Introduction and guest background

Well, I didn't fellowship already. Okay, so minimum, but so you see another science of it at all. So when you're sitting there and you were listening to the science, do you remember when the bell went off when all of a sudden you are like, Oh, crap.

You know, when you can start seeing like the mass implications of it. You didn't build your clinic to feel like an employee in your own business. I'm Matthew Galovly and on Out of the System, hosted by Doctor Talks, we challenge the broken rules holding healthcare entrepreneurs back.

Hear from clinic owners, rebels and builders who are creating bold, profitable patient center practices and doing it their way. I'm sitting across from Dr.

Mark Eisenberg with Iron Mountain. Do you call it orthopedic? Okay, and where's that located? Huntington Valley, Pennsylvania. All right. And so tell everybody a little bit about just a bit more about who you are.

You're relatively young to you have your own practice, you're relative to young. One for our client base, too. Well, we'll talk about kind of your journey a long bit.

But tell anybody a So, I'm an orthopedic surgeon, subspecialty in sports medicine, and many, many days of surgery at the shoulder, knee, hip, ankle, as well as shoulder arthroplasty.

I still do a lot of trauma, probably speaking, uh, aaaand, always try to find a less or more approach for patients. Regenerative medicine fit pretty neatly into that philosophy.

So it's very hard to find a regenerative clinic in modern day medicine, especially if it is owned by hospitals. It's impossible. There's no way a hospital would want to do this.

No, my first group that I was part of after fellowship was a private group and they sold to private equity eventually, which is good for them, but was not really what I did.

The six partners sold and you were going to be number seven and were on the outside looking in or something? Well, it was an expected partnership eventually and it just kept being held up and eventually the whole thing sold.

Left that, joined a hospital and practice. In both of those situations for me to do it even basic quality. Regenerative medicine following the science was hard like I had to.

The story the first one the 1st practice was they were doing. TRP, for example, but what they were providing is actually PPP, platelet more plasma. Right.

But calling it the rich plasma, which is pretty impressive. That's that's what was happening. It's not bad doctors or bad surgeons. There were actually a lot of really good surgeons that just didn't really know the science.

They didn' But trying to bring in a company like with the right kit to just get the dosage at least was a whole thing like I'm trying break this mold that is more expensive.

It was worse when I joined the hospital in practice where they said they had a kit, they have a system in place. And I said, the system's junk. It's going to produce nothing because it's like you're spitting into the joint a little drop of blood that you get any time you stick a knee scope into to the knee, for example.

And their answer was, well, there was a fellowship trained or certified orthopedic surgeon before using the. Why is

it not good enough for you? And. I said, well, here we go.

Here's rings of data that would tell you. Well, so actually, I didn't go that far. I just said well it's because the science said it doesn't work. And they're like, Well why don't you like show us the Science?

And I'm like well that's like probably show you how to be an orthopedic surgeon. It's not something to just show in 30 seconds. Like here is the size.

Let me show the basic stuff. But none of it mattered. Really, you realize most of these practices hired orthopaedic surgeons to do orthoping surgery. That's where they make their money.

And anything that's going to keep patients out of the OR is not the business model. So let's not and I just want to say not. Yeah. Not because they're bad people it's just that's not the business model.

So it sounds like they want to force people to surgery I want make it sound like that what's happening. They just if it is not supporting their growth Then it doesn't make sense to invest in it.

Yeah, they you know, there's a lot more trained surgeons to replace a joint then there is trained Surgeons to do regenerative therapies or the biologics correctly.

I mean, if you think about it, how many orthopedic surgeons, you know, I'm sure you don't know the number, whatever. Let's say there's a thousand orthopaedic surgeon that come out of residency every single year.

Well, they're all trained relatively consistently on how to replace a knee, how do we place a shoulder, right? How to Replace a hip. I never saw a single regenerative medicine procedure in my general surgery, general orthopedic surgery training.

So it's not the same. It's in there, you know, in a private equities mind, which I totally understand. it s not scalable. They're getting free trained doctors that come in that are ready to go versus having to start from square one.

You know, I actually think it's even more subtle. I think that, yeah, don't think private equity has any idea of what regenerative medicine is and why they should even be interested in it.

Just like I don t think most orthopedic surgeons coming out of residency have any ideas what regenerative medication really is. So that happened to me, you know where I came out residency.

Yeah, how did you hear about it? How did your hear bout it so you've been for the record? Tell everybody like how long ago were you how? Long ago? Did you leave residency?

2018 2018 okay, so well that is for those of you watching at home He's younger than most people that come out of this thing so yeah Yeah Well the grays are starting to show but dude you got a long way to go.

That's like a couple years It's not throwing a deck chair up the Queen Mary like your gray is like non-existent compared. Yeah.

Early exposure to regenerative medicine

I'm getting the salt and pepper You know you have a salt with a lot of pepper Okay for now Every day that changes but uh, you got like one noggin of like kosher salt.

That's about it Yeah, so i'll take it. Okay, but, uh no, I did my fellowship here in la so uh In la it's a very different patient population than in philly uh in that What we see is people coming in saying can you PRP my shoulder?

When it is hanging off by a thread and they think somehow regenerative medicine. Let me guess that's LA. It's la. Can you like give me PRPs to fix my shoulders?

Yeah, exactly. They all sound like crush from finding emo. And again, they think anything will save it. Right. Everybody's like, oh, you're in medicine?

Hey man, peptides are really cool, aren't they? I'm like not really. Oh man. I just love peptide. So I was like where are you getting them? That's all of LA.

Everybody's got to do it. So that's how I got introduced to Regen was here in LA and we'd find ourselves talking people out of it sometimes because it is the wrong answer for some people.

But then more and more people were interested and I saw it working even though it wasn't done to the same level that Yeah, like a high level of Regen clinic does it.

It was still orthopedic surgeons who had who are some of the best in the world. Like I have the people I trained with here. You trained under some like the arms.

I still text them to sometimes to say way, way more often when I first came out of fellowship. I got randomly sent a message to someone that I trained with saying, hey, just wanted to let you know I wouldn't have fixed this shoulder if it wasn't for you.

Yeah, you're really good. You take on very difficult cases for fixing the shoulders, right? Yeah. But in general, it's just, I'm thankful to my mentors both in residency and in fellowship.

Again, none of this is like they they were the best of especially here in LA the sports surgeons I trained with are It I would fly back if I needed a problem something fixed.

I will fly it back. You're coming here. Oh come here Yeah, yeah, because I've seen them in the OR and I know that they do a great job But region, you know, I'd see it more but it wasn't still wasn' the main focus, but they will way more educated but were they doing it like were They doing up like?

you know, like pulling out 10 CCs instead of like the 60-year-old. They're losing the less quality. And not all of them. Now some of us use one kit, some use the other kit.

Some of the knew a lot more about it than others. So I don't want to paint like a global picture, but that's where I learned about more. Don Buford trained in the same fellowship where i trained.

Steve Snyder, who's one of my mentors, Like one of the fathers of shoulder arthrosis, he has a lot of why I do what I suggested I see and go to Orthosono, which is Dr.

Buford's. And that's where we met, right? We met at OrthoSono. No, no, I did that in a fellowship still. My first exposure to like high quality regenerative medicine.

So what was that like? What was it like sitting in that room? Because I'm in the room every time. It had been for five years. Well, it was great. In that it wasn't my first real exposure too old sound beyond what I was in time fellowship, hearing about the data and hearing it from someone that's an orthopedic surgeon with the same training background as I had so I have to trust that they are not just peddling snake oil.

