How Hormones healed my patients and my practice with Dr. Clint Carter Transcript

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Show Intro and Guest Background

Coming back to life is literally what it felt like. It saved my marriage, saved my career. It saved my, you know, sort of quality of life. It was, it was night and day.

And, and the fact that I knew I was low T for a year or two before I let my doc do anything about it was just because I was a stubborn ER guy. And then finally I hit the bottom of depression and all the things where my wife was like, get it fixed or else.

And she's not an or else kind of girl, but you know, people can only take so much. Do you feel like your hormones have turned against you? Trust us, you're not alone.

We're Dr. Serena and Dr. Heidi, and on Hormone Heroines, we explore all the root causes that are behind hormone imbalances, and we teach you how to thrive through them.

Join us for real talk, expert tips, and even a few laughs. Hi and welcome to Hormone Heroines. I'm here today with Dr. Clint Carter. Dr. Clint Carter is a board-certified physician with a passion for patient-driven holistic care.

After graduating from medical school in 2004, he pursued a career in medicine with the goal of serving his community in a meaningful way. However, during his training, he quickly realized that the traditional healthcare system often restricted doctors from providing the kind of care their patients truly needed.

Determined to make a difference, Dr. Carter entered emergency medicine after completing his residency in 2007. For a decade, he worked in ERs across Texas, helping patients in their most critical moments.

However, the lack of continuity and deep patient relationships left him disillusioned with the system leading him to consider leaving medicine altogether.

But God and his wife Stephanie had other plans. Through a series of doors that only God could open, Dr. Carter was inspired to return to medicine in a new way.

Joining with his mentor, Dr. Jeremy Smith, he founded MyMD Select, a direct primary care practice in his hometown. Together, they built a model that prioritizes holistic, timely, and patient-centered care, allowing doctors and health care providers to practice medicine the way it was meant to be, focused on relationships, not red tape.

Today, Dr. Carter is on a mission to grow and expand this model so that more doctors, nurses, staff, and most importantly, patients can experience a healthcare system that truly works.

His podcast serves as a platform to discuss medicine, business, faith, and personal growth, all while challenging the status quo of modern healthcare.

So, welcome. What an intro. I think maybe that podcast over. I mean, that's a great story right there. It is a great story, which actually leads me to my first question for you today.

Yeah. Since we're going to focus on how hormones changed your practice and your life, but I want to start with starting in the ER and now you're on a direct primary care practice.

What role did hormones play in that transition from burnout to renewal? Ah, love it. Well, first, thanks for having me on. It's very nice to meet you.

I love what y'all are doing. Yeah, my journey, you know, getting out and interviewing for jobs and regular practices.

The doctors were miserable. The front staff when you walked in were miserable.

The people in the waiting room were miserable. You know, I was just like, okay, I'm not doing this. I'll go do an ER stuff. An ER was fun. you know, off on a random Tuesday, all that stuff.

It was fun until it wasn't. And then, um, I started to burn out, you know, six, seven, eight years into it. And, and my, my buddy, uh, Dr. Smith was kind of my mentor in, in, in, in residency.

And, and I started, I started going to him and I said, Hey, thinking about getting out of this thing. Uh, my wife talked me into not quitting medicine, but as it turns out.

Uh, he did some labs in my, I was low testosterone Hashimoto's, um, depressed as heck, which I didn't really need help knowing that Stephanie had already diagnosed me with that.

And so it was quite eye-opening initially to just allow my doctor to take care of me and start replacing some hormones. to start addressing Hashimoto's and start pulling me out of depression.

Quite frankly, I was in a point where after the hormones only bit, I still was, I said, I'm less pathetic, but I'm still pretty depressed. Let's do some antidepressants for a minute.

And so over the years on and off, I've been on some antidepressants as well. But when my hormones were doing well, miraculously, I'm a different human.

And when my hormones start to slip, my wife and or my staff let me know about it. And they're always right. It's pretty funny. Yeah. Do you want to elaborate a little bit more on like how you experience low testosterone and how that affects you outside of just the mood?

I mean, I've found that, you know, so one of the ways that we replace testosterone in our practice in our, you know, well, in men and women is. with bioidentical hormone pelleting.

And the only real tricky part there is the timing. It's blood flow dependent, which means it's supernatural, it's bioidentical, it's great.

Hormones, Burnout, and the Move to Direct Primary Care

But if you're working out a lot or if you're a high stress person or if you're pumping that heart more, you burn through your hormones a little bit faster, which is great because that's how the body likes to do it.

But if you mistime it, then before your next pellet, you're out from your other one. And when I hit those dips, I tell my patients like, we're looking for the symptom that will let us, that's your canary in the coal mine.

That'll let us know when you're starting to run out. And for me, it's, you know, depression, bandwidth, right? Just, just got less bandwidth for stuff.

You know, I'm a dad, I'm a husband, we run a practice, we've got a bunch of patients. It's like, bandwidth is super important. And when other people start thinking that I'm more of a jerk than normal, then that's a good sign that I'm missing it.

But mostly for me, it's mood, energy, and just my get up and go. I have a lot of patients where, you know, They, they, as soon as their tea runs out, they can't sleep or they start sweating at night or, you know, they're, they're just, they can't think brain fog, all the concentration, all those things.

Me, it's mostly mood, which, you know, which is, I guess in a way it's kind of good because other people can tell me like, yep, you need to check your testosterone.

It's nice you got that community that tells you, but you feel the stress more and then the stress starts wearing on you. Yes, exactly. Okay. Well, let's talk a little bit about your first patient experience that made you realize BHRT could be such a game changer outside of just your health.

