Diet Doctor Podcast
with Tony Hampton, MD
Episode 53

Dr. Bret Scher: Welcome back to the Diet Doctor podcast, I'm your host Dr. Bret Scher. Today I'm joined by Dr. Tony Hampton who is a family practice physician in South Chicago, who is also board certified in obesity medicine and an author of a book, Fix Your Diet, Fix Your Diabetes and a new podcast host with Protect Your Nest as his podcast.

And he is the regional medical director of a large medical institution like I said in South Chicago. Now, Dr. Tony, as you learn in this podcast, is just a wonderful doctor and very caring doctor who has a really wonderful approach with his patients to address every aspect of their health and their life. But specifically he sees predominantly African-American patients, because that's where his practice is.

And he has some insight as to why they need maybe a different approach because of their background, or culture, the way they were raised, their family structure, all these aspects play into how you care for a patient. And that's why is so important I think for Dr. Tony Hampton to be spreading his message about how to interact to help people improve their lifestyle. And it's not all about nutrition.

There's so many hurdles you might have to get there before you can even start talking about nutrition. And then how do you begin the nutrition discussion. He has some great examples, some great tips, but most importantly I think it's just his message of what your doctor should be... how your doctor should be thinking.

He sets a wonderful example for that, leads by example. And I hope that's something that you can take away from this interview, is like wow, people like this exist as physicians. And if I'm not getting this type of interaction with my physician, that's something I should look for or something I should demand from that interaction. I am really inspired talking to Dr. Tony and I hope you'll be inspired after listening to this episode.

Dr. Tony Hampton, welcome to the Diet Doctor podcast, it's great to have you here today.

Dr. Tony Hampton: I'm so happy to be here and to finally talk to you, Dr. Scher.

Bret: Yeah, we talked about having you on the podcast months ago pre-coronavirus and I wanted to arrange a time for us to be in person and then of course the world turned upside down, but I guess the one benefit is now that we're doing remote podcasts. That was that was my excuse to get you on the show right away. So I'm so glad to have you here today. Now, you have really started to become fairly prominent within the low-carb community, but I love you story.

You weren't always in the low-carb community and this has been your own journey. So, give us a little bit of a sample of that journey; how you got to where you are today as a family practice doc, working in South Chicago, promoting low-carb diets, but not necessarily only promoting low-carb diets. So, give us a little bit of that background.

Tony: Well, thank you for that. I am a Chicago native, I grew up on the west side of the city and I then left my home to go to college and going to Xavier in Louisiana, which is actually the only historically black Catholic school in the country, believe it or not, but they are really also known for creating the foundation for African-Americans to go to medical school and for pharmacy. They probably create the most pharmacists of any school in the country, African-American, and they lead the country also for pre-med.

So it was a good landing spot for me. After doing that I came back to Chicago, I did my family practice residency at West Suburban Hospital in Oak Park, I worked for a federally funded clinic, which was kind of nice because it was a community I grew up in, and while I was there I focused on OB-GYN, so I did a fellowship in maternal child health and that training really was, you know, that OB-GYN lifestyle kind of got to me after a while, I love catching babies, trust me, but it just got busy.

And so I left that and joined the Advocate Aurora Health system where I work now, the tenth largest health system in the country. Now what was cool about that is that they create a structure. So, in that structure I am following guidelines and HEDIS Measures and for those who don't know what that is that's called the healthcare effectiveness data and information set I think.

And what they do is they train us how to be good doctors by following and managing disease and you know this as a cardiologist, because as a cardiologist if you're a congestive heart failure folk or not on the right medicine, the beta blockers etc. then you're not a good doctor. So, what they do is they help you-- so that was a good thing, but this is what happened. So, two things happened. One is that a family member got sick. And when a family member gets sick they said I don't want to be on medicines.

And then number two I noticed that my hands were starting to feel-- I would knock on the door and my hands would feel achy. And I also had a bit of an irritable bowel and guess what... I didn't want to be on medicines. So I started doing research and as I did my research I realized that for most illnesses, for most chronic illnesses, insulin resistance was the reason for it.

