food system, that's an opportunity, that's something that they have that someone in the inner cities, in South Chicago, where Dr. Tony Hampton is in those settings, they don't have that knowledge and that connection to foods. So, I think that's really interesting.

Sandra: Exactly. It's a point that they haven't realized. Plus, there is not a big amount, but we have a lot of people around here that enjoy hunting and fishing and that's definitely grass fed, so I say go for it.

Bret: You can't green-feed a wild animal.

Sandra: Yeah, no way.

Bret: Something to be said about that. But I think that's such an important part of just society and knowledge in general that more people need that connection to the land, that connection and understanding of where food comes from and I think that would change a lot of people's perception. So, I really like to hear that that's a population you're dealing with.

And you take advantage of that. You really can use that to their benefit... it's so great. But the concept of, "I don't need to lose weight. Is not important. It's not on the forefront of my mind." So, that's a definite hurdle you have to overcome. And that is prevalent everywhere. Especially when they say, no one's really made it an issue before.

My doctors haven't made it an issue or I've tried and it didn't work... and, you know, I'm a failure, so I'm not going to try again. So, this concept of other people not prioritizing it, or other people giving the wrong message. And when you're trying to teach them something new... I mean, do you have to overcome that barrier of them being like, no, this is just one more thing that's not going to work. I'm not going to waste my time. Do you get sort of like the brakes right away when you start talking to people?

Sandra: Yes, so when I start, I do 100%, because at some point I will do it 50-50 internal medicine and I opened my weight loss clinic and slowly build it up, but now I have all the time to spend with them. And I mean I do have a schedule that I have to follow, but I will always open the conversation to, "How can I help you?"

And I'm sure most of us do that. Because the most frightened patient I have is the one who says, my doctor sent me here. And I don't really know what we're going to do here. So that's a tough

patient. Because you need to convince them that this is an important part of their health and life, etc. Now, when they come to us and they already know... Patients like, "I want to lose weight, improve my diabetes", etc. you can immediately say, you're in the right place, we'll help you.

We're going to do our best to be there for you and help you. So that has been a big one. And like you said, I consider myself-- You know, I study a lot, I know the science, I go to conferences, I follow the guidelines, I see the CMEs and I know all of that. But my big challenge was to explain that to the patients when they come in for the first time. What is obesity? This is not just some extra weight around your belly. This is much more.

And explain it to them and meet them where they are so they can really take this seriously, as seriously as I'm taking it. Listen to them, listen to the history of weight, how they explain to you, how they've been gaining or losing-- or what had happened to them... regaining. And evaluate all the reasons that they think is related to the weight gain. For me to just basically change their mind around it.

Everybody blames the lack of exercise and I'm like, "I'm going to change your mind about this." Everybody lacks... having a craving for something. I'm going to change your mind about this. We can definitely do it. So that was a big challenge for me... trying to bring the science to my patients level and make them understand how is connected to real life.

Bret: So how do you relay the science in terms of the risks of obesity? Because we can think of obesity as a couple of different levels. There is sort of like the functional level where maybe you are winded going upstairs now or you can't play with your kids, your grandkids like you want to. And that's pretty pertinent for people...

Sandra: Powerful.

Bret: ... and a big strong motivator. But then you can read things about, "obesity by itself isn't a risk factor for cardiovascular disease or death. It's only if you have the metabolic dysfunctions. My take is there's a little bit of disagreement in the literature whether obesity is truly an independent risk factor. Do you go into that kind of detail? And I'd like to hear your take on that as well. Because I'm not as up on the literature, I am sure, as you are...

Sandra: No, absolutely.

Bret: What's your take on that and how do you relate that to the patients?

Sandra: Listen, I have created different scenarios that I portray to my patients. It's like a theater in my room. Okay, this is when the foot comes in here and then this is what happens to the food when it comes in. So if you can store much more, you will have obesity maybe without all the changes in your blood work. I try to use all analogies possible that have been working for me with the patients; like storage area and hallway.

How do you keep your sugars at a good level, because you do have a big storage part which is your fat cells. How your fat cell is actually trying to help you not to develop diabetes until things get overwhelmed. And then the patients do understand that having chronic obesity or having diabetes, fatty liver is probably the same disease. Is just we are seeing it from a different perspective. So that's when I introduce the eating plan.

They don't feel like... Oh, but I don't have diabetes and you're asking me not to eat sugar. Well, but we are on the same boat. This is all an insulin disease I will say for the vast majority of the

patients that cross my door.