That's a big deal and that is unfortunately the bad name sometimes it comes out to be. So being exposed to that through another orthopedic surgeon with similar background and knowing like if you know Don Buford You know that he is I say he's my ethical north star when it comes to regen He's beyond the ethical because I'm like he like I know you will never tell me something That's not done.

He is the best his honest truth, right? So I believed it I learned that about him and I started you. No, I came back and it started my practice and said hey Donnie like who's who do you think's the system to use before I fully knew all the science and he said we'll use this system and that's what I would bring in.

So I always did at least PRP to like a basic like quality level. But I want to go back a second because this is really fascinating. When, so you're sitting in, you are sitting at Orthosono, it's in Vegas, two times a year for those of you that don't know, its OrthoSono.com.

It's, in my view, the best ultrasound training, diagnostic training on the planet and Donnie spends at atleast half of the time talking about the know, and be neck and adipose.

They'll do live procedures and everything right there. It's a great switch. If anyone's interested in it's awesome. We are there every year. Yeah, I every ear don't like to give me the dates.

I will be there but when you're sitting in there you had had zero exposure to VRB. Well, idea in fellowship already. Okay, so minimum. But so you see another science of it at all.

So when your sitting there and you were listening to the science, do you remember when the bell went off when all of a sudden you are like, Oh, crap, You know, when you could start seeing like the mass implications of it, what it could do for patient quality care.

The truth is, the bell didn't go off. Well, so you're just happy to be in bed, isn't it? No, no. What happened was, and this is part of like what I'm writing my book about right now, at least it's a little bit of a snippet of that.

Like I learned about regenerative medicine, I learn how to do it the right way. I kept up with it after that conference all the way to starting practice pretty routinely.

But what I found myself doing is offering it mostly to athletes and young people who are coming in saying, well, I'm going to go back to sports sooner.

I want to have the best outcome on the surgery. And I've actually even found, myself in the past, talking to people out of it that were good candidates like Neal Arthritis.

Maybe like in their 70s, they're like, do you want us to spend money on this out-of-pocket? Or do you want to just get your knee replaced, even though 20 to 30% of knee replacement patients are happy?

But that's an astounding number. Yeah, I mean, compared to hip replacements, we feel like 95% successful. But yeah, hip and knees are not that good. And so I found myself telling people what's I was making a decision for them so the that's one of the top three cardinal sins yeah and I didn't realize it though so I would always tell my patients if they ask that I'm going to give you the same option into my family I never realized that wasn't true until I went to the bar.

Actually, I don't know if I ever told you this. I quote you to my patients to this day, and I realize I've never told this to you. So I say, what changed for me and what started my practice and started me offering it routinely, not just as an afterthought for certain people or someone that comes in asking for it, A friend of mine was speaking at a conference and saying, if it's your mother and she had knee arthritis, would you give her a steroid shot, gel shot and knee replacement or general medicine treatment if insurance was an admission?

And so obviously everyone was like, well, insurance is an issue and we would give a regen. And then you said, then what makes you think you have the right as a doctor to make that decision for your patients if they want to pay for it?

God, that guy's brilliant. Yeah, I use that. I tell patients this on a near daily basis. Sounds like something I would say. Yeah. It's I don't know if you still say it, but if no, you do.

But yeah, it's you did a pretty good job of like, yeah. And that was my if I'm being like 100, like I have known Regen for years, But I never got to the point of feeling like it's okay to ask someone to pay for something in medicine.

Like you think that it is a right too. Medicine is service center right for patients. You try to do your best for people

and not afford everything. So you want to just do what you've been trained to do as uh you know some of our other people in maverick said groomed to, do yep through the uh way we're trained uh and i realize it's it''s not like it' s not an insurance company saying hey don't offer regen or like your mentors are saying don''t offer region it just never comes up in a conversation because every person training the next generation not every their ideas in the insurance box.

Right. So, you know, I tell my patients that, like, ideal in insurance boxes, but I really deal in a science box, which is bigger than the interest box and then there's a Buddha box which if you want to talk about we can but that's not something I generally recommend.

And so the science block is much bigger And what's in the insurance box is usually reasonable, not always, but usually, reasonable. But what in a science box, also reasonable is just not covered.

So that's when that light bulb moment happened for me. So the insurance box, I liken it to AI. So if you go to chat, GPT, or plot, and you ask it, like we just got done with a two-week trip down the coast, right, from Eureka, California, actually at the month, Shasta over to Eurica, all the way down to U. S.

1.0, way to LA. Like every good human being, today I went to the chat and it helped me kind of plan the itinerary. But the thing that people don't realize about AI is it's going to give you the basic middle.

So everybody's asking this question. And what it is going do is AI going say, oh, this is what everybody is asking. Here's what the answer is for everybody.

And so what happens is that for most, for 90% of the people, 95% percent of people using AI gives them a very bland answer. Okay? It's the middle ground.

Learning from Orthosono and mentors

It is the same thing with insurance-based care. Now the reason why AI can do that, I'm sure they have legal implications, like they don't want to get too far afield.

If you've ever asked like AI some like really dicey questions, it'd be like, You need to check with a lawyer on that. We need a warn you that doing psychedelic mushrooms is not that I've ever done.

But you know, it's illegal in these states and you need watch all that stuff, right? They're just covering their ass because they want it in the middle of the road.

That's what insurance wants. Insurance doesn't want to take a risk. They want as high a volume as they possibly can on the simplest thing that's going to get the best generalized outcome that they possible can.

So with AI, how do you get it to give you the answers on the fringe? You ask it tougher questions. And to me, that's what doctors are there for. But what the system has done is the systems has made it so that you don't feel safe giving difficult answers because of lawsuits and all that.

So what I always try to explain to people is When you're talking with your doctor, if they're not willing to really examine or look at things outside the middle norm, not saying that doctor's not any good, but to me, a doctor is supposed to constantly be asking questions.

When You hear me say that, how do you respond to that? Well, I actually I agree, but I also I don't think that the problem is doctors not wanting to do Half have the different conversations I didn't know a lot of us are used to having pretty difficult conversations and are willing to discuss the fringes Like I Don't actually think regender medicine is on the fringe is at all.

I think it's like there's a little science I I Agree and I bet I could put ten other orthopedic surgeons again chair and they would say it risk, right?

So the problems not the risk The problem is the lack of training in regenerative medicine. So it's like a training or like about it? It's about training.

Okay. Yeah. 100%. Yeah, so trick question, by the way. I knew the answer. This is a problem. so I'll give you a great example. And he's practically part of the family.

So, you know, it was not a financial decision really for him. We just did it. And his dad's an orthopedic surgeon who's, I think, just retired recently.

I don't know. He, in his late thirties, has a pretty severe knee arthritis to the point where he'll travel. My sister and I will go somewhere. Both are families.

They'd go on hikes and i'd have to sit it out at a coffee shop sometimes. Was he an athlete? He tore his PCL at some point. Recently, we found out his other knee has the same level of arthritis.

It's probably more of a genetic. Poor guy. So, well, when I first met him before I jumped to the Regen world, you know, she was getting cortisone shots before and so she wanted a cortison shot and I'm like, it's not great for you.

