Introduction and Doctor Kelly Haldermanu2019s Mission

Hi, I'm doctor Kelly Halderman. I'm a former medical physician and author of The Thyroid Debacle. I'm now devoting my life to education, research and biotech because I realize we need educated people to bring us cutting edge information, especially when we find ourselves with a diagnosis such as hypothyroidism.

When I was practicing allopathic medicine, I myself became very sick, bedridden with what would be diagnosed as Lyme and mold infections. Along my health journey, I was also diagnosed with Hashimoto's thyroiditis, a condition I was told that could only be managed with medication.

Well, I'm here to tell you that there is more than medication to help you, as you will learn through my powerful interviews with several functional medicine practitioners.

There are tools that will help empower you to take charge of your health. Join me today as I interview leading doctors, naturopathic specialists to uncover the most useful health insights for you.

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Hi everyone. Welcome back to Doctor Toxicities. Doctor Kelly Halderman, your host is with the most and literally I am having a great day today because I get to talk to my friend and colleague, doctor Rob Abbott.

He is a rock star. There's so many adjectives you guys I could use to describe Rob. But first of all, he's a medical doctor. He is the medical director of Resilient Roots.

It's a functional and evolutionary medicine clinic. He's also the director of research for the Ruscio Institute of Research. He's the author of my new favorite book.

I don't think anything's ever going to top this book, Rob. It is called The Breaking of Our Healers Becoming the Doctor. I never planned to be Rob. I mean, like this book underlying like, dog eared.

It's it's just really resin eats with me. And that's why I'm excited for you. I'm excited for the listener, the person who may be struggling, with a medical diagnosis.

The doctor who has gone through the training that we have gone through. So, you know, I really want to get into right away again, welcoming you, first of all, like, thank you for your time, but I want to dive in because I think that the topic today we're going to talk about why, you know, particularly doctors act the way they do, like our training.

What did what what went into it and how how that works. And what we both discovered did not resonate with us was very ego dis tonic. So do you mind if I read from your book to start?

Okay. You know what's okay.

Why the Medical System Feels Broken

What's missing from this medical paradigm, however, is the acknowledgment that human suffering can result just as easily from the absence of an essential element as it can develop from the presence of something pathogenic.

So you call this a lack of basic homeostatic balance. And then you go on to say, do not be blinded by the belief that suffering and disease are only caused by a stressor in an insult.

Everything from the absence of certain microbial species in the colon to failing to hear a good game following a competitive match of soccer can be dead to can be as detrimental to our health and well-being as a single cell of salmonella.

Tell us about this. Tell us about the medical paradigm. Tell us your experience of it as well. First of all, I'm so glad we got this to work. We've been we've been at trying to coordinate this for feels like months.

And I'm just I'm giddy as you to talk about it. So yeah, I think it's it's amazing that the system we've created is has so, so much inertia. And I'm sure anyone listening to this is either experienced it and has probably strong opinions, whether working within the system, being a patient within the system, usually some combination of both.

And sometimes I have to hit the pause button when I feel myself getting a little internally agitated or angry at, you know, hearing another patient's story about XYZ, the doctor procedure experience.

I just really went poorly and I remind myself that I use the terms a lot traditional medical complex or traditional medical system or traditional medicine and and what that sometimes misses is this is actually an entirely human creation.

This wasn't placed upon us by some foreign entity. The complexity inertia of this system is actually all manmade, which can both feel like really crippling.

Just like when some patients come in and are feeling symptoms and you start explaining what may be underlying that, which could include you. Poor dietary habits, disrupted circadian rhythm.

A lack of movement can be really sort of, you know, sometimes destructive in the beginning to feel like, wow, I, I did this all to myself. You know, I am the reason I'm having these symptoms.

And we have to sort of step back and flip that talk and say, no, no, it's you know, this isn't supposed to be disempowering. It's actually supposed to be the opposite.

It's supposed to be radically empowering that, no, these, you know, you aren't resigned to a lifetime of, you know, all of these horrible symptoms. You actually have a say in this.

And in the same way, you know, it's very easy to look at traditional medicine to be like, wow, this system has so much inertia. There's no point. And or this is just like this created entity that's doing all these harmful things, when in reality, you know, it is manmade.

And anything that's manmade has the potential to be changed even in the slightest ways. And I think lucky that fairly early on in some of my own awakening and health issues, that kind of sped through that angry, the angry phase of like, you know, which I think we all kind of go through, like, I want to know that even build something up, you just want to destroy the thing that hurt you and kind of try to move move through that rather quickly.