So, when I recognized that I said, what do I do about insulin resistance? And all of a sudden, that's when I was introduced to the lifestyle. The funny thing about all of this is I got all this information from being on social media, YouTube, Google and so what happened is I shifted my practice, which people don't think it's possible... I shifted my practice to one where I'm not just diagnosing and managing disease, I'm always trying to have a conversation about lifestyle.

So now I spend 30% and maybe even up to 50% of my interactions with my patients for a 15 or 20 minute appointment talking about diet and nutrition. Since doing that I've not only helped my family members, my hands don't ache, my stomach is not irritable and more importantly I have taken people off medicine on a regular basis.

So, once you kind of find this low-carb high-fat space, it's hard to go backwards, it's just been a-- it's almost like a miracle. And I'm like, why didn't they teach me this stuff when I was in school?

Bret: Yeah, that's a great point and I really like how you described that journey that it started with

somebody wanting to get better and not take medications. And why is that so foreign to us as doctors? I mean, we are in such a medication driven society and medicine that for you it had to come from that desire to not take medications and that was your introduction to nutrition and I think that's wonderful. Now, you mentioned how you went to a school that is known for helping African-Americans get into medical school.

So, when it comes to doctors within the low-carb sphere, there is a noticeable absence of African-American doctors. So, I'm curious for your opinion... is that just reflecting the underrepresentation of African-Americans in medicine in general or is there something about this type of medicine, either this lifestyle driven medicine or the low-carb message that is particularly sort of not opening to African-American doctors?

Tony: Well, I will say this that blew my mind... So, when you think about African-American males and this has been probably since the 50s and 60s, they only educate about 500 African-American males go to medical school every year. So, if you think about a country with 360 million or so, there's got to be more than 500 African-American males who want to go to medical school.

So, there is a little bit of a disconnect and because of that disconnect there are issues around trust. So, if they meet Dr. Bret Scher, as well-respected as you are, they will hear you but they may hear me a little louder. So, the problem is that we don't have enough people of color who can then message this message... In fact when I found you and others on Twitter, I couldn't find a lot of people that looked like me on Twitter that was messaging.

So, it really... it even made me even more motivated to start to message that. But when it comes to nutrition overall it's like if you asked me to change my diet and you're challenging my cultural and my heritage perception of diet, I'm going to push back a little bit if you-- Literally, I think it's like healthy food sometimes has a symbolism that is not going to really be good... That's number one.

Number two - I don't know that I can afford that grass fed beef that you may have tweeted yesterday, doctor... And then you factor that in and think about the food... desserts and other factors... these are barriers that people of color face. It's not just everybody wants to live a long healthy life, but if you have all these other extrinsic factors that are making a decision for you, those are the things that kind of get us a little bit off base.

So, as a physician who knows the importance of that... And of course, when I started my podcast Protecting You Nest, that was an acronym and the acronym, you know, talked about not just nutrition, but exercise and stress. And we can talk about how that relates to people of color and how they need-- they are disproportionately impacted if they don't do these lifestyle things.

So, my job is to message, lifestyle is important, we may refer you to nutritionists, but I've gotten so good at this that I've technically... I really don't even refer... I just give them the information and then if I think they are challenged, then I will refer them. But we, as clinicians, have to actually know just enough to give them a little bit of a nudge and give them just enough information that they will act on, because patients will do what the doctor says for the most part.

Bret: That's a good point. I mean there's giving them the information and then the sort of the nudge or the follow-up or helping them logistically. A lot of people say it's not really a lack of information, it's a lack of sort of priority. So, it's connecting with somebody to say, okay, this person has time and this is important, I'm going to make it a priority.

So I think that's a good point that you brought up that me sitting down in front of an African-American patient doesn't mean I can't relate to them at all, doesn't mean they're not going to listen to me at all, but there's something about the camaraderie of having a kinship with somebody; I mean that's just human nature. So, that's why having more African-American doctors is so important especially when you look at the statistics.

So, for diabetes... African-American... the prevalence of diabetes for African Americans is 13% and for Caucasians is 8% of American adults. And then for hypertension and these are by the old hypertension guidelines, African Americans was 39%, Caucasians 28%, it's going to be even higher now. So, African-Americans are disproportionately affected. So, it's even a greater concern and a greater need in opportunity, but why do you think they are more affected?

