TNP EPS 1 FINAL .mp3

Production: [00:00:00] That naturopathic podcast. Hello there.

Dr. Kara : [00:00:05] Hi and thanks for joining us for episode 1 of that naturopathic podcast. I'm Dr. Kara Dionsio

Dr. Dave: [00:00:10] I'm Dr. David Miller. And we hear your frustrations. This show is for you.

Dr. Kara: [00:00:15] This show is for you if you're feeling like your current health care strategy is not getting to the root cause or the underlying reasons for your health.

Dr. Dave: [00:00:22] This show is for you. If you've been told that you're fine but you definitely don't feel very well.

Dr. Kara: [00:00:26] This show is for you. If you're walking out of your doctor's office with one two three four or even five medications without any mention of diet lifestyle or a long term game plan.

Dr. Dave: [00:00:37] This shows for you if you've got several specialists taking care of you but no one is really putting it all together.

Dr. Kara: [00:00:43] This show is for you if you believe that health should be part of health care. These problems have solutions.

Dr. Dave: [00:00:49] We know it.

Dr. Kara: [00:00:50] Our patients know it.

Dr. Dave: [00:00:51] And we want you to know it.

Dr. Kara: [00:00:53] Naturopathic medicine is the solution that you need to know about.

Dr. Dave: [00:00:57] Ok so we need to calm down a little bit.

Dr. Kara: [00:00:59] OK.

Dr. Dave: [00:01:00] Calm! let's calm we're going to get into episode one here. Transition into a more conversational tone. But thank you so much for tuning in to Episode 1.

Dr. Kara: [00:01:09] Ok. So choosing our first guest for TNP was pretty easy. It is our pleasure to introduce you to our classmate colleague and friend Dr. Jordan Robertson. And so if you have struggled with fertility issues or miscarriage this episode is for you. Dr. Jordan is the clinical director of Clarity Health in Burlington. She is a sought after speaker and a lecturer at McMaster University. She's a pretty strong badass cross fitter and a mom of two and recently has released her book "Carrying to Term: A Practical Guide to Reducing Miscarriage Risk". And so let's get going. Dr. Jordan welcome and thanks so much for joining us.

Dr. Jordan: [00:01:50] Thank you. I'm happy to be your guest.

Dr. Kara: [00:01:53] Awesome.

Dr. Kara: [00:01:53] So I think why don't we just dive right in because as Dave was saying with the purpose of the show is to really just highlight where Naturopathic medicine can fit into health care. And I know you're a big proponent of just realizing what our medicine can do and kind of breaking down barriers and labels. And I love that part of you. So how does miscarriage fit into that. Like why did you for about a decade of research into miscarriage thought.

Dr. Jordan: [00:02:21] That's a great question. So I mean I do have a personal history which I talk about quite a bit in the book I've written about miscarriage called carrying to term. So I had three miscarriages and all three of them were in my final year of Naturopathic school actually. It basically just sparked this interest in me because of the

way that my personal health care was being treated through this process. So I got a lot of pats on the head I got a lot of shuffling around from emergency room to emergency room, I was left to you know, miscarrying alone in my bathroom. And there was so much there that I felt like was being missed and misunderstood. So you know at the subsequent miscarriage or it's just chance it's happening again ... third miscarriage and finally I was like, "Well is there something else going on?". Like is there a reason why we're having three miscarriages when we thought we were otherwise like really healthy couples. So I started spending significant amount of time researching miscarriage and fertility in general. And where why I love this topic isn't why I think it's so relevant to us as Naturopathic doctors is because it truly actually embodies preventative medicine because there is a subset of miscarriage.... Certainly that's different than maybe you know a genetic malformation or a miscarriage that maybe you know spontaneous abortion we would call it - like where it's going to happen. There is a significant subset of miscarriage that can be traced back to hormones or traced back to diet or lifestyle or things that we actually can influence and as Naturopaths that's like our favorite place to sit right. We love to sit in the places where (a) we can predict if something's going to happen and (b) we can change that trajectory by using our tools. And that's exactly what can happen with miscarriage if we can educate patients well enough about it and kind of change that culture about miscarriage ... which it really has a significant culture tied to it to (a) not discuss it and (b) not pursue why it's happened.

Dr. Kara : [00:04:25] Of course. Yeah.

Dr. Dave: [00:04:26] Jordan I just want to talk a little bit like how you felt so when you're in the fourth year of Naturopathic medicine and you're having these three miscarriages which is intense. How did you feel?

Dr. Jordan: [00:04:39] I felt like I was floundering through the system. Yeah I felt like I was lost in it actually. So I would see my first miscarriage was probably the most traumatic because we had gone. So it was called a missed miscarriage. So I didn't pass it on my own. We thought we were pregnant for such a long time. You know I would say in the preface of my book I basically had rewritten my future and then had to go back to the life I had before which was totally great but felt really shitty because I was not going

to be a mom. But in that that whole process that I went through you know the stone cold nurse doing the ultrasounds saying Oh no your baby's dead or being given the option of having an emergency DNC or bleeding on my toilet by myself, right, like the lack of compassion that was there was significant. Right? And so and even for someone like ... so I had high knowledge going into that situation that I still had such a difficult time advocating for myself right, even though I knew a much better solution or plan would have been I still couldn't get it, right? I still was part of that assembly line "Well, this pregnancy is not going to work. So just try another one". The second two miscarriages came at very high stress points in my life. So one was the week that we wrote our board exams and then the third was the week that we got our results. And so you know in hindsight like certainly if my picture was very much sort of the stress, low progesterone and then even with my fourth pregnancy that year ... which now I have a very healthy almost 10 year old son ... I had to beg my family doctor for progesterone. And even though I 0had already had three miscarriages and it's technically qualified as a diagnosis of a recurrent miscarrier I still could barely get basic care and that's how I felt was just like that I was being let down. Right. It's not like I'm in the doctor's office every week when I go I want to be supported. And I wasn't.

Dr. Kara: [00:06:47] So it's interesting. And actually I don't think I even have talked to Dave about this but I had exactly the same experience. So I after naturopathic college I moved back to Owen Sound and I got pregnant pretty quickly and I also miscarried pretty late. And and again it was you know rushed to DNC we tried to possible. I kept bleeding and and then it happened again about three or six months later. So and my experience was very similar to the frustrations and how you were feeling at the time too. I guess one lesson is don't get pregnant after natural Catholic health is your your resources are quite depleted at that time. But I mean ... and I also felt I don't know if you felt this but I'm like 'Hey I'm supposed to know how to be healthy' I'm supposed to know ... I eat well I exercise you know I do all the right things how can this happen to me? And I think I didn't tell my story for numerous reasons but that was one of them.