So, I'm feeling very confident preaching to that big choir and then explain to them what are they supposed to be doing. And you will always find those patients that no matter what you do, that their obesity is very stubborn and it's very hard to lose weight. And then you try other strategies.

Bret: Yeah, that makes a lot of sense. And they come to you for weight loss. Do they come to you specifically for low-carb weight loss or are you sort of a weight loss clinic using multiple modalities and low-carb is one of those modalities? How does your practice style work?

Sandra: Well, I like to say that I am very open-minded and I will meet the patient where they are and try to help them however I can, but I have to confess the most of my practice is low-carb and intermittent fasting for those patients who want that, or I recommend and they follow. I did train both my dietitians that work with me in that area.

I even work with a surgeon who... our patients are doing low-carb pre- and post-op and also-- I mean his patients, right? And they are doing fasting. So I do believe like I tell my patients the reason what you're here today with me, the reason why you're having such a hard time losing weight or understanding this disease, is the way you're going to eat, no matter what else happens. The food is most important and that's the basis of the treatment.

As a board-certified obesity medicine, we can always prescribe medications and I decided in my career that I wanted to learn about bariatric surgery patients, how to help them understand pre-op and what to do with the patients post-op, because I thought, no matter what, they are going to have the surgery.

They're not even coming to me for that. But somebody needs to understand how to help them and what to do with these patients for them to be very successful. Otherwise they are going to regain the weight in some cases.

Bret: Right and that's an important point. The recidivism rate of the weight regain can be high. It's not like you can undergo bariatric surgery and then go back to eating whatever you want, like that kind of defeats the purpose a little bit. So what they eat afterwards is important. So what kind of challenges do you face with post-op post-bariatric surgery patients trying to get them to adopt a healthy low-carb lifestyle and stick with it?

Sandra: So, I go back to the beginning. Like, talk to me about it before you have the surgery. How did you gain the weight? Tell me the story. What were the things that you'd tried that didn't work? Which medications were you on? Because that's going to define what you're eating from now on.

For me, maybe I'm a little biased, because when they come to me is because they're in trouble. A lot of patients who had surgery are certain here they may not come back to me. But the ones who come to me are the ones are in trouble and it's a lot of explaining to them that how obesity actually works as a chronic condition in the sense that when you lose all your fat, your brain most of the time--

Your hormones will work in a way that you will actually regain that weight. So you need to understand that our main battleground is not really the weight loss, like you were saying at the very beginning, weight loss maintenance or what I call rehabilitation of our patients with this chronic condition.

So, like in any chronic disease model, you have prevention, treatment and rehabilitation, so some-

body who does undergo bariatric surgery, what I see... It's okay, you were able to achieve a low weight, but now you need to keep it off by understanding how that works inside you with your hormones, with your eating habits and your behavior, so we can keep it under control.

Bret: So, I would imagine dealing with a surgical population is probably pretty different in some ways, although similar in a lot of ways, with a nonsurgical population. Because you're not just dealing with behavioral modifications, but you are also dealing with anatomical changes now that they've had surgery.

So, you know, people who want to eat one meal a day and make sure you're getting adequate protein, or even two meals a day with adequate protein and relatively larger meals, well, that might work for a non-operative patient. Will that also work for someone who was had surgery? So, what kind of adjustments do you need to make with people when they're in the postoperative setting?

Sandra: Right, so in the postoperative setting in the very first six months they normally do work with the surgeon and the dietitians. So they follow their postop protocol with this liquid diet, semi liquid, like different textures until they can eat normal food.

That's when they go back to me about six months after the procedure and basically we're still recommending for them low-carb diets, reminding them that carbohydrates and processed foods give them no nutrition. And now, in on their small space that they have available to digest their food, it has to be filled out with the most nutritional thing they can find in their plate in front of them.

So, I really emphasize that protein will be always first, then we'll move on to the vegetables and there'll be no hunger or there will be satiety by the time they even think about going to the carbs, so it's something that we even teach them beforehand. So for us it's been working really well to do the introduction with low carbohydrate; that's what the dietitians teach the patients too and then postop we just continue with it.

Now when they're more advanced in the postop stages, especially they're having troubles with continue weight loss or they are facing weight regain, definitely intermittent fasting has played a big role in our practice. I'm not saying this is what every surgical practice should be doing, but it's working for our patients. Intermittent fasting is so easy for them to understand and follow that it works really well.

So, even my surgeon is embracing it because we do it in a way that is not about the time you don't eat. It's about eating when you're not hungry and try to understand that... and that will be the principal symptom for you to go back to eat even if it's after surgery.