To me, hormones are so important, individual by individual, but it also represented a door to a world that I didn't know existed. Okay. So I was family medicine trained, ER for, you know, better part of 10 years.

And, you know, people weren't really special. People weren't really individual. And, and, and, and when I got into my primary, this direct primary care, uh, membership based practice, I was, you know, I get to spend an hour with my patients and we get to get way past how you're doing fine.

You know, we do a lot more mental health than I thought I would be doing. But one of the things that I realized is like, I was spending hour at a time as often as we needed with these 45 year old females that were unbelievable.

Like they're working out four days a week. They look great. And yet they come in and their labs look good. And they come in going, there is something terribly wrong with me.

I can't think. I can't go. I can't sleep. I don't, you know, I feel terrible. There's something wrong with me. And I just got to the point, I was like, wait a minute, like what is it we're missing?

Because I'm using all of my residency trained tricks and they're not getting better. So Jeremy, Dr. Smith was like, well, when are you going to get into hormones?

And I was like, when I'm not a weirdo for being a concierge doctor in Tyler, Texas, you know? But eventually I was like, okay. listen, I can't fix these ladies and it's gotta be, it's gotta be that.

So I, I went to hormone training thinking that I was, I was like, all right, this is the hormone cult, right? So I'm gonna, I'll go with my guard up and I'll see if I can pick up.

And then when I got there, it was like, of course this is right. This is exactly everything I already know, but a whole bunch more. And then I started getting a little upset.

I was like, okay, how come I wasn't taught any of this stuff? Like it makes perfect sense. It was just filling in the holes in my knowledge base. Like just plug, oh, that makes sense.

That makes sense. That makes sense. You know, thyroid, what about T3 and T4? I thought it was just a TSH Synthroid game, right? Like there was so much.

And it was like, so after I got past the initial disappointment and, and. anger, if you will, that this had been hidden from me. It was like, oh my gosh, what else is there?

This is amazing. So I, first I started, I came home like in training, I just had it on the front of my, my training booklet or whatever. It was just name after name after name after name of all these people.

They're like, and some people feel like this, this and this. I was like, oh, there's the, it was, I came home ready to roll. Uh, my wife is a physician assistant.

She did it with me. And so we were like, it just. Let's go. So we were doing pellets and creams and whatever the patients, you know, made the most sense and people started coming to life.

Round two of pellets on a 45 year old female that's been just struggling for the last 10 years plus was unbelievable. Menopausal females doubly came back to life.

And so then I realized, oh my gosh, there's so much I wasn't taught. And then I was like, oh, what about peptides? Well, what about this functional stuff?

Like it just, it opened a door to a room of doors that were more things that I could take care of people with that I didn't even know existed. Or if I thought they existed, like hormones, bioidentical hormones, then it was a punchline in my residency training.

Right? So it was quite, quite revolutionary in more ways than one, because I could finally take care of these patients that needed it, but it opened a door to a whole new world.

Honestly, I have to say I felt the same a lot throughout training because it's like even coming from a different background as a naturopathic doctor, we cover hormones probably a little bit more, but there's still so many gaps that I feel like experiences with real people filled in on top of my own experiences of dealing with hormonal issues.

I've had a lot of the similar like, oh, I'm almost like, oh my gosh, I can't believe this wasn't taught to like actually improve this person's quality of life, not just meet the labs and get the labs to look good.

Right. No, we can fix labs. I can fix labs. And, and we were taught almost nothing about lifestyle modification either. I think in the sort of the classic family medicine and classic medicine training, it's basically, yeah, people should do lifestyle modification, but let's be honest, they're not going to.

So let's just throw all these medicines at them. And it's like, well, if you had a little time to sit down with them and figure out what's important to them and where they're, what works in their life, then maybe they could.

But that's that, you know, the assumption is you're going to get out, work in a clinic where you have eight and a half minutes with every patient. And this is what works.

Being a drug dealer works if you have to. It doesn't work. But in the training and the system that we're in, you don't have time to do anything else. And so getting out of the system.

And so I say direct primary care, it doesn't make me smarter. But it's not a fair fight, right? I've got 60 minutes and the competition, if you will, in town has eight, 10, maybe 15, if they don't mind being behind all day long in their clinic.

And, um, and there's some amazing doctors doing amazing work, 15 minutes at a time. I don't know how they do it. I couldn't do it anymore. Yeah, it's definitely a system worth changing, I think.

What I love about what you're doing and what we're doing is it's a disruptive industry. If every If every provider in America suddenly became a direct primary care provider, we would have a 10 to 1 doctor shortage.

I mean, I can see 300 to 500 people in my census well, and then, you know, your average doc has 3,000 in their census. So it would be, the provider shortage would be crazy.

However, I love that we get to do it and I love that some of the patients out there get to experience it, but either way we're proving that there is a better way.

And then I can't imagine what it's going to look like when the system, but the system is trying. The EMRs I'll have for these big hospitals now, I'll have communication ways that you can kind of get a hold of your doctor eventually or.

or someone from their office or some communication back and forth. The transparency piece is a long ways off.

Discovering BHRT and Patient Transformations

The service is a long ways off, but ultimately medicine is a service industry. You're going to go out of business if you can't take care of people and keep them happy.

Hopefully we're pushing the system in the right direction. Yeah, I'm hoping one day the system will really change. I

think the more and more of us that do these types of practices, the sooner we might see a large scale change and actually get people the care they need.