Dr. Dave: [00:07:49] Can I ask both of you a question about sort of separating the experience like what was the limitations of the system versus maybe some limitations of

the doctor or people you were dealing with. Do you feel like people are just trapped by the trappings of the system.

Dr. Jordan: [00:08:09] I think we when even as my experience as a clinician we don't have good emergency room procedures for dealing with women with miscarriage I think that's a significant gap. So I've had many patients be bleeding on the gurney in the hallway or to be alone in their bathroom in their hospital right in their hospital room. I don't think we have good systems in place to deal with that. That is not the same as someone arriving with a ruptured appendix right from an emotional level. Maybe that person is sad to lose their appendix but you can't tell me that's the same depth of despair that a woman or a couple is experiencing during that moment of loss. And yet we deal with it in an urgent care center and so it gets triaged the same way as the ear infections and all the other things that Are being brought into the emergency room. I've done a lot of work on prescribing standards for PMS and this ties in ... Canada is actually one of the only countries where women see a primary care practitioner for their hormone issues. So in almost every other developed nation, your first point of contact as a gynecologist. So women see a gynecologist for their PMS, a gynecologist for their prenatal appointments. They would see a gynecologist to talk about their miscarriage or their Progesterone suppositories. The reason Canada family doctors have become the gateway to subspecialty. And so I think a lot of patients end up getting trapped in family medicine when their case actually warrants a bit of an endocrine perspective or (which would be hormones) or looking from an obstetricians perspective but it delays care because they have to go through that initial step of discussing with their family doctor if their family doctor doesn't agree that it warrants the referral then they still sort of get trapped in that family medicine system.

Dr. Kara: [00:09:56] And I guess the other the other place where you had to eventually say yourself as you know as a person who is educated in health you finally had to ask yourself, 'Hold on a minute. What else can I be doing. Is there a problem here that hasn't been addressed or even looked for'?

Dr. Jordan: [00:10:17] Right. And this is one of our problems just with miscarriage in general is that you don't qualify under the diagnostic criteria to be assessed for your

miscarriages until you've had three. Even though the research suggests that for many women the reason they have their third or fourth miscarriage is the same reason they had their first or second and so early assessment is actually is in the literature. That is what we suggest. But at this point because there is this group of miscarriages that, I'm going to use the term are "supposed to happen or should happen" or they you know that embryo can't develop for many reasons ... because we have that and we have a miscarriage that's related to endocrine or hormonal issues or lifestyle or diet, we group them all together. And so yes if there's spontaneous miscarriage for no reason I guess we would wait but that means that women get trapped. Right? And so that they have to experience three traumas before we run lab work when we actually can predict who is going to be at risk of miscarriage if we take a really good clinical history or if we run through very simple and inexpensive lab work.

Dr. Kara: [00:11:28] Sure. And we definitely want to get there. Just a question before we do is that ... the patients who come in to see you ... So what is their story? What is the common story you hear of a patient coming into your office who has experienced one or two or three or four miscarriages.

Dr. Jordan: [00:11:47] I think the experiences that we create a bit of apathy around the topic. Right? So women are left to feel that they actually can't change the trajectory of what's going to happen. So I am a miscarrier right? And this is what's sort of destined to be and you might be my last hope that maybe you have something magical to offer that would help me not miscarry the next time. Right and I think that's where people get excited about things like acupuncture or you know it's a treatment being done to them versus having a conversation about their baseline health status. Right? Which is a far more important thing to sort of access and change than applying a treatment if that makes any sense. Patients want to be given something because that's the way we made them feel about it. Right? They need to take a hormone like I used progesterone even though I'm quite an advocate for that. They want to get something to stop the miscarriage versus them even having this frame of reference that maybe there's things they can be doing right?

Dr. Dave: [00:12:54] Well, believe it or not you're just sort of going back to old Naturopathic principles which is, like, the body will do better stuff, basically if you remove all the obstacles to it doing good stuff - it knows a lot more than you know any one of us as doctors, right? In a way it's sort of going back to old school medicine but a better sort of modern interpretation.

Dr. Jordan: [00:13:14] For sure and certainly I would say like there's a huge percentage of the patients that I see that have polycystic ovaries and premature ovarian failure both of which we probably can trace back to some kind of genetic or trans-generational challenges with metabolism and diabetes. And so even if those women maybe I don't know they can't do something about that, there is a lot that they can do to try and improve their chances. We just as a culture you know we don't really think about miscarriage in that way or it's almost taboo to talk about miscarriage as that couple can be proactive about preventing ... that's not saying we're blaming them for the last one but the work you do in between your first and second can have a profound impact on what happens but no one's ever made them feel that way. Right? It's shocking. I actually did a talk this past weekend at the Canadian fertility show on sperm health and one of the participants put up his hand and said "you know no one's ever even asked me about my health". The male partner. And he's like and you know just based on his odds you think I would be 50 percent of it. And then he was like why do you think that is? And I was like wow that's a really big question for a different day.

Dr. Kara: [00:14:32] Almost exactly 50 percent of it right?!

Dr. Jordan: [00:14:34] Exactly so ... but it speaks to just how how much we under-educate patients about their the role of their diet and lifestyle and health factors and genetics and all of that have and then how impactful change can be. Right?

Dr. Kara: [00:14:51] It's reminding me of ... I'm just paralleling it with ... imagine someone came in who's had a heart attack and we say to them "well you're just someone heart attacks' your heart attacker" and so in that case it would be ... you know of course we're going to say "hey there's some powerful things you can do as secondary prevention so you don't have another heart attack." Let's do that. Let's talk

about that let me show you some things you can do to change your future risk. And so why. That's you know there's there's maybe some complexities with miscarriage but we shouldn't be approaching it that way.

Dr. Jordan: [00:15:30] And then he wants the side effect? They feel good.

Dr. Kara: [00:15:33] Yeah exactly.

Dr. Dave: [00:15:35] Darn! Would you say then, Jordan, people are more frustrated or apathetic when they end up in your office because it's implied usually that people have gone to their conventional medical doctor before they end up at you .. maybe in the future ... It's more they come to you beforehand which would be great. But I'd imagine you see some frustrated or apathetic women -- which sort of emotion predominates?