Integral chemical. Compassionate phase and realize that, yes, these are, you know, I can make small differences. And if I share that with someone else and I think, you know, we're sitting here speaking about the system in the United States.

And yes, there's a lot of differences from country to country and oftentimes gets cited as you know, we're we're the worst for all these reasons. And I think that's a very near-sighted view.

It's so complex. But I think the biggest thing that, you know, stands out is we are terribly inefficient. And so many different ways that really providing meaningful care and it's bankrupting our country.

And in the process making people sicker and making the physicians or other medical providers sicker and more just disillusioned themselves. So, you know, it's we have to approach things differently, whether that's at the individual level, trying to avoid the system, if that's your goal or as a provider, you know, recognizing what are the

things that are actually, you know, positives or what are the things that are really downsides and how can we we can't transmute this.

But I think approaching it from, you know, no one's a victim in this bill. And yes, we have a huge system that has inertia. It's not going to change overnight, but small changes within our sphere of influence can be meaningful, actually can be empowering versus like, yeah, getting stuck in that victim mindset, which ultimately, like no healing can sort of occur, occur there.

And so I think we both sort of have experienced being in that place of like, wow, there's lots of terrible things happening. And this is so misaligned with what we want to do.

And it's easy to get stuck like external things are destroying me. But we can step out of that. Both on the patient side and the provider side. There is hope for changing the system that we have right now.

That's right. And providers like you again, I love how you quoted Buckminster and I always Fuller, Doctor Fuller, Buckminster Fuller. And, you know, in order to replace the old system, you have to build a new model.

You have to you can't just curse it. You don't have to show that there's a there's a better way. And that's really what you and your practice, what you're doing. And, I really love that, you know, you take, you took you took the good that you learned.

We, you know, we both took the good and all the skills that we paid a lot of money for. And, you know, you took that and yet you understood that there, there was an issue.

There's another quote in your book, if I may, our current medical education system does not cultivate a compassionate, mindful, and resilient healer, but rather the disillusioned, detached, emotionally distant healer burdened by a system crushing him or her from the inside out.

And like you just said, Rob, we can take that and, you know, curse against it. Or we can literally. It's a call to action. It's a call to wake up, wake up.

And and I know that my colleagues, there's a lot of colleagues out there who, you know, they're miserable and but yet they have bills to pay and, and, and and again, it's really hard to look at a system like this, what you said with a lot of inertia and think, what can one person do, right.

What can one person do?

Reclaiming Ownership of Medical Education

And I think that really looking at the transformation, can you can you comment on how you, you were an alchemist to talk to us about how how that came about?

Yeah, it was rather fascinating in kind of the early months. So this is 2013, ten years ago when I was starting to kind of resurrect my life and really changing my lifestyle.

I had been in med school for six months and was in my medical leave, and I had a whole year to take off to really sort of find myself and, you know, better terms.

And early on, I started to learn about ancestral nutrition and or a functional medicine approach. And, you know, I didn't come into med school from a family that was medical in any way or let alone, you know, eating organic food or just doing yoga.

That wasn't it was weren't health nutty like we were like, well, that crunchy, I joked, I think in the book I said, I ate, you know, above average amount of vegetables, but that was about it.

And so I didn't I didn't even have that. I was coming truly beginner's mind. And it was blowing me away, like, wow, this is so even with just six months of education or so disconnected, so discordant with what we're learning, and early on I was like, I don't I don't think I can go back to that system.

Is there can I reconcile that gap? And I just sort of sat with it. I said, I can't make a decision early on. I have all this time. And really what pulled me back was more of the community.

And, you know, I did sort of realize, you know, I am a professional student and I tell this a lot to the students at precept. Yes. You're going to tell you what to learn.

You're going to have tests, you're going to have grades. But at the end of the day, your job is like, I want to acquire skills that will help me to actually support people and healing, and I can take ownership of this.

I can do what I need to pass, and I'm surely not going to shirk by. But like that's my goal. No externally imposed. You have to do this. You have to do this.

Like really ultimately mattered. Yes. You know, there's licensing exams, the different things that I would have to complete. But my true North Star was like, this is my education.

And so I'm like, I want to be in this community. I'm going to be presented with, you know, I'm at this beautiful academic institution that, I mean, hundreds of thousands of people would would deeply desire to be.

And so, you know, let me take that not be bulldozed by it and truly approach anything that they provide with discernment and make my own education. And so that was sort of the kind of light bulb moment of like, I have ownership of this education.

