## Introduction to the Podcast and Guest

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And it's a little bit hard on your doctor and providers that are trapped in a system that makes them see patients every 10 minutes. It's not their fault unless they're as burned out as I was. ah They do care and they want to do more and they're trying and they do an amazing job with the 10 minutes they have. know, it's, there are other options out there that are, you know, this direct primary care thing that I'm doing that, you know, it saved my career along with hormones and some, you know, some, you know, basic functional medicine.

Have you made it past menopause or are you going through it now? I'm Dr. Pat McShane and on the Women's Health Span Voices podcast, I'll guide you through the health challenges of the menopausal years and beyond, guiding the way to thriving in this powerful era of your womanhood. Hello and welcome. Today, it's my great pleasure to introduce Dr. Clint Carter, who has an unusual background. He has a conventional medical… background and then has moved into kind of a novel practice approach and more of a functional medicine approach regarding clinical care as well. So I think I'll let you explain a little bit more about all of those things.

## Direct Primary Care and Practice Model

Dr. Clint. Thank you so much for having me. This is, this is fun. Yeah. I went to medical school and then went to family medicine residency and learned all of, it was a great residency, learned all of the in the box things that that I thought was what all there was. And, some of the functional medicine things that have come about since then have all been, they would have been punchlines during my training. But when I got out of residency, part of my interview process was to go look at clinics that where I was supposed to want to work.

those clinics were miserably depressed. Like everyone there, the patients, the doctors, the staff. I was like, I am not doing this for a living. So then I, you know, I was like, I was screwed. I'll go to the ER. I did a lot of ER in my training. So that's really where I cut my teeth. After residency, obviously I did a lot of moonlighting and ER during residency.

And so I did that and it was fun until it wasn't. I'll… Uh, but by my introduction from there is just really now I'm running a direct primary care practice where my patients pay me monthly and I can give them all the time and attention that I need. And, uh, it's been really rewarding.

And you have a number of other, uh, clinical staff working with you, including your wife, who's a nurse practitioner, as I recall, uh, as, a couple other NPs and you have different.

kinds of medical approaches within your same practice under your same roof. So maybe tell us a little bit about that. Yeah. So, you know, we started out, my wife and I, you know, when I first, know, my story, my bit is that, you know, so I was in the ER for 10 years or so.

last few years of that completely burned out and, and disillusioned and decided that I didn't want to do ER anymore. And I'd already decided that I didn't want to be a clinic doc.

So I decided I wasn't going to be a doctor anymore. mean, apparently though, you know, I didn't know that there would be any other options. And so I decided I was going to build tree houses for a living. There's a, you know, the tree house master guy and then Washington and Oregon looked like he was having a blast on TV and I know how to build things. So I was going to start that company and my wife and the Lord sort of intervened and said, well, why don't we try this concierge medicine thing. And so we went to a conference and came back thinking, I think we can do this. And then one thing led to another. And the next thing you know, I was, we were opening in this

practice, she and I, she was in cardiology full time.

I was doing ER full time. So we started a membership based practice with no members and went on working two jobs until this thing could float. But the goal I think was always to just be she and I and a nurse or MA or two. and it's just, we've had. Really, a lot of the growth has been that patients wanted to be a part of it, but I've had other providers that wanted to be a part of it. so whenever the volume allowed, I would hire one of the people that were begging me to hire them and then, and then next and then next. And so we've been, as it turns out, I think we've been called to grow this thing that is direct primary care, that is membership based medicine where… the patient is again, the center of their own healthcare and that, you know, we get insurance out of the way. We don't take insurance at all. That they have insurance, they can use it with, you know, x-rays or specialist or, you know, other things. But for everything that we can handle in the clinic, everything's at our cost.

## Burnout, Menopause, and Hormone Therapy

And so we just, we've got, let's see, a part-time physician and about four or five nurse practitioners, PA. And it's just been a blast. Being a doctor is fun again. Being a patient is rewarding and, you know, people are taking control of their healthcare. It's fun. Tell me a little bit about some of the lifestyle approaches that you have placed on your background on your website about making the best of our health, especially as it regards women who are beyond menopause, let's say age 50 something or 60 and beyond what kinds of things to work with, with that group of women.

