

English Translation



Episode 3: Challenges in Mexican Healthcare

Dr. Irma Louisa Ceja-Martínez and 2023 ACP intern Lorett Alarcon

[Lorett] Welcome to our podcast. Today I have Dr. Irma Luisa. My name is Lorett Alarcon. I am your host today. I am doing interviews with different doctors and asking them questions about what problems they have in other global chapters of ACP. I want to give a big welcome to Dr. Luisa. In this episode we will address the challenges facing healthcare in Mexico with a special focus on the impact of obesity on patient care. We are honored to have our doctor today, who is a health professional from Mexico and a member of the Mexican chapter of the ACP. Dr. Irma, thank you for being with us today.

[Dr. Ceja-Martínez] Thank you very much, thank you very much Lorett.

[Lorett] Dr. Irma, can you talk a little bit about your work with ACP?

[Dr. Ceja-Martínez] Very good. I have been a member of ACP since 1996 and fellow since 2002 and I served for 12 years. I was the only woman here in Jalisco, where we live in Quino de Bajara and, well, since 2000. I am the first female governor of this ACP chapter. Mexico has belonged to or had ACP chapters more or less since the last century as well as by 1950-something. And well, now it has been quite a challenge to arrive and be the first woman governor in the chapter. It is good for continuity, and it has always been that this chapter is not like the chapters of the United States. In the United States there is about one or two governors for each state, when the states are very large. Here, there is a chapter for the whole country, so it has been a challenge. It is a lot of work, but it has been once again satisfying to do this. I am the governor from 2020 to 2024.

[Lorett] Thank you very much Dr. Irma for that introduction. I know that you also have a very established career and happiness comes from all your achievements such as being the first

female governor of your chapter. I know that can be a little difficult with the Mexican or Latino culture that sometimes has a preference for men just because of history and it is difficult at times to be a woman and try to confront all of that discrimination or just the whole history that has elected men as governors. We have seen a big change in the ACP over 20 years everywhere, not only in Mexico, but in many of the chapters in the United States as well. Can you also talk about your profession, your professional career as a doctor?

[Dr. Ceja-Martínez] Of course, I'd be happy to. I graduated, that is, I finished in medicine in 1986 in general medicine and at that time the speciality (training) was three years long, so I finished in 1990, I started working directly at IMSS, which is the Mexican Institute of Social Security, and I was there for 27 years. In addition, I continued with my private practice. At IMSS, as I have always liked academia and teaching, I was initially there to also give clinical medical classes. By the time I retired, I was also a professor for the residents of Internal Medicine at the hospital, this was until 2018. It was after 27 years that I retired, and well, I just stayed with private practice. And I also had the opportunity during this time to work with the vice-president of the Jalisco College of Internal Medicine and I also participated in the College of Internal Medicine of Mexico, which is the group that has the most associated internists at the national level.

And there I was also on the board of directors, so for many years I have been doing this and this has also allowed me to participate in national and international courses and conferences which has actually also been a learning experience, because when you prepare the topics you always learn, of course, and I can explain them to an audience that may not even know the term internist.

[Lorett] Can you talk about what an internal medicine physician does?

[Dr. Ceja-Martínez] Well look, the internist is a specialist in adult medicine. We're the ones where the pediatrics ends, let's say where the pediatrics ends, that's where we have the patients. We don't just make the diagnoses, which is the difficulty or the diagnostic challenge in patients who have multiple pathologies, but we also have the ability to treat them and to do a lot towards prevention. Minimally invasive surgery is done, let's say. We can do our best to remove fluid or do a paracentesis, do a pleurocentesis, if we do some kind of cath intervention, and so on. However, we are not surgeons.

[Lorett] A question I have for you is what are the biggest challenges in health care in Mexico and specifically how has the obesity epidemic been affecting the quality of care for patients there in Mexico?