I can take this, you know, and yes, I'm going to probably have to spend some mental energy, like being presented with stuff that is just wrong and and deeply discordant, but like, you know, that sort of like loving kindness and compassion meditations, you know, came into play.

But realizing I can take this education and morph it and and more importantly, in the second half of med school, like I was going to be with people in the clinical setting, you're never going to have, you know, such an opportunity.

And to really and I made it my focus like, I want to spend more time with people. I started to freak out the nurses because they were like, who? Like who's like, I wasn't paging.

And it is not the walk over and talk. And I'm like, who are you? Once they got to know me, they're like, okay, this guy's not, you know, weirdo, creepy student.

Like, he just genuinely wants to communicate. He wants to help these people is, you know, staying later to talk to patients. So I really wanted to make that experience.

And I think no matter what industry we're, we're in, like, because I hear all the same stories and, you know, PhD program, you know, pick whatever industry like if we really can sit back and say, you know, I wanted to take true ownership of this education, I'm going to be presented with things that maybe are important, realize you can't learn it all.

And that's okay. You can decide, though, what's most important and also get feedback from your patients of what works the best. That's my main continuing medical education now is patients.

You know what's working, what's helping them, where am I my gaps. And so that really is what allowed me in the community to kind of be in a system. And I still want to tell people that non-medical folks like you went back to school and did the whole school knowing you didn't actually want to be, you know, what they're training you to be like, yeah, yeah, I did that.

And I mean, again, in your book, you detail about how that wasn't a cakewalk, and how you, you just said how there was no going back when you started to listen to podcasts like these.

And that's why I love being the host of this podcast, is that we're bringing this information to people who are hungry. And again, like you said, once you're digging in, you can't go back and again, read this book, get this book, you guys.

It's amazing. You talk about the struggle it was and how really medicine wanted you to be in that box. And when you stepped out of that box, like, can you go through that story when you were.

Yeah. Okay. When, you know, one of the stories, I guess when you were trying to add that in, in your preceptors and, the attendings were like, no, I had so many different stories, I could have made it in there.

One that I think made it into the to the book. Was it in my fourth year with, on the neurology floor, and it was with a pediatric patient who was having refractory seizures and on no less than five anti-epileptic medications.

And there was other developmental just, you know, issues. I mean, it was a it was a very complex case having breakthrough seizures and really like, no, like no other medications as a or a as an option or an ability to really increase medications.

And so I'm like, well, we got at least researched something and that's where, you know, came across CBD, which some people laugh about. Now this was 2016.

And there was at the time it just had letters and numbers after it that there was a phase three study with, drug now called, I think, a Epidiolex, I think is the name of it.

Could be saying that wrong. Basically the CBD drug that's out there now, now approved for treatment of refractory seizures and certain future disorders was being studied.

Like, well, that's fascinating. Like a cannabinoid seemingly having effects procedures. Also came across a lot of the early literature on the ketogenic diet, very low carbohydrate, you know, higher fat diet specifically in pediatric patients and seeing some efficacy.

And so I'm like, well, we literally have no other options. So I know I'm going to bring these up and they're going to be they're not they practically feasible.

They're going to be implement in the hospital anyway. But you know, and probably going to get shot down. But I cannot from a moral standpoint like not share this.

And I was the student when, you know, we'd have the patients and they would tell you go research XYZ. The topic that I would always come back with, like, I'm not just going to bring back that, you know, we use this up to date update like the encyclopedia.

Like I'm not going to reread that and be the 120 more up to date, that up to date. Thank you very much. There's that. And so actually I was with the I mean, she was a very lovely, compassionate neurologist, recognizing the limitations.

Know the rest of the the fellow and the other residents were sort of like kind of ridiculous. And, you know, of course it didn't get implemented, but, and it was easy, I think I talked about my but I was like, well, is it even worth it? Right?

If like, this isn't even going to be listened to, I even bother.

Challenging Conventional Care in Training

And I just always came back to my, my faith and the moral truth of, you know, let's at the very least provide some information and in those cases, truly trying to first do no harm, which I talked about this with a colleague of mine.

So much traditional medicine doesn't realize, unfortunately, like it is starting from a place like, our first like, so many interventions that they don't acknowledge, like, this carries, you know, a non-trivial amount of risk.

And I really, in my practice, want to start with even if it doesn't have the highest potential for benefit, which usually the lifestyle medicine treatments actually do.

But even if it didn't, it carries low risk because I really, truly want to do it first. Do no harm. But that was just one of many stories of trying to bring just a different perspective.