Bret: Yeah, so hunger is such an interesting cue. I mean it's a simple word, everybody knows what that word means, but not everybody knows what it feels like and not everybody knows what satiety feels like and whether it's a brain-gut connection or the fullness hormones, or the hunger hormones, resistance to them.

So, that's something that... kind of different people need to be trained in different ways and I'd imagine that changes for a surgical or nonsurgical patient as well. So, how do you help people become more in tune with their hunger feelings and being able to react to them in different ways rather than, you know, fear it or trying to avoid it?

Sandra: I love this question. Because this is really one I focus on every day. Because I know how

to get it done, but how to explain it... hunger is the best way to explain how low-carb will help you without showing them lab test results and like scale numbers. But patients are amazed. I say in my first ever appointment with them always... listen, rule number one, we're going to decrease the sugar, starch, processed food.

Rule number two, we're going to eat only when we're hungry. And they look at me and say, well, that's every hour. And I say, it will be every hour but you will eat from these options and then you will be amazed when you come back.

And they come back... like today I had a patient who did amazing and she is like, I don't even remember what I had. And I'm like, that tells me you're not even interested anymore. So, that's pretty good. So hunger is definitely a symptom that I follow very strict with my patients. In every visit we discuss when are you feeling hungry, how are you feeling it. I asked them to describe it for me... where do you feel it?

And in can you describe which color, which texture ... Is it hot, is it cold? Because I want them to discover that most of the time we eat not because we are hungry. And even if we are, it's not a terrible sensation that you cannot delay for a few more minutes until you get to your actual meal and avoid all the snacking.

Now for surgical patients... for the changes that you mentioned, the satiety and hunger hormones that they will get from this metabolic surgery, they will be not hungry, because otherwise imagine, it will be torture if they're so hungry and can only eat so little. So, the metabolic surgeries are achieving that so they're not so hungry for a while.

The hunger comes back, and at some point after like nine, 10, 11 months when your body's leptin is so low and they're trying to regain this weight like crazy, so their hunger comes back and this is the perfect time to meet again with me and tell them, listen, we're going to just listen to the hunger hormones, we're going to eat this low-carb approach because we want to eat the most nutritional thing you can have in front of you and then they will continue their journey in trying to lose weight and be successful.

So, definitely hunger is fascinating... It's just fascinating how we all perceive it in different ways and respond to it in different ways. And that's kind of core for my program. And one more thing I want to add in there is like I do use the science to explain the diets and I tell them, is not that I mean-- I'm telling you, this is science and let me explain it to you.

This is how we want you to eat. And I think I'm doing a great job and the patient follows it and some patients even take anti-obesity medications and it's still a percentage of-- someday they'll have surgery...

And it's still a percentage of my population that don't lose weight and that puzzles me so much. And this is when I have to go into this, explaining what hunger is. It's like going to this counseling and behavioral changes... and that finally makes the trick and they are successful.

Bret: So, those are really impressive and powerful behavior health techniques that you're talking about... Where do you feel it? What color is it?... to get people more in tune with it. Now I can guarantee you, you didn't learn those in medical school or residency.

Sandra: No, I didn't. I don't know if you remember, we were at the low-carb conference in Boca Raton and that was back in February, January-February before Covid and one thing I took from

that is that... you were one of the speakers and some of the others that normally treat the body we're talking about the mind. You remember listening about the serotonin... fasting and all that... But the dopamine fast... And that's coming from a surgeon.

So everybody who is treating normally the body is talking about the mind. And those doctors that were there for us, that were psychiatrists and psychologists, they were talking about how insulin change how they treat their patients, so they are working with the body. But for me, that was like I knew that.

I just need to know how to get to these patients and how to explain to them that the behavior that follows this biological change is what you need to grasp to keep these and go through what I call your... so you don't regain the weight, which is like your rehabilitation phase.

When you become this person, like this is what we eat, this is how I keep my body healthy and we are focused on the things we could consume and eat and the times that we could eat instead of focusing on the things we're leaving behind. And that is very powerful.

Bret: Yeah, I think that's such an important point because on the one hand, it can seem incredibly complicated, because not only do you have to give a message of a nutritional program that doesn't contribute to hunger, but you also have to get the patient in touch with their hunger and learn how to respond to it.

And none of these things are things you were taught. So for the average doctor to do that, it's incredibly challenging and that's why is so important to have experts like you, who do this, who specialize in it, who know how to do it so you can educate patients. But also go to conferences where people are talking about it, trying to educate other doctors to then have that trickle-down effect. And so, we need more and more of that.