[Dr. Ceja-Martínez] Look, Mexico is one of the top five countries in the world where there is the most obesity and currently the statistic is that 70% of Mexicans are overweight. We are currently the top country where there is the most obesity. So, of course this has had a big impact, as you said with COVID. It was already known that people who had obesity had a higher risk of complications and even death from obesity itself and well if we add to that all the comorbidities of obesity, say having diabetes or having some cardiac disease, hypertension, and

so on. This also had a serious impact on the mortality figures that we had and the number of people that we had with COVID complications, so it has been a very difficult situation because of the pandemic. Let's say it is an epidemic that we have here, this combination of obesity with diabetes, because in other countries people can have obesity and not necessarily become diabetic. Here in Mexico, people with obesity generally, due to a genetic disposition, tend to be diabetic more often so that has an impact on everyone. impact on health, the economy, mortality, and diabetes is our cause of death in Mexico. It's obesity and diabetes.

[Lorett] Wow, that's very shocking. In your experience do you think it's connected to cultural beliefs and social norms towards obesity and patient care in Mexico, and a very big culture with drinks with a lot of sugar, specifically in soda and sweets and all the things that people crave, and maybe not putting thought into the sugar they consume?

[Dr. Ceja-Martínez] I think it is multifactorial, definitely obesity is multifactorial like it is everywhere else. It, possibly, has a lot to do with socioeconomic situation. It's much cheaper to buy a pizza or a hamburger in many places than to buy a salad. In other words, eating, eating well is costly. So, obesity and diabetes tend to be diseases of poverty. On the one hand, we have this situation in which women who have had to join the workforce have to work. Well, they no longer have the opportunity to be at home, maybe cooking, because that income is needed, also because the woman either maintains the house or also contributes through her income so that a family can be maintained. So, it becomes much easier to send the children to buy a juice full of sugar and some cookies or a piece of bread rather than before when it was best to send us to school with an avocado or bean sandwich that would be much less harmful and more nutritious. So, on the one hand it's that. The other is that we're a culture where we do everything with food, we celebrate with food, we reward with food, we console ourselves with food. I mean, here it's very important to have that comfort, let's say, to want to celebrate someone in some way and make one of their favorite foods. I mean, we really do celebrate a lot with food. There's always food. It doesn't matter if it's a wedding, funeral, graduation. If the child behaved well after going to school, if a certain grade was obtained, the prize is often food. If my boyfriend breaks up with me, again it's about eating. Of course, then it's all about the food. And the other is, unfortunately, the situation is that we have a sweet tooth, and there are a lot of beverages that are sweetened with high fructose. Also, from a metabolic point of view, the metabolic rate of, say, a tablespoon of sugar is very different from things that are sweetened with corn syrup. So everything is, all the soft drinks, many of the juices, cookies, everything that is sold in markets, which is what is cheapest, because it is made with high fructose. And this, of course, in turn impacts obesity, fatty liver, cholesterol, and, well, we know that they cause cancers, having obesity can cause cancer.

[Lorett] Yes, and I'm a witness to that too, that Mexican culture does celebrate a lot with food, and we have a sweet tooth, that's how I would explain it, but I'm also Mexican, and I'm from Morelos and Michoacán, and even though I moved to the United States when I was little, I still live in a traditional Mexican family. And we have a lot of tastes that, I think, like the American

diet, sometimes it's sweeter, and there's not as much focus on healthy food, but hopefully it's changing. I also want to ask you, in your opinion what are some potential solutions to address obesity in Mexico and improve long-term patient care?