I we were talking about yoga and pregnancy, talked about a low carbohydrate diet with folks on a ventilator based on CO2 production. I mean, I brought in all the shenanigans in my fourth year.

It definitely accelerated as I gained knowledge and a little bit of bravado, but I just was like, I cannot, you know, I'm not going to be disrespectful, but I'm not going to sit here and pretend like the drugs and the answer or nothing is possible when, you know, we have, we have potential for implementing things.

So yeah, that was one of my favorite stories to include. There's plenty of other moments of music, plenty of obnoxious, I'm sure. Yeah. I remember when I mentioned in residency training, perhaps using acupuncture for like chronic migraines, and I was like booed out of the room, like I was like a crazy Doctor Halderman.

But yeah, I think that what you just said fits really well in this topic of thyroid health because when people, when mostly women are diagnosed, when they're going into their medical physician and using the antiquated system, medical providers using the antiquated, system for monitoring, for diagnosing, I think that there's a lot of room for improvement.

And there is a lot of, people being told that medication is your only option. And it honestly, it's hard to even articulate that. Like my shock. Like, I'm like, I can't even say that.

It's so far from the truth. And I know that you even in residency or even in medical school, I believe you are training with IFM. You are already looking at, you know, the functional medicine side of things.

And so can you comment on just a brief rabbit hole here, that of of when a person who has diagnosed or maybe, undiagnosed hypothyroidism because the medical establishment hasn't, you know, TSH in their teeth free teeth or is fine, how do you approach them?

What what comes first? Yeah. You know, that was one of the things that even began when I was a scribe in the ER in college. And that was kind of my first medical experience that, you know, I was very much, I need to do something, even if it's obviously not in the field, I would get into the experience.

Is this a direction I want to go? And I remember, you know, people come in, you're reading their chart and seeing their diagnosis and like, what are the most common diagnoses?

And I mean, goodness, it was like pretty much every person was hyperlipidemia, hypertension and also like hypothyroidism. And I was like, what? Why is everyone's thyroid?

You know, so discombobulated. You know, what's what's the deal here. Right. And so, you know, carry that forward to the actual medical school and some of my functional training.

And you still see the same sort of things and you start observing, well, what are these people with hypothyroidism? And, you know, unfortunately, the average American is overweight or obese.

What's the I think this is just a the 97% are metabolically unhealthy. And you start to sort of build a picture of, you

know, these people that were coming in were not like, you know, very healthy individuals.

And they had this hypothyroidism. And you really wondered, like how, how many people need this medication versus, you know, is this just the only coming into the PCP?

And they're feeling tired. They don't know what else to do. And so they put them on, you know, thyroid medication. And as I've done more research and work with, provided you start to see like research has come out, upwards of maybe a third of individuals are, you know, misdiagnosed and placed on medication.

And while functional medicine has its own issues there, this was actually from kind of the traditional population. And I know exactly the patient type was coming in tired, overweight.

You know, maybe this usage is a little bit elevated and which we want to take mindful, you know, be mindful of. But the solution is a jump to the top start.

You know, thyroid medication. But it's like what is going on here. Why is this, you know, dysfunctional and I started to sort of, you know, coined the term like, you know, the endocrine apathy of obesity, what's going on with hormones as a result of an obesity can be metabolic syndrome as well, because you would see testosterone controlling all sorts of, you know, cycle dysregulation and thyroid issues.

And that's really been a lot of your work is like what's actually behind this, you know, thyroid dysfunction. And, yes, I mean, people can develop very serious autoimmune thyroid disease, damage to the thyroid or have to have surgery.

And there's a need. And so we're blessed to have medications. But to think that that's the only option. I had a patient this past week seeing an endocrinologist, and I had actually previously recommended decreasing her meds because she was doing so much better.

He, of course wanted to, you know, that was the lever to pull on. Like she was starting to feel a little bit worse. Let's increase this by the 12 micrograms.

And I'm like, that's never going to be the answer. That's never going to get you where you want to to go. And so recognizing that even if you have a condition that seems very like 1 to 1, oh, hypothyroidism, you know, medication could be part of it, but there's so many inputs from someone's nutritional status and know sun exposure.

I love red light therapy studies on red light therapy, lowering antibodies, and people being able to decrease medication. But just recognizing there are there are so many other things that may not immediately seem relevant, right when we get so granular to the organ, recognizing that, like medication does not have to be the one, certainly the first go to or the only answer.