Well, it, so I started out just what made me special was time, right? Like I say, I sell time. You get, there's no waiting room. There's no wait. When you come in, we bring you right back. Everybody's blood pressure is just a little bit high because we just brought them in from traffic and they, you know, We just, I'm like, hey, let them take a breath before you take their blood pressure, please. And then, and so what I was finding is that an hour at a time, as often as they wanted, wasn't enough. It wasn't all of my in the box residency training tricks. Something was missing. I was getting these women, they're working out, they're eating right. They look good on the outside and they just feel terrible. Whether it's a.

perimenopause 45 year old or post menopause 55 year old female just I mean the world is run by women 40, you know 60 they make all of the healthcare decisions for their whole family.

They buy the things, the workforce, they're everywhere. And it's just everything was getting harder and harder and harder and they their 40s, you perimenopause became really difficult and then menopause would hit and it was just They come in and be like, my other doctor says that I'm fine and that all my labs look normal and I feel like I'm dying and I can't think and I can't sleep and I don't care and I help me. I don't want to be with my husband anymore.

Yeah. Yeah. No, yeah. have no, yes. No. Thank you. Absolutely. And I've, and I, yeah. And so, um, what I ended up, my partner who helped start Miami select a year before me said, Well, what about, 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. And so finally I just gave in. was like, okay, this hormone replacement cult thing, I'll go because my patients need me to go, but I'm going to be very guarded and I'm just going to, you know, I'm just going to try to take some, some pearls away. And of course I got in there and it was everything that I already knew plus infinite, right? Like, So, so, so much more. And so then I got kind of frustrated. like, where was this? Why was I not taught any of this stuff? It all makes perfect sense. It fills in the holes perfectly.

And, and I think the answer ultimately is insurance doesn't pay for any of that stuff. So why would you waste your time learning that stuff? Cause you're not going to get reimbursed for it.

And it all kind of went back that way. So ultimately I came back from that and lives started changing. So that did two things. it at least two things. First, was, it filled the hole in my practice that I saw with my, my peri and post menopause females. the men, was already trying testosterone, but this really filled that knowledge base. And then two, it was the door that opened it to a room full of doors that I didn't know existed of things like peptides and functional medicine and lifestyle. And it just like. You know, the things they don't, they don't teach you anything about diet or exercise in medical school. Not a thing. Like it's, it's, uh uh, you know, it's, it's given lip service, but

there's no, I don't know anything about nutrition after med school or residency. know, low fat, eat less. I don't know. All of it was bad. And so what I realized with the hormone door that opened for me, that helped my practice, my staff, my me. my patients, it opened the idea that there's so much more out there that we weren't taught and that our patients need and our patients are demanding. finally we're able to, I was like, well, let's go find out. that instead of saying, well, that's all there is, it became, I'll go look that up and I'll get back to you. Yeah. And so it really, it's been, it's been a fun journey. I just, I just came back from a A4M conference and again, many, many doorways that were open. This was a women's health through the menopause. And again, the emphasis certainly on hormones, but also everything about lifestyle that, that you just mentioned and just, you know, many, many things that most people have not been trained in.

in conventional medicine and, I'm not sure about the naturopathic docs or the PAs or NPs, whether they're getting anything beyond, or you just have to teach yourself. And obviously our audience is, is teaching themselves today by listening to this. So, so congratulations.

So, so you. Yeah. Kudos to you and tell your friends. Yep. Absolutely. So when you started to use more hormone replacement, did all these kind of non-specific, but quite powerful symptoms diminish in most of your patients at that point? Yeah. So the hormone thing starts to sound like snake oil real quick, right? It's like, Hey, you're tired, you're unmotivated, you can't sleep. You're pushing through and working out anyway, but your body's not responding.