[Dr. Ceja-Martínez] I think a lot of it has to do with improving education and improving the economy in households. We are a country in which there is a great variety of fruits and vegetables, but that does not necessarily make them accessible to many people and, in many areas, people no longer know about them. They don't know how to cook anymore so you also have to educate people so that they can see how it can be done. [For example], learn how to make oatmeal pancakes, that is, look for other options that make it cheaper and the other is to also limit in some way. Right now, we already have the labeling that people see on the soft drinks, for example, that they see on some cookies. If it exceeds a certain amount, there has to be labeling that says that this has an excess of sugar, that this has an excess of salt and so on, but policies also have to change a lot here in Mexico and I can tell you that in Chiapas, for example, Chiapas is a state, it's a state of Mexico that's to the south. It's a beautiful place, it still has a large indigenous population and then the soft drinks factories came in. It was then that Chiapas became our state with the most obesity and most diabetes and everything and it goes hand in hand with the fact that they began to have access to soft drinks because it is a place where it is easier to get soft drinks than it is to get water, for example, so there is also a lack of water. This is about being able to bring greater access to water and healthy things to certain places in Mexico. Still, the people who live in the south, let's say in what is jungle, lacandon, etc., do not have access to water, nor do they have access to vegetables or fruit, as there are in other states of the Republic of Mexico. you know it, it is a different country, Mexico has places of great abundance and places of great scarcity and a lot of poverty.

[Loret] Of course, and I want to repeat and focus on what you said, that in some places it is easier to have access to soft drinks than to have access to drinking water. That is incredible. That is incredible, I can't believe it, but it is true and I have heard that.

[Dr. Ceja-Martínez] That makes it very difficult because if people say that what they have access to is soda, well, that's what they're going to drink, so that also has a lot to do with it, so going back to the situation of the obesity and diabetes that exists in Mexico, in some way it is also understood, because of what I was saying, diabetes is a disease that has a lot to do with poverty and that also means a lot of times people don't take care of themselves nor do they have access to food or medications they would need to be well controlled, which causes the complications of diabetes to begin with. That generates more poverty, that is, people begin to have, let's say, diabetic retinopathy and they can't see so they can no longer work, or if they have a diabetic day and end up in amputation. Well, not only does that person have to stop working, but also the other person who is going to take care of them in the home, because that person has lost their mobility. Oh, well not to mention chronic kidney disease, which is also another of the pathologies that there is a lot of in Mexico, and well, those are patients who later end up on dialysis, etc., and really diabetes is one of the diseases that is causing the most problems in

Mexico from a health point of view. From an economic point of view, it is also a great economic burden for families and for the system.

[Lorett] Yes, yes, for me it's that there are ways to prevent it and there is medicine to treat the symptoms, but there are a lot of people that maybe don't have access to all of that and since they don't focus on preventing it- and when it's something like diabetes and you're feeling all the symptoms, it's too late to get back to health sometimes. I can say that it happened to my grandfather who passed away because he had diabetes and he had access to medications, but he decided not to take them because he was very traditional and he did not understand well that he should take these medications and he died of diabetes at the age of fifty-four and it was completely preventable and I hope that many more people are educated on this because it is a very big issue. Thank you for your information on this, Doctor. Now I want to shift focus to your interests and what you are doing. Tell us what aspects of medicine you have focused on throughout your career.

[Dr. Ceja-Martínez] Well, look, it has been changing, I mean, at the beginning for me the diagnostic challenge was always very interesting. It still is to me, it's one of the reasons why I entered medicine and I continue to be very passionate about the diagnostic challenge itself, that is, what they call the difficult diagnosis. That is, really looking for the unknown cause of that fever, weight loss, I mean, that's really what I focused on for a long time. Then with time, I looked at obesity because there is a lot of it and we see it often. Then, I focused on nutrition and am convinced that a lot of it is nutrition, that is, it has a lot to do with how we eat. And now in the area of the microbiota, which has become very interesting, we see how the microbiota impacts not only our digestive health, but also at the level of the heart and our quality of sleep and our share of nutrients, then also the whole microbiota. Then I also got very involved in this whole area that has to do with the metabolism of sugars, which I found very interesting. And lately I've been quite dedicated to gender equality, specifically about violence against women and its impact on health and, also parallel to this, thanks to ACP that I learned everything that has to do with imposter syndrome and well-being in the doctor which has to do with healthy aging and as I told you about gender equality, equity and its impact.