Let's try to avoid the cortizone shot. We did a course on shot, and actually they stopped working and he's like I'd rather just get it. So at 39, would you…

He was, at the time I think he was saying that he's like 37, 38. So what's the life of a knee replacement? 20 years? If you're lucky. If your… So, what do you do at 59? Or 55? You can get another one.

And if you're lucky, remember, so 20 to 30% of the people aren't happy. Already, and then it closed. Right. So then when it wears down at age 50s, you have to get another one.

You don't have another choice. And then the likelihood of Val and being successful is lower. Yeah. Do you know the numbers? I don' know numbers, but every time we take it out, it's you know grows into your bones you have to chisel away a good bone and so it becomes more and more complex every time.

Nobody wants to do a second ear replacement or a third ear replacements and they prefer to the easy first ones and then not have ever to look at it again.

You know something I see in my clinic now as a side was that people come in and a lot of orthopedic surgery say well You're in your mid 60s and it's you're old enough old Enough to get a joint replacement, which I think is a bunch of nonsense because there's no old and half or young I was thinking about getting it at 60 now, you know what how when we're living right now You were looking at 80 and then think about surgery at a Well, that's exactly the point.

So I have plenty of patients that come to me for a really shoulder replacement when it falls apart at 80 and now they're sick and unhealthy. And so I tell my patients if you're going to do it and sweet spots mid to mid-to-late 70s.

All right, so let's go back here. I'm sorry. Let's get back. Yeah. Yes. Oh, I asked what this friend of mine who I did therapy on and then later stem cells on his other knee.

Right, so when he told me he was going to get the procedure, he thought it was bullshit or after he had the procedures? No, like he said before, it's bullshit.

And then what he says is he thinks it is bullshit until he saw me go on a hike that I haven't gone with him in 15 years or something like that. So the proof was in the pudding.

The truth is, again, most of us don't get any exposure to any of this. our training and we hear one of our mentors or friends say oh it's nonsense because they see the outcomes of the crap human general medicine which is not even with general or you know they're just assuming that surgery is the right answer but most The problem, I think, is just

that people don't know.

We're not trained to even think about it because it's not part of our routine conversation and we don' see the good outcomes. The worst of it is there are very few high quality of gender medicine.

experts. Yeah, country. That is one of the biggest problems. And I hate to say this, especially on a podcast, but I don't even blame that much the insurance companies, because they don t have real data to be able to s ay, hey, it's good or it s bad.

Because there's so many people doing it raw, following the science, that the outcomes suck. Right. Like I did a this happened recently too. I had a patient, her husband had PRP with me and she happens to see a doctor whose husband is the orthopedic surgeon that just retired who also said it's nonsense.

Don't go to that. And don't do that stuff. It's all like… But the data is so clear. All you have to do is read it. This is not, it is controversial.

The most controversial is What's controversial is just your own limiting beliefs about regenerative medicine because you never bothered actually reading the journals.

And rather than say we have journal club, we lead all the things like which server is better than the other and blah, blah. There's not a single time that I read any articles about recommended medicine by training.

Well, the bigger issue is that we're more and more of a society, and it's not as big an issue in the medical space, especially with doctors, because you're trained to read.

You all have taught me how to things that I never thought in a million years that i would read, The biggest challenge though is that we live in a clickbait society that most people like I saw a statistic the other day Most people if they if a 94 percent of Americans do not read a book after high school I think about that 94 of americans do about read book at rise and the the statistic is something like Kindles were supposed to be revolutionizing, like, you know, people reading books.

Something like less than 1% or less the 2% of people ever make it past the first 10 pages. So if you have a kindling, they have like the things that shows all the highlighting.

You'll see like in the first 10 pages, people highlight a bunch of things. And then in chapter two, there's no group highlight. Like there is no F. It goes from like 25,000 people highlighted this sentence to like, in Chapter three, zero people are highlighted.

So I think what that's indicative of is that people have become busier and busrier, especially in the medical space. You're spending 24% of your time doing paperwork, right, charting.

Your work in, you're seeing 50, 60 patients in a day. And if you do have time to read, do you need somebody else to write it for you? And then you just take their work for it.

So I think that there's a huge, what I find in my work with orthopedic surgeons, pain management, those two particular areas, is they just don't have the time to educate themselves to the level that they want to.

It's not that that don' want. Yeah. So just like I knew who Don Beford was as a human being, as I served in his training and I chose to take that leap of faith.

And well, not really. He's proved, he proved it to me in that conference that, you know, why I should trust him. Um, and he showed the real data, which I've never seen before that confidence, because no one really talked about it.

But just, like you could, I got lucky in, that I met him, Which opened up this world of region beyond what my fellowship already did. If I didn't meet him, I would probably do and reach any level that my fellowship taught me,

relatively basic, although the surgery they taught is very high level.

And I would never know better. And then if someone said, oh, well, this regent could save someone from a knee replacement, I'd be like, eh, then I wouldn't have heard about it from one of my men.

Yes, that's the key. I've heard of it. Yeah. Because they are phenomenal doctors and surgeons I work with. But I have the utmost respect for them. To this day, again, would I never do half the things that I do if it weren't for then.

Um, and I told Don Buford at some point that, you know, Steve Snyder, who's again one the fathers of shoulder arthroscopy and the most humble guy you'll ever meet.

He revolutionized how many of us, but for me personally, I fix rotator cuffs to this day, almost exactly to the millimeter how he taught.

Why insurance-based care misses the science

With other docs from SCOE who refined it, and I don't want to go through all the names just to break a lot if you get some of this man's eyes or you know but they're all they talk about i told on before i'm like you change my the the trajectory of my career the same degree as steve snyder did after your fellowship with him from what you do and yet i just even though it was never a direct like one-on-one you're not matter of fact uh…

so and he has a same respect for steven siders i do busy train ever him and so uh i I'm just, I got lucky that I met Don. And so the problem is most of us don't meet somebody that's educated in regenerative medicine.

Just like I could say a certain procedure in OBGYN works or not, it's just because I heard that from somebody, but I am not an OB-Gyn. For an orthopedic surgeon or pain doc to say regenerate medicine doesn't work, because they heard it is not science.

So that is exactly what they're saying is, well, regenerative medicine is it's unpredictable, doesn't work as food. What they are saying, is actually because, they hear the outcomes from a variety of people.

Some that do well, some that don't do. Well, we know we can inject saline into any and have some decent outcomes for a while, but they never bothered to read the data.

So how do you say something's voodoo if you never read that data or even open to hearing about it? I think most of them are not. It's not that they're not open hearing, about is that.

They're so busy. That is because there's what 12,000 plus studies that show the efficacy of regenerative therapy. I don' know about how many studies, But I know that there is it.

Remember one, right? Were you at the event where Dr. Roddy McGee got up and was at an AAO? I was in there. Yeah, it was classic. It was AOAO and, you know, Aaron Demers is there, Schachter's there Roddy's, there's probably about 10 of our clients there right and they did an entire afternoon on regenerative therapies.

Donnie was there, right? And they'd bring Roddy up to talk about whether or not there's any evidence. Roddie's the right guy. It was one of those things where it was almost like you thought Don and Ariana planned this perfectly.

And I think Don had to go after Roddy did this. So here's what he did. For those of you that don't know who Dr. Roddie McGee is, he's in Las Vegas. And he has the driest, funniest sense of humor in the world.

He would be in Mastermind, right? And, and he would just make some comment and the room would stop and then they'd just start laughing. Right? Yeah. It's been him and Jake.