Dr. Jordan: [00:16:02] That's a good question and I feel like apathy has a negative connotation to it. So I don't want to say that my women are apathetic because I don't think ... it's only maybe apathy out of ignorance. Right. They don't know. And so they often leave their first visit frustrated and hopefully empowered. Right. Hopefully we can earn both at the same time. But for your naturopath to be the one to suggest that you might have PCOS or that you know or you know to explain to them conceptually why PCOS causes a miscarriage and to have them like sit back and think about that and go like "well why isn't anybody ever tested my vitamin D If almost 100 percent of my vitamin D in my body is in my uterus?" right? Like I think they leave those visits with a new found appreciation of what they can do but also feeling ... they really end up having to put the past behind them because it's a completely different path when I work with them because it's .... there is heavy, heavy assessment and they don't have that much before they get to an appointment with me. I can think of a specific example of a patient previous that you know when I'm going through my list of all my questions I said I'll get breast tenderness "yes" do you have nipple discharge "yes". And I stopped and I rifle back through the information I had from the fertility clinic and then just had never tested her prolactin which is a milk producing hormone that will cause miscarriage. And I said "well has your fertility clinic ever asks you about your breast health?". She's like No. She said my labs are all fine. You know we run for prolactin and it's out of range. So you

know to even have been engaging with a fertility clinic would make you assume that we've been down all these simple paths right. To be standing in line for IVF. I would hope at the very least that someone has had their fasting insulin and their vitamin D and you know some of these very simple lab tests done to know how we could support them best undergoing this very expensive and very significant medical procedure.

Dr. Kara: [00:18:03] Now when you're going to invest that time and money and hope into fertility treatments I think yeah. That just seems reasonable that you would.

Dr. Jordan: [00:18:15] Makes some 30 dollar Vitamin D tests seem like a steal.

Dr. Kara: [00:18:18] For sure!. And I love in your book you really do talk about how a lot of the same problems that can cause fertility issues can cause miscarriage which is really a double edged sword.

Dr. Jordan: [00:18:30] Well to make it a ... can you have a triple edged sword? To have a triple edged sword ... those same problems also increase your risk during pregnancy. So the women who have gestational diabetes the women who have swelling or who have preeclampsia or preterm birth or small babies or low amniotic fluid they're the same women. Right? And so just because we get them pregnant and we get them not to miscarry doesn't mean they have healthy pregnancies if we never address the root of what's going on. They're the same women. Right? And so when we have secondary infertility so meaning that women can't get pregnant a second or a third time but really desire to, you can learn a lot about their miscarriage risk just by inquiring about the health of their previous pregnancies. Right? And if they had preeclampsia in the first two you understand how to treat them to prevent miscarriage for their third.

Dr. Dave: [00:19:21] So as the person with the least insight into this subject let me ask the question what other people might be thinking of: is there a difference between conception and then carrying to term?

Dr. Jordan: [00:19:34] Yes which is why it's you know it's become sort of this passion project for me because we we know the people sitting in a fertility clinic we know what

they're like health wise. Right? The statistics show us right they are a slightly heavier than their ideal body weight. They smoke more they drink more they eat less vegetables they eat less fish. And certainly I'm not saying that about everyone but as a the general rule of thumb the patient sitting in a fertility clinic have more room to grow in their sort of baseline health than women not in a fertility clinic. And then when those patients get pregnant that's where we have the risk and that's where we have the issues with them carrying to term.

Dr. Dave: [00:20:17] Yeah I'm just thinking of the person maybe who conceives many times so like in the year you conceived three times ... But some people have troubles like conceiving at all.

Dr. Jordan: [00:20:30] At all right. In part yes. So lots of the reasons why women have trouble conceiving in the first place also increased the risk of miscarriage. Good examples of that would be premature ovarian failure where their ovarian reserve is generally diminished and so the eggs maybe have suffered that consequence as well and are not as healthy. Women with endometriosis have difficulty falling pregnant but and then difficulty with miscarriage for thousands of reasons. They have structural issues and inflammation and hormone imbalance and progesterone, low progesterone or progesterone insensitivity we call it. And so it's a lots of times it is those women that maybe have never conceived but then that same reason is going to increase the risk of miscarriage as well.

Dr. Kara: [00:21:13] And then you're saying also increases the risk of the pregnancy.

Dr. Jordan: [00:21:17] Yeah. It increases the risk during their pregnancy as well. It's interesting I always use the phrase like we can use technology to jump over a lot of problems in fertility. We can pick out the best egg we can pick out the best sperm we can wash it of the fluid we can grow it in an antioxidant rich medium which interestingly they're doing a lot of trials with using melatonin and green tea as the growth medium for embryos. Now in the States. So we can make all of that happen but at the end of the day we still have to put it back in right and what we're putting it back in to is what's creating that risk of miscarriage not that. And so if we never have a discussion about

that underlying health the technology only gets us so far but we can't force couples to carry to term.

Dr. Dave: [00:22:01] Sort of like the flower when you take it from poor soil poor hydration not enough sun, the same flower and different soil flourishes.

Dr. Kara: [00:22:13] Exactly. And you can do that with eggs too right?

Dr. Jordan: [00:22:16] You can do that with eggs. That's right. And that's something you talk about in the book Women with PCOS are great egg donors right because the egg isn't actually the issue it's that we're trying to grow a placenta with cardiovascular disease. Right. And so women with PCOS have you know high insulin and lots of inflammation and then the new blood vessels that they're forming are in the placenta and doing that in the context of inflammation and maybe high blood sugar. And so the health of their placenta is actually the challenge and we can't do anything with fertility medicine that would change that. Women with PCOS actually should delay their fertility treatment by six months in favor of doing diet and lifestyle and it's maybe the only time in fertility medicine where waiting is the option. Yeah because if they wait they do better.

Dr. Kara: [00:23:06] Why don't we get to ... we've talked a little bit about assessment and where perhaps it's not in general done well or done the right tests or really that question why is asked in too much depth at all. So how do we get there ... where is where do we get to a place where ... whether it's with a medical doctor or with their naturopath. What does optimal assessment look like?

Dr. Jordan: [00:23:32] So a really really good clinical history and sort of I would say from menarche onward so I'm going to start with like talking about specifically women because yes ... we know that the men have a huge impact on miscarriage but the assessment in women is maybe a little bit more challenging. So a really good hormonal health history starting from menarche onwards and so these are simple questions that may get missed. Right. So. Well when did you get your period. Oh I was seven. Or when did you get your first period. Oh I was 19. Right? These are simple questions that actually can help us understand a lot about a woman's health history was she a

competitive gymnast? Was she underweight? Did she have anorexia? Did she have you know a breast reduction? Did she have significant menstrual cramps and then was put on the pill for the last 20 years? These are ... there's a lot of questions in their history that teaches us what is going on and since many women are medicated on the pill for their last sort of five to 10 years before they try to conceive we've actually masked a lot of their menstrual health history right? So we have to go way back to the beginning to maybe learn a little bit about that. Did they use Accutane which may teach us that they have PCOS but B might teach us that they have ovarian failure since we think Accutane might have some effect on ovarian reserve. That clinical history goes such a long way. And so I spend a lot of time in that assessment ... like "in the beginning" you know how was your period and then we go all the way through up until present day ... we talk about whether or not they were small for gestational age which if they were a small baby it's more likely for them to have PCOS and have difficulty having babies. So that I spend a lot of time on. And then we talk about the value of lab work and this is where you know I'm certainly trying to branch and have a collaborative relationship with their family doctor. I'm being delivered a coffee. Thank you. Because it wouldn't be me if I wasn't having a coffee.