[Lorett] Of course, and since you spoke about the same topic, how did your career start? I would love to hear a little more about why you wanted to be a doctor and how the process to become a doctor was as I also want to be a doctor one day and it is always a great inspiration to see Mexican doctors because I have not seen many of them here in the United States, so I would love to hear a little bit of their story.

[Dr. Ceja-Martínez] Well, you're not going to believe me, but I always knew I wanted to be a doctor. There was a program, one of you, someone from the past century, will surely remember, there was a program about Dr. Kildare, which was like that, I don't know, like the show Dr. House, but I'm talking about the sixties, and I was like three, four, and five years old when this program came out of this Dr. Kildare and I loved it and I loved the idea. In my family there are no doctors, I'm the first doctor in the family and it was I said, I want to be a doctor

and that was it. I can't even tell you that I had an interest in anything else. I never said, oh well, if I can't be a doctor, I want to be an engineer or something else- I never thought to be something else. I mean, when I entered elementary school, I was in a nun's school, so for a short time I wanted to be a nun, but it didn't last long. I fell in love with a priest. And I said oh no, this isn't for me. I do like men and I'm not going to be able to become a nun, so I went back to the initial idea of being a doctor. And now, fortunately here we are, I'm from a very, very large family. There are seven siblings in total. And well, as I said, I'm the only doctor, but yes, I did have the opportunity to study here in Guadalajara, at the University of Guadalajara. At the beginning I was very interested in the endocrinology part, but as I was telling you, I have always really liked the diagnostic challenge. I felt that if I got into endocrinology, there wouldn't be as big a possibility of doing diagnostic challenges as with internal medicine, and that's how I got into medicine.

[Lorett] Oh, wow, that's good, so you always knew that you wanted to be a doctor. That was a good story. My mom also went to a nuns' school, I don't know why so many went to nuns' schools. It was a way for people from poor families to go and have their daughters get an education and they could study and it's good that that was like a resource at that time. I think a lot of people already go to nuns' schools, right?

[Dr. Ceja-Martínez] Well, I don't know, I think it also had to do with my mom. In her time, she was very Catholic and all these kinds of things were very important to her. And yes, I mean, in some way being educated in a private school does give you more advantages than you would have in the case of people who received a public education. In Mexico, there is a difference.

[Lorett] Wow, yes, that's what I had heard as well. So now you can tell us a little bit about your contribution to improving health care in the country and how you've worked alongside ACP.

[Dr. Ceja-Martínez] Belonging to ACP being Mexican is a challenge because we have our own school to which we have to belong, which is the College of Internal Medicine and we have to belong to it because the Council, which is the American Board, if we also have a council here and you have to certify and be recertified to be able to practice, then the points that you can give yourself for 100 minutes of this, who gives them to you in Mexico is the college of internal medicine. Not the ACP, because the ACP is from the United States. Although it is recognized that one has activities in the ACP or that I am governor or that we go to the conferences, really the scores are given more by belonging to the college of internal medicine. So on the other hand, although many doctors and even more specialists read English, they don't necessarily speak it, they don't understand it while talking, right? So this also limits the number of people who are interested in joining ACP. even though ACP is a great platform where you have access to analyses, and you have access to the Consult Guides. I don't know if you've heard them. And they have access to a lot of new and valuable information. Not everyone feels confident to belong because they know they won't take advantage of it. So, we are a group, although it has been growing little by little with the ACP community, Mexico chapter, we really are not that many. Well, I mean, I think that between members, fellows, masters, which we only have three