You don't have, you're anxious, you're depressed. Brain fog. Your, your mood is all over the place. don't, brain fog, you can't think, you can't concentrate, you can't remember. veto is like, well, yeah, I mean, is there much more to life than that? And so what I found was I could get people through some of that stuff without replacing hormones and addressing their hormone balance. But so often. This person's thing was brain fog and energy and they just bounced back. you know, we do, so we do bioidentical, we do creams, trochies, but pellets is a big part of our practice because we can really, we really feel like it's as sort of natural as you can get, blood flow dependent. When you exercise and your heart rate goes up, you get more hormones. When you rest and don't, you get less hormones in it. It sort of mimics kind of how your body would do it anyway. And every once in a while, if we time our pellets wrong, they'll run out before we get the next one going. And we're pretty good at avoiding that, of course. But what you would find is that symptom is the first thing that comes back. So if brain fog and energy were their main thing, towards the end of their pellet life, if we time this thing wrong or they start working out more and burn through it faster and we didn't know it, that's the symptoms they get back. If it's sleep and libido, if it's depression and anxiety, know, whatever your combination of symptoms were that were just unwilling to improve without replacing those hormones, that it's life-changing to that patient who's been battling with that for usually a decade or two by the time. They give in and go to someone outside the box, outside of their, you know, insurance, primary care and OB, the OB-GYNs in my area are not on the hormone train at all. That's still, I recently got a report from a patient that we had, that we sent to them and on the bottom of it was like, you know, a women's health initiative, you know, disclaimer at the bottom about hormones being bad for you and how they're. that they're going to kill us all and the smallest amount and all that stuff. And it was like, do you guys, I mean, you're supposed to be the hormone experts, keep up, but oh it was hilarious. Yep. It's not hilarious if you're the patient with all the symptoms. the other piece of the hormone replacement story is all cause mortality and cardiovascular mortality, which again, isn't something that the woman comes to your office saying, You know, I'm trying to prevent heart disease. I mean, some people do, but, uh, they may come and say, I'm trying to present prevent bone disease, but not, you know, heart disease and all cause mortality. So that is improved by the use of hormones, seemingly, you know, most of the data. It's amazing. They, they really, most of the time when they, most of the time when they come to me, they are thinking that what they're about to do potentially is trade.

health and longevity and heart disease and cancer risk to just not feel like they're dying all the time. to not be leathering is the opposite of that. It's the opposite. Yeah. It's like, it's, they've been, mean, listen, the women's health initiative, they were trying to do the right thing. In fact, they assumed at the beginning of the trial that it would make people healthier because estrogen and progesterone do that. However, progestins and synthetic, you know, estrogen mimics don't do that. They're bad for you as it turns out, but they didn't know and they were just doing the best they can with what they had. they've since, the authors have since come back and said, hey, are bad, go get some bioidentical hormones and it'll be okay.

I mean, maybe not quite that endorsing, but they have at least admitted that there's a generation of demented, broken down folks that were deprived of… health because 20 years ago, 25 years ago now, the information was just off. Faulty. Yep. Definitely faulty information.

## Thyroid, Adrenal Support, and Functional Medicine

Maybe not designed the best either, study starting people so late at 65. So ideally you get people in in their fifties and or whenever they go through menopause, but it's not too late at any age. sounds like, yeah. Yep. So well, good. Yep. And, and I've got, I've got the oldest person I have. on, oh, sorry, the oldest person I have on hormones right now is like in their eighties, I think. might have, I don't think I have anyone in their nineties anymore, but um everyone's like, well, if I start this, when do I, I mean, is this going to be forever?

like, well, you can stop it anytime you want to feel terrible and start dying faster. I mean, it's up to you. Tell me, tell me a little bit about, besides the sex hormones, know, estrogen and progesterone. I, I not sure whether you use testosterone. DHEA, then also adrenal hormones and thyroid, if that's part of your general workup and recommendation for people.