Now, do you find some your colleagues are maybe confused about what you do, or opposed to what you do, or argue with you? How do you find that?

Sandra: When I started, I mentioned before, that I used to do this obesity medicine in my own practice as an internal medicine and I have to say at the beginning I was just used to working with my patients. Nobody would refer anyone, because I was doing it inside that same building, I imagine. They've known me for two or three years being a primary care in the area.

When I moved to do it in another office, totally different and 100% weight loss, I got a lot of referrals from my colleagues that are primary care too, because you can only imagine how long it takes me to go through all these teachings. Now they are being my best supporters and they send me patients because they want their patients to get better, they don't have the time and we always complain about that, right?

So I make the time, we do talk, even though my appointments are the same 15 and 30 minutes, depending, but I do emphasize in these areas that we have no time where we're doing the primary care. So they've been very big supporters. And when they see their patients going back to them, that have lost 3%, 5%, 10% of their weight and improving all their numbers in their blood test, they keep supporting for them to continue to visit with me because our visits are very frequent.

Now, at the beginning when I started the low-carb high fat, because this is the program I follow; low-carb high-fat... and the patients would go to my colleagues, the cardiologist across the

street, and they will tell them, no, I don't think you heard her right, I don't think she said that. And the patients will say, yes, she told us that in her class.

You know, we were all there. But now, the years have passed and they are very good supporters. All my colleagues around say, just do what she said, to the point-- For the first time obesity medicine was included in the top doctors of Delaware. It was always the surgeons there and your colleagues are the ones who vote, and they gave me their award for these years.

And that's for me a recognition of the whole obesity medicine group which is totally a new thing. And they thought I was sitting here just prescribing diets, which is not really what I do. I will not prescribe a Monday to Friday diet to somebody who doesn't understand why we're doing this. So, that's a big recognition from my colleagues.

Bret: Yeah, and I mean that's showing that success speaks for itself. That when your patients are having success doctors take notice.

Sandra: Take notice, right, absolutely. And the government too... one other thing that we do here in Delaware... I don't know if you have these numbers, so let me just tell you quickly, but Delaware is like number 16. This little state is the third smallest state and we are number 16 in the obesity map.

With a prevalence of 35% or 34% obesity in adults. Those are patients with a BMI of more than 30. So that prompted me to contact Medicaid, I mean as part of the STAR program, which is the state advocacy representative and say, listen, it's a little bit concerning that Medicaid... we need more help in here. So, I mean it was just an email and I went to visit with the medical director and deputy director, they listened to me for 30 minutes.

And they said, Dr. Palavecino, we're going to do changes and now Delaware-- Well, I have to say that we are already open to obesity as a chronic disease. That wasn't new for them, but all the treatment... And said, listen, I'm sitting there every day helping patients to lose weight. You need to support.

So, with that meeting, they even changed some of the prescription panels. Now Medicaid has the same number of visits as Medicare for obesity in Delaware and that is fantastic. And it was just an email away. So, those are things that we can do to help this population.

Bret: That's a great example of not just sort of sitting back and being passive about how you take care of your patients, but being active not just with your patients, but with the whole system to really make an impact and make your job better at helping more people. I mean that's fantastic. I love to see examples like that.

Sandra: That's another advantage to being in a small state, that you still have a voice and you can go and get things kind of done.

Bret: Yeah, but I think so many people just see it as like, oh, there's this big bureaucracy and it's an too much work... I'll never make any headway, so I just give up. So okay, so maybe in smaller states it's a little bit easier than a larger state, but still the fact that you have a voice, use that voice and you did and that's a perfect example.

Sandra: Delaware, until a year and a half ago had obesity treatment as cosmetic treatment and that has changed and that was amazing for me.

Bret: Really?

Sandra: Yes. I said, how could you have this as cosmetic treatment? This is 2019. Let me about this.

Bret: That's great... good for you. Now, we've talked about nutrition, we've talked about surgery. Now, there's also a kind of a laundry list of medications that people can use for obesity. And let's face it, a part of the American culture is sort of looking for the quick fix and wanting the quick prescription to 'just give me the pill I need to take to fix this'.

So, do you use prescription medications for weight loss? What do you see is their role? Give us your take on that.

Sandra: Yes, so I will say I did start prescribing some of these medications because I was curious to see how much could these help a patient. But even though I disagree with some of my colleagues, I will not prescribe on the first appointment. Because I told them, most of the research done in these medications were done after patients have changed their diet.

