Discover Therapy Stacking In Integrative Oncology Transcript

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Introduction and Welcome

All right, everybody, I am incredibly grateful and excited for the conversation we're about to have with the renowned, if not sometimes infamous, Dr. Nathan Goodyear.

Welcome, welcome, welcome. Nasha, my friend. Always good to join you. I love it, I love it you. We were just talking before we started recording that you, just had a lovely interface with the social media world of trying to deplatform your messaging, and we'll dive into this a little bit later.

But that's what you've come here to do, is to educate, empower, connect the dots in a in a, in a different way. And so it's just an honor to have you and your perspective here today.

It's about truth. And somebody's got to stand up and say it. And you and others have done it for so long. if we band together, that's how we get the truth out more.

And that's how we build this legacy for the next generation. And who benefits from it? Our patients. 100%. This is. This is what it's all about. This is why we're having this summit and these conversations.

So, you know, it's really cool to me is getting to know you over, over the years because we've had that opportunity and you've had me on your podcast and webinars and, you know, other many conversations, many shared experiences at conferences.

I mean, you're definitely no stranger to the integrative medicine movement in general and to the integrative oncology movement in particular. But you've moved into this space of your passion and purpose of telling telling a story.

And I think that's something that, I would love for people to understand how you got here, because you didn't start out in this space. So can you give us just a brief background about how this path brought you and I together in this conversation today?

Yeah. So my life is a series of chapters that we call stories that make up our life. And so I got into actually, I played college football. So that's kind of where begins.

And I actually had two gentlemen that I played with that passed away within five years because of, cardiovascular disease. And, because, you know, I was an offensive lineman, I was quite heavy and they were quite as well.

So when I went through medical training and residency, I knew that I wanted to focus in the wellness industry. And I have a gorgeous wife and, you know, a growing family at that point.

And I wanted to be there for them. So I ended up, you know, focusing on wellness and getting into that arena as a pelvic floor surgeon. But very quickly as I got out of residency, I started to notice that a lot of the therapies we were taught, they work for some, but not others, and in fact, not for most.

And very quickly, I discovered that, you know, what we were taught was that there's this mean evil, humorous in the body called the uterus, and it must be taken out at all costs.

From Surgery to Integrative Oncology

obviously a little joke aside there, but, so I got into hormones very, very early. And that further, brought forth the idea that what we were taught was a lot of, propaganda because, you know, the people that would teach us about hormones, whether that be in the reproductive years or post-menopausal, they were all sponsor by the

pharmaceutical manufacturers.

And so when we got out into the arena of actually helping patients, they come back and they go, yeah, that didn't work. It's like, well, that's interesting. I was told they did.

And so that that was my foray into, integrative medicine. What really caused me to pivot was the whole pelvic floor mesh debacle. And and that was where I was one of, a group of docs that were doing a lot of pelvic floor surgery, the vaginal approach.

And we, brought on that, that that procedure very early under the presumption that there was data that was available. They just hadn't published it. They gave us preliminary data.

You know, everybody knows that story. If you don't, please go back and read it. They ended up settling, I think, for like $2 billion. They knew they had a bad product when they bought the market.

At that point, I knew I would never, ever do something to a patient without trying to know everything I could about it. That's why I wrote a book, two books on testosterone and men, because I started treating men, and I wasn't going to do that before I did that.

Then I just moved into the wellness movement, and patients with cancer kept coming to me. Yeah. And they show such strength, such bravery. And I was attracted to that.

But where I was at that time, I was able to do so little. So then I was diagnosed with my own tumor, a like tumor. And at that point I knew that, you know, I was my destiny was in place what I was supposed to do.

And so we actually came out to Arizona in 2018, so I could actually begin the process of doing, you know, learning integrative cancer full time. And I've been out here since then being medical director, I mean, integrative cancer clinic.

So the way I look at it, I came out here to do my fellowship because it has been a deep dive and it has been the best years of my clinical practice. And so with that, you know, I talk about this a lot.

Everybody focuses on longevity. And that's the big kind of catch phrase word. Today, the greatest threat to longevity is cancer. And working with patients with cancer is enough.

And I think we need to pivot and actually focus on prevention, because once you get cancer, I don't want to say it's too late, but the best opportunity is before that, not early diagnosis prevention.

And that's where it really where we can change that. You know, I was just with Thomas Seyfried. That's where we can change that body can. And we need to desperately do that to save lives because otherwise I think we're going to be, seeing that, trajectory, the trend that is not going to bode well for us.