The issue, like you mentioned, is the doctor shortage that we're going to face. But hopefully when the whole system changes, we can get more access to getting doctors trained, getting more doctors and other tools to support us.

All right. Well, let's kind of circle back around to bioidentical hormone placement therapy. So coming back to your patients, what kind of symptoms or struggles do you most often see improving with your patients?

Like we've talked about some mood and just coming back to life. What's coming back to life for you with them? Man, you know, so we're seeing low T in men, you know, in their thirties pretty regularly now.

I don't know if it's diet related. I don't know, you know, that's a little, that one's a little bit strict. It could be stressed, could be a lot of things.

But, uh, so we're seeing that more and more, but women specifically, like they were designed by their creator to sort of be done having babies by, you know, age 40 or so.

So the testosterone sort of falls off naturally. And then let's say menopause around age 50, but life expectancy used to be 60. So, you know, you were quote unquote old for a little while, but now modern medicine has increased lifespan to almost a hundred, but our health span is still 60, 70. And then after that, you know, people are just kind of like miserable waiting for God to take them.

And that needs to change. The first things that I see in what happens classically in my female patients is things start getting harder in their late thirties.

early forties, it's harder to focus, concentrate, you start, you know, forgetting things, multitasking becomes, you know, something altogether new and your kids are older and your, your challenges are new and maybe you're working and you're, you know, there's a lot going on managing a household and all the things that go into it, you know.

women do an amazing job, and then it gradually gets harder through the 40s when it doesn't have to. And so that means different things to different people.

I see a lot of menstrual irregularity, even though technically, you know, they're in that perimenopause phase, right? Their moodiness, anxiety, depression, you know, brain fog, concentration, energy, the body's not responding like it used to, and you know, we're 40, not 20. At some point, patients come to me and go, there is something terribly wrong with me.

My other doctor says that I'm fine. My labs look fine. I'm just tired because I'm a mom. I'm like, well, yeah, but there's a lot more to it than that.

Typically, you find the patient whose biggest problem is sleep and brain fog, and that's what you see. You see them come back to life. They can sleep.

They can think. Their energy improves, you know, you've got your patient who's, you know, motivation and you know, their, their, their body's not responding like they want to, uh, you know, you name it.

It's fun. On one hand, it sounds like snake oil. It's like, oh yeah, it fixes that. Yeah, it fixes that. And so it doesn't do everything for every patient, but you find, I find that those patients that come to me with those, with anyone in that realm of complaints, you know, libido, you know, orgasm, some of that other stuff too.

But you know, that's, if you listen to the radio or watch TV, everybody thinks testosterone is sex and muscles, right? And it's like. No, it's quality of life, it's inflammation, it's cancer prevention, it's all those things for both men and women, but then you get the female going through menopause.

What's the hardest part about that is waiting. We pulled the trigger a little early on someone whose last period was six months ago and then they get the breakthrough bleeding and you're like, ah.

I was impatient. I just want to help you so badly. And, but that's where there's so many other tools in a toolkit besides estrogen. And, and you know, you can, you know, lifestyle modification and, and all that, you know, the supplements and the things that can go into that.

But the, the, the tool that I'm the best at with my level of training is that when they're clearly into the menopause, getting the bioidentical estrogen, estradiol and progesterone in play makes all the difference in the world.

They can, they can think they can. Their mood stabilizes, their, you know, post menopause, not having a period every month and having some hormone balance.

It's not the end of the world, quite frankly. Yeah. Well, I wanted to ask you more about, like, I do a lot of bio-dental hormone replacement therapy starting in perimenopause.

Is it kind of more of your practice to really wait until they're like thoroughly into menopause to start doing it? We just, I guess my way to, you know, if I were to make a generalization, I would say, yeah, like as far as giving estrogen perimenopause, it gets tricky.

And, you know, because the natural production of estrogen is sort of sputtering. It's, it's, it's got these spikes and, and I don't, what I don't have in my area is a hormone friendly gynecologist that can help me with some of the complications that come with, and we get, you know, going to be doing hormone, eventually you're going to get some breakthrough bleeding in a very postmenopausal female.

Okay. It's like, okay, well, first of all, let's make sure that, you know, let's get an endometrial ultrasound and maybe a biopsy. I'm going to do all that.

And there are, there's some gynecologists around that are not aggressively against us, but for the most part, they come to, they come back to me saying, Hey, they said that you're crazy and that this is that you're trying to kill me and you know it's like woof so for us we have what we will if the if the symptoms are you know it's shared decision making if the symptoms are significant enough and we feel like we can make a good enough difference in their lives yeah a little a little estradiol You know, as low dose is what makes sense.

A lot of progesterone. Progesterone is great. Estradiol is tricky. Progesterone, let's go. Let's get some sleep. Let's even out some of those spikes. Let's maybe make you less estrogen dominant if that's what's going on.

Some of that stuff, progesterone is great. The pelleting, you know, it's theirs for three months, whether they're getting side effects or not. Maybe we use a lot more creams in the perimenopause phase.

Yeah, same, when we're doing perimenopause, it's a lot of progesterone. It's definitely in agreements there. A lot of progesterone is where I always start, but we'll use a lot of transdermal patches.

So if it's not working, you're not stuck with it for three months during that phase. Yeah, amen to that. Yeah, makes it a little bit easier to adjust with the natural ebb and flow of the ovaries deciding when they're gonna.

Officially kick the can. So when you're doing progesterone, are you mimicking the cycle? Are you doing, you know, are you phasing this thing? Are you going every night?