Right? Right. Yeah, that we talk about that in our book, The Thyroid Debacle with Doctor Eric. And I talk about this, the cellular hypothyroidism. It's not starting in the gland. The gland is the end stage.

It's just like heart disease does not start when you have a heart attack. This process starts long ago, and it's a protective mechanism. It's that cell danger response.

Your body's very, very smart. It's divinely designed. So these downstream effects tired, gaining weight, your brain fog, they're actually. Your body's coming indicating with you, right.

Thyroid Dysfunction and Root-Cause Medicine

Your body is telling you that the environment, the stress, the diet that you know, on and on is not working for you. And I think it's really challenging, Rob, to for people, that means, you know, mainstream medicine just doesn't offer that.

And we've kind of, you know, really dug that one into the ground with the right. Like they don't have much to offer. So it's it's really great to interview docs like you who really step back and go, let's figure out those root causes, let's figure them out and then empower people, empower them.

I heard a doctor say the other day on a webinar, I'm not your doctor. I'm your consultant. You are your doctor. You know your body like, I will give you information and I will help you.

But ultimately, you know, there's a lot of things that are in people's under people's control. And that is that is wonderful. That is wonderful to know that a your body talks to you.

Right? So listen to your body. And then be that that you have agency, you have agency over that. And I'm sure in your practice you, you're, you're, you're putting this rubber to the road, you know, you're, you're helping people understand what their bodies are telling them because, you know, I, I got diagnosed with Ms.

and was told to just go home and basically die with my two and my three year old, enjoy the time I had left and given some pills. And I'm like, wait a minute here.

Like, this is this is not this is not the path that I thought, I, I don't have any tools in my toolkit. Right? In my alphabetic toolkit. I don't have anything to help myself.

So going back, getting the naturopathy education, but then thinking my body was appropriately responding to my crappy, residency life and, you know, my diet.

And so it all makes sense now, you know, I can make sense of it. And at least I have, you know, the wherewithal to be able to be in places like this, to bring information to people like that.

So I do want to ask you in your book, you talk about bringing more feminine energy into into that patient, relationship, and you talk about balancing the feminine in the masculine.

And I wish we had kind of different names from because people go off in left field when they think about that. But can you kind of touch on what you what you mean by that, bringing more feminine energy in?

Yeah. I agree that, this terms are getting more charged by the by the weak, it seems. So they're the best terms that have in terms of is using in the, in the book.

But you know, I think each of us can sort of when, when I talk about femininity or, you know, masculine and feminine, we sort of think about certain attributes, about those characteristics, whether that's receptivity, you know, gentleness or openness.

Conscientiousness. And some of these are actually studied more specifically into the the big five personality traits. And they look between men and women.

You see, on average, women, I mean, men and women are actually reasonably similar. But there's some differences. So whether you look at it, you know, the personality traits or other attributes, you know, there are kind of some fundamental differences.

And on average, a biological man or a biological woman may have certain attributes that we, you know, see more commonly. And what we see in medicine is that what's the system that's developed in part because it was mainly, male profession, but now it's way beyond that.

There was more women in my, medical school class. And I think the numbers have generally, you know, changed that way. It's that system itself, is very, well, we may say paternalistic and that it's very driven in a kind of power dynamic.

I didn't you I loved to talk about power over rather than, you know, power within. And created a really sort of

strange hierarchical structure where, you know, there's the hierarchy within medicine, like, here's the attending doctor, here's a fellow doctor who's a resident, doctors and medical students, but then also power structure between any one medical and you, the patient, as if you know nothing about your experience or your or your body.

And so that gets driven into, you know, you observe that like, oh, the only way to sort of practice is this, like I make the decisions for people if they don't do what I'm saying, you know, they're bad patient and I can the only way for me to really get them to do what I want is like threatening or anything on that spectrum, but some aiming, right, right.

It sounds crazy, but I mean that like or excuse me, you're nodding like that was kind of the spectrum of and again, you would see that, but, you know, whether it was a man or a woman, because what people should have learned was like, well, that seemingly is the only way to, to operate.

And you didn't have the time to really kind of understand someone, to build some trust or intimacy, to sort of let compassionate, awareness come, come forth.

And so that was something that I noticed, you know, fairly early on was like, you know, that's what a lot of folks, again, male or female were missing was that ability to kind of cultivate that receptivity, and through that, like generating of not only like, you know, compassion, but like practical, meaningful action.

And so that's, you know, I think everyone, again, sort of not wanting to say, yeah, our system is sort of very structured in a hierarchical way, very, you know, paternalistic.