Wow, wow. Well, I mean, talk about a compelling story. And I also want to reiterate to the listeners the fact that you've been only in this sort of integrative medicine and integrative oncology space in a relatively short period of time, you were a very quick learner, and you have immediately attracted in and sought out some of the top people in this field.

And so it's it's really beautiful, your your humbleness, your curiosity and your hunger to learn. This is really beautiful. And the fact that the patients, like, somehow saw something in you and started coming to you long before you had all this information.

it's just beautiful to see what you're creating now. We have several patients in common now, and I get to see that firsthand of the the deep relationship that you have with them.

That's so much beyond just a protocol. you really care about who these people are. And one of the cool things I

think you've got this beautiful, keen, keen, keen interest in personalized precision medicine or personalized precision care in this space.

So, yes, protocols are, you know, maybe you brought on, but they're based on that. And of one that individual, one of the areas that you're most excited about that you and I've talked extensively about is your interest in the area of Multiomics.

For a lot of people that maybe a first time you're hearing that word, can you please break that down for us, what that means and how you got interested in that.

Well you know what I, what I've always told the patients that come to us is this chapter called cancer. We want to close this chapter as quick as we can, but then what we want to do is start writing new chapters.

It's healing because what defines people with cancer is not the cancer itself. It's that they were a mother, a father, a sister, a brother, a man, all of these.

That's what defines an individual. What we let conventional medicine do is redefine.

Understanding Multiomics and Precision Care

It's like, no, no, no, no, no, let's get back to what you are and what you were meant to be. So and that is that precision and individuality. When you look at, back at cancer of the last 100 years plus or so, it's been the one size fits all approach, which, you know, intuitively, patients recognize.

Well, wait a second. I'm, you know, six foot six, 360, which I'm not, but and then the person sitting next to me is five foot two, 125 pounds. Intuitively, they know they're different.

And so why should the treatment strategy, let alone the cancer type, dictate a different treatment response, the same response, but it should be a different response.

So Multiomics was actually it's born out of the bench research world. A lot of the, major pharmaceutical companies have been using it for a long time in the arena of research of drugs, and it's simply looking at different areas in more of a dynamic, functional perspective.

We like to think about things sequentially because it makes us comfortable. You know, we can say A plus B or C, but unfortunately the body works in a, you know, quasi quantum physics approach where A plus B is going to equal XYZ.

ABC actually, you know, it's just all over the map and Multiomics through a collective field is saying we understand the dynamic principles here and the interaction, and let's just embrace that complexity and now try to work simply within it.

So genomics, epigenomics, transcriptomics, proteomics, metabolomics, immunological mix. You know, I jokingly say whatever omics. Exactly. They're just fields of study.

And I would say this real quick, I was actually working on a vitamin C lecture in a coffee shop here. a couple of years ago. And there was this guy kept looking over my shoulder and I was like, how rude.

But then I turned. I said, can I help you? Because it was so noticeable, you know? And he said, I see that that slide you have there on metabolomics, what are you doing?

And I said, well, I'm a physician. I'm actually lecturing on this concept of Multiomics with vitamin C in cancer. And I said, are you a physician? He said, no, I'm a PhD, just graduated in the arena of metabolomics.

And he said, physicians are using this. And I said, why shouldn't we? He said he just was not aware of anybody.

And so that right there showed me I was on the right route.

And we see that in our patients are amazing amazing. And you know, one of the cool things is you could talk about all these different omics environments here.

But one of the things is okay to like to that exact story of this man in the coffee shop who's he was at the bench. You're at the bedside. How have you bridged this information?

From the bench to the bedside? How have you brought it to life in the clinical space? Well, we could we could write a book on that. I hope you. Do. Because, that's one of the things that patients desperately need.

And when I say we desperately need, what I'm saying is patients because you and I see this a lot of, like, we as physicians, we are servants. Yeah. Now, I know people may be may get confused about what they see out in the medical community, but at its core, that's what we are.

We serve our patients and we serve that through that curiosity of mine, not the group thing that is propagated today, but that critical thing. And so to do that, we have to recognize everybody has a strength.

You know, I don't know why more doctors don't want to just go travel around. And number one, meet people that are shattering paradigms like yourself and others and learn from them.

We should do more of that, because then somebody one might go, well, have you ever thought about doing that? And it's like, whoa. Yeah. So I like to build bridges.