Yes. So in my training, we didn't do a lot with DHEA or Pregnant Alone or a lot of the precursors on that front. Definitely have seen benefit from… folks that even aren't on full hormone replacement. really feel like there's a big role there. There's probably a very important role for balancing your hormones with DHEA and some of the other, you know, precursors slash sex hormones. But my main practice is testosterone in men and women. Men run out of testosterone these days, surprisingly earlier in their thirties. think the… Most likely reason for that is something between stress and this stuff in our food, just the toxic environment that we live in that your body is just not sure what the heck's going on. And you're all stressed out and your body moves its resources away from procreation to just surviving with the adrenal gland until those guys run out. And so I do a lot of, I burned out in my mid thirties and was depressed, burnout, low T. Hashimoto's, I was a disaster. I wasn't going to jump in front of a bus, but I wasn't going to jump out of the way either. was, it was the end of my medical career as I knew it. I wasn't going back to that. But then my partner took care of me and he, and my business partner started replacing my hormones and started addressing my Hashimoto's. so that brings us to, so females, the way that I treated is women tend to run out of their testosterone in their, around the age 40. naturally because their reproductive years are mostly behind them. so things get a lot harder and then menopause hits and they're out of their other estrogen and progesterone and then it all sort of, it's like, you know, the hill gets a lot steeper after that. And so I encourage testosterone replacement in the perimenopause phase for sure. Maybe even a little progesterone where it's helpful. And then estrogen and progesterone for sure in the post menopause phase for… The thyroid, when I went to hormone training, they introduced me to the concept of T3 and T4. Honestly, in family medicine training, all they taught us was TSH and Synthroid. So TSH is thyroid stimulating hormone for our audience. That's a brain hormone. That is your brain's opinion about your thyroid. So didn't measure a single thyroid hormone. actually during my residency.

And then the only solution to that is if your thyroid, if your TSH got high enough that it was technically out of range, nevermind your symptoms, you had to be out of range. Then we would fix TSH with this synthetic product called Synthroid that fixes the heck out of TSH, which it doesn't necessarily make you feel any better. So the training was, hey, guess what? Your thyroid hormones matter, your TSH. matters less and Synthroid is not the best way to address it all. So we use a lot of T3, which is your active thyroid hormone, whether we get that in a desiccated thyroid product like Armour thyroid or NP thyroid or we have some patients that just do synthetic T3 and T4, but the And then Hashimoto's just checking for antibodies against your thyroid. So Hashimoto's is what I have and that's antibodies attacking your own thyroid. And you know, we would have just given a bunch of synproid to low to high TSH and never looked past it. But now we know, oh gosh, your thyroid's down because your body's attacking yourself. Let's see what we can do to help address that. And in the meantime, you need some T3 as well. And so that you, you're not just… You know, your TSH looks better, but you're still cold, tired, fat, and your hair's falling out. But hey, your TSH looks good. So don't worry about it. we go a better. get better. It's aging. Let's change gears and talk about our toxic environment. And if you do any kind of testing and what your approach is to reducing the… toxicity that you may find or think may be part of the woman's symptoms or medical conditions. Absolutely. know, so, you know, especially in that period. So when you go through menopause, your body's just, I don't know, for lack of a better term, it's kind of out of its hormones. All you're left with is your adrenal glands, you know, squeaking out a little bit here and there, which can be optimized. And I did kind of skip that. do.

We do have some supplements and things to help support the adrenal, you know, adrenal stress and the adrenal fatigue that come with living in fight or flight all day, every day and most of the night. Cause you can't fall asleep because you can't turn it off. And the cortisol and the way that affects how you feel and your weight gain and all those things. It's crazy. But you know, so much of that and You're, especially in a perimenopause state, that 40 to 50 age range where everything's getting harder and their testosterone is low, but their cycles are getting irregular and the mood is getting a little crazier. So much of that can be addressed by cleaning up the diet, getting rid of the preservatives and then the additives and trying to go organic whole food and kind of watching your… you know, watch your macros at the very least and then start paying attention to your, um you know, supplementation of your, of your micros as well. So we, I am not functionally certified yet with A4M or anyone, but a couple of my nurse practitioners are going through it now. I've gotten sucked into uh the continuing education of running a practice so that more and more of my people can continue to help folks. But I've been getting my functional training one patient at a time because I'm surrounded by docs and providers that are. so it's been, and running and hey, and having a podcast has been super educational. It's been so fun with getting everybody's slightly different point of view and perspective on gut health and all of the inflammation that comes from there.

And the, know, the credit card worth of plastic that we eat every day and the, the, the toxic sort of things in our food and in our environment. And, know, just open our patients' eyes to the, to the truth that what you put in your body and what you put your body through matters.