And we need to sort of cultivate that whether you're a man or a woman. And that's where, you know, I see, you know, a lot of the nurses who are sort of the frontline workers, which is a predominantly female profession.

So a lot of I don't like the term burnout because it's sort of not very descript, but what to say a lot of, dis ease at the individual level, and a lot of it is becoming is coming from that discordance of, well, maybe more innate natural feminine qualities.

They just basically get squashed, in the hospital setting. And as soon as you start growing that gap between your expression and also how you desire to express yourself in the professional setting, that's where suffering, you know, sufferings in the gaps.

I think I made a post about that years ago, but suffering is in those gaps, the gaps between how you want to express yourself and what the system is seemingly allowing you to do.

And so that was sort of the point I was trying to kind of make in the, in the, in the book. And it was, I say this kind of jokingly like, you know, as I was going through school, again, people didn't quite understand me and just, you know, and seeing that I had were these feminine qualities, I mean, every now and then, like, someone would, would, you know, question my sexuality because of that, I'm like, this has nothing to do with it.

No, it doesn't matter that you can, you know, we can have that. You're a newlywed. Congratulations. And it's like, I'm, like, sitting here laughing, like, you know, now and in those moments because, like, that's how that system had worked.

Everyone to like these qualities, like, don't even exist. Your level, you know, certainly not from a from a man. And, that's what we have to, to really bring back.

And it takes intentionality. I don't think like I'm a very practical person. So I say this and it's like, oh, poof, you know, that's just going to wake up tomorrow.

And I want to, you know, do x, y, z, and that's where it's the training is. So knowledge focus and so minimally language interaction, communication a focus that those truly skills are developed to talk about in the first part of my book, like I in a year off, is doing interviews with patients that were very directed at reflection, gratitude.

Masculine and Feminine Balance in Medicine

And I think in with, I think, great communication skills or really ability to sit with people. And I have this gift to really just sit with people not even medically focused for almost a year.

And that's just not a part of my medical training. I don't think it's a part of anyone's medical training. So if we really want some of those attributes, which I think we can all agree on, would greatly help the administration of care and the patient experience, you actually have to spend time focusing on that, which means something else has to take the backseat.

And of course, you know, that'll never change because we just increasingly learn to learn more. But yeah, I can go on on that topic, but it's something that, I still try to really demonstrate in practice and with, with students so they can see like, wow, I can now set about them as a practitioner, but they can be more authentic in their expression and find that balance of nurturing, perhaps with, you know, direct action that wasn't seen as accessible to them.

In a traditional hospital setting. Right, right. And I found that in training I was rewarded for my, my masculine skills, you know, power over and tell them what to do, and.

Oh, that's, you know, really good. Would you shame that patient for not vaccinating that their child? And I mean and then I was I was almost shamed for having the feminine qualities in you.

Right. Right here. So a better balance between action and receptivity. Instruction with listening, stoicism with, empathy, endurance with rest. We could do both people.

We really can. We really can. And like you said, we have to make room for both. And, you know, that's that's changing that paradigm. And maybe it's slowly coming around because I point out that our medical providers are suffering.

I don't like the term. I don't like the term burnout either. But certainly there is something going on. And you nailed it when you said there's suffering in between how you have to act and how you really feel that you should be acting in work.

Just clenching down on every last breath of the doctor's experience. They have no time. I mean, what do they. I mean, you really have them. So by the throat of trying to implement that in.

So it's it's a sad situation, but it's absolutely necessary. And again, it's, it's building the new model. It's showing like with you're doing with the students and with the residents that come in, you're modeling it for them.

We just need to get you in front of like a quarter million people around, you know, to really to really get this, this, you know, driven home. But there's certainly is a very high suicide rate in, in practitioners and doctors and it's it is it's just really upsetting.

And I think that this is absolutely one of one of the reasons it's just kind of it's getting a little worse and worse and we just don't really know how to fix it.

And that's why, you know, like your, your clinic, you have to you, you built the model that you want to practice, you stepped out and you built the model.

And so that's why I wanted to absolutely have you on this podcast. Because you you display that for people. It's like, well, how do I do this? Well, Doctor Robert ever knows how to do this.

He's actually done this in practice. And I forgot to mention to you're also a published author and that so, you know, you you took that education and you also published a paper.

Remind me it was on the IP diet, right? Yes. Yeah. I had and the and I still don't know how I ended up doing this. It

was my crazy residency. Single days, you know, did, two studies, but.