Is it genetics? Is it lifestyle? Is it culture? Is it sort of a combination of all those? What you think is the reason and how do we impact it?

Tony: Well, if you can bear with me I can-- But let me just say this first; life is not fair, right? So, if... like I remember recently hearing about this whole idea about hydroxychloroquine. And what people may not know is that African-American men, going back to that demographic for obvious reasons, 10% of them have a deficiency of glucose-6-phosphate dehydrogenase.

With that deficiency if they take chloroquine they will then be at risk for something called hemolytic anemia. So, that's not fair and that's just a genetic thing. But what I tell patients is that we're going to focus on-- we're going to know that information so we can keep them safe. But my focus is understanding if they know the root cause of like 70% of diseases going back to insulin resistance, then we can have a path.

So what I in do my community of color-- And the reason why I have an acronym like NEST, it's because it helps me to say something that they'll remember. And so when I talk to them so, what are the barriers that you--? Because that's the question. So, if you look at the E of the NEST is exercise, so why is it that people of color-- I live in a nice suburb. I didn't grow up in the suburb, you know. I live in a different neighborhood than I grew up in.

So, if I see people jogging, that's normal. But do you really expect an African-American who doesn't live in this kind of neighborhood to jog in a neighborhood where is unsafe? Would you really expect them to do that? Would you do that? I would ask. So, the next thing is what about the school programs? What are they going to cut first? Are they going to cut the physical education teachers?

Are they going to cut the, you know, in the communities of color? So what happens is now the key is not exercising... And then I go if you go to the stress piece without even putting a statistic in your face like you just did, is obvious that communities of color are going to have more stress. I have been at people's homes in the evening and hear gunshots going off. I'm thinking of fire cracks and... "No, those are gunshots."

And they're just casually saying that. The sleep issue of people of color in general when we look at studies, they don't get as much sleep; they have more sleep apnea. They work on a night shift, they have night shift work, so they have this dysfunction. And then we think about that T in the NEST how we think and the trauma part, if you think about it my kids have been gifted with a dad who can encourage them to think a certain way and when they're challenged-- so the kids in the communities of color a lot of times they don't even have a dad at home.

Then the other piece is this idea of just being able to... just the trauma... Like I just had a Facebook live of my organization... When we're talking about our safe care promise and how we're going to make sure that people come back to the clinic and we can reactivate the clinic and make sure they wear a mask, temperature is checked, etc.

But they asked the question about social inequities and I told the story about-- Just imagine this, Dr. Bret... Imagine going into your hospital for the first time, you are a new resident, you are nervous, you are excited and you walk into the doctor's interest. And when you walk into the doctor's interest somebody grabs you by the jacket-- I had on a big, you know, husky coat... and says, "Where you going?" And I said, "I'm one of the new doctors."

And they said, "Oh, I'm sorry." Now, the question is would they have grabbed other people that didn't have my demographics? And the answer is... well, I asked my resident colleagues, most or all of which were not African-American and they all said they hadn't had that experience. The other thing that happened was that I was driving to the hospital and the first week I literally got pulled over three or four times.

And I asked my colleagues if they get pulled over and they said no. So, what I am saying is that's a trauma. And even as I tell you the story now, you just hate thinking about it, because those are traumas, so this is the NEST... So, when I see my patients and I think about the NEST... and a ROPE is the other part I haven't talked about yet, I think about the fact that they are disproportionately impacted and all of these things, all of these traumas, all of this lack of sleep and stress will then lead to inflammation in your body and insulin resistance.

And so my job as a physician is to not ignore that. And for any clinician who hears this, make sure you're thinking beyond just low-carb high-fat. You are thinking beyond intermittent fasting, you're thinking and what else is going on in these patients lives. And if you're dealing with communities of color, it's going to be a little bit-- there's going to be some more issues that they're dealing with. And those are the types of things that you want to be.

And like I said, I will touch on the ROPE part of the NEST and ROPE concept, because it's really those other factors as well.