of in all of Mexico, we don't reach 350. It has been growing a lot in the last three, four years in the community of medical students, so there's another thousand. It has grown a lot, but we don't have the possibility of holding a conference ourselves because there are very few of us, right? When it comes down to it, there are very few of us and that doesn't allow us to hold a, let's say, a conference like the meetings that are held in the United States. Yes, we participate with other schools, for example, with the College of Internal Medicine, when they have their events, we participate with symposiums or we have participated with the National Academy of Surgery which has a lot of renown here in Mexico, with the national academy of medicine, with general practitioners and national councils of general practitioners. And so, we participate locally, regionally, with other schools or participate with other universities in their events. Well, for one, making known what ACP is and also, in some way, participating in everything, right? For example, we had the international medical course. It was here in June, in Guadalajara. And well, we had ambassadors come, Dr. Douglas Powell came who is from the United States from the Seattle area, and he talked to us about medical integration, about medical myths. Dr. George Jacob came, for example, as an ACP ambassador, he gave us a leadership talk. So, we do all these kinds of things to go about making ACP known and also, of course, talking about medical issues that may be of interest to doctors here in Mexico. We are dedicated.

[Lorett] Thank you very much for the clarification. I don't know if the audience or even people here, part of the ACP in the United States, know that, that there are difficulties with everything, that even though people can write in English, it is more difficult to speak it, especially in the context of Mexico. I know that the English language is so difficult, because they don't have the same sounds and the language isn't built the same [as Spanish], and they don't even look alike. It's hard to learn English as a Mexican. It's incredibly difficult. And thank you so much for making all the effort you have with ACP and all the accomplishments you've built. Is there a focus in your chapter specifically that you'd like to talk about. Are there other challenges we haven't talked about?

[Dr. Ceja-Martínez] I think so. Above all, it has to do with gender equality. For me, this is a topic that interests me a lot. I have a reputation as a feminist. And I think in a way, I am because I had a time when, in fact, I was the only female resident in the whole hospital so it was very difficult to see what some doctors think, because I was the only one, it touched me in some way. There can be bullying in the workplace. There may be some famous mansplaining, right? That is to say, that if I said it, then it did not have the same weight as if a man said it. Or in some cases, even harassment, right? So, fortunately, there are more and more women in medicine, but it continues. There is still in some way that challenge in many places where we need it to be known that it is indeed a big deal. Because sometimes it's as if it's no big deal, right? I mean, it's happening, it's okay, it's just a joke, but no, I mean, it is really impactful to a student. Another thing that continues to be an issue, not just in Mexico, but in a lot of places, is this idea that you're building a career in medicine, you're building a career in ACP and, well, how do you handle the guilt of leaving your husband and your children alone? And it's knowing, why don't you ever ask a man a question like that? I mean, for a man, he's not wondering how to balance

between home, family, profession, etc. Because it is still in some ways, culturally, the obligation of the woman to run the house. Now if we talk about COVID, with COVID, the children were homeschooling, so the woman had that in addition to all the obligations of the house. You're also supposed to dedicate yourself to the children, right? So that generated a lot of problems and it's a lot of it is cultural, to continue with this idea that the man, the husband "helps" the wife. "Oh, I'm so lucky that my husband helps me." It doesn't help you. In other words, this obligation is also a team effort. If not, I have to thank him because he takes out the garbage. I mean, it's part of all of it. So change this idea of how we continue to function from a cultural point of view and also with the challenge that for many, many years all studies have always been done on men. So we believe this idea that women have "typical symptoms" because for us, the chest pain when we have a heart attack is not like that of a man. I mean, then we're used to the idea that yes, the pain has to be in the chest, it goes to your jaw, your arm has to go away, and so on. So when the woman arrives at an emergency room, with complications, sweating, with a pain, an epigastric pain or back pain and was brought on by an event of, for some, strong emotion, what they do is put you on diazepam. I mean, it doesn't occur to anyone around them that this is a heart attack. Why? Because we have the idea that heart attacks happen as they do for men. So right now, it's a lot and to think that as women, we don't have a heart attack the same way as men do. Women are getting sick with cardiac disease because the diagnosis is not being made in a timely manner and also once we have the diagnosis we don't follow the pathways. For example, things are not done with women like they are with men. We give fewer doses of statins than necessary. We are perhaps less aggressive in proposing that a woman be taken for cardiac catheterization, etc., and this has to do with a lot of ignorance, not knowing that the woman is not going to have her artery blocked, let's say, but that it is easier for women to have heart spasms. Everything is very different and we are lagging behind in cardiac disease, but also in other things. There is a study that is actually right, in fact, in which they reviewed for 20 years. They were looking at diseases and it was seen that there is a delay, in more than two thousand diseases in women, a delay of four, five years, to diagnose and I am talking about diabetes, very simple things, so for women, they are diagnosed with a much greater delay, diabetes, for example, of course. By the time she starts treatment, she already has a higher risk of complications and in fact a woman has more complications from diabetes than a man and many of those delays also have to do with this. Not just this, but the other one that is very important is intra-family violence. The intra-family violence impacts metabolic diseases of a woman who suffers violence and has a greater impact on the regular health of the woman with diabetes. Alcoholism, work, obesity and death from a cardiac problem are more likely. So, if there's also intimate partner violence from men, from women to men it's less, it's much less, then it's true violence behaves like an inflammatory disease, a rheumatologic disease. I mean, you don't have any control over when the next episode of violence is going to be and we're not just talking about physical violence, this can be financial violence, which in Mexico is a big problem. Because maybe in the United States you separate, you get divorced and the man is still obligated to support the children. Here in Mexico, the man can leave and although the laws exist, the system is not necessarily going to support the woman so that the