How are you doing that? So I usually, if they're still cycling regularly, I will start with timing it with the cycle. But what I find often is that women feel so good on it that I'm just like, give it to the whole cycle.

Cause they're like, I feel so much better during those last 14 days. Like. And I'm like, okay, well then let's just make you feel good the rest of the time because it's not going to hurt anything.

Your cycles may become a little bit more irregular, but most of them are not upset about that as long as they're sleeping and feeling better. I like that.

Yeah. I'm not as good at timing the cycles as I should be. We do a lot of every night for just around. Right. But, uh, good. I like that. That's great.

Thanks for that. Yeah. Um, I also really was curious because you mentioned with men, like testosterone, seeing a lot more low testosterone early on in their thirties.

And I feel like, you know, my, my practice is a lot of women, but I still do see men and that's kind of an area where I am not as experienced in and lack.

And so I'm really curious about your take on like how to help men, especially in their thirties. Like, why are we seeing it? What can we do about it? And how are you treating it?

Why we're seeing it is the million dollar question. It's probably the crud in our food and you know, just the, the, the toxin rich environment that we're living in.

I like to explain it to my guys too. It's like, you know, we're so available to our phones and our bosses and our, and our, and our, the whole world is able to get at us all the time.

And so I just feel like we're in this adrenal dominant state. This, we live sort of, you know, like we're running from a all day every day and our body doesn't know the difference and our body's thinking well surely This is a terrible time to procreate.

If we stop, we'll get eaten by a bear. So let's move our resources away from procreation over to the adrenal glands just to get away from the bear. And then we'll settle back in the woods in the valley and have a baby.

And it's like, yeah, we're not getting away from the bear. And there's multiple bears. And eventually your testosterone just suffers along with your sperm count.

So God forbid you're in mid thirties, low T and trying to have more children. For me, I find that in these folks, it's possible to pump up the system a little bit if we treat the adrenal overstimulation.

Uh, you know, address the stress itself, um, maybe clean up the diet. And then on like the medication side, it's, if, if, especially if fertility is important to them.

I've actually had some kind of crazy good responses to Clomid on some of these guys that are trying to be, or they're not ready for more aggressive testosterone replacement.

And I'm like, well, let's try it. And, and, you know, some people have had some side effects they didn't like that I didn't see coming, but, but for the most part, you know, a couple of times a week, you know, I have to have it.

It's been, I've gotten patients go from like 400 on their testosterone to a thousand. I was like, that's incredible.

Treating Perimenopause and Menopause

Maybe I should be doing this more. Uh, you know, getting. The, taking a look, you know, like, like you would normally do, I'm sure. Coming more on the natural side of things as a, as a, you know, a family medicine trained drug dealer, I would tend towards, you know, my, my instinct is just give them a pill.

But, you know, once you've sort of cleaned up the diet, the exercise, get some sun, let's deal with some stress. Let's, let's see what I, I've had some people that have been going through a really stressful time, like an acutely stressful time more than normal.

And then when they come out of that, their testosterone doubles, like from 300 to 600. Nice. No, there's something to this. But for most folks, once we kind of get past that and they're no longer interested in fertility, that's when kind of I start talking about just, just frank hormone replacement, whether creams, patches, shots, which are not bioidentical, but some of the guys that's about as aggressive as they're willing to get.

And then ultimately I find that pellets being sort of bioidentical and blood flow dependent and you kind of get it when you, when you need it and you, you get less of it when you don't.

It really fits naturally with, with the way that our bodies are made. And I get better results with that, but it's being a low T in my mid thirties guy.

We have those discussions all the time. And, and like coming back to life is literally what it felt like. It saved my marriage, saved my career. It saved my, my, you know, sort of quality of life.

It was, it was night and day. And the fact that I knew I was low T for a year or two before I let my doc do anything about it was just because I was a stubborn ear guy.

Right. And then finally I hit the bottom of depression and all the things where my wife was like, get it fixed or else. And she's not an or else kind of girl, but you know, people can only take so much and I wasn't the only one suffering.

So it was pretty, it was pretty awesome. So, I mean, I think that's amazing for you, but also just kind of going back to like treatment around it. So if they're really focused on fertility, you don't jump to biogenical hormone replacement therapy or just hormone replacement therapy in general at that phase.

Right. Like once you start replacing testosterone in a guy, you turn the feedback loop turns off the testosterone factory, which happens to also be the sperm factory.

And so on testosterone replacement, I have to, I give this speech, I'm like, hey, on testosterone, you're not going to get, your chances of getting pregnant are very, are almost zero.

And I followed it up immediately with this is not birth control. You can't, you can't count on that. You know, the soon as you don't, as soon as you try not, as soon as you stop worrying about it, you will get, someone will get pregnant.

So, um, but however, that being said, when you turn that factory, mostly off. That's where the testicular shrinkage comes from. It's like, okay, there's a little shrinkage there, you know, 10, 20%. I'm not an underwear model.

I think I'll get past that. And then, you know, I was way past, you know, fertility at that point, as far as like wanting to have kiddos. And so For me, you know, the next step was a vasectomy anyway.

So getting on, getting on hormone replacement made perfect sense. There's some guys that are like, no, we're thinking about having that one more or two more, or, you know, I'm not ready to, to, to take that leap.

And then I've, I've kind of had really good results with, you know, I had some people that were trying to do like HCG therapy to on testosterone to maintain some of the sperm production and, and, and the body's own testosterone production.