If you look back at, I'm not going to name, but some of these drugs, they will do like 8 or 12 weeks period of diet changes before they start using the medication and I hang out from that to say actually this is-- remember, most of the battle between diet, medicine and surgery is in the maintenance phase, which is the hardest of them all. So there's a reason for me to start if you haven't done any changes in your diet.

And I lost some patients maybe because of that, because they say Diet Doctor, and they're like, okay, I'm going to get my medication. And when they come to me, I say, I don't know you, I don't know your blood work, I don't know if you are pregnant, I don't know any of that. So, we'll have to wait and we'll apply it, but this is great, this is all the things that you can start doing even today... changes that you can do...

And the patients stick with me and if it gets to some point that we have a discussion about obesity medications, I do use it. Recently, with a volunteer here in the clinic... he is a patient who lost a lot of weight and really wants to help all the time, we did a little bit of a research project in the clinic, evaluating... it's like a weight loss register for patients who have been very successful, lost more than 30 pounds, so we call them and ask some questions.

Out of that big group only a 50% of them had ever or are taking medications. So it's something I do; it's not the biggest part of my practice, because mostly is the diet plans. But yes, some of the jokes I've been trying explaining to the patient... This is not going to change any behaviors. This is just to maybe show you how not being hungry means, so you just try for that with your diet; kind of like that way.

Bret: Yeah, sort of like the classic the Band-Aid on the problem, rather than fixing the problem itself.

Sandra: Exactly, even though some of the most newest drugs that you could use for other reasons, for example diabetes, that have been proven to help with weight loss if the patient is diabetic, or can benefit from it is a consideration, but definitely it will go with the changes on the behavior and the diet, which is my strong point.

Bret: Yeah, and I guess that's a good point to the sort of new class of diabetes medications, the GLP-1 agonist that can really target hunger and reduce hunger that help people just decrease

what they are eating. Sure, I mean, that's a pretty strong benefit.

Sandra: Yeah, it basically increases the satiety feeling. So they end up eating less, but it's because they feel full faster. But it's been targeting their sugar metabolism for the diabetes, so we just might as well instead, using others that could increase your weight, I will support that.

Bret: Yeah, right, but then the flipside is, instead of taking an expensive medication to reduce your hunger, why don't you just change the food you're eating to reduce your hunger?

Sandra: No, no, I definitely go back to that. Always, I agree with you always.

Bret: And I get that you do, but the patients sometimes don't get that. The patients sometimes don't understand from one step to the other. That's where I can see the role of medication almost as like a bridge sometimes to help people who aren't quite there, aren't quite ready to change the nutrition. So, I think the role of medications is interesting, but so is the role of the very low calorie diets.

Whether it's the meal replacement shakes or-- And, I don't know, I think when I was sort of training, these were seen as potentially dangerous. You know, cardiac arrhythmias and electrolyte imbalances and low protein. It seems like they've gotten a lot better from that standpoint, that they are paying more attention. So, do those play a role in your treatment as well?

Sandra: We do have that option for when I see a patient who will fit in-- for example, patients who don't cook any other meals and they are eating out all the time, I say, you might as well pay for something different. Now, I have to say that even though I kind of follow more a sparing protein modify fast program than the very low calorie diet, so it's kind of a different approach, because you don't take so many replacements.

And I will tell my patients listen, you at least one meal will be a meal, because you need to learn how to eat and not be in fake food forever. But it has a role, it has a place... and we have had independent research in diabetic patients when they took it-- you remember those studies from the United Kingdom for a year, even though they were getting the checks for free. And half of the population got rid of diabetes, etc.

So, there is scientific independent research about sparing protein modify fast as a program that they can follow, especially if they are diabetic. So, I do offer it, but in my mind at least one meal will stay a meal, because I want them to learn how to eat. And a mix in a shake may not give you the full concept of what is the protein, what is the fat, what is the high-fiber carbohydrate and what are the processed ones that we want to leave out.

Bret: Yeah, and my impression of the meal replacement in the very low calorie sort of medical supervisor weight lost, it's always been, it works great in the short term, but the long-term success is awful. Now, the evidence doesn't always support that though.

There are some studies showing pretty good effects at a year, some at even three years, but that's definitely not what I saw clinically. So, I'm curious what you see in terms of the long-term success of that.

Sandra: It's not something I support long-term. I tell them "Really, listen, it could be something we start with, get you excited. Maybe get your sugar control." If somebody's already having like shortness of breath and very high sugar, that's definitely helping, because they have like a more rapid event. But, so will do a low carbohydrate diet with natural food.