Dr. Kara: [00:25:29] We're going to see you like boosted by now which are you.

Dr. Jordan: [00:25:32] That's right. And you thought I was jacked before! You know I really view my role as that person who gets to sit with them for seventy five minutes and play detective. Right. And so ...but then when we start to talk about lab work now it's you know now some of it may be the responsibility of their family doctor some of it might be outside my scope. But when we talk about lab work and this is how I communicate it to the patient so that they can have a productive conversation with their doctor. But this is also how it heard it to their doctor. Is it lab work needs to tell us something we don't already know or it has to change their treatment. Right. And so I never send patients to their doctor with a laundry list of lab work that I know is not really OHIP's priority. OHIPs purpose or the publicly funded health care in Ontario for our non Ontario listeners... The purpose of it is for screening for prevention of big disease. Right. Which is why we have screening programs. But it's also to look for really acute illness that maybe needs to be picked up with urgency. The purpose of OHIP is not to monitor whether or not the dose

of vitamin D that you're taking is adequate to maintain adequate levels. Right. Like that's not what the publicly funded health care system is for. So certainly there's some lab work that women should or deserve to have done as part of OHIP and then there's some sort of different lab work that maybe is a bit more of an integrative approach or if the patient wants to be proactive, I would maybe expect that patient to pay out of pocket for that assessment. Something like their HOMA-IR scoring which is looking at insulin and glucose sensitivity vitamin D for example or the nuances of hormonal health like testing their day 21 estrogen and progesterone that that may be the responsibility of the patient right if they wanted to be treated differently than they may have to approach their treatment differently and have a little bit of out-of-pocket lab work done. But certainly there's some big things that should be tested within the setting of their family doctor like a diagnosis for PCOS. And so I will refer back for that often.

Dr. Dave: [00:27:33] What's your reaction when a patient comes in and says "My doctor said my labs are normal"?

[00:27:38] I say well there's there's normal and there's optimal. And for me like I'm so evidence-based like there's lots of times where I agree right and I'm not looking for the difference between 0.1 in their lab working and say oh you have a deficiency in such and such. That's not really my scope of practice or that's not the way I practice. But we do know for fertility specifically that there are some reference ranges that are not optimal; Vitamin D being probably the most important. So miscarriage decreases by 2 percent for every one point of vitamin D we increase a woman's numbers by up to 110. Women that have their vitamin D levels over 110 have a significantly reduced risk of miscarriage and if we know the Ontario lower limit right now is seventy five so women could could technically fall inside the reference range and still miscarry because of a vitamin D insufficiency.

Dr. Kara: [00:28:34] Those are Significant numbers.

Dr. Jordan: [00:28:35] The studies that were when they were published on this, I think I said out loud to my computer like 'oh my god!' as I'm reading this article because.... we talk about optimal ... I probably said 'holy shit' ... well probably ... I mean we talk about

optimal numbers but when the evidence starts to show us that there is a difference between normal and optimal that like lights my brain on fire right. That excites me... the thyroid research is the same. So.

Dr. Kara: [00:29:08] The other one that you talk about I've heard you talk about it with with similar. 'Oh my goodness' is thyroid numbers.

[00:29:17] So Canada is one of the sort of least aggressive when it comes to assessing thyroid ... meaning that we let women walk around with a TSH a little higher than other countries. But there's there's a tablet trial is the current as one of the trials going on right now. I think it's the tablet one where they're actually pre treating women with a TSH that's normal to try and reduce risk of of miscarriage. So even though they test normal they're treating the many ways to find out whether or not being optimal as far as thyroid function reduces miscarriage risk the... Yeah. We know that if one woman's TSH is above two she's less likely to conceive and the upper limit of the reference ranges for.

Dr. Kara: [00:29:58] It used to be five and up to about 5 years ago.

Dr. Jordan: [00:30:02] And so I mean that and I use that same reference range when I'm talking to my menopausal women and I'm like I can't get someone pregnant unless they're TSH is 2. So the fact that yours is like 4.3 I think we need to have a conversation. But that's. Yeah. So we have these like optimal lab numbers. We're starting to see some better lab work or more optimal ranges for progesterone too. And that's only been published in the last year where progesterone we used to think it was just fine if it was there. And now we're finding that if it's below 30 luteal that women are much more likely to miscarry and maybe optimal is over 50 which certainly brings in the idea of maybe supporting progesterone levels more emphatically and more heavy handedly than maybe we have in the past.

Dr. Dave: [00:30:45] Do you have any insight into B12 you know as a test is it useful? And if so is it an optimal level that you'd like to see.

Dr. Jordan: [00:30:54] So I haven't seen in the research any significant data to say there is in more optimal range for B12. Unfortunately I do know that when they change the reference range to include an upper limit that sort of made it feel like we were being squeezed in not just to for listeners the reference range for B12 used to be above 200. Right. And then infinity was the upper limit. And when they added an upper limit I think it's six fifty seven. It's something some weird number six seven. And now if patients are above that it gets flagged as high. Even though V12 is not toxic and we don't worry about maybe 12 levels in patients that are being supplemented. And so but I haven't seen any data to say like oh eight hundred is better than five hundred is better than three hundred. For me I use b12 as a test more to predict whether or not there's something else going on in a patient like Celiac Disease which is a major cause of miscarriage and infertility but our time to diagnosis is 10 years and that's someone's entire fertile life. And so I'm usually using that to try and make an early prediction on celiac.

Dr. Kara: [00:31:58] Sure. And you kind of roll in...There is some element of looking at these in relationship to homocysteine which I know is an important factor in miscarriage.

Dr. Jordan: [00:32:08] For sure.

Dr. Kara: [00:32:09] Which I don't think I have I have never seen that tested ... come into my office having being tested.

Dr. Jordan: [00:32:16] No I would say maybe with the exception of one or two patients who have been treated at fertility centers in the States. Yeah I've successfully helped two couples get pregnant with twins out of the Cleveland Clinic in Cleveland. And so they do ... they routinely test more and I've maybe seen it a handful of times in some of the more comprehensive fertility clinics in Toronto. Truthfully it's hard to get an elevated level for homocysteine at our level of care because patients have often been haphazardly taking a prenatal before they got to us. And so they're homocysteine levels are often normal even if they do have challenges with b12 and folic acid metabolism in general I would say the goal would be to just treat b12 and folic acid rather than test in that scenario.

Dr. Dave: [00:33:05] Do I move on to NMRx ... a basic sort of lifestyle assessment that maybe Jordan would go through.