I have not found that to be. Wildly successful, but just not getting on T and getting on Clomid. I've been kind of surprised at how well that's worked on a few of my patients.

Do you ever use a DHEA at all? Like supplementing with them? I don't. And that is probably a weakness on my part because I have definitely have patients that I share with other sort of natural type docs that we sort of, we run different lanes and we work together and the DHEA is great as a precursor hormone.

So, I mean, if I put someone on. If I've got that person, I'm trying to preserve their own fertility and their own

testosterone process. DHEA makes perfect sense.

And now that you say it out loud, I do not know why I'm not doing that on my Clomid patients. So yeah, helping the body heal itself when you're doing those lifestyle modifications and, you know, I've got somebody I'm pregnant alone and DHEA and some of these others sort of in that process of trying to be well-balanced hormonally tends to work great.

So last question on that topic, and we're kind of focused on this a little bit more. Once you're past the trying to preserve fertility at all, you really prefer pellets as far as the type of testosterone placement therapy?

I prefer bioidentical. So I think that that puts me in a. You know, so really creams you can get, you probably get a patch. I don't know. I don't really do patches as much commercially produced stuff, but I've got really good compounding pharmacies in this area.

And so we can do, we can get real. specific on creams and even trokies. Trokies more for women, I think, on the dosing. But we can do creams and pallets, bioidentical, and then shots are obviously not bioidentical because it needs to last a week and your liver would eat it up in a day if you didn't have that sippinate group stuck to it.

So I just, I find that this is where shared decision-making and patient preferences come in. I tell my patients all the time, like in our practice, you're the pilot, I'm the co-pilot.

I'm just here to tell you where the landmines are, where to think, you know, what I see. But it's, it's your life. If I prescribe something you don't want, guess what?

You're not going to take it. Why would I, you know, let's not do that. Let's talk about what fits well into your life, into your philosophical worldview.

And then. Let's go from there. So I've got a lot of people that are like, yeah, I'm not ready for pellets. I do have a hefty percentage of my guys that start with shots or even start with creams.

The thing I don't like about creams is that you get a bump in the morning and then your liver eats it up. And then you get a bump at night if you're doing it twice a day and then your liver eats it up.

And your body has to average that out. And it does a pretty good job. It's not like you feel good, you feel bad, you feel good, you feel bad. You know, from a subjective standpoint, your body does a pretty good job of averaging.

And to that point, pellets are, you know, you peak every week and you trough every week. And so the body does a pretty good job of averaging that out.

But the, the creams, it's. almost purely subjective dosing. And I don't like that. As the control freak doctor, I like to know that I can say, hey, your testosterone is awesome.

So if you're still tired or if you're still, if you've got a, you've got, there's lots of reasons for tired, right? There's lots of reasons for motivational issues.

There's lots of reasons for depression. There's lots of, you know, there's lots of, you know, testosterone on one hand sounds like snake oil because it, it can potentially fix a lot of things, but it's not the only fix for a lot of those same things.

So. Be able to say, no, you don't need more tea. You know, let's, let's move on to something else. That's fun because on shots and on pellets, I can, I can measure that and tell you exactly where you are.

And on the creams is kind of like, how do you feel? I don't know. You want more? Okay, let's go up. You having side effects? Okay, let's go down. And then, you know, a lot of those guys, when we do kind of get finally proof to them and their family that it is what they need and it is showing positive effects.

They're like, okay, I'm tired of this cream thing. Let's, let's move on. Let's, let's up the ante. So for me, the control freak, I love pellets on everybody.

I feel like it's super natural, super space, natural. But you know, really it's the patient's call. Okay. Well, I tend to personally that too. I always have the same kind of conversation with my patients where I'm like, I'm just giving you the information.

You get to decide. Yep. Go figure, huh? It's a pretty crazy thought process. Yeah. All right. Well, kind of circling back to what we were originally talking about, you know, you said hormones healed not only your patients, but also your practice.

What do you mean like that hormones healed your practice?

Low Testosterone in Men and Fertility Considerations

It's amazing. So, you know, it started out me and Stephanie and like a nurse, and we were never really planning on getting much bigger than that. Because in the direct permanent care world, it's not about big, it's about You don't, you just take care really, you go really deep with your patients.

You limit your, your patients, the numbers of patients in your practice, and then you ultimately sell into the sunset, right? You can maybe weed out the people you don't like, let in a few more that you do, make your waiting list, raise your prices till it makes sense and sell into the sunset.

But we've been called sort of, you know, one step at a time, it became clear that we're called to spread the gospel of direct primary care, if you will.

What would happen is we would have a, in this case, I had an interspec-tioner that I had worked with that was like, hey, when, when can I join your practice?

When can I work for you? I was like, well, I don't know. I don't have enough patients to pay you. I'm barely paying myself right now. And so she went and got another job and was just kind of like, wait, just check in and check in.

And then I would, I'd use her very part-time and she's like, yep, no, this is the greatest thing since sliced bread. Let's go. When can I? And so we, we now have, you know, I probably, I have five, you know, not counting Steph and I, I have five providers.

spread out across three locations with almost 25 employees. But coming back to the hormone piece is first thing I did with that nurse practitioner was get her hormone trained and she was drinking the Kool-Aid right away.

And then once people see that this is what changes lives or it's the thing that it's one of the first things, the lowest hanging fruit that the system doesn't do.

And, um, doesn't do well. And so one patient, they're having lunch with their, our whole marketing budget was zero dollars. It was happy patients and they go out, they have lunch with their friends and their friends like.