Bret: Right, so it goes so much beyond just nutrition. And actually it sounds like some of those things may be even more important than nutrition. I'd imagine it's hard to prioritize--

Tony: Yes, they are.

Bret: Yeah, so the first time you meet somebody as a patient it's got to be so hard to prioritize. Because you can't just say, okay, fix your diet, fix your stress, sleep better, get physical activity... They're going to say like, "Forget it, this is overwhelming me." So, you really have to prioritize.

And if they're worried about-- you know, a perfect example of George Floyd and BlackLivesMatter, if that's what they're worried about on a day-to-day basis, then nutrition is not front and center on it their mind. So, in cases like that, I mean you really just have to sort of piecemeal it together and trying to make small incremental changes?

Tony: You can do it. It's always small incremental changes, but this is the key. So, motivational interviewing, right? You're saying to them, so on a scale of 1 to 10, what's the chances you're going to do it? They say five. You say, how do I get to a seven? Now, when I ask that question, how do I get it to a seven, that's when they may bring up something... "My wife, she's not going to be

engaged."

And then I'll say, well, how is the marriage? Because this is a very important issue for you, I need you to say to her, "This is so important to me, "there's never been anything more important. I need you to be engaged and work with me." Now, if she says, "I'm not interested", now we need to talk to the therapist, because how could she not be interested in trying to help her husband or vice versa to be healthy?

So, this idea of... and that's going to the ROPE... this relationship, as they are... if the relationship is dysfunctional, you have a problem. The problem with African-American communities is that 75% of those folk in the community are in a single-family home. And in the Caucasian community is more in the 30% range. So, now you have twice as many people in an environment, which is not ideal.

So, my job is to hear what their barriers are and then, once I hear it... Like, if I'm thinking about the P of the ROPE is pollution... so, if I have an asthmatic, and they are struggling, but I know they live on the south side of Chicago where there's a lot of factories, I may not be able to change that, but I think there needs to be an awareness of that.

So, maybe I'm going to treat them a little bit differently, maybe I will have them on a longer like an anti-inflammatory inhaler... You know, I have to think about what other- - why are they not being successful. They are not lazy, they don't care? So, those things is because they have other things? And that's why I like video visits because sometimes I can see the environment and when I see the environment, I can say that's not the best environment. And then you can kind of work your way through that.

So, there's a lot of things to think about, but I think that if you're from the community, you can kind of know a little bit in advance. The good news is that, you can be Dr. Bret Scher, and be the most popular doctor in the building... because when I was working over in an underserved clinic before I start working for Advocate Aurora, which has a little bit of a more of a mix, some of the most popular doctors were the doctors who weren't people of color.

But they cared of-- people know when you care about them. They can feel it in their bones. So, when they know you care, they can get past all this stuff and they can over time as you build rapport and develop those relationships, over time they will then learn to trust you.

Bret: That's a great point, I really like that and it's very powerful right there. So, in this discussion so far we have already come up with a few reasons why African-Americans may be disproportionately affected for hyperinsulinemia and resulting chronic medical conditions. So, that brings up what are some of the interventions that can help.

So, do you have in that single-parent family who is working till 7 o'clock and doesn't have time to cook dinner, but has three kids to feed plus herself, what kind of advice can you give someone to improve their nutrition? And someone who can afford, like you said, the grass fed steak and the pasture raised eggs. And what kind of advice can you give them on how to eat better with no time and low-budget?

Tony: So, let me tell you what we're doing in our health system. You know, I was the medical director for something we call the Advocate operating system and I was very lucky, my vice president, his name was Alex Andrade-- He is not in our system now, but what he did was he said, "Doc, what do you think is the solution?" He just asked the question.

And in most health systems you have a paradigm where they-- Every time you try to present an idea there's a lot of barriers, right? What he would do is say, well, let's just try it. So, I would say, I think people need to learn nutrition, so we started a healthy living class. So, me and my colleague-- I have another doctor I work with, Dr. Katina Hope, and we would get in front of 200 people or so and talk about nutrition.

