Menopause Bootcamp: Ditch the BS and Get to Solutions – Dr. Suzanne Gilberg-Lenz – #988

Dave Asprey:

You're listening to The Human Upgrade with Dave Asprey. Today we're going to be talking about something that affects everyone on the planet whether you thought about it or not. Am I going to talk about the erosion of our soil and what to do about it? No, we're going to be talking about menopause because about a million women every year go through it, and some for way more than one year. And whether it's happening in your household, in your place of work, in your country, on the planet you live on, it affects society. And it's something that seems to be getting worse and something that's always been a problem. So let's go deep on it in the episode today.

There's isn't very much taught in medical schools about what happens during that time. It's better now than it used to be, but we just don't have as much research as we would about, oh, I don't know, cholesterol, even though most of that research turns out sort of maybe a little bit made up and worked to sell a lot of drugs. So you're going to learn about how to think about menopause because it's actually not an illness. It's something that happens. And given that I'm building a world full of people who live way past a hundred years old, if you're a follower, you're probably going to spend a meaningful percentage, like maybe more than half of your life, postmenopausal. But you're going to go through it, at least if you're a woman.

Now, our guest is an expert on this, who's a doctor for more than two decades. Dr. Suzanne Gilberg-Lenz OBGYN, board-certified in holistic and Integrative Medicine. And she focuses on this in her practice. Suzanne, welcome to the show.

Dr. Suzanne Gilberg-Lenz:

Oh, thanks for having me, Dave.

Dave:

You could have focused on any kind of medicine. You could have been an elbow doctor. You could have been a proctologist. I mean, I don't know why these guys want to look in people's ears. That just seems like a weird thing. It's all waxy and hairy in there. Why did you go after menopause and hormones?

Suzanne:

Well, I mean, that's a great question. First of all, it evolved. And when I was doing my medical training, I... I actually started medicine thinking I was going to want to do OBGYN and focus on the lifelong medicine. And I loved the opportunity to both do surgeries but also practice more medicine. And of course, delivering babies as hard, as it is, is a really incredible experience.

And now in retrospect with many, many decades behind me, I see that I was much more interested in lifestyle medicine, preventive care, and focusing on health rather than disease.

I was much more interested in lifestyle medicine, preventive care, and focusing on health rather than disease. And that's probably ultimately what motivated me to do what I did. So I loved the broad spectrum of opportunities afforded to me by being a gynecologist. Over time, really what happened is, I think, two things. I'm always interested in the things that nobody else seemed to be interested in. I'm super curious. And as I aged with my patients, I was following people through their life and wanting to continue to be able to address their needs and my own needs selfishly. And as you mentioned, really got almost no formal training in menopause in medical school. I mean, don't... Granted it was a long time

ago that I was a medical school, so I don't remember a lot of things in medical school, but I really don't remember it being discussed very much. Probably it was like one slide.

But even in residency focusing on women's health, we got almost no training in it. And there's a lot of data also indicating that people come out of OBGYN residency feeling very, very unprepared to manage and support people through the menopausal transition. So this is not just my personal experience. It's borne out by the data. And I think the conversation that's now happening culturally around a lot of things, it's a collision of how are we dealing with aging and longevity, how are we dealing with women's bodies. It's such an interesting conversation. So I could go high level for you, I could go micro, but that was where I was coming from.

And then as I started getting into it and getting my own training and reading and researching and going to places like North American Menopause Society, combining it with my background in herbal medicine and Ayurveda, I have training in Ayurveda Indian medicine, I just saw the need really opening up. And I saw that people just did not know what to do. And then we're falling prey to a lot of bullshit, to be perfectly honest. And I wanted to help people understand and relocate their agency in that process. You said some very interesting things in that entrance, some very important things. This is not a disease. It doesn't need to be bad. Just because something's challenging or hard doesn't mean we can't do it. We just have to have the right tools.

Dave:

So menopause is like an ice bath?

Suzanne:

Yes. Yes. We probably need more of ice baths. You know? No, it's really true. Yeah. I mean, I have a very specific perspective based on my own practice and on my own person. Right? I mean, I'm a person who likes challenges. I went to medical school for God's sake. Obviously I like doing hard-

Dave:

You're a masochist by nature.

Suzanne:

[inaudible 00:05:55] crazy. It's pathological. And I'm a surgeon too, so you know-

Dave:

Oh, you have an ego then. So an egotistical masochist. All right.

Suzanne:

Yes. All of it. It's amazing.

Dave:

This is going to be a fun interview. I got it.

Suzanne:

But I've learned humility a lot. Practice.

Dave:

Oh wow. Okay. So an enlightened surgeon whose ego is smaller than mine. I love that. Good job. Yeah.

Suzanne:

Okay. You like that? Okay, good. So far so good. Check.

Dave:

I'm wondering if part of the problem is that OBGYN as a practice, I mean we're lumping together female care and childbirth as if-

Suzanne:

It's really hard. It's a lot.

Dave:

... they're the same thing.

Suzanne:

Yeah.

Dave:

You think they'd be maybe different. And I wouldn't hire an endocrinologist unless I had an endocrine cancer probably. And even then I probably wouldn't because endocrinologists cause more harm than good on average. There's holistic ones and all that, but they look at everything as a silo when the whole body's a system. And you change this hormone and this one changes. So we have this built in problem where maybe looking at women's care is not about childbirth. And when you lump it all the same specialty, we have a problem.

Suzanne:

Well, yeah. Yeah. I mean, and I will to the credit of the people that I work with in the field, I mean, people are coming in with the best of intentions and trying to apply the knowledge they have the best they can. And I don't know that we want to spend the entire... We could do another podcast on medical education for sure because all of us feel that there are some issues. And as these fields grow and we understand more and we understand what we don't understand... Like, how can you do four years and know everything?

But I want to remind you something, which you know, it's the practice of medicine. We don't come out of residency fully baked. We still have some... We got to add some spices and we got to, just like anything that you do as a profession, if you're not remaining curious and open and humble, you're not doing the right thing for the people that you want to serve no matter what your intentions are. And I think that is a lot of where I was coming from with the book and in my training because I knew I came out, this is my training, and now I have to learn and grow with my patients, as I said. And the tools that I got in residency and medical school, I'm grateful for, but that's not everything. You have to continue to be looking at data even as it evolves. Stuff that I learned in medical school has changed. I graduated medical school in 1996. I mean, come on, things have changed.

Dave:

Yeah. We could barely spell internet back then.

Suzanne:

Correct.

Dave:

And now Dr. Internet, who has by the way replaced Dr. Google because Dr. Google has been neutered by itself, so you can't really search good medical stuff on Google anymore. It's very hard to find it. So it's changed the practice of medicine. And there's something going on too where just more people are taking control of their own biology, which is the definition of biohacking. So all of a sudden I'm seeing women now in my... I've run an anti-aging nonprofit group with people three times my age for more than a decade. So compared to 10 or 20 years ago, the number of women who are saying, "What the hell? I don't like what's going on during menopause. I'm going to change it." And then they're willing to call a functional doctor and it works.