So if you look at a shake-- Don't tell me it's wrong, I do promote when is the appropriate moment, and in has 10-15 ingredients, when eggs have one. And my patients grow chickens in their backyards. So, you know, that makes to me a whole lot of a difference. So I don't really try to keep patients long-term on it, but I do use it when it's appropriate. Now, patients who goes to the surgical route they'll be in a lot of shakes.

So, I try to make sure that they understand that some of these ingredients nonsense, for example sucralose, is not something we support so much. Some of the products that we have here don't contain sucralose or aspartame anymore, so, okay let's try to at least use those. But, economics is a big thing and if the patient chooses a meal replacement he will probably get it from a Walmart store.

But, yeah, I explain that is a way to do it, is as a way to start, is a way to change things around when things are not working, but I do not support it long-term, I haven't seen much results with it long-term.

Bret: When it comes to weight loss, we don't just want just weight loss. We want healthy weight loss right away. Right?

Sandra: Absolutely.

Bret: So what does that mean? That means, you know, improving your metabolic health, it means maintaining lean muscle mass. And it seems like the research will support low-carb diets, will support bariatric surgery and will support these very low-calorie meal replacement, that they all can really help metabolic health and can do it fairly quickly.

So, what do you see as some of the best ways to improve metabolic health for people, that they can start, see the benefits and stick with? Like, what do you use as motivating factors?

Sandra: That's the word I was going to tell you. It's all about motivation. That's why I told you the patient that scares me the most, is the one who walks into my office and says "I don't know, my doctor sent me to you." I'm like, okay, that is very hard, because this is not going to work as smoothly. Do those also have the motivation?

So we work on that. I need to know your "Why" even if the "why" is "I want to fit into this dress" or "I don't want to die from all these other chronic conditions. Whichever it is, it has to be powerful enough for yourself. So, whatever I'm trying to teach you, you will go and you will get it done. And we work a lot on the positive aspects.

So low carbohydrate diet has a lot of things you can use and consume as food, they are very tasty and focus on that, instead of focusing on the things you are not eating and remembering that, losing weight does not depend on the food that you eat. Because then I have my other groups, that are so focused, and they say, "Okay, Dr. P, What about this keto diet?" and I say "Well, that's what you've been doing, I just haven't given it that name."

And they start using all these keto supplements for example, And I say, "Listen, you're not going to lose the weight with all these products that you are using, you're losing the weight for the things you're not eating. And so, controlling your hunger with a more natural approach that you can have, instead of buying all these products... you can have eggs for the morning and tuna with vegetables for lunch and then your dinner.

And try to eat that natural food which contains one, two, three ingredients and it's going to be

so easy for you to do. Plus, I always tell them, "Don't feel alone because anything I ask you to do, any homework that I gave you, I'd be on it too." So, I do follow low-carb, that's another thing about being in a small community, whatever you go, everybody knows you, everybody knows you. Even with the mask, people recognize you.

And they look at your cart in the supermarket and they carry away so I don't look at theirs in the store. Or when you're in a restaurant, people are paying attention. So, I say, "If I can do it in Seaford Delaware, you guys can do it and we are going to teach you how and we go on. But definitely, that motivation is the most important thing for them to make that move and make this change.

Bret: Yeah, leading by example is so important. You know, there's that old joke, "Never trust a skinny chef." as if like everybody who works with food is supposed to be overweight, right?

Sandra: Well there is a lot of bias from doctors and from patients about weight and I'd say, "You need to strive to be healthier, leaner, but also healthier and to stop that-- change your tape up here of how you're going o get there and that's going to be your more powerful advice."

But I have to say, one day in the store, like I'm saying here, wherever you go, people recognize you, and I was looking at yogurts for my kids and the lady says, "Listen, which one is the yogurt with the most fat?" And I look at her like, "This is a weird question, but, not many. Maybe this has a little, because it's made with whole milk." and I said, "Do you ask me that question because you know who I am, or--?" She says, "Yeah, I know you're the doctor who likes fat."

Bret: That was great.

Sandra: That was funny, yeah. That's a small town for you okay.

Bret: Yeah, it's funny to be known as the fat doctor, when what you do is you get rid of fat.

Sandra: Yeah, but the first one in town that even introduced the idea of eating fat. And when I do my group visit and give them a whole scientific background on why do we do this, their faces, they go like, "My goodness this is so new, this is so different." but they have embraced it. And like I'm saying, in that little report that we did for my patients, over 90% of them are doing low-carb and intermittent fasting, with more fat. So, that is great.