man will support and give what he has to give for those children. And this becomes financial violence, "ah, you don't want me anymore, I won't give you money anymore, keep the children and see how bad it goes for you." And this also has a serious impact on health. So, right now, a lot of what I'm doing within ACP is to create our own gender equality committee to look at all these kinds of things and also to make the situation of this imbalance very public, which is what is so important, as doctors, how we're taking care of our male patients and how we're caring for our female patients.

[Lorett] That's fascinating, what you just told me. I believe that you, as a feminist doctor, you know these problems very well and your patients probably recognize them very easily. And in your experience, this is necessary, right? That other doctors also know about these problems and know what women in Mexico face so that they too, can better understand their situation and what is affecting their health as well, right?

[Dr. Ceja-Martínez] Yes, right. And also, I mean, we are not made the same. So, it turns out that many of the drugs, have only been studied and tested on men. I mean, you've heard of MRFIT, for example, with a study that changed what we were doing in terms of prevention and it was only done on men. So, the study that was done on aspirin was done on 20,000-something men, not a single woman. So, of course, over time you see, no, aspirin doesn't work the same for women, no, it doesn't work the same. Or if you give a man a benzodiazepine or you give him a sleep medication, the recommended dosages are made with them in mind, they are made for men, not for women. So if you give a woman a medication, and the next day, she wakes up still drugged. Why? Because the study was done thinking about the metabolism of the man who has different muscles, different liver, different everything and of course, it's going to change the bioavailability of a medication and the hours that this medication lasts. So, whenever you hear about the warning effects of medications, most of the time it's women. And it has to do with that, that is, because women have not been studied. And the reason why it happened, this is very interesting, it has to do with the history of medicine. Because many years ago, back in the 50s, there was a drug that was given to women for nausea during pregnancy and it turns out that many children were born with many deformities and, as a result of that, a law came out from the FDA that studies should not be done on women of reproductive age. The thing is that no one cared about whether the woman wanted to reproduce or not. Nothing. I mean, if she is a woman, no studies are done. But it wasn't just women. I mean, it's perfect, we don't want to take into account hormonal variability, cycles, nothing, so, not even mice, no dogs, no cats, no microbes, that is, nothing that was female was taken into account. No woman was taken into account to carry out the studies until a few years ago so then, we have had very few years that women have been included in studies. It is not necessarily discrimination against women, but we don't have the knowledge of how many medications impact women, there are no studies.