I kind of go to the doctor in a minute and they're like, oh really? And they're like, yeah, my doctor's great. No wait, no waiting room, hour long visit.

I'll text him a question right now. Let's see how long it takes to get back, that kind of thing. And next thing you know, I've got another patient or someone says, oh my gosh, you look great.

What's going on? Like, oh, I placed my hormones. I had no idea. It was, you know, And so it became sort of this practice, I don't know, it healed our practice in two ways.

Number one, we got a bunch of new patients because it's truth is what people, it's what they need both now and

long-term. It decreases inflammation. It's part of longevity for everybody.

And then secondly, it fixed our practice because we went from residency trained and time. to residency trained, which has got a lot of good stuff in it, time, and outside the box.

It just opened up the world of non-residency, outside the box treatment options that work amazingly well for, you know, depending on what you need, you know, functional options.

You know, functional medicine was probably also a punchline. presidency, to be honest with you. So to find out how much research and data is out there to support all this other stuff, come to find out the only reason I wasn't trained in it is because insurance doesn't pay for it.

So there's a limited amount of time in residency. There's a limited amount of things you can learn in a limited amount of time. So they focus on the part that you're probably going to, you know, on the part they were trained on because that's all they were trained on, you know?

And so it's an insurance. controlled world, he who pays the bills makes the decisions. And so to get outside of the insurance world and all of a sudden the patient's paying the bills and the patient's making the decisions and to have options to give them that hormone door that opened, it changed our practice in so many ways.

We love peptides and IV therapies and, you know, it's, you know, functional. It's so great. So on that note, on the other therapies, you talk about like peptides and IV therapies, like are there some of your favorite like peptides out there you want to talk about or your favorite like IVs that are for beneficial or are there other treatments that you're really passionate about outside of the hormone replacement therapy?

You know, I think I love all of it, so I don't want to get too You know, I don't want to spend the next four hours going over all of it. I do like the cutting edge nature of peptides in general.

It helps that like Joe Rogan's into peptides. So now like it's cool all of a sudden, but it, it does hurt that the previous administration, especially under some pressure from big pharma went and took all of my favorite peptides away.

About, you know, two years ago, that was a bit of a hit, but they're coming back. A lot of them are still available. But, you know, the, some of the classics are the growth hormones, secretagogues, somorlin, hypermoralin, tessamoralin.

Tessa is a little hard to get, but the hypermoralin, somoralin world where, you know, someone, they got stressed, they eat right before bed. They don't sleep great.

Their growth, their naturally produced growth hormone is at a minimum. I tell my patients, I'm like, let's assume that your body's happy with a growth hormone between zero and 10. Living like most of us live, you probably have a growth hormone of two.

I mean, it's within the normal range, but it's terrible and you feel it. You're not healing well, you can sick easy, you stay sore if you do any exercise, you're just inflammatory, you're just aging.

And then so you do, what I like about Samoralin is you have to stop eating 90 minutes before bed because that's, your body secretes growth hormone after you've not eaten for at least 90 minutes and you're sleeping, like for real sleeping.

And so a lot of people never do either. They eat right before bed and then they never get good sleep. And so their growth hormone is terrible. And so in this case, it makes you stop eating.

And then you have to, you take an injection, a small sub cue injection under the skin. five nights a week, and then your body overnight, it just tells your body, hey, why don't you make your growth hormone level more of an eight than a two?

It helps with that process. And then once you've gone through a vial, you know, a couple hundred bucks, a vial lasts you a few months, your growth hormones better, you feel better.

And you just let it ride for a while and eventually, um, life and stress in the world will start taking a hit at it and you might do it again. But in the meantime, it might be, it might be a great time to take that budget you were spending on Samorin and maybe use, um, do, you know, BPC one five seven for gut health and other inflammation or.

you know, thymus and alpha for, you know, the thymus, you know, what I love, it's such an obvious, easy example for my patients. And I'm like, you know, you know how like, Kids that are 10 and under get sick or injured and they bounce back like that.

And then once you get these middle school, high school kids and adults, when they get sick, it's like the end of the world and it takes forever to get back.

And injuries take forever. Yeah, it's the thymus. Thymus is an immune gland that goes away just before puberty. And so why don't we just get some of that back?

And they're like, so I want some of that right now. I want some of that. And like, okay, I'm not, I'm not selling you the energy and the vitality of, of, of you, but I am, you know, it has been great.

One thing that, you know, we were using it. And during the COVID time to help with immunity, we were not selling it as a cure all for COVID, but government lost their mind that people would, how dare they use thymus and alpha during, so they went away for a minute, but it's been back and it's great.

And I've got patients that do it all the time, but cold and flu season is great. We use it as part of our, you know, We do immune boost IVs and we do immune injections and with glutathione and vitamin C and sort of a Myers cocktail approach, we can do, we have a thing called a triple threat where you come into the office and you get your sort of your vitamin C, glutathione, you get your B vitamins and you get a thymus and alpha, you know, one time dose.

And it really helps because these people are like acutely ill right now. You're sick. They've got a virus of some kind, I'm sure. And it really does help bring people back to life.

Plus the immune IVs with, with all the extra volume and vitamins. And then you chase that with a little glutathione and then you give them a thymus and alpha L on the way out the door.

It's, it's night and day. Cause ultimately people are sick and they want help. And you're like, I can't fix that virus you've got. Now we've got viracid, that orthomolecular.

We've got some of these other supplements that are antiviral, but To be able to hit them hard like that and make a big difference right away. So fun as a provider.