Yeah, it's great. And if you're lucky, you sit next to him, and you like it. There's a comedy show. He's fun guy to go out with. So anyway, they get Roddy up there.

Roddie is a typical orthopedic surgeon, right? Bone broken, bone fixed kind of thing. Right. You know what I mean? Got a hammer. At first, he's like, oh, my patients won't pay for it, He is going to be on the podcast a couple of weeks.

They won' t pay it in Las Vegas. Is the science really there? And he's been a Joe Rogan. Like, he treated a lot of, like, the UFC fighters, way back in the day when, you know, they were doing third-party stem cells, that kind of stuff.

And so he gets up and he goes, so I want to talk to everybody today that thinks that this stuff doesn't work. This is a one, this is 1,500 people on the conference, right?

They do an entire four-hour session on region therapies. I'm gonna talk everybody in a room that doesn' think this thing works. He puts on The Who, Bob O'Reilly.

And he's playing the thing, and he goes, I'm just going to put 10% of the studies up to show that it doesn't work. And, he got the music, that song starts kind of slow, then it goes faster and faster, faster.

He's just pumping, there's like… And that's 10 percent of studies. That's rock. Donnie gets up there and is like, I have no idea how to follow that.

He's trying to talk about, don't get a coding, there's no coding for it, come see me or something like that, it was great. The point is, is there are so many studies but they don t have the time to go One of the core issues is not that they're not studies.

The core issue is that the journal editors accept junk studies with things that are called PRM. I think that it's okay to think about And I agree in a lot of ways, I could trade this company bad.

They're trying to limit us, but I don't even agree with that for this because I think the journal editors have the same issue where they don t know what PRP is.

There's no such a group that can write a big enough check to get their opinion up. Well, so they're getting these well-done studies So that's what they want for publication.

But they're well done for an injection that is being called PRP, for example, but it's not PRT. It's like barely more platelets than what's in your blood.

So again, you could have a study that has an 8cc blood draw, call it PRB and it stomach, a beautiful study. And it shows it doesn't work compared to saline.

Sure, no shit, because it has 8 ccs of blood and you're getting no platelet. There's no dose there. Compared to using 60 or 120 cc's and having a real platlet dose, But the journal editors don't know that, yes, it's a well-done study with a crappy quality product that's being injected.

So they publish this and it is just globally known as PRP doesn't work. Not PR at this crappy dosage doesnt work, thats like saying Tylenol doesn t for pain control when you sniff the pill.

You have to take the pill. There were studies that determined whether you want to do 325 or 500 or a gram, where that right dose is. And we know at this point where the minimum is, but most people, a lot of those studies don't talk about that at all.

Not because, again, bad people or bad surgeons or journal editors, because it's a lack of knowledge. So I think that's being problemated. by all these studies coming out that are crappy and that no one's that good.

And the sad thing is, normally I tell patients, don't, you know, overdo the chat GPT, but sure, go ahead with chatGPT and ask what are the differences between good PRP's or bad PRPs?

The patient's never gonna ask that. You have to educate them. So when you do your videos, let me show you how to use chat GPTs the right way. So, you don't want to say, does PRP work?

Right, because ChatGBT will say oh, we dont, same thing. But if you ask, but you can then ask ChatGBT or any of these AI things, what makes good PR versus bad?

And it will come up with dosages and number of blood draw and all that. And the sad thing is I've had patients come into my clinic that are like, oh I had PR.

I went for a PR consult at this end-of-year big name institution. And I asked them like, well, was it a single spin or is it the double spin system? How much, what's the dosage that I'm getting?

And they had no idea. These like big name institutions. And that's where I have to say like these might be phenomenal surgeons and doctors. They just don't know.

Regen, a simple screening question for a patient. Now there's a lot of nuance to regen, obviously, but the simplest screening questions to ask if your doc knows what they're doing even a little bit is what dose platelets am I getting.

If they- Well, that's the trick question. Yeah, they won't know. Then you're in the wrong place. If you would have asked me that in 2015 when we started using Magellan for doing PRP injections into the penis, I'd be like, what the hell are you talking about?

didn't think the penis will come up in this podcast today. Highland Rectile Dysfunction Clinic, come on, it always comes. Not the bone I'm used to working with.

Yeah, yeah, I know. There is no physical bone in there. So, in case you didn' t know, but yeah. I mean, you just, y'know, when I think about it, think back to when we first started doing PRP for rectile dysfunction and for perones and all of that and venous leakage.

We just drew 60cc's out, we stuck it in the machine, spun it, got down to 8cc or 6cc, and we re-injected it back in at the peak. Luckily, I asked Donnie about it one day.

I'm like, why is that in a gentle machine? He goes, actually, it was pretty good. He said your plug was probably… you know, three to four billion. You just don't know.

Yeah, that's why it's so important that you, like, I love when our doctors start counting their platelets and tracking it and the results. Now, do you use data biologics for tracking results or do use any registry?

I do, and so they're redoing their registry right now, so we're waiting for them to come up with any system to, we pause, then we'll come back on. That's probably why Luke probably won't call me back, because he's busy doing that.

I was going to be in New York in like two weeks. Yeah, and you know, you don't even have to count like it's pretty intimidating I think for the general orthopedic surgeon or paid up Well, this is not part of their day-to-day to get like a chemo analyzer and like that, but you can just simply Have a kid that draws at least 60 if not 120 cc's of blood for a large joint and And though that you're going to hit that minimum of six billion, ideally at least 10 billion platelets for arthritis at the knee, for example, almost no matter what if we're doing 120 cc's.

And I used to do more 60s and I have people come in with a guarantee if they're not making enough progress and do 120. Now I just do one 20 every single time.

What are you going down to? Well, it depends on the joint. The other day I had some of the CMC joint arthritis and I spun it down to two cc's. Wow! Holy shit!

But it's telling us, now it is a lot, but there's no data that says too much, right? Right. You know, you'll have your

limiting returns, But, its very clear that there is no back.

There's not downside to increase the STL of limiting return if you go to whatever, 10 billion, You're not going to get 2x or 5, per se. So for like, you know, my clinic, something I decided really early when I left Austin, sort of thing, is it's not going to be the cheapest clinic but it is going be no corners clinic.

So instead of drawing 60 now, which I used to do more of because that's what the data showed, if you want to get 60, that generally gets you the dose that you wanted.

I do 120 because then I know even if, unless the patient's platelet count is so low that they're like life-threatening bleeding, they will hit that limit.

So I don't have to send them for a separate blood test. I know that on a routine basis. Now if they're not making progress, if it's story, we start looking into more details, but that's so rare.

Do you have your patients to like go into anti inflammatory diet prior to a supplementation with regards to? I'm not doing any hormones stuff. I also told myself I don't ever dabble in anything.

So I would be open to hiring someone that does that well. But I never want to provide some par mix. I get it. So I always want to offer patients the very best that I know, and I need to know the best.

Yeah. I'm pretty sure this is a reality like that. Your body's a pharmacy, right? So, you know, don't smoke. Go for a nice walk if you can on routine basis before you get this done.

Don't take unnecessary medications. Eat healthy. And those things do matter. Some patients have actually turned that into, like besides getting the injections, they'll go on like a weight loss journey.

I've had patients lose weight. One of the first guys that came in, who had a knee replacement, he came to me to see me for a new replacement.