Dr. Kara: [00:33:13] Yeah I think maybe it would be a good point. I mean we can't get into all of the labs and assessment and even we could probably do a whole show on that. But you do have a free download of you know guiding people into kind of some labs that they should.

Dr. Jordan: [00:33:31] I do. Yeah. So it's available on my ... it's on my Instagram. Actually it's on my my Instagram and the Instagram ... The book has its own Instagram "carrying to term" and it's available on on both links there which basically gives an outline of all the labs that really should be considered as part of an initial workup for miscarriage and certainly not every test needs to be done in every woman. Like I said like if it tells us something we don't.... it needs to tell us something we don't already know or change what we do we certainly go into those tests a lot more in depth in the book but at least it's a starting point to see you can compare whether or not your current lab work has been that comprehensive or not.

Dr. Dave: [00:34:09] We'll put it in the show notes and.

Dr. Kara: [00:34:12] Yeah it's a great resource. So ... Let's just get into some kind of things that we can get started with or where you start. So you know as Naturopaths our foundations are good nutrition, movement, stress (management) that sort of thing. So where does that come in to to your approach. Like how how do you address those foundational health topics.

Dr. Jordan: [00:34:38] So it's still from a very evidence based approach although I'm very mindful of how challenging behavior change is for patients and so I need to link those two up right? ... that I want to talk about things where we have high levels of evidence and that will fit into sort of a good behavior change model for patients. So I'm really not an advocate of restrictive diets. So you know I think our profession gets kind of labeled for the you know everybody is gluten free and dairy free and drinking their

green smoothies and that's that's not necessarily the the approach I take with patients because whatever it is that I get them to do I need them to do it for three to six months. This is not a 21 day fix right? And so we need to have a rule like that.

Dr. Dave: [00:35:23] I love when you talk about stuff like that. This is not a 21 day fix or not a 10 day detox.

Dr. Jordan: [00:35:28] No.

Dr. Dave: [00:35:29] Yeah. I love when you talk about stuff like that really hits home for me as a practitioner because I say it all the time.

Dr. Jordan: [00:35:34] So yeah I think we need to talk about sustainability because most of the most of the challenges that patients have are ones that took years to occur. They're not going to unfold in 21 days. And if the patient can't imagine themselves doing the plan for three to six months their failure rate is really high too. And so we certainly need to take that into account. So when I work with diet and lifestyle with patients it's always talking about sort of the absolutes the nice to haves, sort of and then you know what else do you think you can manage or what else would you like to tackle kind of at the same time. There's some strategies there around motivational interviewing we call it where you're encouraging the patient to make a lot of these decisions for you. So the things we talk about with miscarriage that are sort of absolutes and that have the best data is alcohol restriction and caffeine restriction given you know the high failure rate of basically IVF or IUI cycles and that's for both partners actually. So if either partner drinks alcohol in the four weeks leading up to their fertility treatment it fails twice as often. So they're two times less successful which is crazy. A huge study done in the States looking at 15000 couples found that 20 percent of couples were still drinking the month of their IVF and that that's just an education issue. Right. I'm pretty sure that most of those couples would abstain or we should be working on help how to help them abstain because now this is the biggest obstacle to their health. Right. And so alcohol and caffeine are sort of off the list. The only other foods that show significant negative data would be trans fats and interestingly cold cereal as an independent food has been shown to increase risk of infertility and miscarriage which is probably you would call it a

spurious correlation meaning people who eat cold cereal maybe also eat McDonald's maybe also don't exercise. Right. And so maybe the cold cereal is just the tip of the iceberg and maybe there's a lot more going on under there that we don't know.

Dr. Kara: [00:37:40] But the same can be said for trans fat right because what food are trans fats in.

Dr. Dave: [00:37:46] I don't remember the last time I had a trans fat.

Dr. Jordan: [00:37:48] No and we're lucky in Canada now that they are certainly easy to find because they have to be labeled and certainly lower in numbers and they maybe were 10 years ago but those are the things I say without a shadow of a doubt have to come out ... the things that have to go in are things like a serving of nuts you know a couple of servings of fish per week plus or minus maybe some fish oil olive oil and then we talk very conceptually about the Mediterranean diet and how impactful it is to eat whole foods eat lots of colour how your genetics are turned on by all the antioxidants and bio flavonoids that are coming from those foods and so variety is key. How to eat grains in their most natural form. So I'll say patients can have rice but they can't have rice that's been turned into a gluten free doughnut. And that's it. And it was very conceptual conversation. When patients have 30 or 40 pounds to lose before an IVF that is a very different conversation right that the goals are really hard core of the plan maybe needs to be slightly more healthy.

Introduction: [00:38:52] That Naturopathic Podcast. TNP.

Dr. Jordan: [00:38:58] So we also talk pretty conceptually about the Mediterranean diet. So lots of fruits and vegetables lean protein healthy oils from plants avocado nuts and seeds hemp Chia all these things we talk about that very conceptually that that's what we want though sort of the basis of their diet to be... we talk about including grains in a healthy way meaning you know eat rice don't eat rice turned into a gluten free doughnut. And that being sort of the basis of how we teach them. Certainly that's very different than patients who need to lose 40 pounds before their IVF. Right. That is a different conversation. That's you know the goal is pretty hardcore. We need the plan to

be equally as hardcore and talk about things like caloric restriction and how to do all of that but in general when we're looking at reducing miscarriage risk by helping patients focus on that very Mediterranean style diet maybe with mild caloric restriction or at least not over nutrition then that's where we're getting sort of the best success from a diet and lifestyle perspective.

Dr. Kara: [00:39:59] Sure ... When .. actually, just going back to the alcohol that was another night when I read the statistics on that on alcohol with respect to IVF. That was a jaw dropping study for me to read.

Dr. Jordan: [00:40:12] Yeah it was for me too. I think what was more disappointing was how many couples don't know right. Like that's the part that hurt. That was hurtful.

Dr. Dave: [00:40:20] I didn't know.

Dr. Jordan: [00:40:21] Yeah it was that if we screen fifteen thousand patients a huge percentage of them are doing things before that day that are having an impact on how successful they are. And even the research says if we feel like a five minute conversation with women about the importance of eating fish if you check in with her six months later she eats more fish. Right. So it's it's not ... I think we often get worried about compliance when it comes to integrative care. People say well you know the patients won't do that staff and so we're going to do you know do it this way. We just didn't given them a chance right.

Dr. Dave: [00:40:57] If you don't tell them.

Dr. Jordan: [00:40:58] No if you don't tell them then you do now you've made it your call right rather than letting it at least be theirs. But even the research says that if you slide them a piece of paper across the table that shows them what to eat and you check back in in six months a bunch of them have lost some weight. And so imagine what we do with relationship based care. Right. Sure. It's not like they're opening an envelope blinded and following a diet which actually works right. Right. We have relationship

based care with them as Naturopathic doctors and so their success can only be better than that.