And to my earlier point about endocrinology or dieticians, there's functional endocrinologists and functional dieticians who listen to the show. But dieticians make hospital meals, guys. Like, that practice is fundamentally broken from an educational perspective until people who are licensed free themselves of it and then their own licensing boards go after them for actually caring for people. So those will get fixed. The job of this show is to find people like you who are working at the, "Wow, here's possible," and shine a light on it. So we move the average expectations more and more in the right direction because everyone knows it's possible. And on menopause, it's like the lowest hanging fruit ever because a lot of women just suffer through it and soak their sheets at night with sweat one night and they're cold the next and it's just [inaudible 00:10:01]-

Suzanne:

And they're getting dismissed.

Dave:

Yeah.

Suzanne:

Even those of us who are not ignoring those issues that are really disruptive to, not only our activity of daily living, but are to our long term health. And I have something very specific to say about that. Some of those people, a lot of those people are getting dismissed. They're coming in to physician's offices. And again, I walk a tight rope. I mean, you kind of just named it. Look, I'm a licensed physician. I believe in a lot of what I do from the conventional standpoint, but I have a bigger toolkit. I feel that restricting myself and restricting you in your interaction with me does not make sense for me. But I have to work within the system sort of.

So having said that, people go to the doctor all the time and hear bullshit. They hear there's nothing you can do. They hear you can't do it. The flavor of the week this week in my office was people coming in and saying, "Could you please talk to my other doc because he or she is telling me I have to come off my hormones." Oh girl, come on. So that's the thing now.

Dave:

Wow. It's so easy to... If I take my car in to get it worked on, and if the mechanic says he can't fix my flat tire, I don't just drive the car with a flat tire. I fire the mechanic and I get a different one.

Suzanne:

Well, but people are doing that increasingly. But this is in a very privileged environment. I'm in Beverly Hills, California, where people have access and sophistication. And even people who maybe aren't coming from Beverly Hills but come from West Covina, and they figured it out. These are sophisticated users of the system. I forget sometimes, Dave, because I have these conversations all the time, how few conversations are actually happening out there and how many people don't even know that there is a place that they can go to get better information, that there's a place that they can go to individualize their care, that there is a place that they can go to have community and not feel isolated.

I mean, that's why I started doing menopause boot camps and that's where the book came from. Because what happened was, even in my community, I just didn't have enough time to give people what they needed. And I actually started having these boot camps, like four-hour experiences where we would go do a deep dive, answer questions. My life partner is a 35-year fitness pro. He's really knowledgeable about movement and nutrition. And we did a whole thing. And people really, really needed it. And it was so interesting. I thought people were coming for the information and they were, but they were leaving with community. They were leaving not feeling isolated, stigmatized. People didn't want to say the word menopause.

Dave:

What did they want to say? Like, "That time," or something?

Suzanne:

Listen. What direction do you want to go in here, friend? Because this is like... I tell people all the time. This is the... Misogyny and ageism had a baby and called it menopause. This shit is fraught. So I will just tell you, being a woman in West Los Angeles. Okay? And I grew up here, so I have an interesting perspective. And I think being a doctor and being in my brain a lot, I've protected myself in some ways. I'm going to get personal here. But at the pressure to look a certain way and be a certain way and hide who you really are and hide your power is immense. And people don't even always understand that that's really what's going on. And it speaks to some of the stuff that we know about control and other things.

But that isolates us and then we don't get the information. Or we get information that's... How legit is it? I don't know. Is it legit because you have a business based on this and you're making a lot of cash money or is it legit because you're really helping somebody? Remains to be seen. So I'm dealing with all of those things and trying to create an environment where people feel safe, where they can get information, and then they can have more of a conversation with themselves. What are their priorities? And then yes, they can go out and try to locate people who are going to work with them and guide them through this in a much safer fashion. And I mean safer on all levels safe. I mean safer spiritually also because how we treat aging as a culture and how we treat ourselves and the wisdom that we gain being on the planet for a longer period of time says a lot about our culture.

Dave:

It says a ton. And one of the reasons that I am ardent supporter of longevity is that I think the world will probably die unless we have more wisdom.

Disclaimer: The Human Upgrade™ transcripts are prepared by a transcription service. Refer to full audio for exact wording.

Suzanne:

Yes.

Dave:

And wisdom comes with age. And if you know that you're going to have to eat the plastic you threw in the ocean because you have another a hundred years on you, maybe you won't throw it in the ocean. So I love that. But why do I have to have gray hair and worse posture and be slower and have a walker and a wheelchair and a diaper, and not remember my name at the end?

Suzanne:

You don't. You don't.

Dave:

You don't. Exactly.

Suzanne:

We don't.

Dave:

And that's part of longevity. But when we talk about aging, people see that.

Suzanne:

That's exactly right. Yeah.

Dave:

So why do we have to say, "Okay. Menopause is a natural part of life." Why don't just say, "I decided I'm going to stay fertile and I'm going to set my hormones like I was 35 and I'm just going to do that till I'm 105"? What's stopping us?

Suzanne:

That, I will tell you philosophically, I'm not sure that that's really beneficial. And I think that's a philosophical conversation. And I will say this.

Dave:

It is.

Suzanne:

I will say this. Here's where I stand on it. If that's where you're at and that's what you want to do and you understand the options, the risks, and the benefits and you have been thoroughly counseled and you want to decide to do that, I'm not here to tell you not to do that. That's not exactly what I'm promoting. What I'm promoting is, again, people locating the agency that they actually have, which they can't do fully in a culture and in a healthcare system, we all know that's not actually a thing, but we're going to call it that because what was the language we have available, in a healthcare system that doesn't even talk about it or teach about it. How is a person supposed to get all the options? They can't.

So I feel like I... Top level, I totally agree with you. If we don't allow for room for people with wisdom, we're just doomed. And if we continue to also commodify absolutely everything, we have some problems as well. The thing that we can do for ourselves is value ourselves, prioritize ourselves enough to avail ourself of the information that's out there. And a lot of my book is really, and the stuff that I've been doing, the work that I've been doing is stuff that anybody can do. They don't have to have so much access, or so much money, or even the best insurance, or be able to pay cash money to do it. I want this to be something that people have access to no matter where they are. You know? Otherwise we're... I don't know. This becomes a very elitist endeavor and I don't think that's helpful long term.

Dave:

Hold on. You work in Beverly Hills. Aren't you inherently elitist?

Suzanne:

A hundred percent. Yeah. It's a struggle I have. The struggle is real, friend. I know that sounds so gross. Hello, White lady. I mean... But I'm doing what I can. That's why I'm trying to reach other people. And the interesting thing about this is that when I was doing the boot camps and then of course Covid came and made me have to change everything, which is fine. I pivoted and it went great actually. But one of the things that I'm working on right now is creating templates for people to be doing their own boot camps. And it's in the book as well. In their location. Because how am I going to Cincinnati or Compton or Cleveland and I'm telling them what to do? I can give them the basics and then they can create the template or take the template into their community and tailor it. Again, that's individualizing again.