Building a regenerative practice with better dosing

It was like 50 something and he wanted a replacement I talked to him about PRP and I talk to them about the bodies of pharmacy and so he's like you know what let me try the PRT.

Now he is playing basketball and bone-in-bone arthritis for PR which PR for bone in bone arthritis is less predictable but He's two years out, happy as a clam, bone bone arthritis, playing basketball with his kids in his fifties.

And he liked his ear replacement. He was not one of the ones that hated it. I have a guy like that too, who's 78 now, plays pickleball three times a week, came to me saying, I haven't ear replacements, and told him it looks great on x-ray, which it did.

Uh, And I don't like it and I want anything but for my bone and bone knee. and he's already gone through like unnecessary surgeries like an esco. Wow.

Uh, which I get it. His surgeon was just trying to do something. That's not a knee replacement. And he got worse. No surprise to the knee scope, but a bone-in-bone knee makes no sense.

Again, I don't blame the surgeon for doing it because they're just tryin' to help. Uh. So I didn't even talk to him about BRP. I'm like, your goals are playing pickleball.

Can't promise that either way because that's a heavy duty pivoting sport on your bone in bone knee. But the best thing I have for you is, you know, VLAC.

And so we did that, he's now a year and a half out, playing pickleball three to five times a week at 78, crushing people half his age. And this face is on the banner that we just put in that pickle.

Oh, that's perfect. Ask me about my knee replacement versus my stem cell knee. Uh, and he is, He's loving it. Right. So like people that say it doesn't work.

Yeah. It's just, it's sad because until you see it, If you think if you see it you can't unsee it if You are if, you are a doctor or even a patient but let's just say you're a Doctor listening to this and you believe that regen doesn't work prp Bone bmc adipose that it doesn' work Let me know and what we're gonna do is i'll have you come to ortho sono and spend two and a half days in vegas And listen because your world will be changed And I'll do an open invitation to anyone that sees this podcast if they want to come spend a couple days with me in the office just to see patients that are over a year out from Regen and ask them how they're doing.

Perfect. So I had another guy, I replaced his shoulder two and a half years ago. I just saw him a week ago and I PRP'd his other shoulder and gave me the option, right?

And he's a year and a half out from PRP and bone-in-bone arthritis of his shoulder. Two and half years out, from his shoulders replacement. And, he just did a video for us, and I'm like, well, so what do you think?

He's like I like both of them. But I hated the rehab. Took almost a whole year. Yeah. I mean, shoulder sucks? I love shoulder replacement surgery. It's great for the right person.

What I ask my patients every time they come in, I say is it pain or is a function and if they're going like this and they can't lift their arm up and They're saying well, I can I could live with the pain, but I Can't move they need a surgery they needed a mechanical solution to their mechanical problem if They say it's pain even when it was pretty bad like you could potentially help them with Regen.

Not always. It's not a 100% success rate, neither a surgery. But I would argue that some Regens for the right things has a higher success rates than surgeries would do for this same indication.

Well, it's in Rome. Paul has been here and sat in that chair. And I mean, he's, you know, a walking encyclopedia of all the data. He sat here for an hour and a half and just shared data about the progress that we're seeing in the last 10 years.

the outcomes, like what we have learned. I mean, we're at that stage where we are learning. so fast about the adjustments and the changes, because now we have more and more doctors putting into registries, like at Data Biologics, and getting the outcomes that, you know, we had doctors all over the globe.

Now we've clients in England, your clients are in Australia, Australia not Austria. And, they're living off the data that you're creating and learning that and they are expanding it out.

So it's really starting to pick up some amazing speed. The sad thing is most of us orthopedic surgeons are used to like level four evidence. Oh, Surgeon A did a surgery that did well for 20 people.

It must be the surgery. And we understand that it's not as good as Level 1 evidence. But it is hard to do a fake surgery versus a real surgery, right?

So you can't double-wind out when he does a surgery. You can do that with a surgeon. I think they should do blindfold surgeries. What do you think? work yeah you try it's better than blood and not knowing which in jack what's here if he probably yeah probably got that or me as you're like not doing it with all your own your ultrasound guides and just that's in the it to the knee I know that yeah I love it I I lost my point.

That's all right. So let's do this, I'm curious. I want people to understand a little bit about your journey. You had a residency in 2018. Yeah, fellowship 2019. Fellowship 2019, and you started your practice in what year?

When did you start for your cash, your own? 2024. Okay. And you were working where? Did you tell everybody a bit of this journey? And I am going to let you kind of guide this a litte bit because I know you have to be a Well, yeah, so I was, you know, I left a practice that sold to private equity that I initially thought I'd be at forever.

And I thought it was a great gig for the right person to probably would have been a pretty good game. But I realized it. It was all about, well, it's all the project.

So the original dreams of partnership and what that would bring were never were we're never going to be realized at that point. that um because i would be a perpetual associate yep and i just that's just not what i was looking for he's not going to make you a partner yeah uh and then i joined a hospital group and um ran into some of the same issues that private equity and like private practice would have brought and it's did that hospital were they still in pennant or are they brought on private equities no no it was it wasn't an independent group sort of that was mostly owned by the hospital okay And I don't want to go into some of the details that happened.

But, you know, there were things like it was a Catholic institution, which I'm not Catholic, but I read their Tenants of Medicine and I am like all on board to take care of someone that can't take of themselves or can afford to pay.

And then I realized that It just, in the end, it's still a business, like, and I get it, you have to keep the place open. But you couldn't always take care of people that needed care for free, even if you offered it because then the hospital lost money and then they can't afford it.

I don't blame them again and get, hospitals are going under everywhere. That happened, I realized everything's about numbers. everywhere. It's all about quantity over quality.

And I thought there was no out. I felt that that's just what medicine is. And you were what? 36 at the time? When you're probably 30? 35, 36? Yeah, I just was like, okay, so I tried to run medicine my way as well as I could.

I gave people as much time as it could, and I was never rushed in any case of chin visits. Maybe not never, but I try to never be. And I call people after hours sometimes to talk to them more if I didn't think it was enough time.

and I try to kind of make it work. But there's always those like middle managers, people that are not involved with patient care at all that breathing over your neck saying, what can you see the next 10 extra patients?

And sometimes you can't, but you just when costs arising of personnel and reimbursements from insurance companies are going down, And then you have to see more patients to be able to afford opening the doors, which then, you had to hire more people to staff those doors.

It's like just and never anywhere else. And it's a race to the unbound. Then you sell to private equity or fold into the hospital. So, I learned pretty quickly that I was a loss leader for the office.

Meaning, me being in the offices doesn't make the money. Being in an OR makes money, that's how it works, just in general. The reimbursements don't keep up.

And so I thought originally, like the way I started was actually I texted down to you for the stupidest message for a guy that's incredibly busy and probably hasn't known people text it all the time.

I tested them a picture of the logo I was thinking of making for our practice. You're going to leave the hospital, you're gonna stir your own thing, put our own shingle.

Yeah, and I didn't know that I was leaving necessarily yet, but I need a way out where I could at least control how many patients I'm seeing a day so I can give them more time.

My plan was I want to do enough workers compensation, which is much more, it just pays better. The insurance companies pay more. that medical legal work pays more.

And you could stay honest with it. You don't have to do it, some people sell out to work calm. That is how I was doing. Right. I'm gonna do enough of that so that my doors open and then take a loss of insurance and just see patients and not care what pays.