Bret: So, we've used the term intermittent fasting a number of times during this conversation, and you know, intermittent fasting is hot right now, especially in the medical literature. We've just seen in the past month, we've seen three studies...

Sandra: Tons, absolutely.

Bret: ...that they have come out, just in the past month. And we have written about them in Diet Doctor and they've got, you know, sort of different definitions of what fasting is, and different outcomes at their measuring, different protocols. So, what are you sort of fall back on, as the main protocol that you like to use and that you see the most success with, with your patients, with intermittent fasting?

Sandra: I see it with the intermittent fasting protocols, not the alternative days or prolonged fasting. Even though, other type of hard patients that are showing up in my office, are the ones who are already fasting and already do keto or low-carb and they come to me for further advice.

So, those are very tough, because they are already doing most of it great. But, okay, let me go

back to the intermittent fasting protocols. So, at the beginning I tell them, "Listen, I know I've asked a lot from you, but now I'm going to ask you to really actually wait and delay your meals. And we start with a 12 hours, 16 hours and they just move on and they do great.

You can see here in Delaware, you can talk to people about 16 days and 23 ones... windows to eat and they do it and they follow it and it's really great. I do have a few that do prolonged fasting on their own because they say I wasn't hungry for so many hours and so many days... Great, but mostly I support the intermittent fasting protocols. And I will say 90% of my patients get either introduced to the plan and a big majority of them do follow it.

Bret: So, the time restricted eating patterns of the 16/8--

Sandra: Is this way to explain it and to get them to adhere to the protocol even though I said, at the beginning you're going to be looking at your time and see, what time is time to eat until you finally figure that you will eat only when you get hungry.

So, it will be at the beginning like paying attention to the timing until you get trained on this and then you will do it on your own, eating only when you're hungry. And when my patients get there, they are super happy. They tell me I don't even know how to explain your diet to people, because I eat only when I'm hungry and that's it.

Bret: Right, it's funny how that's such a foreign concept for so many people. But yet when it sings in, it just sort of makes sense and it's like this is just the way it's supposed to be.

Sandra: I have a few patients that I told, you need to trademark your comments, because he will say he was very super successful. And he is like, "Eating makes me hungry". Like yeah, that's totally correct. When you are fasting, your body is fueling from the jet fuel you have. So it's amazing when they come with this on their own. And I just support them.

Bret: One other question I wanted to ask you is when you see patients for the first time, do you see a number of them who say, I've tried everything... Like they feel like they've exhausted all avenues for weight loss and are sort of disappointed that they haven't been able to succeed. But they really haven't tried everything. Do you see that sort of defeatism a lot or--?

Sandra: Absolutely. I will say much more two, three years ago when nobody was pretty big on low-carb and keto, these last two or three years patients come to me and said, "I even tried keto Dr. P, and it didn't work." So, my job is to make them see what other circumstances are going around them, that may be beyond the foods that we need to interpret. Like for example can we be having--?

First of all let me tell you, most of the patients that come to me in the first appointment, they are doing two or three different diets in a day. They are doing meal replacements in the morning, low-carb for lunch, low-fat for dinner and then they do portion control. So, it's like okay, let's focus on one and let's try it. And then the next time we also explore other areas, we do the history of weight.

So, changing jobs, working shift work, having sleep apnea... which medications are you on? A lot of my patients are on heavy mental health medications... all the things that don't feel like you cannot be successful, this is just we find your challenges and we work through them. And even if is one at a time.

And we do discuss all the-- like outside the box, beyond checking for your thyroid, which I think I

found one hypothyroid patient in this whole practice, because my primary care docs around here are very good at figuring that one out. But is the other things that we need to address and I love that the patients are like, I never thought that could be a problem, I never thought that could be a reason. Okay, let's figure that one out.

And definitely, whatever you are doing right now is not working, so let me give you a plan that we are going to follow, we do it for each one of them, and each patient has the first appointment with me and in the follow-up visits could be equal. They used to be groups with the dietitians and me and now sometimes they follow with me or the dietitians, but we are all like in the same tune there.

Bret: Such an important point that we focus so much nutrition, but there's so many other factors that can impact our success or lack of success in our weight loss journeys. So, that was great. Now, you've mentioned shiftwork a couple of times. And, you know, the easy answer is, well, we'll get off shiftwork, get back on your regular circadian rhythm and all is fine... but people don't have that option.

You have to work the graveyard shift, you have to work the graveyard shift. So what kind of advice or little techniques can you use with those people to help them have more success despite their inflexibility of changing their schedule?