Dave:

Okay. It's interesting that you'd write a book called Perimenopause Bootcamp. I mean, it's such an intriguing title.

Suzanne:

Oh really? Do you think so? Tell. Why?

Dave:

Okay. Your book is really called Menopause Bootcamp.

Suzanne:

Yeah. It is. It is.

Dave:

And you mentioned that perimenopause is a word that triggers people. So I was just seeing if you would be triggered by it. And I could see you grit your teeth, but you really handled that triggering really well. Why is perimenopause triggering?

Why is perimenopause triggering?

Suzanne:

You know? It's really interesting to me. I think early on it was great to have this name to the longer lead up in transition. And so actually, let me back up here for a second because part of the issue we have is how do we speak to each other and have a conversation if we are not speaking the same language. And

language is the most important communication tool that we have in this media. Right? We got to talk to each other. So I think laying out the terminology is very important. And often people come in to see me or they ask me questions, whether it's online or whatever. They don't understand even what these things are.

So here's the deal. When we're talking from the medical perspective, menopause or postmenopause... Gets confusing. When I say menopause, most of the time I'm talking about the transition. And I think that's what you're talking about. And I think that's what... That is where perimenopause falls in. Peri just means the Latin for the time around. Menopause itself is retrospective. You don't know you're there until you're there. 12 months consecutively no menstrual cycle for no other medical reason, hysterectomy, cancer, thyroid disease under, I mean, excuse me, over the age of 45. That's menopause. And now you are postmenopausal.

The transition is really what is so hard for people. I mean, the whole ageism thing is... That's a bigger conversation and that's the rest of our lives. But let's talk about menopause, perimenopause. So why is perimenopause triggering? It's almost turned into a diagnosis, which it's not, or some kind of an accusation. People don't want to be perimenopausal. And I think that that's because they are afraid of the symptoms of the aging, of the invisibility that they think... They're buying into the narrative that they think they're no longer going to be valued or important. And they also, again, don't have the tools with which to get themselves through that ice cold bath and understand they're going to get out of the ice bath and feel awesome afterwards.

We aren't talking about it. So we are anticipating what we don't know. And that causes fear and anxiety, which is never a good way to approach anything. Right? Your frontal lobes closed down, you can't make decisions. Okay? This is just basic stuff. So perimenopause, I think early on, let's say 5, 10 years ago depending on your community and where people are at, was an amazing tool because it was naming something that was going on that people were not talking about. Women in particular were experiencing changes without their period changing. Mood changes, PMS, breast tenderness, sleeplessness, weight gain, and being told by their doctors, "There's nothing wrong. There's nothing wrong. There's nothing wrong. Your labs are fine. Your labs are fine. There's nothing wrong."

They didn't feel good. What are you talking about there's nothing wrong? This human being just sat across the table and told you something is wrong with them. So even if you don't know what it is, or I'm going to own it, I'm the physician, I don't know what it is. Do how often I say to people, "I don't know, let's figure it out together"? I've done that my whole career.

Dave:

Wow.

Suzanne:

Yep. But I-

Dave:

You're unusual because-

Suzanne:

I know. I know. I know.

Dave:

... the I don't know is a very hard thing for a doctors to say because it makes patients feel unsafe sometimes, because you're trained to know.

Suzanne:

My experience has been it doesn't. It validates them. Because when I say to them, "I don't know this. We're going to work on this together. This is what I know. This is what I don't know. What I do know is you came to me, you're having an issue. Something is not okay for you. So we're going to figure it out," I've learned... That's how I got to Ayurveda.

Dave:

Yeah.

Suzanne:

Do you think... I didn't walk into Ayurveda on the street for God's sake. Somebody brought it to me and I was like, "I don't know what that is. Let me check it out. Oh my God, I'm very interested." That's really what happened. So perimenopause early on, I think, was empowering. Now, now people come in and they be like, "Oh my God. I'm in perimenopause," like it's a disaster. Like, someone told them they have cancer. So it's just words. I mean, again, if that word works for you, cool. To me, it's starting the conversation so that we can get the toolkit going.

Dave:

So is it your view that as soon as things start to get wonky with your hormones on a monthly basis, sometime around that age, is that the beginning of menopause? Or what's the name for that if perimenopause is the wrong name?

Suzanne:

We can call it what we want. I mean, I refer to all of it as the menopausal transition, which also scares people.

Dave:

Okay.

Suzanne:

Because if you're 37, you don't want to hear that. But you don't want to hear that because of all the things we just talked about. And I think we have to destigmatize this word. Lord have mercy. This is great. That means you're still alive for God's sake. It's the puberty of midlife. If people feel better with that, we can call it that.

Dave:

I'm going to have to be a little skeptical on that one.

Suzanne:

Okay.

Dave:

So I was the only 27-year-old in this anti-aging group full of people 60, 70, and 80. Because when you are in your 20s, you do not care about aging.

Suzanne:

No, you don't.

Dave:

It's number 17 on your list.

Suzanne:

Yeah.

Dave:

What you care about is building a career and getting laid.

Suzanne:

Yeah.

Dave:

That's what Mother Nature programs us to do. And we care about those things before we even think about them. We just know them to be true. Right? So-

Suzanne:

But I mean, I don't think that this book is... I mean if it reaches the 27-year-old, great, but that's not who it's for. You know?

Dave:

But they're the ones who you have to destigmatize. Everyone who's already been through menopause or transitioned into it, they already know it. Right? People who reach their 40a and have some friends who've started, it's a different thing. The problem with ageism-

Suzanne:

No, Dave, I'm going to tell you something.

Dave:

Yeah. I'm listening.

Suzanne:

I do this all day every day. And partly because I... Look. My patients know what I'm up to and they follow me and all this other stuff. But no, women get to their 40s and they really don't know what is going on. It's shocking.

Dave:

Yes.

Suzanne:

Or they get to my cohorts. So I'm 56 and a half and my cohort is sort of Gen X, how we are. We're like... We're a little bit about some stuff and with like, "Why did nobody tell us?" You know? That kind of thing.

Dave:

Right.

Suzanne:

And then the people older than me are like, "Ah, fuck it. It happened." But I will say it's very interesting. This is really... This is pretty funny. I had something in the office and I was talking to one of my patients who was 30. And she was really into it. They are very curious about what's coming next, and they are very much interested in advocating for themselves. And she said to me, "She's right taking notes. So what's the book called? Menopause for Millennials?" And I was like, "Oh no. But okay. Of course everything's about you guys." But that was amazing. That was amazing. She was so into it. So you might be surprised.

Dave:

There are a percentage of people who are into it. The point about telling younger people that they should listen to older people has been a theme, I think, since the first Greek tragedies were written.

Suzanne:

Yeah.

Dave:

And it hasn't worked yet. And I think it's biological. Right? So we either have to put it in their language. And I'll be straight up.