And that message to Don came back as, hey, you should come to the bot. Right. For those of you that don't know, it was the business of orthobiologics that Dr.

Ariana Demers and I did, we did twice. And it an event where half of the sessions were about ortho-biologic, and the other half were business. So that was an even that we ran with Dr Demurs for a couple of years.

Yeah, so I went from that to that and thinking that my way out was making enough revenue from more of his compensation to afford taking care of where I'm on my shoulder problem, not care where it pays, to, hey, there's another potential way up.

So I signed up with Mavericks at the bottom, even though I didn't have a place, I barely had a logo. And I was like, you know what, this has to work. I came back saying, and I negotiated a day off per week to do this, So you were just kind of moonlight, basically moonlight doing this one team?

Yeah, that was a plan. So that I could at least, you know, and I took a paint cut and all that stuff around, listen, pay me last, I'll see if there were patients, i'll take care of them.

Eventually just didn't. The new administration came to the hospital too. It just, it wasn't working. And I think I was naive to think that it would have worked, where I can grow one thing and just.

Yeah you worked. Sorry. But yeah. That's okay. At least you started, started you on the top. Yeah, and you know, I don't want to keep I wasn't trying to like, like I wanted to make both things work.

Right. But I didn't and thank God I did it because now I'm on my own. It's it's great. Everyone was trying convinced me to just fully leave right away and probably would have been the right answer, but I am glad I used that a little bit just because it gave me some time.

Look, it worked for you, right? There's this is we get asked this question a lot. We get a lots of questions. A lot of doctors. I m working for the hospital here, got a non-competitor, you non-circumvent or whatever i have no patient list i'm making water half million seven thousand whatever it is uh…

we apply right now he's making seven grand right kinda in your age group uh… and he is walking out cold turkey just like six month notice he should get out walking on cold turkeys now his wife is also a doctor so that helps right she's a urologist but anyway the thing is is that What was that like for you to start to do that?

So you were doing it one day a week and you worked how did you get patients? What can you share? I mean, I know some of it you're we talked offline that you you know I'll let you kind of just guide that a little bit into what you want to share.

Yes You know patients found me. I found them sometimes it was um, i'll negotiate my contract that the stuff that I was doing there is separate Um, so that was fine clinic that she was starting.

It was completely separate. Yeah Yeah, you know, it wasn't so there happened to be a patient that had come into the hospital and they happen to find you and go there what there wasn t a conflict of interest.

No, and I also promised them if someone needed surgery, I'd bring them back. Yeah. And I did. You know I've done that also. So you I followed through what I promised him.

But yeah, no, just started the difference from the Bob.

Leaving hospital employment and starting independently

What what happened was I started offering regenerative medicine for every science based indicated patient. not just when the patient brought it up or when I was like, oh, this is an athlete that wants to go back to play faster.

And so some internal drivers of, okay, maybe they don't think it's worth cost. That's what changed. and that's, what also led to the revenue that increased because people choose to avoid surgery and no shit.

Obviously like people want to have void surgery whenever it is reasonable. I sometimes I still tell patients, This is not reasonable, you need a surgery because that is the case.

It's nice as a surgeon, And again, I wanted to sports because it's minimally invasive orthopedic surgery. It's not like we just treat athletes. So root gen is great because the least invasive way I could treat somebody with real long-term solutions for the right problems.

That was my gateway in doing that one day a week. And then how long did it take for you to so you do that one day? How long? Did it? Take for? You to realize?

Hey, I could be doing this full-time in this good work. Did you then go to two days a week? did you go part-Time where you just cut off cold turkey and what was that time online?

Yes, so it was Pretty fast actually really fast. I remember correctly. It was really fat Yeah, it's fast because I just decided to believe in process and make like this has to work What was it like?

That's scary Yes. I mean, I knew I could always fall back on what I used to do. Right. But the problem is once you realize that he could, you know, for me, my own practice is not.

It's not just about growing revenue or, it's about controlling patient experience. Like I always said before I even started, like I want patients to be wowed from the sign to the first step into the door to first person they meet and all the way back out.

I hated, and I used to think when I was a kid, I wanted to be a doctor. And I remember people treating my parents or family members crappy on the phone or whatever at doctor's office, because everyone gets cheated.

I'm like, oh, someday I'll have my own clinic and secret shop my people. Then as part of one of my practice that I don't want to name, which one, there was someone that answered the call that everybody knew was just so incredibly rude to patients.

And I brought her up repeatedly and I'm the last person to like push that too hard. I don't want to lose somebody's livelihood. Right. And, I've brought up multiple times and then the, last time I bought it up before I left, this was one of the things that pushed me out.

Cause they kept saying, Oh, they're, there being disciplined. They're being discipline. Now at what point is that discipline turning into action? Right?

And the response I got is, well, what do you expect? You get what you pay for. they can't pay them more because that's just the way it is yeah because yep so um yeah so that that was one of my pushes but so anyway so yeah i subleased from a friend of mine who's a podiatrist and like from across the space essentially by the by all the diatrists listening to this you totally could we're helping podi atris too yeah we've got a couple good that are just a year in and they're like killing it yeah Yeah, it's amazing podiatrist.

It's a frickin your you're missing. You're leaving a ton of money on the table. So I anyway started uh subleasing from her place in may So i went to the bobbin march.

Yep. I definitely 24 20 I did my first Regen day may 17th, I think it was uh and She hired another doctor at some point and I knew that was going to get tighter because she was off one day That's just how it worked out And I went to look at places just to see.

And there was a place I looked at that was at 1,500 square feet, and I was like, eh, it was 5,000 bucks a month. I'm like this isn't for me. Then the owner sent a message to the realtor saying, hey, why don't you see this urgent care that's closed, 4,00 square foot.

Now I can't even afford the 1.500-square-foot place. So I remember talking to you about it. And he said, and then I got the message again, so he believes in what I'm doing.

He has a concierge doc himself and he offered it to me for practically the same price of the 1500 square foot place for the first year. And then, you know, he's like, when you're successful and I think he will be, then it'll work out for you too.

and she was right. You know? And so I have a lot of us and there's that splendid speaking to you. Yeah. Do you think about that? Like, I can be listening to your story.

A lot whispers that you've followed. It didn't make a whole lot sense. Did it? Yeah, I guess it didn't make that much sense, but that was in November.

November 1st of 24 is when I started that lease. And so I don't remember anymore if I start seeing patients immediately, But I spent my days finishing one job, going there, building out the place, like freaking putting slats in the wall.

Oh, speaking of whispers, the other thing happened is my surgical scheduler goes at my prior office left. This happened to me multiple times in both my part jobs.

where someone that's really good confiding me that they're not happy. I went to the administration or whoever's involved and said, hey, they are going to leave.

You need to keep them. And every time they end up leaving, the administrators are like, no, I don't know. They'll stay. We never stay, and so I remember joking with her.

Oh, someday if I could start our own press, that would hire you. Totally as a joke, this was before I even met you, so she left. Opened this place. I needed to staff it and I still was working four years a week at the hospital and Well, I could staff like one day a we get out to sit there We're gonna go figure it out and it just happened to to talk to this person who left and went to another practice and She was like hating it in tears practically hated it asked for her old job back and all the bureaucracy there and kept him from making a decision of offering her job back, which she was one of their best employees, if not the best.