That's, that's been super helpful for our patients because they're getting the same information that, you know, I was getting when I was in residency, which is, you know, just kind of.

Eat a few less calories and pray and hopefully you'll feel better and maybe look better. that's not, it has not proven to be true. There's a lot more.

## Toxic Exposure, Nutrition, and Learning Beyond Residency

What I love about the functional medicine world is the, like one reason I'm not functional medicine trained because biochemistry, it wasn't fun the first time and there's so much. information to know and how the body works. I'm finding it very refreshing to hear your honest, um, retelling of your journey, not, not just setting up the practice and your personal journey, but the journey of learning.

Because most of our audience again has probably started out with the Western medicine approach with their physicians or those of the audience who are physicians, you know, and. Even naturopathic doctors, again, things are changing all the time and there's more to learn and know. So it's very refreshing and I appreciate your honesty. Thank you. We're all learning. I do think that, I do think, I think the data suggests that with all of the information that's coming out where the information age, there's studies going on all the time about all these things.

I think the amount of information that we would need to know as physicians or as providers doubles every five years. So it's literally not all knowable, but we do, if you're not trying, you're so far behind that it's kind of laughable actually. Yeah. Yeah. It's sad.

It's hard. It's, it's hard. It's a lifelong commitment basically to healing oneself and our patients. yeah. um A different topic, cancer screening. And our patients know it.

Yeah. Yep. Yeah. And it's too bad because conventional medicine anyway gets very siloed and, know, oh, you have, you know, trouble breathing. I'll send you to the pulmonologist. You know, every symptom deserves a different specialist. Once you get into a certain age range, I can. Relate to that. And that's unfortunate, especially since often the symptoms are again, a reflection of an underlying situation that isn't going to be fixed by another prescription. Just to reflect something that was on your website, cancer screening testing that I presume by that, mean going beyond the typical things that we do to rule out colon cancer, breast cancer, et cetera. Have you started using any of the laboratory tests? have. think that, you know, we, everyone who comes through gets screened for genetic risks. So we use a company called Myriad that, that, you know, if you've had enough of the right cancers on the same side of the family, there's a good chance you have a gene that puts you at a higher risk. And we, so we do that at a, everyone gets screened, you know, over a certain age, 40 or something through there.

And then, because we are probably younger because, know, women with breast cancer are 40s when you start anyway. So I think everyone who comes through as an adult gets that family history screening. And we do it every year just to make sure that there's no new information or no new genes out that we need to know about. And that's really just risk. And then for pure cancer screening, we've, we use a blood test, a single blood test that can detect up to 50 cancers in the bloodstream. It's put out by a company named Grel and it's up and coming technology that is pretty good. It's really good at the aggressive, more dangerous cancers that are going to be in the bloodstream, right? You're doing a bloodstream test. So if you've got a well walled off cancer in a distant part of your body, be it breast or prostate or someplace like that, it's not going to catch that very well. But anything invasive, anything trying to metastasize, it's dropping um free DNA. Like cells die and break down, the DNA gets into the bloodstream and before it gets processed and recycled and reused, um this test can pick up DNA and kind of tell you where it's coming from and… You know what the primary probably is and there's 20 cancers or so that it's really good at that are the top, the top 12 cancers that kill folks in this country checks for all of those. Breast cancer already has a pretty good screening test. This one doesn't replace that for sure. Prostate cancer is tough because it's really walled off in there. But those were pretty good at catching and treating. at baseline anyway, but this helps with colon cancer, especially anything aggressive.

helps with the big killers in the space. And it's just a young evolving tech. So I think by the time our kids are getting of age, they're going to be able to test for most things in the bloodstream or something similar. I'm almost ready for the Star Trek thing where they just do the light up and down you and then you're like, oh, okay, gotcha. eh That's good to know.

One of the advantages of our practice, yeah, and one of the advantages of our practice is time. We are able to spend the time to really dig in with it be like, okay, what's in your family? And they're like, nothing. And then you keep talking and like, oh, well, yeah, there was that. And then you keep talking and oh, there was that. And so we're really able to, and be like, oh, by the way, did you know that low testosterone is a prostate risk factor?