Yeah, with the autoimmune protocol for Hashimoto's thyroiditis, which was a pretty wonderful study. And then another study on, patients, a multidisciplinary study, sort of diet and lifestyle for those with a history of major depressive disorder.

And did those, you know, did that research and learned about the research process, did, you know, did all of it because there is, you know, traditional medicine, like, oh, there's no research for what you're saying, x, y, z.

And so I'm like, well, okay, let's hear. I go there, right here, I come with that. Can you comment on that? Can you go into the findings from your study for the Hashimoto's patients?

That would be really appropriate for our audience? Yeah. So this was really borne out, I got connected with two women, Angela Altes and Miki Truscott, who had formed a group called Autoimmune Wellness, really around trying to help individuals not just from diet, but that was certainly a big focus, you know, implement a nutrient dense elimination diet that was sort of a step beyond paleo or what I would call kind of an ancestral diet.

I typically refer to it as the autoimmune protocol or the acronym AP therapy, and they had actually partnered with a physician in California and San Diego to implement Angie's program, which was sort of a phased elimination rather than cold turkey.

Tomorrow you're changing your diet or removing all these things. It was like, let's do a couple things week one and build in some coaching support and have a community.

And they implemented this for folks with inflammatory bowel disease and saw some pretty amazing results on quality of life and colonoscopy. And this was the more traditionally minded physician, you know, in California.

And so, I was in residency at the time and had met them in a conference, and I get with that eager, you know, Beaver energy was just like, you know, let's I want to do more with this.

And so they were wanting to do more research as well. And so I said, well, we have to start with Hashimoto's is I mean, that's truly by prevalence the most prominent what I mean condition and also like this generally works well for that.

And so designed an intervention with her program, which in total was about 1010 weeks. So folks were sort of reducing, removing some of the problematic foods over a six week period and then continuing that for for further weeks.

So in the grand scheme of things, it was roughly three months. So not no time, but not, you know, do this for a whole year and see a teeny bit of change.

And the symptom questionnaire changes just blew my mind. And in the published study actually ended up adding an appendix of each individual case even more detailed, which is, again, the human part of me was like, we're so used to numbers and statistical, I want to bring, you know, each individual, this there's 17 in total to the study as well.

And we also had we looked at some markers of nutritional status, even, you know, heavy metals, which are sort of that wasn't actually the original plan.

We were, Genova Diagnostics, a great lab company, had donated some of the testing and stool testing. So I was seeing some of these changes just from diet and lifestyle.

There was no, new supplementation. People were on things and had been on them for more than a couple months. I was like, fine, continue them. That's actually as controlled as as anything.

And so like, you know, gut health get better. From on stool tests like heavy metal levels dropped, which was fascinating. And just, you know, symptom burden changing.

And I think almost half the women, I think almost everyone came in on medication, half of those on medication decreased their medication by the end, which, there's a but there's a couple different reasons for that.

But that was so powerful to see. And they, you know, I wish I had the research to follow them for 6 or 9 months. But the education, the community, the empowerment from that, was just so profound.

And, I mean, I did get to follow like a couple of them became my patients. I did get some longitudinal care with them, but it was just so amazing to see, that change rather quickly in that population.

And, you know, those people, people show up for their families more vibrantly and, fully for themselves. And so just knowing like, well, you know, I always joke like, you're the mom, heal the family. Like, heal the dad, heal the family.

But, like, really like the those the ripple effects are can be, tremendous. And so that was such a awesome study to to to do and I, I'm so blown away.

I log in every now and then to the other portal and I forget the statistics on it, but it's had over 100,000 views or something like that. Some number that like to me is insane, you know, and citations and downloads and they ever know I get an email from someone who's read it and it's just like, that was the first thing I'd ever, like, published.

Autoimmune Protocol Research for Hashimotou2019s

And I mean, there's a lot of, oh, we're talking about my book here, but like, that study, is just something that was so wonderful to, to be a part of and seeing that, you know, and it's besides it there's like people in Poland.

I mean, it's, it's wild to me that like, it's truly a, you know, kind of a, a global phenomenon. But that's the we'll just we will have to link to that for sure.

Well, I mean, people are going to be asking for that study and they're, they're also going to be asking for where they can get more information. So is that on Nikki, or Angie's website, or do you know, off top of your head?

I know they have a book. They have the R. I. P. diet. So a fabulous cookbook. Like, I know that. Yeah. So one of the requirements I had when I was choosing a publisher was had to be open access.

So, actually, if you must be, if you just type in Hashimoto's and diet, not even IP, it's usually the first study that that actually comes up in Google.