And so just this past weekend, you know, I've been down to, your humble abode down there with your wonderful husband, and you are by you are the most gracious host in the world.

And so just a wonderful person at heart. But it's bridging. And so from that bench research to clinical application, just last weekend, I had the pleasure of, interviewing Thomas Siegfried on my, podcast.

And we actually just sat down with his lab team in his lab. And just for lack of a better term, shoot the ball for 2.5 hours. It was amazing. But here's a guy that has this.

Here's a professor, excuse me, that has literally changed the way people are thinking about nutrition and cancer. But not just that, but how cancer originates.

And how to treat it from one of a somatic gene mutation to one of a metabolic disease that we can influence. And but he's doing it from a bench research.

But we've got to apply that. So this is a bridge between somebody that is doing amazing research now to the arena of clinical application, because that's now how we help patients.

We help patients. People go, wow, how do I donate to somebody doing amazing work like that? Well, here's how you do it. It's a partnership and understanding.

We must do this together. Right? Doctors holding on to things, saying this is my proprietary information. That's such bull. It's like we need to band together, help patients.

Unfortunately, there's too many patients for us to treat today. Unfortunate. And that is so, so right on. And I love that you had that experience. I would have paid really good money to be a fly on the wall for that conversation.

So I'm looking forward to seeing your webinar. But that comes out. Have it have an idea for you. We'll talk about it after. Okay. I think we can change.

I think there's some things we could do that would really, change perspective and change approach and delivery.

Yeah. I love it. And you know what's also interesting is in his lab and I think you said that you got to meet him Doctor Thomas garage I'm actually going to be interviewing on this summit as well.

This is a man who is a PhD MD.

Bridging Bench Research to the Clinic

He is literally the living example of bench to bedside and has still keeps his toe in the water in the clinical care of patients as well as in the laboratory understanding of patients.

And so these are really unique people out there. that it's just it's beautiful when you see that trans lation happening in real time. And so brilliant minds that are open for dialog that that that was the funding ideas.

We were just bouncing ideas off each other. And it's like, okay, something big can come out of this. So great people, great work. And I'm so appreciative of people like that, that open their time to people that are interested in sharing their voice.

We might be seeing our next Nobel Prize coming out of this conversations. I can't wait to see about how that, Yeah, I asked him. I said that, Thomas wins year's Nobel Prize.

Oh, no. He said that there's too much opposition. I said, well, maybe if we get your voice out there more, it will go. That gives me goosebumps yet again, yet again, yet again.

And you keep like I said, you are the seeker of these people who have stories to tell and important legacies to leave. And so I just, I, I love that, I love that.

And so when you think about how you now apply this information of what you're learning from all these people over since 2018 and before all those other life experiences are just as informative to this moment.

You know, as, as some of these more specific integrative oncology ones, you have a really unique, approach compared to a lot of colleagues of ours, you know, so there's a lot of people out there who practice integrative oncology or practice conventional oncology, but you have, gosh, you call it stacking of these therapies.

Can you speak to that a little bit and how you kind of why you approach it that way? Because most people understanding oncology today understand it as looking for a single target with a single agent or a single treatment.

And that's how we that's how we do our research. That's how we come up with our, treatment plans. And that's what we do until that comes to a dead end, and then you switch it to the next target and the next treatment.

So talk to us a little bit about maybe the old school standard of care to this emerging understanding that you now carry forth in this stacked approach.

Yeah. So I mean, the somatic gene mutation, which is cancer, originated from a single mutation of the DNA, which on its face is ridiculous. and that fact goes back to the late 19th century, Paul Urich, the magic bullet theory.

And this, it actually was called chemotherapy. The first chemotherapy, the use of solverson, a treatment for neuro syphilis. So one disease, one treatment.

So basically, what we had there was a successful story, no doubt. But what that brought is very interesting because that eventually passed its way on to the chemists war, a World War one where now we took this process of using chemicals to treat disease.

Now chemicals became the process of how we, you know, combatted war. Yeah. Then that process then translated into World War Two, where there was little Port Harbor and the Allied forces were bombed in, Italy.

And there was some investigation because of what happened there. And lo and behold, that then became the groundwork for chemotherapy in going to war on cancer.

Then of course, Nixon declared war in 1971. We've had a war for the last 50 plus years. It's the longest war, I think, documented on record and probably had a higher body count than any other wars combined.