I mean, we just want to be help. And that's why so many docs prescribe a Z-Pak every time you get sick or the old docs used to do the penicillin shot thing.

Right. It's because we just want to be helpful. And you really, and you're paying me every month and you don't have time to be sick and all those exceeds like, let's just come in and get your triple threat.

You're going to be okay. You know, it's, it's so great. I think that's great. When I first got out of school, I was like working, running an IV clinic for another ND doctor.

So we had a lot of those where they'd come in for their, well, I'm feeling down, feeling sick, get their IV, get the glutathione.

Pellets, Creams, and Shared Decision-Making

We've got a few cancer patients that are, that are, we're like, listen, I don't have the protocols. I don't take responsibility for the protocols, but if you have a vitamin C protocol.

that you want to do and you can afford the vitamin C cause it's a lot. And, you know, you're going to get it basically at our cost with, you know, but, but it adds up.

But if you want to go, let's go, let's, let's, you know, we can do a high dose vitamin C protocol. And then I've got a bunch of patients that are, they're like, Hey, I don't want to sound like the weirdo, but, um, you know, I was.

at chemo for my cancer and the person next to me asked if I was doing ivermectin and I'm like, what do you want? Let's go. Not going to hurt you. Uh, plenty of data saying it's not the end of the world and it might help, you know, and they're like 1 million milligrams.

Okay. Well, let me back off on that just a minute, but, uh, yeah, let's, let's get you there. So, you know, it's, it's really, um, It's really fun to be able to offer stuff that first do no harm and then secondly, let's see if we can add some outside the box stuff to what you're doing already.

Absolutely. So, you know, we've been talking about how much of a quality of life it's made a difference in these patients' lives. How do you feel like being able to offer these treatments has changed the depth and the quality of your doctor-patient relationship?

First, just being able to, just a direct primary care piece added, I mean, that almost infinite value immediately. Cause we could just sit and get to know each other and you know, we'll sit for an hour and it's not nearly enough time anymore.

Cause we know each other so well and I've gotten into their, I know their lives and they call and they're like, oh, I'm sick. I'm like, no, no, no, no, no.

You've got a trip coming up next week. You can't be sick. Let's, let's, let's, let's talk about this. Um, uh, and then to be able to take that person that I've been sitting with, not making that, being able to figure out what's wrong with them and add that piece, like those, those, those, those 45 year old women that I was talking about earlier and, and, you know, that, that, that perimenopause crew is low T and miserable and to be able to add that on.

Um, it, the quality of the, um, you know, our relationship was probably good, but to be the satisfaction that comes with them feeling good and me being able to help them.

It's, you know, on one hand, it was almost, it was frustrating. It was almost a negative that I was spending so much time with them and not able to help them.

Right. Like, well, you're doing everything else. It's not, I can tell you to eat better or exercise more. If you exercise more, I'm going to call the cops.

Like this is something's going on. And to be able to make a difference in their lives is so like satisfying. I mean, one reason I burned out in the ER is I'm not an adrenaline junkie.

I don't need all that. In fact, when an actual emergency came in, I was like, I don't have time for that. I've got all these primary care people, I need the disposition.

So to be able to have that patient relationship, it's where the real fun of being a doctor is. Okay. So then, you know, for other physicians who are curious about EHRT and bringing that into their practice, where do you suggest they start and what mindset shifts do you feel like are most important?

And you could expand on that with like any of the therapies we talked about today too. Right on. So I think, man, so it kind of depends. If you are in a small private practice, then let's go.

Let me, I have an OB gynecologist in town that I just want to pay her some sum of money that will get her to go to hormone training. with all of her vitriol for it intact.

Just take it with you and go into the room and just listen to the literature, the studies, the data. Find the hole in the argument. Tell me where it's wrong.

I'd love to hear it. You know, I'm not, I'm not above reproach. Um, and there's, you know, I just think it would be amazing for some of these folks that work for the hospital system.

Right. In my town, it's a hundred thousand folks. We serve maybe a million people in between Dallas and Shreveport. Arkansas and South Texas and it's like, it's all one hospital system or the other.

Everybody's, you know, there's two big hospital systems and they buy up anything worth having. They can't buy direct primary care clinics as well, but they've tried to sort of like, loop us in and give us an EMR.

And we're like, no, you may go now. Thank you though. So those folks are a little more stuck. You offer, you know, we have really cool compounding pharmacists in town.

So that's where I would have them start. I would have them go get some training, go, go pay your own money. Maybe they'll. Maybe there's a CME budget at your, where you work.

Otherwise, go pay to one of these hormone training things. I let the pellet companies train me and I always lead with like, I know they're making money on this and here's a book and they make money if you do.

So take that into consideration, but there's lots of independent hormone training out there as well. Peptide training as well. And so, but go get trained up and then just decide how you want to handle it.

Like if you work at an insurance based clinic, you can still prescribe bioidentical creams and patches and leave it up to the pharmacy and the insurance company.

How Hormones Expanded the Practice

What's covered, what's not probably not going to be covered. It's Tyler, it's 60 bucks a month for your creams. No matter what's in it, make it put T and E and progesterone.

I don't love the progesterone in the cream. I like. the oral to make sure that they're getting enough if they have a uterus, but whatever, but start somewhere.

And that, like I said, that's the door that opens up the other doors to, to be able to, you can prescribe peptides from an insurance based practice. I mean, they just have to get it mailed to their house, but that's great.

Um, it's possible to do fun medicine. If you listen to podcasts at all about some of these, um, outside the box medicines, even then. non-doctor talk, doctor themed podcast.