Dr. Dave: [00:41:30] Can you bring this back to the person who's listening wondering like how much booze are you talking about. Because when I hear it I go OK well does that mean like one glass of wine is allowed. Or like ... are we talking zero. Can you further clarify that?

Dr. Jordan: [00:41:44] So as far as we can tell we're talking zero. And it's in the researcher is mostly on the four weeks leading up to an IVF. Although I would sort of argue that maybe we should prolong that to the 90 day mark given the natural life cycle of sperm and eggs. Right. I mean for women their eggs have been subject to all of their alcoholic beverages in their entire lifetime by the time they go to get pregnant for men they've got a bit of a 90 day process there that perhaps if they abstain for 90 days then they would see the benefit. So ... but unfortunately we don't know a safe tolerable limit at this point. So when I have that conversation with patients I always say you know I can't ... I can't tell you that two drinks is fine because I don't know that what I know is it's bad. And so I get a blanket statement and say no alcohol.

Dr. Dave: [00:42:35] Just this conflict's a little bit with what I've seen. Like because I've researched wine specifically ... it just always comes up ... like a glass of wine because the polyphenols and the way they may modify your microbiota and all this sort of stuff because it's a fermented food ... Is this a tonic or a poison? It sounds like more leaning towards poison which is not what I've read in terms of general health, cardiovascular health ....

Dr. Jordan: [00:43:02] Yeah. And that's why studying nutrition is so hard right. Because your ... the baseline status of your population matters so much right. If the wine was the closest thing to a vegetable someone's had all day then maybe it does improve their health. Right. Or if the blood thinning effect of wine is saving them from the fact that they only eat McDonald's and they are on the verge of having a stroke then maybe the wine does good things. Right. But what we're talking about fertility. We we don't have a safe tolerable limit. And so I have to recommend that women take it out. I would say that

there's lots of other examples where we don't have a safe tolerable limit. But it's tough because the group are studying wine in you know they at their baseline health may not be that great. Right.

Dr. Dave: [00:43:46] What about any relaxation or stress relieving techniques that you recommend if any?

Dr. Jordan: [00:43:52] So I do recommend it. I talk to patients a lot about exercise and try and encourage them to do more of what they're already doing. So if they like yoga let's do more of that. I'm a big fan of outdoor walking. That is a common prescription coming out of my office. But an intentional walk I call it where I don't know your activities of daily living or you're walking around during the day doesn't count; it has to be an intentional outdoor walk for thirty five to forty five minutes. I think we often underestimate the impact that 200 calories worth of exercise can do from a metabolic perspective and really a 45 minute walk kind of achieves that for most patients. We also underestimate the value of being outside and the mindfulness that can come from being outside and so that's a fairly common prescription that comes out of my office.

Dr. Dave: [00:44:44] What about the mental emotional sort of patterns that you may see if any. I don't know if you see this but you know you'll see patterns with other sort of conditions or whatever ... do you see any patterns in terms of mental emotional contributors or just the way people are made up when they come to you.

Dr. Jordan: [00:45:00] Well for women with PCOS there's really high... Call it "comorbid" meaning that they have both anxiety and depression when it comes to PCOS. Inflammation in the brain is depression. Right. And women with PCOS have very high inflammation. And so we often see mental health challenges in those women as well. And very often under assessed and under treated ... we sort of we'll chalk it up to say oh well she has terrible acne of course she's depressed. No that's a physiological consequence of her condition. That's why she's depressed. And so we certainly see a lot of that. And I would see just a lot of like I use the word trauma and I don't mean that lightly. The experience of going through fertility care is quite traumatic. And so I think I see that quite a bit in patients where they really don't feel like they have a voice. They

don't feel like their concerns are being heard ... in so many of the patients I work with... You know at the end of the day they say you know what... Even if I don't have a baby I just need to feel like my health care is not this, right? That it's something bigger than what I'm experiencing. And so you know that that maybe is a sort of a common thread of mental health in women that I treat.

Dr. Kara: [00:46:14] And so OK. Just taking the journey of the patient. You know we've done all the right assessment. And you've you've talked about the foundations, exercise, moving mental emotional health, getting outside, eating well, all with evidence based directives towards fertility and miscarriage. What's the next step? I assume ... well ... you know that the assessment dictates where the treatment goes from there. But yeah how ... what are the next steps then after you've kind of done the assessment and you you've worked on the foundations. What's next?

Dr. Jordan: [00:46:51] It depends on what we're monitoring and what our goals are. Right? So depending on the scenario ... we may check back in after two or three cycles like you know two or three periods. Or if at you know the 12 week mark that patient hasn't fallen pregnant then we may check in to see how they're doing. And certainly we offer more care around that that positive pregnancy test ... right ... especially for our recurrent miscarriages we want to sort of hang on to that for dear life. Our next steps are really dictated by what the underlying concerns are and how frequently we're going to check in with those patients to tweak their plan to layer on more diet and lifestyle change too. And really we should be tracking pretty specific metrics in most patients. So my patients with endometriosis are tracking their Advil or opioid use. Right. We're tracking their painkiller use because if I'm being successful it's going down over time. Or we should be tracking you know the hair growth or we should be tracking acne because if those things are getting better then again we know that we're on the right track or we're tracking weight and that requires some distance in between appointments right because we need those things to get better but it also requires check in to make sure that you know they're compliant and that they're finding their treatment plan is easy and something sustainable and then layering on more change sort of as we move through that.

Dr. Kara: [00:48:22] I think that's a really important point. Perhaps more specific to any practitioners listening but also for a patient to ask themselves. You don't want to be with the practitioner who says "OK here's the course for the next six months and we'll see how it goes". Or we're gonna do 10 IV's and we'll see what happens. Right. So I really love that about you ... of that analytical ... What are we measuring? What is the outcome we want and how do we know if we're moving in that right direction?

Dr. Jordan: [00:48:51] That's how we frame it to patients to I tell them that my you know the way my brain works is pretty linear and logical and I need to know that we're hitting those metrics so that we even have them in the first place so that they know what to track. I give home a lot ... I send home a lot of like standardized rating scales for patients to track their symptoms with over time. I would get them to think about which things I'm tracking right like their headache frequency or whatnot ... their fatigue after eating these kinds of things because I always ask patients I could sometimes it's hard to know if you're 15 percent better. Right. Like we might let those small improvements fly under the radar when they're actually important. Right. So tracking those like soft symptoms is really important over time and it also helps us know if we're on or off the right track. But yeah the metrics are huge for me because I need to know that what we're doing is having an impact. I need to know when to raise the white flag or how to call in reinforcements or refer. Right.

Dr. Dave: [00:49:50] And the patient needs to know for traction really good to keep someone interested. It's really important to get some sort of objective end point happening.