So, part of what you do is you have to have a mechanism by which to educate-- Now, the good news is, the good thing about Covid is it forced us to go virtual. We will reach more people if we go virtual anyway. So, we're going to try to take that model and go virtual, but we also had diabetes prevention programs and I'm sure you're familiar with that.

We have a great community leader, Jackie Rouse, and we took the same model of the diabetes prevention program for borderline diabetics and we created a COPD class. A lot of people listening would realize that COPD, a lung disease, bronchitis emphysema is all inflammation too. So, we have a great population health leader Dr. Rick Bone, another young lady Dixie Jerick, who helped to put programs together.

And I kind of create the nutrition piece, they do the operations piece and so what we're doing is creating a mechanism to educate people. So, I think the first thing is to do that. And we're also trying to create-- So, we merge with Aurora, which is in Wisconsin and we are in Illinois. With that merger we're taking some of the stuff they've been doing, we're taking some of the stuff that we've been doing on the Illinois side and we are trying to come up with some tools that we can use to help educate our patients.

And we're going to do it through our medical record so we can identify people. We can identify their BMI and we could just target those people, we need to do clinician education and I know that Diet Doctor has a free CME for docs...

I think that it's kind of like all hands on deck and if we get the clinicians educated and we get the patients educated and we learn from other health systems like Geisinger and Mayo Clinic that may be doing some of this stuff already and onboard certified in obesity medicine; we need more docs who are board certified in obesity medicine.

The good news is that this weight management program that we have has about four or five board certified obesity medicine docs and truth be told when I wrote my book I did not think that there were other people out there who thought the way I did and I was very concerned about saying reverse diabetes in my book, but I just had to have the courage to do it.

Then I learned that there were other people with the obesity boards that believed in low-carb and then I found people like yourself Dr. Bret who also-- So, I actually felt like it was a homecoming to find some common ground, while also respecting people who do it the other way. Like, I was a vegetarian for eight years, so I would never demonize or minimize that way of thinking, but trying to move the needle in the African-American community with vegetarianism and veganism is like pulling teeth.

But when I went to low-carb and I said, hey you can still eat the ribs, you're just going to remove the barbecue sauce, they pushed back just a little. But they didn't push back so hard that we couldn't get the-- And I would easily argue that 40% of my patients or maybe 50% are actually engaged in what I'm doing. And the ones that are not is because of all these other things I've mentioned with that NEST and ROPE.

It's those doctors are the barriers... it's really because of who they are. Is the other things. And so, what I'm saying, Dr. Bret, it's hard, but it's easy. When you shift your practice towards wellness and you're always thinking about these things, you're going to identify them, because when people struggle, you're going to say so-- And you think about that, mnemonic, like what could be going on here? Are you depressed? The E in the ROPE is for emotion, right? Life experience. So, are they depressed? Are they anxious? Why are they anxious?

Let's address that. I just had a patient today who was postpartum depressed. I don't deliver babies but I see the patients and I said, if we don't take care of this postpartum depression it's going to be hard to take care of the baby, it's going to be hard get back to work, so we have to address that. We can't just put a Band-Aid on it.

Bret: Yeah, so again, another great example on how it really is, the whole life experience and so much more than just nutrition. But you brought up a great example there about trying to get people in your community to go vegetarian or vegan is going to be a much harder sell than trying to get them to go keto or low-carb.

And that goes against sort of the vegan movement or the eat Lancet report or these attempts to provide one global diet or one national diet even, which just doesn't work and that's the perfect example for it. And I think that's something that more people need to hear. Those saying that we need to reach people, patients where they are and find the healthiest diet for them. So, you mentioned the barbecue sauce, like I'm sure that's a big pushback. Or, you know, the classic Southern grits, I'm sure that to be a pushback.

Tony: And the cornbread is the biggest pushback.

Bret: Yeah. So, do you recommend like cornbread substitutes, low-carb substitutes or you just say cut it out?

Tony: We just get rid of it. You know, I've seen some-- I am still learning. So, we play with some low-carb... But, cornbread, it's hard to duplicate that texture. So, I haven't been able to come up with a really good one yet, but that is exactly what I do. I actually say to them, everything that you like has a low-carb version.