Sandra: Right so that's a big number of patients because those are the ones we already know are going to have the toughest to treat obesity and insulin resistance. So I'm not surprised that a big number of patients have finally decided to go for a medical program or somebody with a doctor involved. So my trick is to try to decrease hunger during the night hours by increasing their protein and help them fast through those very tough hours of the night.

And then focus more in the early morning or before work. And it has worked great with the patients. The other problem is the excess of food they have available doing the shiftwork for some of them... snacks and things like that happen a lot through Covid. So now, just changing also the behavior, already with the hunger decrease, by eating a more low-carb high-protein diet in between the shift and then try to keep that behavior focus willpower kind of moment during the night shift.

For those who don't have food available like some truck drivers or delivery persons, I would just say, just change your circumstance. Don't have the food available and then wait until your meal. So we apply the same. It's just that I want my patients to feel that I'm focusing on their problem.

I'm not giving them one regular diet for everyone and expect that everybody will be successful when they have to work through the night and semi-sleep through the day, or have a second job and they will have to-- Instead of stopping at this gas station, why don't we stop at this other one where they have this available and so on.

So, knowing your area and knowing the areas where they work and where they are getting their food from is very important for me to give them a plan that they can actually follow.

Bret: I think that's so important for a doctor to be aware of those circumstances. Because I mean, I can remember working late nights in the hospital where you are working overnight shift, you know, what food is available if you're hungry? Only junk. It's the only thing available. And it seems to be everywhere in the hospital in the middle of the night.

And I can just imagine if you're a truck driver driving through the night what's open for you to stop and eat at... only junk. You don't have those healthy options. So we really train them to think ahead and not get caught off guard and sort of preempt that. It's got to be so important. But if you don't think about it, if the doctor doesn't think about it, you're probably not going to even bring it up. So it's so important that you are talking to patients.

Sandra: I say, tell me the places that you see in your road... you know, what are the places. And then let's look at those menus. This is what you should be eating, if you're hungry. If you're not hungry, don't eat anything. It's the simplest of all the answers and then you move on. But that has been illuminating for them because finally there's a plan that they can actually follow and it's not from a magazine that you say, why am I not losing weight after following this magazine plan? It's not working for me. And then, you know, we talk about that a lot.

Bret: Well, you certainly lead as a fantastic example, both what you do personally, but how you approach your patients and the behavioral aspect, the communication, the way you communicate with your patients, the time you spend and just sort of your understanding of them and your way to explain this. So I wish everybody who wants to lose weight could see you as their doctor; obviously that can happen.

Sandra: Yeah, please.

Bret: They can certainly use you as the example of what their doctor should be doing and how they should be relating with them and look for a doctor who does that. So I mean, it's a wonderful example and I hope people can take that away from this interview of hearing you, hearing your approach and saying, that's what I want from my doctor and that's what I should expect from my doctor.

Sandra: Yeah, so being the doctor in charge of food and we can manage their medications when we are de-prescribing. That makes them feel so much comfortable because they feel like this is a whole aspect that we're trying to cover for them.

Bret: Yeah, great. Well, any last words you want to leave our listeners with? And then if there's somewhere they can find you to learn more about you.

Sandra: Right, so I do have-- We didn't even talk about this but I do have a strong will to try to help my Spanish-speaking patient population, especially with Covid, that was a big eye-opener for me. So I created YouTube videos, free, in Spanish. You can find me under Dr.sandrapalavecino... in which we explain insulin resistance, the other hormones, how to do a low carbohydrate diet and how to do intermittent fasting, just like an introduction.

I'm also growing my Instagram account with both English and Spanish. So that will be also under Dr. Sandra Palavecino. dr.sandrapalavecino Because in Spanish will be "doctora", but in English is a DR.sandrapalavecino and here, in Seaford Delaware... the one and only, so you can find me easily. If you search weight loss programs in southern Delaware, you'll find me.

So that will be easy. I have had patients that have come to me after researching DietDoctor.com, or Megan's and Dr. Fung's website. I even have have patients coming from Washington DC, driving two hours to come here. But, you know, we tried to serve the areas as best as we can.

Bret: I am so glad you brought up the language barrier. We talked a little about the socioeconomics, but then on top of that, if you throw in the language barrier, it can get even more difficult.

So, the fact that you're doing those videos in Spanish is great. And at Diet Doctor we have a whole Spanish section.

Sandra: Yeah, I would love to help. I think they need a lot of help.

Bret: Yeah, thank you for joining me. Thank you for all you do. It's been a pleasure and I look forward to hearing more from you in the future.

Sandra: Absolutely, thank you for having me.