But I can definitely going to have a link to the PubMed and, the, the journals called curious. But yeah, but if you have a link to the permit to you, it's open access so you can read the, the whole thing.

That's awesome. That's that's very helpful. I think a lot of people just get stuck with, with diet. There's just so confused. Should I be carnivore. Should have you vegan.

It's like, you know, this is, published literature that shows you can move the needle with this, this type of diet. And I actually did use the, the I p diet when I had, Lyme and I really I, I moved the needle a lot just using the dietary interventions.

Every once in a while. I'll go back to it too, because it's just, it's really helpful and I know it can get expensive. I realize lab testing, gut testing, you know, a food allergy testing.

First of all, they're wrought with issues usually, like they're not the perfect. It's better to do the gold standard elimination. And so quite often, I'm glad that we were able to bring that point up to, you know it, Rob.

It has been awesome. Like, I don't I don't want to take up much of your time because you are out there saving the world. And, you know, if I have to take you away for another patient, I just feel like that the world is not right.

So I do want to thank you for your time, for the contribution you put out in the world, for the book you've written, for the research you've done, for being a really good friend.

Like you've been there for me since 2018, when we were both really going through a lot. If you read, Rob's book, which was it was absolutely touching.

It made me laugh. It made me cry. I mean, I was texting Rob, like, your book is a treasure. And so are and so are you. Rob, what you're doing with medicine and you're paving the way.

I'm just very grateful and blessed to call you a friend and to have had your knowledge today. She's so very kind. I'm, They me wordless with that. I we were joking beforehand during a unfortunate grilling with some very close friends that I realize I have yet to meet in person.

And so I'm like, I'm committed despite my growing family. I'm like, we're gonna find a way to pull this off. There's just, this close group, which I if I had to know if I've learned something through all of this, and it's really community, and it doesn't have to be huge.

And it can be virtual. I mean, some of my closest friendships and colleagues have been entirely virtual for for a few years. But it does seem like we can always just pick up a conversation, even if it's in months between text and work right there.

But that was something that, in my own experience, I had to spend time. I was not a social person investing. And, you know, you know, friendships, seeing the effects of, community and the research that I've done, seeing it for those of my patients, it's, I know one of our colleagues, James Maskell, who's been doing a lot with the evolution of medicine.

It really shifted to community focus. And, that's just something that is so seems intangible. It's very hard to kind of describe, but, you know, observing that and experiencing it.

So saying it doesn't have to be dire, doesn't even have to be exercise maybe isn't even, quote, meditation. But, you know, getting creative of of ways that you can maybe invest more, you know, in your wife or your husband or you go and you want to do a bird walk, with a group of people or go to the gym.

We love doing group workouts. It's, yeah, the benefits, they're hard to articulate, but something that has continually surprised me. And oftentimes people don't realize that that's an option.

And, you know, other than Diane and the more common thing, so, so grateful for our community for for you, for organizing this and sharing your experience and thoughts and for those, you know, listening, with your eagerness.

So, yeah. Thank you. Yeah. And let's just end by telling people where they can find you in your clinic. And I'll insert information like Instagram and social media.

Yes. So her clinic is in Charlottesville, Virginia. I kept roots there after going to school at the University of Virginia. But we do work with folks virtually.

What's great is where that consultant hat, as you I think, articulately described, for folks.

Community, Practice, and Closing Remarks

So we do work with people across the country, but mostly have folks in the Central Virginia region. We I do technically have an Instagram. I used to do so much more with it.

My wife's Instagram and what she does on our clinic are so much more, Oh, nice. So looking at, you know, resilient roots, we have some cool stuff on the website which we, we've updated as well.

And yeah, we'll have those links to the research studies for the science minded folks. And Julie would be a blessing if you want to read a medical book, a memoir, that's not, your typical but please do get it.

It is. I've I've read it probably myself. 70, 80 times. It it is actually, it's it is actually kind of a quick read. It sort of goes on to get into it. Yes.

You can, you can get into it, but it would be really touching if, you want to get it or share it with a, with a friend and it's available on Amazon. Of course, you can also get it from the publisher.

You know, please, if you want to read something or listen or, listen to it, it would be great thing to do to get an audio version. But, you know, I have a Kindle.

Kindle version, please. Yeah, I get the ebook, share the ebook. Great. We'll link to that as well. Well, thank you again, doctor. You are a treasure and a blessing, and I wish you a wonderful, wonderful weekend.

Thank you. You too. Thanks.