And so basically it was born out of that one hit hypothesis. And here we are today, still struggling with this. But now look at the expansive tests that we have to evaluate patients right.

Do we do we ever see one thing wrong. Never ever. And it's a multitude of mess. Yeah metabolic mess. And and so we have to understand that cancer was not caused by one thing.

It cannot be treated by one thing. It would be nice to be simple. I actually had a patient one time said, well, doctor, good. You're brevity is a solar wit.

That's exactly right. But trust me, I'm not witty. So yeah, that's not accurate. So we have to focus on the reality of the science. And that can only be, that can only happen by the stacking meaning, the combination and sequencing of the therapies as the literature guides us.

Because that's the other thing to go. Where's the science? Well, that's what guides us in stacking this. So you see this. And for example, Thomas supersedes or sees on the front of my mind, but his work.

But there's many other processes and people that are doing amazing work showing how these therapies sequence and stack together. Amazing, amazing and, you know, it's interesting because that's so the stacking piece is one component of this.

But like, I would love for you to give a real world example of a patient who's come to you that, maybe a case that really comes to mind that has gone through that single target, single treatment approach, who that approach has failed them.

Now, just for the listeners, a the the language is actually used in medicine is that the patient failed the treatment. But, one of the things that Doctor Nathan and I are really good about is changing that narrative to understand that that was actually a failure of the treatment to the patient, you know, for the patient.

And so you I'm, I'm sure like myself and other colleagues like ourselves, we get patients like this all of the time where standard care has failed them.

That one approach, you know, that one target, one approach. So give an example. Maybe that comes to mind of what that looked like, how you determined maybe using omics profiling or other biometrics that helped you choose a different approach.

And what types of stacked therapies when you tell when we say that, what does that mean to you?

Stacking Therapies in Complex Cancer Cases

And just through an example and recognizing there's millions of variables, variations on this theme, but you but one individual, example might help people understand what it's like to come and see somebody like you when standard of care alone has failed.

So I'll, I'll go back to a patient, that was diagnosed with stage four breast cancer. She had actually been diagnosed originally with stage two, and she had surgical resection, a lumpectomy.

But then she wanted to, move beyond, chemo radiation at that point and take a more natural approach. Now it's a little bit pivot because the oncologist did not embrace her.

I think there could have been a bridge there, and then colleges could have walked alongside her with a natural doctor. And I think what happened there, the oncologist said, no, I will not confirm and barter and and so at that point, I think that hurt the patient because the oncologist wasn't interested in her perspective, but she so she had a lumpectomy.

She didn't have any chemo, radiation. But then she came back a couple years later to the oncologist because she had been discovered to have stage four bone Mets, liver Mets, lung Mets.

And so at that point, her oncologist, who had fired her before, told her at that point she had actually killed herself because she had chosen this approach.

Yeah, I'm always amazed at what doctors say because they say the dumbest things. and in fact, that'd be a great title. You know, a little toilet book you put by the door, you know, not the dumb things doctors say.

Oh, but, so she came to us. And so what we did is we, you know, there's, there's new advanced testing with circulating tumor DNA. And they allow us to we can go back and restaging the tissue biopsies.

We can do circuiting tumor DNA assessments to evaluate, you know, genomics. There's some great metabolomic testing out there. Hormone metabolites. This patient was zero PR positive or negative.

And we looked at the gut microbiome in this patient. Now this was a little bit earlier before the fecal transplantation area that I'm getting into. But so what we did is in this area we looked in in the genomic manifestations, mutations of the cancer.

We were looking at the hormone metabolites. We're looking at the metabolomics and then assessing the gut microbiome, not understanding where we were going.

So at that point we then instituted a stacking therapy strategy based on that, based on the information that the the cancer gave to us through the testing.

Now clearly there's more information there, but it's what we got. So let's work on it. So we brought together strategy for her with bone mass. Of course, we were using high dose vitamin C, particularly because of the bone Mets.

We did stack that with a very old antibiotic doxycycline. There's been some, some, animal studies and some in vitro studies that show that that's really alcohol down nets.

And it is we stack that with, hyperbaric oxygen. We stack that with, whole body hyperthermia, heating them, paying them up to 41°C. And then we also use low dose metronomic chemo and, and we, we, we use the chemo agents there to match the mutations that we were seeing, on the genomics.

So we, we brought those together in sequence and stack. And so for example, taking the and we were also doing a kitchen metabolic diet by the way. So using that plus hyperbaric oxygen plus low dose metronomic chemo, you know, plus full body hyperthermia and that that is a that is an incredible powerful therapy.