[00:49:59] OK. So I guess as far as treatment approaches that might be beyond what we can even go into today because that's going to be very different for someone with endometriosis versus someone with PCOS or someone with you know unex--- Well perhaps we don't like the word unexplained infertility but those underlying causes are going to dictate where you go with kind of the more therapeutic approach at that point. Are there are there any things that that span a lot of the underlying causes of miscarriage or fertility in general.

Dr. Dave: [00:50:37] Something find yourself implementing with more people than you don't.

Dr. Jordan: [00:50:42] Certainly the life like the diet and lifestyle the healthy diet and lifestyle and its most women don't need excessive or very very low carb or an extreme diet to see change right. They need small sustainable change. And we see improvements in all of those conditions by following those very basic lifestyle changes and so I think I probably blanket prescribe a lot of those things and maybe with the specificity coming in with some of the functional foods that we know have a big impact on a particular condition or being more specific about well how much carbohydrate right based on a particular person's condition as well. That just made me think what you're seeing there Kara is that you know it's kind of ... thinking about like what is a patient's next steps right. Like how would they take what we talked about today and learn more or you know what would their next steps be? Interesting when I was talking at that fertility show on the weekend I told the audience which was you know an audience of 200 mostly men trying to learn about sperm health. I said it's really unfortunate in fertility that we've made the patient the one who's responsible for finding all of this out right and these men had given up their Saturday. They were sitting in a packed very very hot room to try and figure out how they can change.

Dr. Kara: [00:52:05] What isn't good for their sperm.

Dr. Jordan: [00:52:06] No. Terrible.

Dr. Kara: [00:52:08] Very bad.

Dr. Jordan: [00:52:09] That's right. Actually I missed that joke there..

Dr. Kara: [00:52:13] I'll write your jokes for your future talks, ok?

Dr. Jordan: [00:52:18] I actually opened with maybe we should turn the heat on and nobody laughed. So yeah I said to that group of men I said you know isn't it unfortunate that infertility and maybe this is in medicine in general right now. Maybe this is the state

of our one of our issues is that we've made the patient the one responsible for being at home on their computer trying to figure out what the hell is going on right and how just disappointing that is to feel like you don't know who to go to or who to trust or how to consume information and then you end up reading on message boards to try and find out if a particular treatment or drug or something is going to work. And that's not really how we should be making medical decisions. Right. Because you say like on TripAdvisor Nobody gets on there and talks about how great the hotel was right. You only hear about the bad stories and lots of information on Google is disseminated that way and so it's hard for patients to know what's good information and what's not good information Certainly, that's what I tried to do with the book. Right. I go through every condition, every lab test, every supplement to every drug right. I didn't discriminate every drug and every natural treatment for each condition so that at least at the very least patients can be educated enough to have a conversation with their health care practitioner and be a better advocate for their own care because unfortunately we put them in that position. So I wanted to create a tool that at least someone could take the book into their doctor's office and say well this says I probably should have my insulin tested I know OHIP doesn't cover that but can we at least have a conversation about it so that hopefully they can get a better outcome because they can't treat everybody in my clinic. I ... it felt like it needed to make like a bigger impact.

Dr. Dave: [00:54:03] It sounds so good to have the basic sort of map of what you're trying to do with someone in that person hands so that they're armed with that. Sort of like you should know how to change your tires on your car at least ... doesn't mean you have to rebuild it or whatever, but ... empowering patients with that information is so key. But what you were talking about there is when they go to their doctor. So I'd like you to talk maybe a little bit how you coach your patients or directly interact with their doctors in the most productive way.

Dr. Jordan: [00:54:37] Yeah. I think you know one of the that's a good question. I feel like it's loaded.

Dr. Dave: [00:54:45] I picked you!

Dr. Jordan: [00:54:47] I feel like that's a loaded question. So ...

Dr. Dave: [00:54:51] Then I don't have to answer it!

Dr. Jordan: [00:54:54] That's right. So I never treat another practitioner like they're ... and I'm going to use colorful language. I never treat another practitioner like they're my bitch right because I have a job and a role and they have a job and a scope and a role. And if we all did our things that were in that scope and role then it would be very clear when we would ask each other for help. Right. It would be very clear for me to say I can't run the antibodies for anti-phospholipid syndrome because it's not in my scope of practice in Ontario. Would you please run them for me and my patient? I've run these other 10 lab tests that they wanted done but I can't do this one and this would help us along our process or I've run these couple of lab tests and now this patient needs an ultrasound. It's outside my scope of practice to run an ultrasound. So please would you run us an ultrasound? I would say every single letter that I send to a medical doctor has the phrase it is outside my scope of practice to do the thing I'm asking you to do and I'm handing them back a case that's on a silver platter. That's well assessed that has some lab work and evidence to suggest what we want. And so I'm not asking for you know them to to pick up the slack or for them to do things that they're uncomfortable doing. Right we know what OHIP was built for and in lots of cases it wasn't built for what we're looking for in naturopathic medicine unfortunately right. It's not built for wellness. It treats patients beautifully if they go in horizontal right. It doesn't treat them well if they walk in and say something's wrong. Right. And so and that's where ... that's what we do. And so if for 80 bucks a patient can pay for some lab work and be well assessed and if I hit a sticking point where I need help from their doctor of course they'll help me. Right. I did all the things I could do and I'm recognizing there's a limitation in my care. So when I send them back and say Can you please prescribe metformin can you please run this lab test can you please refer them to a gynecologist. These are things that they would do anyways. I just have helped them get to that point maybe faster or more thoroughly than they had the opportunity to do and so our working relationship is quite good. I think where they say they struggle with naturopathic doctors is when patients taken a laundry list or .. or for patients if you're listening it's when you've read a book... you know the hormone diet or whatnot and then you take in all this lab work and say I want all my

hormones done. That's where they struggle right because that's not really what that part of the health care system was built for. And if you want that kind of care at this moment unfortunately you have to access it outside of public health.

Dr. Kara: [00:57:42] You've got to see one of our faces. Fortunately I'll say ... fortunately. And so I don't know where should we go from here.

Dr. Dave: [00:57:54] I think where do you struggle. I think that would be a good one because.

Dr. Jordan: [00:57:57] Where do I struggle?

[00:57:57] We have to humanize you now. You know we've we've built you up as this expert because you are ... where would you turn? What are the first things you sort of look outside of your expertise for.