Suzanne:

Yeah.

Dave:

The anti-aging nonprofit work that I did, I could get no one from Google, and we're four minutes from their headquarters, no one would show up for the meetings, which is why I stopped talking about anti-aging and I started talking about biohacking. And now I've got teenagers biohacking because it's a performance and longevity thing. So how do we talk about menopause for people who really aren't that interested in it so that they become interested in it? That's how you destigmatize. Right?

Suzanne:

I think just saying the word. And again, I think maybe, and I don't want to be too... I don't want to generalize too much because I can speak only for the people that I have had experiences with. But I think in general, the red tent situation, communal conversations amongst women, that actually is ancient and it is innate in a lot of indigenous communities and a lot of ethnic communities.

Dave:

I don't think everyone listening knows what the red tent is.

Suzanne:

I'm going to explain it.

Dave:

Yeah. Yeah. Would you, please? Yeah.

Suzanne:

It is a place that in ancient, ancient times, many, many cultures, my own included, Judaism, it was actually a tent where people went to menstruate. Right? But what was going on, and to take care of themselves during that time, not running and doing, but being there, being cared for and attended to. And the other thing that happened was that... So you had intergenerational conversation going on throughout women's lifespan and you weren't... So you knew through when you were a girl this is coming next and this is how you're going to be cared for and you're participating. And you knew as an older person you're done with this time, you have the wisdom, you went through it, you're going to assist people through that time.

Same thing with childbirth. The fact that we have to take classes now to have a human come out of our bodies is... Okay. Thank God we have them. But obviously in the way past... And I don't want to romanticize the way past because women also died largely during childbirth, so that wasn't good. But you would've never gotten pregnant and had a baby without having had some contact with that. It wasn't the first time you ever had contact. You saw it on a farm or you had family members. People had births at home. Again, I'm not saying all that was great in every way, but the loss of wisdom and the loss of the intergenerational conversation is profound.

And I do think that using the word and talking about it and reconnecting... And I will tell you, Dave, it's been really gratifying how many groups have been coming to me to want to specifically have an intergenerational conversation to reestablish those lines of communication. Women are very tied to our bodies in a very specific way. I'm not saying men are not. I'm talking about my experience and women's experience who I [inaudible 00:28:18]-

Dave:

Why don't you just say that women are more that way than men? It's okay because it's true.

Suzanne:

I think we are. We live by cycles. We live by cycles.

Dave:

Sure. I mean, I see it too.

Suzanne:

Where we are identified. We are identified.

Dave:

Women are better biohackers than men on average-

Disclaimer: The Human Upgrade™ transcripts are prepared by a transcription service. Refer to full audio for exact wording.

Suzanne:

Interesting.

Dave:

... because you notice changes in your bodies. And we only notice if there's a problem sticking out. Then that's stereotype-

Suzanne:

Yeah. Totally. Or you're bleeding to death.

Dave:

Yeah.

Suzanne:

But stereotypes are based in reality.

Dave:

Totally. I'm fine with it.

Suzanne:

So it's really, really interesting to me. In fact, the actual, the big inspiration for all of this I shared with you. But the actual aha moment came when my dear friend, Erica Chidi, asked me to come to the wing in 2017 or 2018. She's 20 years my junior. She wanted to interview me about menopause. And I was like, "Really? Okay." And during that conversation, this is where this aha about intergenerational conversation loss happened and it all rolled from there. So even though initially this has been focused on people who are more immediately concerned with it, I do have a bigger picture in mind, which is for people to feel less uncomfortable with it. And I'm comfortable struggling against the tide of humanity. I'm comfortable with the fact that we have been trying to get people to listen to elders for millennia. That's cool with me. I'm happy to be a part of the conversation just in general. And I do see things shifting and changing. It's really, really interesting.

Dave:

I think they are changing. And some of this goes back a couple generations. There's a researcher named Chris Masterjohn, who was on my show like 900 episodes ago. Probably one of the first 50. He just posted something the other day about how the American Medical Association back, I think, in the '20s or '30s came after someone who'd written a guide on women's care and specifically on birth and on infant and childcare. And they basically said, "This is the doctor's job. Not the mother's job. You're not a doctor. You're not allowed to do it." So they put a panel of physicians in place to muzzle the woman who had done this. It's been going on for more than a hundred years by the trade union for doctors like AMA. We've got your number. You're not serving healing anymore. You're serving the profession and you got to back off a bit.

Suzanne:

Oh, I would beg to differ. I'm not sure they're serving the profession. I've never been an AMA member.

Dave:

There you go.

Suzanne:

But I'm not such a weirdo outlier. I just told you I have a totally conventional practice in Beverly Hills.

Dave:

Sure.

Suzanne:

So a lot of us are not AMA members. But that organizational medicine and a lot of the regulatory bodies that we deal with are complicated, let's say. Let's just... I'm going to call it complicated today. That's my-

Dave:

Okay. Complicated works. All right. Well, let's talk. In your book you talk about menopausal hormone therapy versus hormone replacement therapy. Why is it controversial and what is the controversy itself doing?

Suzanne:

And I don't think it... Again, and this, it's so interesting to me how words affect people. I don't think there needs to be a controversy, but this is just a matter of shifting the language. And this is an interesting conversation that's getting re-instigated again because in the UK there's been all this information and all this attention on menopause and there are a lot of people there who are very focused on menopause as a disease and menopause as an estrogen deficiency syndrome.

So here's the deal. How I feel is you get to feel however you want to feel about this. I'm just going to tell you what I know. If you want to call it estrogen deficiency syndrome, I think that's ridiculous. It's just a state of being. Now, that doesn't mean that giving estrogen isn't going to be helpful because estrogen replacement, if you want to call it that, or menopausal hormone therapy, which is now the more modern term, whatever, it's... I'll tell you what gets people really going. Bioidentical. Wow, that word really gets people upset. It's silly. Who cares?

Okay. It's a marketing term, not a medical term. Do I care? If I want to speak to my patient in a language she understands, then I need to understand the language. It's a word. It means that this hormone that comes from a factory, my friends... It's not being harvested in the wilds of Ecuador by a shaman. Okay? That's not happening unless you're killing somebody and you're eating her ovary, which I do not recommend you do. So these things are just biologically as identical as possible to what our body was making. Period. Full stop. That's what it means. So I use the term because my patients use the term. And if my colleagues get upset, they should maybe go to therapy a little bit more. I mean, it's a word for God's sake. That's it.

Dave:

Anyone who gets triggered by anything ought to go to therapy some more. Right?

Suzanne:

Yes, I include myself. I will do it. I do it.

Disclaimer: The Human Upgrade™ transcripts are prepared by a transcription service. Refer to full audio for exact wording.

Dave:

Well, you did handle the perimenopause boot camp thing remarkably well. So I appreciate-

Suzanne:

Oh, Dave, I meditated a little bit before our podcast.

Dave:

So-

Suzanne:

Just a little though.