So, this is an experiment and all you really need-- Like I do the DietDoctor low-carb chocolate cake literally every month. I make cupcakes. So thanks to you guys I do that every month. And so for me I can take that and turn it into like a 7 to 10 carb snack. I barely eat 20 carbs prior to that, so who cares, I'm already at the ideal weight. So, what I tell people is I am about simplicity and I can express that as we, you know, kind of get started.

But it's simplicity and making bite-size choices. Most people-- I had a patient today who did not know that barbecue sauce was issue. And he says he puts barbecue sauce on everything. He was like, "What's wrong with barbecue sauce? You know, it's tomatoes, right?" I said, "No, it's fructose corn syrup."

Yes, so I think that people just have to be educated. And once they are educated you will be surprised that they'll do it. That's a form of racism... I should mention, I mean... The bias that people have towards other cultures are not going to do it. That's racism. It's very subtle. It's bias at the minimum.

Bret: Automatically discounting somebody because of their socio-economic status or because

of their cultural status or because of the color of their skin, saying, in my experience there are less likely to follow, so why bother... I'm sure that is rampant among medicine, yeah.

Tony: It's rampant and it's unfortunate.

Bret: Which brings us back to you. I mean you're not just an African-American doctor. You're a doctor, you're taking care of all patients, of all walks of life, with all sorts of medical conditions. And so how has low-carb sort of revitalized your practice or rejuvenated your practice or changed your practice in any way? What have you noticed with how you were appreciated being a doctor?

Tony: That's a great question because it is... I'm going to talk to my doctors with this one, right? And I know that change is hard. Now, it wasn't hard for me because I had a family member, I had my own person stuff. And people say, "Why are you so...? Like it's so easy for you do these things." And I said, well it's easy because if I don't do it, I am having irritable stomach.

And if I don't do it, I'm going to have problems knocking on the door. If I don't do it, my family members are going to be back on medicine. So I think what you do is you have a reason. But, anyway, change is hard and we're kind of designed to be the same, homeostatic, right? And I'm in school right now to get a Masters in nutrition and so we talk a lot about these homeostatic things that have to happen to keep our body stable.

So, anyway, I asked myself what's my "why". You know, one of my "whys", believe it or not, Dr. Bret is to be able to be healthy enough to do a podcast at the end of the day and not be tired. That's the why. I want to feel good. And I realized that the things that I do impact the patient more than maybe the average. Every time you look at studies, they say what the doctor says the patient will do, right?

So once I understood that, I-- and then I started looking at life differently. I said, why did I become a doctor in the first place? And most of us wanted to do it, because we wanted to be healers. So, this is what happened. I changed my approach to this idea what we do... nutrition and fasting and exercising and all those things. And then all of a sudden I would come to the clinic and I would have a testimonial... literally every day. "You changed my life." And I would always say to patients, I just gave you the information and you just acted on it. "Doc, you don't understand..."

I mean, people crying in office and all they needed was a little coaching and guidance. So, just imagine if you are a clinician. Instead of going to work every day, unfortunately having to increase the dose of the medicine, unfortunately saying, "I'm sorry, your kidneys are starting to fail", unfortunately saying, "I'm sorry, ma'am, but we may have to amputate your foot." Instead you're like literally being hailed as a hero and you are celebrating the successes of your patient.

"Oh, my God, look at your A1c! It went down." In fact in an article that I just wrote that's going to get published in the Chicago Tribune I celebrated a patient whose A1c was 11 and it got down to 4. The same patient was also able to lose 100 pounds. The same patient was able to come into the clinic initially with a walker and then now she's walking... barely needs a cane. So, imagine what that would feel like... this is why we became clinicians.

And I just didn't know that what I was doing prior to this discovery would not lead to healing, it would lead to disease management. But if you did a lifestyle, you did the nutrition, the exercise, the stress reduction, the sleep and then you have the-- So, this testimony is important because a lot of people say, "I don't have time for that." You have to have time for it. Because if you're going to get return on investment, you will not get return on investment doing the same old, same old

that's not working.