But trying to do that in very intense sequence. Right. And and so what she had and they were just wonderful people is she ended up having a Pet scan that was clean, beautiful.

And and I remember sitting there with her, husband and wife and her husband saying, I want to go tell the oncologist. And he didn't say it in such a positive way.

He wanted to go, you know, rub it in his face. I said, please, please, please, please give. Destroyed the bridge, not build the bridge. Yeah, yeah. He did, he did, he did.

And so that ended up creating some problems. for sure. And but here's a patient that had a lumpectomy, a little bit of a different take on what you were asking me to describe.

But I think it's important because oncologist conventional colleges and I'm conventionally trained, I'm an MD. They will tell patients it's my way or the highway.

Exactly. I control this ship and what I tell patients all the time. Last time I checked, it's your body. Exactly. So you're the captain of your ship? This doctor is just coming along to be the wind.

Help blow it in the right direction. And so that oncologist, I think, had a chance to have a positive influence and didn't. Right, right. And I think that is what set her for the stage for that transition to stage four.

And but even in that route, we were able to take her to a situation of no evidence of disease. Amazing. But it has to be through an understanding of what is at hand, how is the cancer behaving and how do you bring these therapies together?

Because as most people, that may be watching this realize, if you're diagnosed with cancer that spread to bone, they'll tell you at that point there's nothing they can really do.

You know, it's purely palliative. It's it's you can't achieve a cure. But here we achieved no evidence of disease completely. And she did so for two, two years.

So the point in that situation, the two she was out riding the bike, a road bike of no things and ended up fracturing a bone. And that started a cascade of events. But, so she was able to achieve the impossible.

Beautiful. But I think the bridge could have been the oncologist bridging. Early on, but. Then bridging when the patient went back home. Yeah. So for me, when when patients leave our clinic, I always tell them that my job is to continue your healing at home.

So I'm going to reach out my hand to any oncologist, any cancer doctor, integrative, whatever. I'm gonna let them slap my hand or turn their back because my job is to that patient.

And that means if I have to have a difficult conversation with a doctor who doesn't like me, so be it. I'll have it. But it's bridging it with the academic, bridging it with clinical practitioners, and then bridging it in the future when patients go home.

All of these are what it takes to help the patient achieve what they want, which is longevity, healing and wellness. Right? Yeah. As physicians, it's our obligation not to a system, but it's our obligation to the patient to provide that.

So huge. I mean, what you highlight here is so important. I just feel like a few pieces to just kind of reiterate is just the importance of the patient autonomy, but also like their own understanding of their own bodies and their own wishes and the ability to be able to communicate that effectively with whomever is on their team.

That's really important. And we don't often have space for that in a lot of environments, including in alternative medicine environments. So true. Yeah. So you really want that.

The other piece is like, let's talk about that part in the beginning, because today you and I are not likely. It's really rare that we see someone who's diagnosed with like a stage two cancer.

We see them at stories that you just described. Right. And so my wish is anybody listening to this who might have a diagnosis of a stage 1 or 2, really early on and has opted to do like full standard of care or components of it, like this woman just opted for a lumpectomy and to kind of step away from the rest of the offerings.

What is really powerful now is we can actually have assess that woman dead, right, or anybody who's listening to this, who's in a similar boat to say it's not all or nothing or it's not all good or all bad standard of care, all bad alternative, all good or vice versa.

So it's not that way. We need to understand because a patient with the same diagnosis, the same demographic,

they may have a low proliferation score. What's known as a 67 score.

They may be er positive, no negative, but have a low what's known as an uncle type or a mammogram score, which means that additional therapies like radiation or endocrine therapy will give very little benefit.

Right. So you can look at that patient and say, okay, that was probably a good choice for you to just do the the lumpectomy and forego the rest of it.

But you still need to understand why you got here to begin with. So it's important to still dig under the hood and see what allowed this cancer to express the way it did.

Now you can have a similar patient, which might have been this woman's case. We'll never know for sure. Although even when I get patients like this down the road who've come to me at the stage four level, I'll go back and look.

Just do I have the data to back what I'm seeing, which is that maybe that person actually had a high onco type score or a high, proliferation score, and maybe did not have the wherewithal to know that they needed to change a lot of things in their life, their diet, their, their relationships, their self-care routine that that maybe they stayed in the same container that made them sick to begin with.