[00:58:10] That's a good question. So sometimes I'll talk to their medical doctor just hop on the phone with them and say you know I've got this case I'm not you know we co-care with this particular patient and usually that's not the first time we've had some back and forth about that patient right ... like that that I'm often that shouldn't be the first contact I've had with them and say you know what do you think. Like how are they presenting to you. Because this is what I'm seeing because often we will see different sides of the patient, right, and different sides of the case. So I often will call them or try and have a communication with them. I also have a pretty good working relationship with a few of the gynecologists in Burlington and also with the endometriosis clinic at McMaster so if I have a case that I am struggling with I will talk to them and say you know do you think that this is appropriate. This is the lab work I got back. Like how would you approach this. Can I refer to you for this procedure in particular. That's kind of how I would approach it is mostly with a conversation with their practitioner.

Dr. Jordan: [00:59:10] Yeah I would say that's ...

Dr. Dave: [00:59:11] So you've got some relationship currency with these doctors usually.

Dr. Jordan: [00:59:16] Yeah yeah I do. I had I've had some great working relationships with those practitioners. And that goes such a long way because they do the same back. Right. So they will say OK well Jordan prescribed this I'm going to let you go back to her to have a conversation with her about this or they will supplement my prescription in a way that's enhancing the effect rather than you know being a conflict. So I feel very fortunate for those relationships that I've got to make over the last ten years in the city that I work in because I think patients just get way better care when that happens.

Dr. Kara: [00:59:54] Again taking a back to that patient who's had you know two three four miscarriages. What is something you would like them to know? Is there one take away that you can say you know "listen woman know this".

Dr. Jordan: [01:00:07] Yeah I think ... I think it's that you should be ... still be hopeful and that's not ... that's not coming from a place like ... that's not flaky. And I don't mean that in a flaky way at all. I am the least flaky person out there. I mean to be hopeful because there are probably answers that you just need a curious and experienced person to think about you writing to think about your case.

Dr. Kara: [01:00:38] No one has ever asked why. No one has ever asked why

Dr. Jordan: [01:00:42] You just need someone to think right. And it's like and it's funny when I'm in patient visits I'll be like OK just one second ... I'm thinking. And it's ... we don't do that. Right. Like we're so quick with ... and truthfully like ... and now we're gonna get big society here. But we give out a lot of gold stars for having the fastest answer not necessarily the right one right? But we need someone to just like sit there in our case and think about it and you should ... unless you've had that and like you should still remain really hopeful that there are things that you can do because you could do work and have your next pregnancy not end in miscarriage. I think that having that hope is important.

Dr. Kara: [01:01:28] Yeah I think that's a great way. I think that's a great takeaway and I think for those women who are in that situation that is something they might not have heard yet.

Dr. Dave: [01:01:43] How about add this ... how about get the guy tested? I can't tell you I've had and they're like I'm like OK this is a little more complicated for you. Has your husband or partner been tested at all. Do you realize what's required for him to get tested. It's pretty easy.

Dr. Jordan: [01:02:00] Yeah. Yeah. And the men are easier to treat right for multiple reasons. You just have to get their butt in the office right.

Dr. Dave: [01:02:06] That's the hard part.

Dr. Jordan: [01:02:10] And it's not it's not necessarily that they're not motivated right and it's that they're under-educated that it matters.

Dr. Kara: [01:02:16] And no one asked the question again.

Dr. Jordan: [01:02:18] Yeah. We make it so focused on females and even then the research we generally De-prioritize the impact of the man. It's not -- male infertility is not a reportable disease in Canada. Right. And so we're not tracking it. We're not ... we're not researching it. We just check the box that say all of the sperm is a problem but we don't actually investigate it and they think actually was a study just published this past week that suggests that maybe men should be taking a prenatal and it's like ... this is the first time we're we're going to think that maybe men should be taking your prenatal vitamins.

Dr. Kara: [01:02:51] Right.

Dr. Jordan: [01:02:52] But you know when I read it ... what a great idea!

Dr. Dave: [01:02:53] I never thought of that. Men's prenatal!

Dr. Jordan: [01:02:57] But as we said ... there's a market there. We definitely have under ....

Dr. Kara: [01:03:02] My my male my males get given patients get get prenatals.

Dr. Dave: [01:03:08] So good.

Dr. Jordan: [01:03:08] Your depth of knowledge on it is as deep as it gets. So we really appreciate that. Anything you think we've missed or.

Dr. Jordan: [01:03:17] I don't think so. I mean I will give a small plug for my book so it is available on iTunes and Amazon both in e-copy and in hard copy.

Dr. Kara: [01:03:29] So it's called Carrying to Term".

Dr. Jordan: [01:03:31] Carrying to Term and it's written for .... it's written for the lay person it's not written for ... it's easy to read right. That is kind of the point ... it's in the language that women can understand. There's an entire chapter on men's health as well and their relationship to miscarriage. It's I feel like I'm actually quite proud of that project and how that came together. And so if patients are looking for a little bit more information I think for 20 bucks it's a great resource to have in your back pocket.

Dr. Kara: [01:04:04] Yes. I've had many of my fertility or miscarriage patients buy it and it's been a really great resource both for them to understand. Oh that's what Kara was talking about but also then they they bring me questions and it just gets everybody on the same page which I think if there's anything we've talked about today is between the patient all and all health care practitioners it's really a subject where it does take that integrative care.

Dr. Dave: [01:04:29] Thank you so much for kicking off episode one. It's it's a high standard

Dr. Jordan: [01:04:36] Now it's the dress code that you're allowed to wear a Batman T-shirt. I think

Dr. Kara: [01:04:42] Reflecting back on your list of the introduction I think the woman ... she needs to be Batwoman.

Dr. Dave: [01:04:49] You do have some superpowers ... super passionate, super smart, super accomplished. Thank you so much for getting us off on the right foot and helping us bridge that gap between people's frustrations and what's possible with Naturopathic medicine.

Dr. Jordan: [01:05:05] Thank you so much for having me guys. Thanks doc.

Dr. Dave: [01:05:08] All right. Dr Kara, what you think. We just had a good talk with Dr. Jordan Robertson an expert in miscarriage and fertility. What do you think at the talk?

Dr. Kara: [01:05:17] It was a great talk. I think it would be really great for our listeners to pass on to anyone who knows who has suffered from miscarriage which is actually a lot more common than anyone would imagine. It wasn't until I had my miscarriages that I understood and heard stories of other women. It's not something that's really openly talked about. So I think it would be it's really empowering episode because she really talks about ways that you can kind of just dig in to it a little bit deeper and see what's going on and maybe change the course.

Dr. Dave: [01:05:51] Yeah a super knowledgeable very passionate about the subject matter and she knows her stuff. And I think anyone who listens to this show is going to get a lot out of it regardless of whether you're suffering or working with your fertility or miscarriage concerns. But if you do know anyone who is experiencing some of the problems that go along with miscarriage and fertility then for sure direct them to this podcast; they're really really going to benefit a lot from the producer of Dr. Robertson.

Dr. Kara: [01:06:21] Yeah. Join us.

Production: [01:06:23] That Naturopathic podcast. Hello there.