## Personalized Medicine, Screening, and Patient Advocacy

And did you know that this lifestyle, this increased adipose tissue that you're carrying around is a cancer risk? So there's so much more. mean, the three killers in this country are heart disease, cancer, and dementia. And diabetes being sort of the fourth horseman that feeds the other three. And those are all things that if you start addressing them early, make a big difference, but cancer included for sure. Yeah. I think certainly for heart disease, somewhere around 70 or 80 % of it is supposed to be preventable by lifestyle changes, know, smoking, diet, exercise, you know, the long list, sleep. And, and similar for dementia.

I think that picture's starting to get a little bit clearer. When I was an ER doctor, no one was special. No one was individual. Everyone thought, I run a fever at 99. I'm like, sure you do. I don't care. Right? Like whatever. I got you. You're not dying. You can leave now. And what I've learned as I've got less burned out and more into the weeds is that This whole personalized medicine thing is for real. And as patients, you have a right to demand it. And it's a little bit hard on your doctor and providers that are trapped in a system that makes them see patients every 10 minutes. It's not their fault. Unless they're as burned out as I was. They do care and they want to do more and they're trying and they do an amazing job with the 10 minutes they have. But, you know, it's, there are other options out there that are, you know, this direct primary care thing that I'm doing that, you know, it saved my career along with hormones and some, you know, some, you know, functional medicine, uh medicine. You know, what's fun about it is that it shows that there are other ways.

You know, if every doctor in the country or every provider in the country became a direct primary care provider, we'd have a 10 to 1 provider shortage because a regular doc in an insurance system has 2,000 to 3,000 patients on the rolls easy. And a direct primary care doctor can only have 300 to 500 and do it well. It's not necessarily the only way, but it is a way and it is a disruptive industry, which means we are out here proving that it can be done better and different. the, you know, all of the EMRs now have in the last 10 years have that are coming out or coming out with their version of something like a patient communication portal that kind of works sometimes, right? And that they're They're trying, but you have the right as the patient to demand more. And if there is a direct primary care doc, which direct primary care is a terrible name, but it just means membership based with no insurance. I want you to have insurance probably for emergencies, but I don't want you to need your insurance for

access to your doc. You know, your average, or if you have insured, some doctors are true concierge doctors, which means that they are, they take your insurance for the stuff that's, you know, basic stuff. But then you pay a membership for added access to your doc. But that, what that means is ultimately in either way, um, that you have 24 seven access to your doctor.

You can call them, you can call me anytime of night. Now, if you call me in the middle of the night for a refill, I'm going to get a little grumpy maybe, but for the most part, my patients understand that they can just… text the app for a refill, but call me if they're having an urgent concern and it's not abused and it's lovely. So that brings me to the second point.

Not only should patients demand it, but providers don't have to settle either. There are more and more of these practices popping up. um There are, we had a residency reunion here recently and two other Well, four of us in a two year span are all doing some version of direct primary care or concierge medicine. And it's really, and we only had classes of six or seven per year. So it wasn't, know, it was a pretty good percentage of people. were like, no, we're smart and good at this and this system is killing me. So we're going to do something better.

And so I would encourage the patients and the providers out there that might be listening to, do not settle. and to demand better. And if you're a provider and you've got a good following and you're thinking about busting out and starting a thing on your own, um definitely reach out to me and I would love to help you in any way I can because I've been there. Well, I didn't do it that way. That's the smart way. I did it with zero patience. But if you have a following as a prep, that's a really great way to start. Yeah. Good. Well, that's good to hear. And thank you for saying all of that to both the patients and the docs and other providers who are out there. Anyway, I hope that my audience agrees that we've learned a tremendous amount from you today and thank you so much for your insights and please like and share this information with your friends. So thank you so much, Dr. Clint. Hey, thanks Dr. Pat. I appreciate it. Thanks for listening to the Women's HealthSpan Voices Podcast. If today's episode spoke to you, follow the show and share it with a friend ready to take charge of her health. And please leave a review. It helps more women find us.