And so that's a very different outcome than the than the first example that I just gave here. So I feel like you and I, it could be utilized, like you said, more in both prevention or an early diagnosis or lower grade diagnosis stage.

and so when it comes down to the folks who come to us at a later stage, more aggressive process where standard of care has failed, or maybe they never took a standard of care approach, and now it's really gotten the bigger, bigger piece here.

What you speak to is so important about we need to understand exactly what we're dealing with so we can make a sure fire, thoughtful, precise path forward.

Because you can throw a lot of very expensive therapies. You can throw a lot of things at it, and you don't know what's going to do what and why. So we have the ability today to assess all this.

And you speak to that so beautifully. That is the beauty of of the omics that is the beauty of the precision personalized medicine.

Patient Autonomy and Personalized Treatment

And that is the beauty of just the deep relationship and partnership and collaboration between the patient and their team. And so I think that that's something that you have always done well since you, I mean, your whole whole life in practice, but for sure in the last, you know, six, seven years of diving deeper into this arena.

You know, I came from the arena of college football. And so that taught me so much. And, you know, there on the offensive line, there was five of us. And of course, I always tell people that, you know, they go what position?

I was like, I was the smartest one on the offensive line. And that's the center. So and they're like, yeah, well, there's some things that I might say that's not smart and appropriate here, but I won't. But anyway, because, you know, I was the one that got their hands on there, but every play.

So but more of us could block perfectly. But if one person missed the block, guess what? That quarterback is getting killed. So it took all of us communicating together.

There's a novel concept, all of us working together, another novel concept, and and us basically, you know, creating a strategy and a game plan. Yeah. And that is what we did every week.

And that's really what I'm trying to bring into this is recognizing purpose. And I think that's a bigger and a deeper

problem. Is medicine as a whole is losing touch with its purpose.

The purpose is the patient. That's that that's our purpose. And there's a lot of things that are getting in between. I really think would be a great cartoon if you had a patient here in the doctor way down there and show all the things that are in between it and the patient saying, hey, remember me?

You know, that's what we're dealing with. And so doctors, I think, need a little bit of a come to Jesus moment to come back to what am I supposed to do?

And so then, okay, now who do I work with to do that? And, and, you know, we can all dive deep into the science. I think a lot of what we're also dealing with is this pressure to conform, this pressure to speak the quote unquote approved message.

Right. And I call that groupthink. But we we desperately need more critical thinkers, because groupthink is just going to regurgitate what everybody's saying.

And that's why I love to seek people like you out and others because I'm like, man, I want it. Let's critically think it's that when I call that curiosity of mind, this is how we change the trajectory of cancer care for patients.

And now what we have is we have people that are saying, you know, what is really interesting? If cancer is reprograming the cells around it metabolically, which being reprogram, might we actually reprogram it?

So we're heading into a new arena. I think the future, which is finally we're going to be able to declare declare a truce. So going to war on cancer, right, because we've had enough collateral damage there and basically pivot to say, now let's focus on guess what?

Healing. That's what we do as physicians. I always say the word roofie in Hebrew. It's a word that literally means healer. That is the word physician.

We are healers. In fact, when I get up on stage, nature, the first thing I love to do because I want to know my audience who I'm speaking to, is, I say, okay, how many healers do I have in the audience?

And I love seeing doctors reactions because those that are uncomfortable with the like, you know, they kind of trust. Me, guy. So and this I love this science.

Oh my gosh, I'm a geek about it. Yeah. But it has to apply, right? It has to apply. It has to be evidence based. And we have to empower more doctors. Because one of the things that I've learned in just a short time doing this is that I've met a lot of doctors that were in their 70s and beyond, and a couple of them have passed away and they've done amazing work.

And I started asking, why has this work been passed on? Yeah, and it hadn't been. And I was like, that's tragic. It is tragic. So that's one of my, colleagues.

And that's your calling, too. It's that legacy. Because this cancer, things are not going away. And so if we can build a legacy, you know, I kind of touch with you when, when I came down to visit you, you helped 30 patients.

Fantastic. I helped 30 patients. Fantastic. But if you teach 30 doctors. If I teach 30 doctors. Oh, now we're on to some ripple is. Yeah, it's exponential.

Yeah, yeah, that's how we change. That's how we change. I think that's how we change medicine. And I think that's how we restore patients to the center.