Dave:

So it's all right. So let's say a woman's listening to this and she's saying, "Well, I'm pretty sure I might be going through this at some point coming up here." What do they get by looking at it as a boot camp? Do you test for hormones? What's the first step?

Suzanne:

I don't always test for hormones. In fact, I test for hormones under very, very limited circumstances. If somebody's quite young then I do want to make sure what's going on. In other words, again, I said to you, right under 45, no period for 12 months. That's not normal. So there are some genetic conditions we want to look at and things like that.

In terms of testing for hormones, this is where I do differ with some of the practitioners out there. I'm not replacing the number. It's very different than things like thyroid or even testosterone in men, although I'm going to put testosterone aside for a minute. We don't have reference ranges that we really understand to be normal. The word reference range, I think you've actually talked about this on your podcast. I don't think people understand what even this term means. And I don't want to get too far afield.

But if you walk in and you're 47 and your PMS is on fleek, and you're skipping periods and your periods are getting heavier and every... Now your PMS was three days and now it's 15 days. Hello? You're making the transition. I don't need to test it. What you need to look at now is drill down. Do you have any other medical issues? What's your personal history? What's your family history? What's your lifestyle? How's your sleep? What's your stress? How do you exercise? How are you eating? Are the hot flashes really the main thing for you? What's going on? And then we can prioritize what the issues are for people. And now we can look at whether or not you want supplements, you want hormones, you're appropriate for hormones.

I have a lot of patients who come in who are very leery of hormones for a number of reasons that are legit for them. And they may or may not be science based. And that's cool. I will tell you that the vast majority of them will start with botanicals and end up on hormones because it's going to work better. And the other thing is that we want to help prevent the long term issues. Okay. So what's going to cause problems for us? Heart disease, dementia and Alzheimer's, osteoporosis. Menopausal hormone therapy is beneficial for all of those things despite what you have been told. And the risk of cancer is low.

Dave:

Yes.

Suzanne:

I am a breast cancer survivor. At the moment, I am not... I'm doing vaginal hormones only and I'm not doing systemic. I don't know. Do you know Avrum Bluming? You read his book, Estrogen Matters?

Dave:

I have not.

Suzanne:

You should read it. It's a takedown of the Women's Health Initiative, which is a big study that exploded everything 20 years ago and created havoc and was highly political and really terrible, and not looking appropriately at women in transition. It was looking at women in their 60s who already had heart disease, who were largely overweight and obese. And, yeah, you put them on estrogen 15 years after menopause. And of course they had medical issues, because they had medical issues. It wasn't the hormones.

Dave:

Right. Kind of like the Ornish diet.

Suzanne:

Yes. Exactly.

Dave:

Like, let's say it's the diet even though it's the meditation you made them do with the diet. Yeah.

Suzanne:

Right. It's not... So people... Science becomes a religion too. I get so pissed about this. Here's the other thing. Breast cancer survivors. Not saying you don't want... I don't want you to have breast cancer. It's terrible. It sucks. I had it in my 40s. It was not fun. Here's the deal. Most of us get diagnosed in early stages of breast cancer. So I'm not talking now about metastatic breast cancer or people who are 35 with breast cancer. I'm not talking about those people. The vast majority of us who are diagnosed with breast cancer are going to die of what? Breast cancer or heart disease? Heart disease.

So we are doing people with disservice when we weaponize this stuff. And again, when we don't remain open and curious and having a conversation. So I'm not going to do this based on testing or hormones. I'm going to do this based on a much more comprehensive and nuanced approach, which is going to change over time.

Here's where I do test. Somebody is on therapy and they're having a weird reaction. They're bleeding strangely. I'm going to look at their uterus, do an ultrasound, maybe do sampling. I may look at their estrogen numbers. And this is one of the few places that I think the DUTCH test, the urine test can be helpful because we metabolize through different pathways and we have genetic predispositions to make good estrogens versus bad estrogens that are more cancer promoting or not. Testosterone. People on testosterone, especially when they come in with a pellet, I'm going to straight up, not okay with pellets right now. I just don't think the data is strong enough to support their efficacy or their safety.

And I've had people come in with testosterone levels that are insane. And testosterone, so your people know, can be aromatized, can be changed into estrogen. And that'll cause other problems. This is not

benign. So I do follow my people on testosterone with testosterone levels sometimes too. But I don't do it by lab testing because, again, this is not a disease. This is not a disease.

Dave:

You mentioned a couple things there that would be really helpful. We've got to talk about reference ranges and we've got to talk about vaginal hormones.

Suzanne:

Oh yes.

Dave:

So let's start with vaginal hormones. I'm assuming you mean specific hormones delivered via the tissues of the vagina.

Suzanne:

Yes.

Dave:

Walk me through that versus the [inaudible 00:39:30]-

Suzanne:

And things delivered to the vagina.

Dave:

Yeah.

Suzanne:

Yes. So here's the deal. I mean, there are some hormone delivery systems. One in particular, a ring that can be used for systemic absorption. Why? Because the vagina is very, very vascular. It's a great way to get medication into the body. So aside from that, I'm not talking about that, the Femring, we can deliver estrogen and also testosterone locally to the vaginal tissue; because one of the things that happens as our estrogen levels decline is that that tissue in the genital urinary area, so it's not just vaginal, vulva, our clitoral, but also the urinary tract, bladder, urethra is suffering. The tissue is getting thinner. We have collagen loss, we have less elasticity, we have less blood flow. Arousal can become a problem. Sex can become painful. UTIs, pH changes, microbiome changes.

So the pH changes were more susceptible to both bladder infections and vaginal infections. On and on and on and on. So there are a number of modalities that we can deliver vaginal hormones to that tissue to help replenish it. And it is so game changing. Again, I see people walking around who have dry vaginas and painful sex or aren't having sex who want to have sex, or think they're having a UTI and taking antibiotics all the time. And nobody is addressing their vagina. And it's like, "What? Is that..." So that's a pretty easy fix. And again, you're not going to get substantial absorption into your entire system. So you're not going to get the benefits that I just discussed. Brain health, heart health, bone health, muscle health, metabolic health. But you are going to have really profound improvements in your everyday life and in your health in other ways.

Disclaimer: The Human Upgrade™ transcripts are prepared by a transcription service. Refer to full audio for exact wording.

Dave:

I've been talking about Scream Cream for a decade on the show, which is a vaginally delivered hormone, usually including a little bit of testosterone, sometimes oxytocin that have just a profound effect on the health and other aspects of the vagina. So there's complete evidence for this. A lot of hormone doctors do that.

Suzanne:

Yeah. Yeah.

Dave:

I've also seen though recently, I wonder if you see this in practice, there's a group of about 40,000 women on Reddit who are applying stronger testosterone only to the clitoris in order to actually increase its size and function. And they're doubling and tripling the size of it and saying, "I'm having mind blowing orgasms. Everything works better down there. And I just... Maybe it was not... Maybe it needed that." I mean, some of the testimonials are ridiculous. Some are biohack. We have control of our own biology. As far as I'm concerned, if you want three boobs, you find a way to do it, you do it.