So why not try something different? And you have testimonials out there that are saying this stuff. Your patients are saying it works if they're doing it, the doctors down the street are saying it works. So, at the minimum it's worth just giving it a shot. And then all of a sudden the thing that you thought your career would look like becomes reality. One more thing that's unrelated happens, I have to say this, but this is important.

I do have a virtual note-taking service. It's called Scribble, from this company called IKS. And I just walk in the room, I talk... even as I did video visits today at home... all I did is talk and it writes the notes for me. So, now I have work-life balance, I have even more time to teach... so if those types of opportunities are available at your health system if you are a clinician please take advantage of it, because when you get your life back, you will then have the energy to do all of this education I've been doing in my practice.

Bret: That's a great point right there, because I think one of the biggest pushbacks I hear from physicians all the time is I don't have the time to talk to patients about this. I can't spend 20 minutes of my entire 20 minute visit talking to the patient, because then I have notes to write. And that takes, you know, when I got to check the boxes and-- So, to have that part taking care of can free you up.

Now, I think that should be mandatory for any major medical group that cares about prevention, that cares about doctor-patient relationship because it just gives you more time and that's what we need. Unless we had hordes of ancillary staff that could do this for us, but like you said, it's even more powerful when it's coming from the physician. So, that's pretty–

Tony: It's a game changer. Yeah, no doubt.

Bret: I like to hear that, for sure. So, what do you think we need to do and we, as the medical community, or even we, as the low-carb community, to reach more underserved populations? Whether it's African-Americans or whether it's just low socioeconomic class, whether it's just people in areas of food desert. Is there something that you think we can do today, tomorrow, next week to say, "Look, we need to address this now. Here's what we can do"?

Tony: Well, everything we said at first... So, you know, by educating our clinicians about the fact that they don't even talk about it, that's the first thing you need to do. So, once they start to hear lifestyle, lifestyle, lifestyle... Like our motto for Advocate Aurora is this, We Help People Live Well. That happened, with the merger, about a year ago and when I saw that I said I got them now...

Because if that's true, how do we define living well? Does living well mean--? If you look at the rankings for top-quality of care health systems, we are always in the top five, so we're doing a great job for quality of care. I think like, you know, I can't remember who... it was in the Cleveland clinic or Mayo... probably was Mayo... but the point is this. If we are doing a great job there is that really living well? And I would argue not at all.

That's not how you optimize person's health. I mean, the World Health Organization, how they define health, they didn't say health was, you know, making sure they are managed well. They basically said you are helping people to maximize their health. Everybody should look that up. Look at the World Health Organization's definition of health. It just makes it very clear. So, I think it's important that we say to patients, "We're going to do that." But the other thing we need to do is say, "Go where they are".

You mentioned that earlier, right? So if you're in a community of color it's important to collaborate with the folks in the community. I need to hang out... When we did our health living event, one of the churches that we do it at is called Compassion Baptist Church in the South side of Chicago. Now, when I go to this it's like 300, 400 people. And if pastors say, show up at the meeting, they're going to show up at the meeting.

So, what happens is you have an engaged audience, the pastor is engaged and I don't have to go out and recruit anybody. You just convince the leadership that this is something that may help the congregation and you make that connection. So whether it's the church, the YMCA... you collaborate. When we do our healthy living event, we do it with the Chicago Food depository.

So, I don't need to know how to do Chicago Food depository work. I just need to know how to have a conversation about how can we work together so that you can get your work done. The only thing I say to Chicago Food depository is what is on the menu. So, we had to change... so, I need some cauliflower... Do you guys--?

I need some kale, I need some-- So, what they did is they were able to tweak the-- and then we would sit down with the patients when they come to-- in order to get the food at the "food pharmacy" where we do this at the Trinity Hospital in Chicago on the south side, they have to hear us, our "spill", about, you know, how do I turn a cauliflower to mac & cheese.

How do I do that? How do I cook it differently? And so they had to get information and that's how we kind of get-- So, it's a multifactorial thing. You have to think you can't have the nutrition person saying low-fat and a pharmacist saying low-fat if you're saying high-fat. So, we have to have a compromise and we're still working on that as we develop our weight management program. We're going to come up with a compromise.