[Lorett] Wow, how fascinating that is. I didn't know all of that. I had heard about the drug, the FDA, that they saw that children were being born with different defects from that drug and

that's why they didn't let women in the United States take it. But that also has a big effect on medical studies to prevent birth defects of babies, but it also has an effect on the way women were viewed in the eyes of science, from a scientific perspective. And that's not good either, that women didn't count in that.

[Dr. Ceja-Martínez] Yes, I mean, and that was the way the studies were done, how they've been carried out, how many things have been done. And we're not the same. We are not the same from the point of view of microbiota, of hormones, of how we relate, of how lupus can be expressed in a woman or in a man, these are different. And for many diseases, it is very different how it manifests itself and also how it should be treated. And also let's go back to the same thing in the case of diabetes. We know that how diabetes presents is very different in men and women. There are even medications that men have a better response to than women. And this has to do, you see, with microbiota, hormones and biology. There's nowhere to go [there's no choice]. And we have to know this so that we don't go around recommending things to women that don't work on men or the other way around. Now, this not only happens, I mean, it's not discrimination, I was telling you, because it also happens, for example, with osteoporosis. The elderly also fall and break their hips and die from a hip fracture. However, we aren't carrying out campaigns to search for osteoporosis in men here in Mexico. Whereas women are at greater risk of depression, men are most at risk of suicide. And there are no campaigns for depression in men. And many times no one asks men in the consultation room whether he is depressed or not. So a lot of things also have to do with the way we have practiced medicine or the ideas we have from the point of view of gender. Here in Mexico, men die from accidents. Young men die a lot when they are healthy from accidents or acts of violence and it has to do with this idea that men should take risks. They have to be risky. So they take unnecessary risks and many times they die in accidents because they are driving at high speeds, or they're under the influence, etc.

[Lorett] How sad is that. Honestly, that doesn't come as a shock to me. I'm not surprised by that. I believe it and I can see it a lot in Mexican culture, but hopefully that will improve and thank you for educating us about all this, I think it is very necessary for other doctors in Mexico to educate themselves on these social problems and also that our audience in America also learns from this because it is always very important to learn from other countries and the culture that affects medicine. We talked to another doctor from Panama and he was talking about similar things and how culture affects both medicine and the way doctors treat their patients and with good intentions, but you just have to know all the aspects, all levels of a culture and how many things really affect a patient's health.

[Dr. Ceja-Martínez] That's right, that's right. And that's why we also have all these pseudosciences that make it seem that the patient is doing very well because if the patient feels heard, if the patient feels empathy from the person who is seeing them, their response can be very good. And yes, many diseases end up being a manifestation of our emotions and we see that because people who have herpes or who have immunological disorders, when you're in a

situation of anxiety that's when there's a flare-up, right? And our mental health, our emotional health, our social health, has a lot to do with our physical health, doesn't it? That is, with, with how this affects our body and maybe this is what they talk about, emotionally, right? Of eating out of anguish, of eating out of anxiety and it's very real, isn't it? So, yes, it's very important. And in the United States there's a lot of, not only Mexicans, but Latin Americans in many parts of the United States. And I think that the, it's important for doctors to understand a little bit more about the culture of the patients they are seeing.

[Lorett] Yes, yes, that's very true, and I completely agree with you. I think that's all the time we have for today. I want to thank you very much, Dr. Irma. You have shared so much information and all your knowledge has helped me to have a better perspective of Mexico and the medical system and especially the problem of obesity. Thank you, it's been a privilege to be with you and thank you so much for being a guest on this episode.

[Dr. Ceja-Martínez] Thank you very much as well, really, thank you very much to all the team that I know is also supporting you and I think that you are doing something that is very valuable by being able to share these types of topics that can be of great interest to all doctors in training and all doctors as we continue to learn, no?

[Lorett] Of course, you always have to learn. That's why there is CME, Continuing Medical Education, for the doctors and our listeners. We thank you for joining us. We invite you to continue learning about the challenges of healthcare in Mexico and support initiatives that improve the health and well-being of everyone in the country.