If you just listen to Joe Rogan or somebody, Huberman or whatever, and it sounds fun, go figure it out. You're the doc, man. Let's do this. Start, start there.

And then the, the warning, the asterisk there is that once you start going down this rabbit hole, you're going to get less and less satisfaction out of working in the regular clinic, doing the regular thing.

And you're going to want to. You're going to want to do more, be more and, you know, give me a holler. I'll help you, maybe help you start your clinic or find someone else in your area that's doing it that would love a partner and go.

But first things first, you know, first taste is free. Go. Go get that training and enjoy what it feels like to be able to

help in a way you've never been able to help before.

And know that we're not drug dealers. Like we're not, I'm not doing it because it feels good. I'm doing it because it makes them healthier and wellness feels good.

Lower inflammation feels good. Your joints hurt. us brain fog and all the things that come with just being full of junk. It just feels good to get the junk out of the way, supplement what your body needs and then let it heal itself.

You know, that's, we're not, I tell some patients like, I don't know if I haven't felt that much better. I'm like, gosh, that's hard because I know you're healthier for being on it.

You know, you've got other things going on. Maybe you're depressed. Maybe you've got this, maybe you got that. But I'm not going to, I'm not going to tell you to pay the money and do the thing if it doesn't make you feel any, I'm not going to tell you you have to do it.

You're the boss, but why don't we keep doing it while we work on some other things as I know it's making you healthier. Um, uh, cause a lot of people until recently, I would have told you that hormone replacement is a trade.

You're trading feel good now for risk of cancer later. And that's just not true. Your, your risk of cancer goes down. Low T is a prostate risk factor.

You know, estrogen is at least breast neutral progesterone. You know, testosterone is certainly, I mean, certainly you probably breast protective, but you know, The point being is that it's not cancer causing, you know, unopposed estrogen to a uterus.

Sure. But that's, that's, you know, it's cause God made it where there was always progesterone. So that, that's part of the game that any, any good doc would, would never do that to you.

So other than that, you're, you're healthier for having done it. So we're not drug dealers. We're not just trying to make you feel good. So you'll come back and pay me again later.

It's, it's really about. Feel good now, feel good later. I tell these guys like, hey, you're 60, you're doing amazing, but do you want to do what you like to do when you're 70? Well, then let's get going.

Let's, you need to build some muscle mass. Muscle's the, the currency of longevity. You need some, you need a hormone balance and you talk about what you're eating.

What are you doing for exercise? Let's go. It's just more fun than sitting in, prescribing statins and blood pressure medicines all day. Yeah, definitely is.

I love everything that you just said in that last question. I think that's amazing. I agree so much with the aspect of longevity and how protective hormones really can be.

And I don't know if we're talking about it enough, but you know, before we wrap up today, I wanted to ask if you have any last minute thoughts or anything you want to add to today's conversation before we And I, you know, I think I would say kudos to you on the podcast.

Peptides, IV Therapy, and Functional Medicine

Um, and I'm sorry that, you know, I just got to meet you and not your, your other hormone heroin. Love the name by the way. And, um, you know. Kudos to what you're doing with the direct primary care practice and digging in and taking care of people the right way.

Um, I love that this, that you're providing an avenue for people to hear this side of the story and the truth that it's hard to find sometimes. I'd love to come back anytime.

You know, we barely scratched the surface on so much of it, but you know, our attention spans are only so long. Anybody out there that's, that's. You know, looking wants to talk direct primary care, anything in that range.

I'm happy to have those conversations anytime. Just frustrated with where you're at. How can I help you? Ultimately, we are going to expand. We are in the process of sort of opening up new clinics that are my MD select.

in Texas and beyond because it's, we've been called to do it and it's the right thing. And we want more doctors and more nurses and more patients to be able to get to experience medicine this way.

And it's just better. So, you know, if that's where, you know, if you're like me and you come home from every Of course I was an ER guy, so maybe it was a little different, but you know, you come home from every shift and you say, is it a job if it steals your soul every shift?

Like I just can't do it anymore. And like, like your intro suggested, like I was done being a doctor. I mean, I, you know. being a clinic doctor wasn't, didn't sound fun.

And then being an ER doctor had proven not to be fun. And so I guess, I guess I'm not going to be a doctor anymore. So I was going to build tree houses for a living.

The guy on TV that builds tree houses out of Oregon and Washington, he's, he looks like he's having a blast. So I was going to do that. It was going to be fun and, and God had a different plan and luckily Stephanie and God talk a lot.

So we, uh, we ended up here and we've been called to, you know, spread the gospel, if you will. And part of it is being able to take care of people the right way.

Advice for Physicians and Closing Thoughts

And part of that is time and the business model of direct primary care. And part of it is just getting insurance out of the equation. It's the doctor and the patient and nothing in the way.

And then we can add what we want. And if that includes outside the box treatments such as bioidentical hormone replacement or peptides or, you know, functional medicine or IV therapies or all those things, then all the better.

So good job. Thanks for having me on. This has been a blast. Yeah, thank you for joining us today. It's been a pleasure. Thank you so much for joining us.

Yeah, let's do it. Yeah, absolutely. I'll have you on my show as well and we'll spread the gospel, as it were. It's great. Thanks for having me on. This has been great.

Thanks. Bye. Bye-bye. Thanks for watching Hormone Heroines. If this episode spoke to you, follow the show and share it with someone who also needs to hear it.

And write a review. That helps more people find their way back to balance. See you next week.