Suzanne:

Totally.

Dave:

You do you. Right?

Suzanne:

Totally. Totally I agree. I think as long as you're not having a huge amount of systemic absorption, because that can be problematic for them. And do you want to have a big clit? Cool. I don't care. It's not my clit. Do you.

Dave:

Is there a reason not to do that?

Suzanne:

Well, I mean the only thing is going to be that if you change your mind later, like, oh, too bad now your clit's really big. I don't know. I don't know what to say about that.

Dave:

Yeah. There's that, but you're not seeing that in practice because that was a surprising number of people.

Suzanne:

I haven't. I haven't seen that. That's really interesting. Now I'm going to have to go check it out. I have not heard about it.

Dave:

Disclaimer: The Human Upgrade™ transcripts are prepared by a transcription service. Refer to full audio for exact wording.

It was in Vanity Fair or Glamour, or... It was Glamour or Vogue. One of those. One of the women on my team sent it to me. I'm like, "Oh, that's biohacking if I ever saw it," if I hadn't come across it.

Suzanne:

Yeah, totally.

Dave:

All right. Well, there you go ladies. Now you know about that. For whatever medical use it is, we're just going to go there. So that's vaginal hormones and they don't absorb systemically unless you use a lot.

Suzanne:

Right, right. Right, right.

Dave:

Right? And for guys... I used testosterone cream for a long time before I had kids because my testosterone was really low, and it was under a doctor's care. But the best spot was perineal for absorption, followed by armpits.

Suzanne:

Right. Right. I know. Interesting.

Dave:

And I'm guessing women sometimes do that as well?

Suzanne:

Yeah. So here's the thing. There's the vaginal application for more of what we were talking about. Then there's also testosterone. We know testosterone is really important. Listen. We have more testosterone than estrogen, women do, when we're younger. I'm going to say that again. We have more testosterone than estrogen. We don't have more than men, but we have more testosterone.

So as we age, all of these hormones are declining. And these are the things that we are not only feeling in our bodies and feeling differently, but do have health effects. So systemic testosterone, for sure we have very clear data on libido. And there is safety data. This is now here... Ooh. I'm going to say the word. FDA in all of their wisdom and all their misogyny won't approve it for women. It's cuckoo balls. We have data to support its use. We know that it helps with libido. We also know that it will probably help with sustaining muscle mass and other lean body mass, which is important for us to decrease our risk for cardiometabolic health issues.

And look. Lifestyle and specifically resistance training and eating a certain way are super, super important for many, many reasons. But I think we need to be looking a little bit more at testosterone for overall health in women. And I hope that that will happen. It's very, very hard to get that funded.

Dave:

And anyone who's listening to the show who's a woman has heard me talk about testosterone over and over and over, not because it makes you horny, which it usually does, but it's the hormone of desire for everything. So if you want to go out there to make a difference in the world, you're low in testosterone,

I don't care if you're a man or a woman, your levels will be different, but if you're low for what your body needs and there's a large range, you just can't really wake up and give a shit. And when your testosterone's there, you're like, "Yeah, that really matters. I'm going to do it." And then you got to address thyroids so you have enough energy to do it.

Suzanne:

Correct.

Dave:

That's the different thing we already talked about.

Suzanne:

Yeah, yeah.

Dave:

But talk to me about reference ranges. What's wrong with reference ranges?

Suzanne:

I mean, listen. I'm not a lab director, so I'm not an expert other than knowing a little bit. And I just know that reference ranges are based on exactly that: reference points. So I believe that they are set by community standards and bell shaped curves. So you're really just looking at you in comparison to other yous out there. Right? And I can't tell you much more than that other than to say, as things shift in the population, those numbers can change and shift. And is that really "normal"?

But here's the other caveat I really want to make clear here when people go and get their hormones tested. And they spend a lot of money doing this, Dave. And I'm not really sure what we're doing with this data. Or they come to me and they want their hormones tested. I don't know what your testosterone was when you were 27, feeling your best. So I'm not sure... Seriously. I'm not sure what is going to be best for you. We're going to have to just carefully look at how you respond and use the best available information and that's how we're going to do it. [inaudible 00:46:31]-

Dave:

You said something so important. And my advice for people under 30 is always get one hormone test so you know your ranges and you can pin yourself there when you're a hundred years older than your current age. For instance, a friend who's a woman has testosterone levels naturally that are as high as some men. And she's very feminine and that's just what her body needs. So if we were to treat to the average, she would be completely testosterone deficient. If we gave her levels to someone who has a more normal range, then that woman would probably grow a mustache. So you just don't know, but you can titrate your hormones for how you feel.

Suzanne:

Exactly. What do they say? Start low, go slow, and follow people carefully. Here's the other thing too. I'm kind of backtracking a little bit, but I feel like I need to say this because I feel like your audience will understand this. I have had people come to me from... I call them refugees. The refugees from other practices. And especially when we're talking about sexuality and we're talking about vaginas, if you're

working with someone who does not really understand that physiology and anatomy, think twice about working with them.

I've had more than one person come to me who had their libido fixed and nobody ever looked at their vag. And it hurt and it was dry and it wasn't being addressed. They were getting systemic testosterone. This person don't want to have sex? What are you doing? And they were seeing a person in the community who doesn't understand vaginas. We'll just leave it at that. But this happens a lot and it upsets me because this is not doing a service to vaginas.

Dave:

Okay. What are the top three things you would recommend a doctor do to be more familiar with vaginas?

Suzanne:

Train in it. And I don't think you can do a weekend course.

Dave:

Okay.

Suzanne:

Sorry. I'm going to say what I say. I think if you're going to deal with sexual health, and you're an MD, you should be an OBGYN or a urologist. You should be a sexual health specialist. Or you should go do a fellowship or training with International Society for Sexual Medicine, which is an outstanding organization. Yeah. Because that's not something you just get to know.

Dave:

So you would say that if someone goes to their regular practitioner and says, "I have low libido," that they should then, for women, refer out to OBGYNs who are more-

Suzanne:

Not just to all OBGYNs and also urologists. I'll tell you. I think our colleagues in the urology community have really... They're on fire right now because they're attending to this more seriously than we are. I mean, if what I'm seeing online, and I've been in the digital health startup space as well, Dave, I was a chief medical officer of a sexual health startup, it was really, really interesting. And I've been involved in the international, ISSM and ISSWSH, which is the American organization for a long time. And the urology community has been leading the charge way ahead of us. I think OBGYNs should be ashamed of ourselves. You know?

Dave:

Wow.