And so I just hired her. I didn't have the money to pay her, I, uh, I didn't know what she'd be doing. She ended up painting the walls. I knew she was the kind of person I'd hire and I could trust to just try her best, do her She was sitting there she was painting.

She's trying to help I didn't give the best guidance because I was busy four days a week So, you know, she'd be sitting they're watching shows sometimes that's fine because there was nothing for her to do, right?

And then it went from that to her painting walls Now she's at the office manager. We went one employee to five in less than a year It was a a year, August 11th, that I was solo during the non-compete thing went away.

As far as not competing. Yeah, because that's a big question we get. What can you share about that? They share that as I'm sure you have a noncompute about talking about it.

I could be. Well, I would say is, you know, so I think sometimes you could get out of it easily, but easily isn't always what feels ethical to you as a doctor, you know what I'm saying.

And so I didn't choose the easy way out, which sucked for a while. Did it get a little dicey? It got dice, but eventually, even though it was a costly thing, it worked out.

I still bring cases to the hospital where I left and stuff like that. And I love the docs that I work with there. And so like, it's cordial from that and they more than cordially friendly.

It's just that, you know, these places, businesses business sometimes and the long term relationships don't always matter as much to people as as a short term and sometimes showing making a point out of somebody.

But also, a lot of states have now practically outlawed non-competes. Federally, that didn't work. On a state level, even in Pennsylvania, which is where I'm at, with very certain exceptions, there are really no non competes, but they didnt apply retroactively towards my contracts.

So public policy is obviously going towards getting rid of noncommites for doctors. Well, getting to rid noncompete in general. So, for example, we've had some clients come to us from Colorado, and Colorado has passed the same law that non-competes are no longer viable.

No one has tested, like, okay, so the noncompete, the law went into place, let's say, January 1, 2024. Does that mean somebody who signed the contract on December 31, 2023, that the No one's really tested.

So that's what that was my situation. OK. But for Pennsylvania specifically did not apply to prior contracts. That's where things got dicey. And even, you know, it's just I think you have to make a decision on what you really want and then just decide and do it.

Now, the the sad thing is and this is a problem in general in the country is that you don't have But you just have to have clout behind you financially.

And so obviously, hospital systems have been part of the practices of having more clouts than most physicians, let alone someone like me who didn't have a ton of savings or anything like that to fight it.

So that was the scariest part. I was like, I don't know why I'm going to run out of money fighting this, whether the business might go fast enough to offset the losses.

So it was a hard decision. And at times after I made it, there were times I thought about, man, maybe I should have taken the easy way out. But in the end, it worked out and I'm proud that I didn't take that easy out And you're free.

You're completely free? I am pretty much free, yeah. Yeah, it ended up essentially being what I offered originally without guns. Yeah. And while you have a financial decision about whether or not you want to hire the attorney to fight, while the hospital has in-house counsel, they have their own lawyer on staff, which technically means that it's less expensive.

They still have financial decisions to make because that lawyer or that group of lawyers doesn't have unlimited resources. Well, I I'm trying to see what I could say without it being too much but what i would say this is not part of any agreement but just in general hospitals have a great way to make physicians feel not valuable to them and they think And they're correct in thinking that most orthopedic surgeons don't understand the value they bring to the system.

Right. Beyond just the service they do. And part of that's probably because insurance companies we versus less and less, less. Unless and so we think our value is that.

But to a hospital system like an orthopaedic surgeon is is a big deal. and the sad thing is like we lost so many with the surgery in this hospital since before I've been joined over years.

And they kept telling the orthopedic surgeons at State, hey, cover more and more call. Right. And, oh, we're trying to hire, and they haven't really tried to higher.

They wanted us to cover call for free, which is crazy because it went from having call split over, I think, at some point to, 10, to then it was getting to the point of six or something like that or seven.

or five it was going to go down to five because a couple left and Eventually, like I was saying like you guys are acting like residents, you know Like you're just because they're telling them we can't afford to pay for call, right?

Right. And so eventually the orthopedic group decided you-know-what Yeah, we have to be paid for a call after this date.

Patient outcomes, surgery, and the future of medicine

So they we all took a bunch free call for awhile and And eventually they settled on will take call for a rate and that rate is 750 a night and Which is way way below the average rate for orthopedic service $750 a month.

Yes, and But what's worst is from in my situation? It was not all in-house counsel It was outside council too. And I know for a fact they were paying more per hour for than what they offered us for call for our night.

So, and, they kept at it, you know, like obviously like without disclosing details, which I don't want to disclose. Lawyers were involved and lawyers are expensive.

They were expensive for me. I'm sure they're more expensive at the hospital eventually. And you have to understand, hospitals are not generating money anymore.

And even in big cities like Philadelphia, they are struggling. A friend of mine just bought a group of hospitals in Kentucky. They had lost something like $16 million this group the year before.

he bought him about two years ago he know they were lost six million he got him to 16 million dollars profitability right of course he's selling them off but like that's just I mean that thing education like his his business model is he buys failing hospitals right this is what this guy does so that that what really confused me early because I might I will continue to do cases here.

And because I knew I was a loss leader in the office, I'm like, wait, you don't have to pay me. I'll still do the surgeries. Yet it still led to this and I am sure again, the business of it fell into it.

But I never understood for a struggling hospital to be spending any amount of money and then saying they can't afford to, to paid orthopedics or to take more call.

Uh, and then the worst of it, like there were days that were uncovered. So patients would be transferred from the hospital to another hospital with pretty simple way to beat injuries, but there's no one to do it.

Jesus. And that's a huge loss for them too. I just, I happened to learn relatively early in my career that, um, that big systems like that don't move well.

At some point, they actually asked me before things went to me leaving fully, because I actually offered to stay involved in some way more directly, which was a mistake and invited to work out.

But they were like, well, can we essentially get you fully back in with your practice that you started? And I'm like, you guys, like the whole purpose of me doing it on my own is that, we'll move quickly.

That's like saying a bus can move faster than a Ferrari. Like I could, tomorrow, a simple thing is, a dirty tile or a leak that went through and there's a stain on the tile.

That stain's going to be in the hospital for the next 30 years, guaranteed. In my office, I'll be like, there is a staining on a ceiling tile, get me a new ceiling.

Because it sounds like a no good deal. Or another example, we have really simple things like Fiji and Pellegrino in our office for everyone who sits in a waiting room.

We have a little coffee menu called Iron Mountain Summit Sips. And we have a little latte machine all this stuff for people. It's not just a curate. There's no chance a hospital No, just oh by the way the same god most of these hospitals are getting rid of Simple coffee machines in the doctor's lounges like for me i'm doing a server.

You have to start cutting 75 cents for coffee Because it's they don't be in a doctor lounge. Yeah when you have To start doing that Well, in the last couple of years, coffee machines have disappeared from the floors.

The cafeteria closes at, I don't know, four or five, whatever it is. I was just there doing surgery until like nine o'clock a couple weeks ago, and I wanted to try to find like an ounce of coffee anywhere, but I couldn't find it.

And the physician lounge has nothing. Like nothing. There's a Turing machine, but there are no cups. And like, you hear from other people in other places, like people are not buying paper plates anymore.

Like they're not providing that for staff, just paperplates. They're cutting those costs because I think that's what matters, because they are trying to do anything they possibly can to make the P&L and the cash flow statements look better.

Because they only want to own it for three to five years, and they all looking for the next person to buy. Well, what they don't realize is that kills morale.