I'm hoping it's a low-carb Mediterranean, a low-carb vegetarian. That will be a better model. And then for those who are not insulin resistant then maybe we can allow them to do the same, but the results, what we are going to focus on, if they are not getting results, we may then push them in a different direction.

Bret: Yeah, I like what's you are saying about getting out in the community and that's such an important message. The healthcare doesn't end within the little exam room, right? The healthcare doesn't end within the office building. It extends into the community and that's where people are probably going learn the most.

So I think for people listening, a take away that they should have is that they can have a doctor like you, they can have a doctor who's going to spend the time with them, who is going to be part of their community, who is going to understand their culture and where they're coming from and wants to understand their life rather than just giving them a prescription. I think that's probably one of the most powerful take homes. Now not everybody can work with you; you are one person, but everybody should be able to work with somebody like you.

Tony: That's right.

Bret: And that's what's the main sort of just hopeful message that I get from talking to you that there are doctors who think like this and that you are doing something about it both from an individual perspective and an organizational perspective to try and educate others. And I assume that's probably a lot about what your podcast is about as well. Tell us about that now.

Tony: Well, I think that again I just want people to be empowered, so I don't want to put my life in anybody's hands. So, if you were my cardiologist I would want to hear your expertise as a cardiologist, but then I would say, what can I do to help myself? So, my podcast is about empowering people with the information and the tools. And maybe they never thought about the fact that, you know, I am in a toxic relationship and I haven't addressed yet.

And my blood sugars are running high, pressure is high and so the doctor said, "I need to address that." And he gave me some tools, he told me to listen to inspirational people every day, he told me to read the five love languages, he told me to read the principles of marriage by Gottman, which is a great book. And I know this stuff because I'm trying to have tools. And I have a dot phrase and/or a button... it says "marriage"... I just click it.

And all the books I need to read pop up. So, I can't sit there and read the book to them, but I can give them tools and I can say, I know you're not going to read, get the audiobook. It's going to take you 20 minutes to get home. Download that book before you leave here and listen to it on the way-- I literally do stuff like that just to ensure that they are going to do it.

So, really I think that for everybody listening the podcast, the YouTube videos and other thing I'm going to do, Bret, for those who can do it, I'll probably do a Facebook live, kind of a post-game show kind of thing and then introduce the Facebook and the YouTube audience to these folks who may not ever see the podcast, but the goal is to reach more people.

And then my partner, I have Dr. Katina Hope who is a family doctor, who's engaged, get her involved in and-- We need more soldiers out here spreading the gospel, if you want to say it that way. And then again we are going to always respect other methodologies, because we don't know... Like I've heard you say it in interviews... we don't have a 50 year study saying that this is going to be the answer.

All we know is that in the moment it works really well. And I just know that my patients get off medicine, their metabolic metrics are stabilizing and that's all I can go with right now. And I've never had this type of practice before, so it's been exciting.

Bret: Yeah, I have a lot of doctors saying "I've never had this type of practice before", and it's been reinvigorating for so many doctors and it's because we are helping so many more patients. So, that's a really powerful message and I think you're leading by example, which is such an important thing to do. So, where can people go to hear more about you and find more about you with all the amazing things you are working on?

Tony: Actually, I'd say by mid to third week of July, my new website which is being designed will be up and it's just doctortonyhampton.com Just spell out the 'doctor' completely and that will be up like the second or third week of July. With that you'll be able to see the podcast and the videos and I did make a couple of videos that people have to see... Why do low-carb? How to do low-carb?

And if you just google Dr. Tony Hampton on YouTube you can watch it just as-- And I did that because it's a workaround, I don't have the time, so I always tell my patients, you have to watch these two videos. So that you'll then have the way of thinking and then we can grow from there. So those are the locations I would go to.

Bret: And then, of course, on Twitter.

Tony: Oh, my God, you want to hear some interesting discussions.

Bret: Well, thank you for all the work you're doing and thank you for taking the time to be a guest on the DietDoctor podcast.

Tony: Absolutely, keep doing great work you're doing.

Bret: Thank you.