Suzanne:

We want to own the vagina, but we don't want to deal with the vagina. I mean, I'm really being a little cavalier here. But seriously. Or your plastic surgeon. God bless your plastic surgeon. I don't think your plastic surgeon should be doing the energy based devices, which I do and I use. I know my way around that vagina. Okay? Not only do I have one, but I've been doing this for 20 something years. And I just

Disclaimer: The Human Upgrade™ transcripts are prepared by a transcription service. Refer to full audio for exact wording.

have an opinion about it. I think you should be very careful about who you are allowing to discuss that with you. And again, if someone's going to think they're a sexual health practitioner and talk to you about libido and not talk to you about the parts that are involved in the libido, I don't even understand what that is about. What are you doing?

Dave:

Yeah, there's physical parts to libido and then there's the hormonal energetic parts.

Suzanne:

Totally.

Dave:

They both need to be lined up like that.

Suzanne:

Yes.

Dave:

And sometimes you just need to have a good lover too. If you think you don't like sex maybe your partner needs to go to a class on how to have good sex too. That's the other thing that no one talks about in the doctor's office, I'm sure. We're happy to talk about that in the realm of biohacking because it turns out sex is a nutrient and an environmental variable that controls a lot of how you show up in the world. So it's fair game here.

Suzanne:

Yeah.

Dave:

Now, one of our Upgrade Collective members in the live audience wants to know what is the right testosterone level for a woman postmenopause.

Suzanne:

Oh, okay. So as you heard me say, it's more that I want to make sure that you're not getting too high. So I'm not going to test you for that number. The right place for you is going to be based on what was your objective in starting the testosterone. So was it libido? Was it sexual function? Was it something else? I mean, I like to be very careful about the fatigue energy thing because as you mentioned, Dave, it's also very much tied to thyroid. And thyroid is another thing that gets a little bit ignored and sidelined. So I'm going to obfuscate a little bit there. I definitely don't want it to be higher than 80 or 100. That I start getting worried about that. But this is not knowing anything else about this person.

Dave:

Okay. My answer as a non-doctor was, "Until you can't wait to have sex every day and you don't have a deep voice or a mustache." But it's a wide range. Is that a good answer?

Suzanne:

Disclaimer: The Human Upgrade™ transcripts are prepared by a transcription service. Refer to full audio for exact wording.

For you, it's perfect. How do you know they don't want a deep voice or a mustache?

Dave:

That's a fair point.

Suzanne:

Yeah. Okay.

Dave:

If they want a deep voice or a mustache, they can do that. Most of the women that I know who are looking at testosterone replacement don't want that. But they're willing to have it and get it removed as long as they have good sex.

Suzanne:

Yeah, yeah. It's a really... This is where it gets... You know, you can really get into the weeds. And like you said, it gets complicated because people need to have their own personal decision making power here too. Again, as long as they're being counseled appropriately.

Dave:

Of course. How do women in menopause lose weight?

Suzanne:

Oh God. That's the bugaboo. Right? How do they lose weight? First of all, I will tell you that focusing on the number is ultimately going to be a big problem because that number is not where it's at. And even though a lot of the data that we use is derived from with BMI, which is, that's a whole other wastebasket term. Right? God, that's not very meaningful. I understand what the question is because I too have been through this myself.

One of the things that happens is as we age in general, we lose lean body mass, we put on more fat. Some of this is because our body is actually converting adrenal hormones into estrogen in that fat tissue. And there's some thinking that maybe the body is trying to retain some estrogen that way. That's maybe more of an evolutionary biology topic, but it's pretty interesting. We have a weight redistribution. So we go from having more butt, thighs to belly. And the shape change is really a bummer for a lot of us because our clothes don't fit and we don't like the way we look.

More importantly is cardio metabolic health and the risk that we are incurring as we end up having more risk like men because we don't have the protective estrogen. Estrogen is really protective in terms of the endothelium, the lining of the vasculature. It's very, very important. So how do we change that? A lot of it I really think is going to have to be resistance training and building more lean body mass. Not overdoing it. I saw a really interesting study just this week. Did you see this with the training one day a week versus two days a week versus three days a week? That was so fascinating.

And of course it appeals to me in my philosophy of the middle way. But it turns out that the people who... These are women in their 60s, well past menopause. If they did weight training and cardio once a week versus two times a week each versus three times a week, the people... First of all, the weight training was the same. Wasn't that interesting that their lean body mass was pretty... Or not. Their strength was pretty much the same. But the people who did two times a week cardio had the best weight management. So not doing enough and overdoing it is not good.

Dave:

Yes.

Suzanne:

As you age, overdoing it, you're going to hang on to weight. Your body thinks you're getting stress and you have cortisol released and you're going to gain more weight.

And then the last one is... And I'm going to tell you something. I live with a former pro body builder. And after seven years I finally listened to this guy. And listen. My portions are so much smaller. I'm a small person. I'm like 5'3" on a good day and I don't need to eat that much. And I need to eat more protein and I eat smaller portions. I'm not restricting. And I drink less and I don't eat late at night. That works for me. But I think the data supports a lot of that stuff.

Dave:

It does, especially not eating late at night because the circadian relationship with hormones. It's just so well proven now.

Suzanne:

Yes, yes. Yes.

Dave:

I'm a huge, huge sleep teacher for that kind of stuff. And I'm a little bit though, just thinking about when you go through that list, what was the second thing on there? Oh, it was about eating.

Suzanne:

Yeah.

Dave:

So, at any age, whether you're in menopause or not, I'm seeing an epidemic of women who exercise too much and don't eat enough calories.

Suzanne:

Yes, yes.

Dave:

And they get fat from that.

Suzanne:

Yes.

Dave:

Because you end up getting so much cortisol, it breaks your hormones and you put on weight from cortisol even if you eat less calories.

Suzanne:

Right.

Dave:

And that life. And I had this. I used to work out six days a week, an hour and a half a day to try to lose my 100 pounds. And oh my God. I was just so over trained. It broke my thyroid. Not as much as the vegan diet did, but it did break my thyroid. And this idea that you can do it, it's absolutely awful. And if a doctor looks at someone and says, "Maybe you should exercise more and eat less," my advice today is fire the doctor on the spot. The words are, "You're fired and I don't want to pay for this appointment." It's that big of a deal.

And so otherwise don't take advice from your doctor if it's that advice. You just can't do that because it's especially mean to women. Women are more sensitive in their fertile years to a lack of energy or a lack of nutrients and an excess of physical or emotional stress because your body's like, "Oh, the world's not a safe place? Let's turn off your fertility."

Suzanne:

Exactly. It's not safe to ovulate.

Dave:

Yep.

Suzanne:

I see so many menstrual disorders. I mean, we could do another podcast on that one. You know? And a lot of it is, again, accepting a narrative that's based in nothing and really at some level is really baked in misogyny. And that person providing that information does not recognize their implicit bias in that statement. It's really... It's not only not science based, it's mean. You said it. Thank you for saying it. It's not cool.

So we need to rest. We need to rest. We need to sleep. That is when our body literally does the work of detoxifying. You have detoxification organs, you have kidneys, you have a liver. They can't work if you're constantly feeding them and they can't work if your body doesn't rest. Energy has to be distributed to different parts of your body. Your brain has to clean shit out, too. Like, sleep. It's funny. The first thing I really try to address, and it's the hardest thing to address when somebody comes in and this state is sleep.