PE is not the only thing that has ruined modern medicine, but it's a majorly fucking contributor. Well you know, PE doesn't own the hospital that I was working at, It's I mean, they don't get paid enough by the insurance companies to well P is in the Insurance companies private equity, right?

Yeah cut funds on they own huge chunks of the stock and they look, you know, the funny thing is is we joke about this We were having this conversation the other day in a company well Who's releasing the latest?

Who is releasing a lily? Eli Lilly is really releasing, try to try it. The latest version of 7Glutide, you know, the GLB-1. And so we are all joking, yeah, we need to go buy Eli Lily's stock and then when we sell it we can save that to just go out and buy the peptides that we want to buy.

So we're going to invest in the thing that like we cate to fund the things that love, right? And I just think that there's going be a lot of that. Yeah, it's not getting any better.

As a doctor, what saddens you the most about modern day medicine? I think what sounds mean them very most is that doctors no longer tell children and it is a good path.

And you knew at a young age, right? When did you know? Five, something like that. Five or six. You know, it was silly then, but it stuck. And it wasn't anyone pushing it on me.

But that's the saddest, because even when I was applying to med schools and stuff and shadowing doctors, even for me then they were like, oh, I've had people or speak to service.

Why would you ever want to do this? Like I don't know if I need to one piece of the dice, change your mind, find something else. That's the thing that saddens me the most because it's it and it why could you how could You blame them?

No, you can't right because now they used to be respected and trusted and they were able to practice more freely and have their own practices and Treat patients the way they wanted to treat them and some were better some are worse now The system forced them to see more and more people get paid less and less work their asses off true patients with the I just read a study from 2025. I hate to not have the quote who it's from, but that the average patient visit within work to be a surgeon in this group, I think they had like 10 surgeons and like almost 1400 encounters was seven minutes and 52 seconds.

And so how could you verify J to birth and No, I mean that's Emmys but the point is just you are becoming a robot

and then they come home often They're they're dictating at home.

They are doing the charts at Home And so they are missing out on their own family life. In the meantime, most of us have given up our 20s just to get here thinking, oh, it's gonna get better any moment now.

And then you realize that you're stuck in this rat race of seeing 50 patients a day, coming home, dictating a couple hours. Like one of the guys that worked him out after this, he's in his late 60s, and he still, I know he does charts for like two hours a night.

He goes, Ash Goy, come home. Six o'clock, have dinner, then spend the next three hours charting. I'm like that? So of course they're not happy, they don't want anyone to do it.

What's even worse, You take that with doctors already burning out and then you have patients that don't trust their doctors and they think that doctors are all part of this system.

also for good reasons sometimes because they get seven minutes to stand with the doctor and it's barely a conversation before the steroid injection comes into play right so It's the system is forcing both patients and doctors to be in a crappy environment which is burning everybody out and getting patients to distress the System and the doctors they hate their lives and burn out And I recommend it for young people the the brightest and smartest set used to go into things to try to help people.

Mm-hmm are now going into other things that are more focused on helping themselves sometimes, which is okay. And we're helping people in other ways, you know, like, it's just that medicine is becoming, um, It's becoming roboticized before even AI had a chance to take over.

So becoming a roboticist and then on top of it, I think, again, private equity is one of the worst things has ever happened to medicine. because they try to make it like you're making cheeseburgers.

You know? Well, yeah, I mean, that's their job. Right. And that is, look, and that what they're paid to do is you know, fine, but it doesn't, you more of KPIs was how long were you staying with the patient being pretty straightforward, right?

Can you the visit shouldn't take more than 15 minutes, 15 to 20 minutes and then again, try next shot. And I used to get so frustrated because our doctor And I've wrongly got frustrated.

I have since told myself it's wrong. At first I was like, why are you spending like 45 minutes? He's like they get a bunch of other questions and they want a doctor.

But I answer for him. And it took me about six months to realize I'm like oh, yeah, fuck. That's what this was 2014. And I'm like, okay, that makes sense.

Like I didn't realize, like I was just coming in from a business standpoint and I can see how the people of private equity, they don't understand. I mean, but when you, you know, owning clinics for years and then, sometimes I'll hang out at the office and shatter you all if I am in town.

The hunger from the patient that just wants somebody to give them some straight answers and spend some time. How long do you spend with your patients when they come in?

new patients get 45 minutes an hour. How's that? You know, it's funny. Sometimes I feel rushed. Weird, right? So I have to actually consciously, you know still realize that, yeah, and most of my patients that have any procedure done, certainly surgery or regen will seek to get myself on.

Yeah. And you're still doing surgery to serve everybody. Surgery is my calling. Regenerative medicine is part of that because I shouldn't be operating in someone that doesn't need it.

That's really what it is. The whole identity of my practice is I'm a surgeon who's going to give you every option that makes sense whether it's surgery, not surgery or just living with it which you can't believe.

How many patients I see A simple example again, I do shoulder replacement. I did complex shoulder replacements and redo shoulder placements. And then someone sent to me by another orthopedic surgeon saying I am told I need a shoulder placement.

Great. Well, you don't need a shoulder replacement until you come in begging for it. And their eyes are like, yep, well then I don' want one. You don''t even realize as a doctor that when you tell a patient you need shoulder replacements, a lot of patients believe that like flatly exactly how it is.

Oh, I must need it, not you needed if you can't live with it right. They think if we, like I had another lady came in, she had bone and bone arthritis.

She saw another surgeon and he told her, um, you can end up in a wheelchair if you don't get your knees replaced. And she comes to me for a second and I'm like, okay, great.

So like where did they hurt? How much did it hurt. She's like well, they don' really hurt that much right now. And I'm like, then why would you get a newer place if they don't?

Right. Yeah. You know, you're walking, like what's the problem? She's like I don' really have a problem. Like you told me I was going to end up in a wheelchair.

That's something similar with my college friend's wife. So I like you know we don''t realize that because we have seven minutes to spend with a patient and we're just saying, oh yeah, bone and bone arthritis.

you you''re not going be able to walk eventually. Maybe, we dont know that. And because there are plenty of people, I tell people I don't treat with pictures that treat you because they're people with bone and bone arthritis all over the world that don' t realize they have bone or arthritis right now.

And that's actually part of the things that got me into regenerative medicine because I would see someone with Bone and Bone Arthritis in my training and someone else with Mild Artheritis and the person with mild arthritis says cut my knee off.

And with bone in bone, I just realized it's just creaky. It hurts a little bit. And so our bodies have a great capacity to adapt to what we have. All that Regen does, it not magic.

I wish it wasn't called regenerative medicine, but it doesn't regenerate things. Right. But all it does is it helps your body adapt. To what you have, which many of us do naturally.

So we're out of time, but if people want to find out more about who you are and what you do, what would be the best way? You want them to go to your website?

Whatever they want do is fine. My website is ironmountainortho.com. You can find it at LinkedIn. Again, if anyone wants to actually come see patient outcomes.

If someone across the street from my clinic wants come to see how to do it right, I don't believe in competition. I just believe doing the best job for our patients, and there will always be patients that could use us.

So anyone who wants to stop by is always welcome. Cool. Thanks, Mark. I appreciate it. And great. Enjoy the conversation. Next time you're in LA, I know you'll reach out, but let's get you on again.

Sounds good. Bye, buddy. If this episode got you thinking differently, hit follow and share it with someone stuck in the system. Please leave a review, it helps us grow.

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