Dave:

Yeah.

Suzanne:

It's so hard, but it's the most important thing. And if you don't clean it up, your mood's going to suck. You're going to feel like shit. You're going to eat crap. You're not going to be able to have a nice life. You know?

Dave:

It's completely true. You got to deal with sleep. And the other thing that I think goes unsaid a lot is that it's okay to receive care.

Suzanne:

Oh yes.

Dave:

And this is a fundamental thing. And I'll be whatever, politically incorrect here. But in the yin and yang teachings and the sexual polarity teachings, the feminine receiving energy, it's important that women receive care.

Suzanne:

A hundred percent.

Dave:

And it doesn't have to be care of [inaudible 00:59:05]. It's just care. And if you don't feel safe to do that, I believe that you're more likely to have symptoms before menopause. And after menopause, you're going to have more hormone things. It's going to be harder because-

Suzanne:

I think that's so true.

Dave:

Yeah.

Suzanne:

I think that that's addressing the spiritual aspects. And I think it's enormously important because the other thing that's going on for women in this age group, thank you for bringing this up, is that we have spent our whole lives caring for everybody else. I talk about it in the book. Look. I got breast cancer at 47. And I have some explanations to myself. I mean, yes, there's family history, blah, blah. But I feel like there was a spiritual message for me too, which was, "Stop it." You are like, you're not taking it... It was my left breast. It was my heart.

Dave:

Wait a minute. Medical doctors-

Suzanne:

But it changed my life.

Dave:

Medical doctors can't talk about spiritual connections to cancer. How dare you?

Suzanne:

I know. I know. Have you not noticed that I don't do it the way I'm supposed to? I mean, I can't help myself. But I'm very sensitive to it with my patients too because then you get to 47 or 57 and you've got aging parents, you've got kids maybe. Maybe you don't have kids but you have neighbors. You're literally

taking care of everybody else but yourself. And you're... Talk about burnout. I mean, come on. So if you don't stop and just... Receive. I love it. Yeah. Wow. Huge lesson. I love that. Thank you for saying that.

Dave:

You're welcome. And people will say, "How dare you as a CIS White male say that?" Well, because I'm a male. That's why I can say that.

Suzanne:

That's not-.

Dave:

Or at least that's what they assume about me since I've never actually come out and stated that I'm a male. So there. Now I've stated that. So now if anyone was curious, now you know.

Suzanne:

Okay.

Dave:

But honestly, I just think that it's important, especially during pregnancy and around childbirth. It's kind of our job as a society to take care of women. Right? And we don't quite get enough of that going on right now. And that creates long standing problems. And it's just not that hard, especially during periods of need. So I would just ask everyone out there like, "Step up." If you see a pregnant woman you can open the door for her. It's okay. Give her your seat. Just little stuff like that is important. And it's hard for us to know if a woman's going through menopause unless she tells us. Right?

Suzanne:

Yeah.

Dave:

And if you know someone's going through it-

Suzanne:

But I want people to start saying it.

Dave:

Yeah.

Suzanne:

I want people to stop being afraid to say that. I think there's a lot to be said for just saying the word out loud. And I understand right now that people may feel that that would be offensive or something. But I mean, obviously you're not going to offend me by saying that. And I think if we can decouple it, like I said, and deweaponize the term and just be talking about it like we would any other life phase, then we can be there for each other and we can also learn from each other.

Dave:

And also, if it offends someone, like you said, they should get a therapist. So I-

Suzanne:

Or you can apologize. You know? Jesus. You know? Just like, okay, you didn't mean to say anything. Just say sorry.

Dave:

Well, so you're telling people that they should say that they're dealing with menopause symptoms and then apologize if it offends the person?

Suzanne:

Well, I mean, I think if you... I'm just saying in general, if you offended somebody you didn't mean to, you can be like, "Oh, I didn't mean to offend you, I'm sorry," and move on. Okay. So you and I can go to our own therapy.

Dave:

Oh. I was just like, "That's an interesting approach." I usually just say, "I'm sorry you're offended. Get a therapist so you'll be less offended," and then I just go on my way. Is that not a good apology?

Suzanne:

Okay. That's cool. [inaudible 01:02:48]. We have different... [inaudible 01:02:48].

Dave:

I'm just kidding.

Suzanne:

It needs a little work.

Dave:

Look. I identify as triggered right now. So we're just like the-

Suzanne:

Are you going to get me in trouble?

Dave:

I'm think I'm already in trouble. It might rub off on you. I apologize in advance.

Suzanne:

Oh, okay.

Dave:

But the idea here is we can all act with kindness around menopause or any other thing like that.

Disclaimer: The Human Upgrade™ transcripts are prepared by a transcription service. Refer to full audio for exact wording.

Suzanne:

Yes.

Dave:

And I'm going to be incredibly sexist here and say, "If you're a guy, it's your job to do that for a woman when she needs it and asks for it." It's okay to just be, "Yeah, sure. I've got that." Right? That's how society works. Right? And likewise, there are times when guys need help and we ask for it from women. And sometimes it takes different forms.

But when we talk about menopause and we talk about fertility, it's hard to talk about any of that stuff without just recognizing that men's behavior is a variable that changes women's hormones and vice versa. So it's a complex system, this species of ours, and you got to look at all the variables, including the phase of the moon, which we know affects it and behavior of others.

Suzanne:

Yeah.

Dave:

So let's just throw all that in the mix along with some testosterone replacement, and I think we can create a pretty happy and functional society.

Suzanne:

There you go.

Dave:

That's my goal.

Suzanne:

We've fixed it.

Dave:

We're done.

Suzanne:

Amazing.

Dave:

One thing though I do want to recommend as we wind up the interview is your book Menopause Bootcamp. For women who are looking at it, women who are going through it or have gone through it, there's a lot of wisdom. And from this interview, I think people can understand. You've got the numbers side of things, but you've also got a perspective on it. So congrats on writing a really, really good book about a topic that needs some more attention. So appreciate you.

Suzanne:

Thank you so much. Thanks so much, Dave. Thanks for having me on too. This has been a pleasure. Really. I'm serious.

Dave:

Hey, interviews are supposed to be fun. That makes them fun to listen to. And I apologize for getting you in trouble at least 47 times. I mean, we talked about AMA, the F letter agency who shall not be named, we talked about menopause, we talked about men versus some... Good God. We're in so much trouble.

Suzanne:

Dude, can I tell you? Like, this is me. This is not... We found each other. Let's just put it this way.

Dave:

There we go. I look forward to meeting you in person sometime when I'm around the upgrade labs down there at the Beverly Hilton, which is probably down the street from you.

Suzanne:

Yeah. Yeah, yeah.

Dave:

All right. Thanks again.

Suzanne:

Oh, thank you.

Disclaimer: The Human Upgrade™ transcripts are prepared by a transcription service. Refer to full audio for exact wording.