Absolutely. Bring them back into the core. What like you said get us back into the purpose of what this is all about to begin with which is huge. This is huge.

The if you like you talk about legacy. You talk about future. You talk about where we're going. I know that you've had a couple a couple projects and a couple interests that of course, this is kind of we've now gone into this concept of stacking in a, in a multi-omics approach.

And the idea there's multiple doorways we have to go into to support the patient and to support the terrain to, to deal with the cancer process. But I know that you've been doing some interesting research and are pretty curious about a couple of therapies that seem to be that they would be a great addition to that stack.

Can you maybe give us a couple that might be really firing you up right now, and how would you see how do you see them playing into this space? Okay, so I have to put on my pre-game music and get ready to go to war.

so yeah, what we have to do is people that advance the science, we also got to be adding to it. It's not enough to know it. We must advance it. And so being active in the research is something that has been very, very powerful to me.

Hats off to the people here where I'm medical director of biomedical. A year and a half ago, they said, where's the Lord leading you? And I said, research and speaking.

If so, they said, okay, so they got behind me. So so research two project very very intriguing to me. And we got and working on some others too.

Emerging Research: Cannabis, Ivermectin, and the Microbiome

So when, whenever we get that cloning idea in place, you know I really I know you need it as much as I do. My goodness gracious. one is actually I love medical cannabis.

Oh my gosh. it is a powerful tool. It's natural. And it really helps to prevent, the use of a lot of opiates and other issues associated with this. And so for me, I've always been interested in that.

Most of our patients are stage four. How do I deliver this systemically? Because the bioavailability of oral CBD is so low, it's estimated somewhere between 8 and 16%.

Or whether it's fasting or with the lipid diet, lipid based meal. And so I b CBD it's something that's available. It's something that's very preliminary. It's something that's very early.

I've actually been using it in my clinic with a group out of California for over four months now. And, you know, really seeing it change, you know, the inflammatory markers and of course, not just wanting to use it in cancer to reduce inflammation and reduce pain, but also to really build it into the strategies that all doctors can use.

So the CBD and outside of that, I'm super excited about its potential use in traumatic brain injuries. So if you're ever if you're listening to me, you know, he sounds a little bit off his rocker.

Yeah, I hit my head a few times. Maybe I need some CBD there. Yeah. You're right, you're right. So. But then also, is so the traumatic brain injuries, the, you know, just the massive issue there, whether it be stroke etc..

But in IBD, there's some doctors have actually been using this inflammatory bowel disease that are seeing traumatic results. So I think that is going to be something that is super exciting in the very near future.

There's actually we have a clinical study there actually in RB, which we're going to be announcing that very soon. Do little T's to cross and I's the dot.

And then the other one is with another just dear friend of mine, Paul Merrick, who I used to speak on conferences about vitamin C, and I'll speak about him and the work he did on sepsis in 2017.

and, I'll never forget meeting him, and I'll never forget standing up on stage at one of the conferences and calling

him a teddy bear. I was like, it probably wasn't a good thing to say, but but I said, Paul, it's your heart.

So through him, his leadership really, and others involved Kathleen, Rudy, Pierre Corey and others where he just launched a multicenter observational study on ivermectin in cancer. Wow.

and so because I've been using that for over six years now, and so that those are the two clinical studies, RB approval that are moving forward at, I want to say breakneck speed, but that's probably not the best.

And moving forward into the clinical arena to really change and again, change the trajectory. But bring doctors into this. And, you know, I'm super interested in the gut microbiome and the ability of the fecal transplant to immediately change the microflora to impact the immune system.

And it really interested in the connection between that and the tumor microbiome. So, so that area of research is adding to the science. I think it satisfies my curiosity of mine.

I tell all of our patients that there's only one bad question, and that's the one you don't ask. But then it's also getting that message out. And that's where you can tell I have a big mouth, but you know, that's where the that's where the podcast came in.

Because I want to speak truth. I want to empower patients when they go into their doctor that they can say, hey, what about this study that said, Tylenol suppresses my immune system and you've just had me on Keytruda?

Yeah, shouldn't should I not do that? And the doctor goes, well, I don't really think about that. Well then at that point we can, you know, instruct the doctors through the podcast.

The patient can be empowered, the doctor can be empowered, not embarrassed. And so then all that happens is the patient benefits. And so it's those two things together that I think really honestly, I think that's the core of what doctors used to be.

And I think we need to get back to that. So huge, so huge. And what I think is also just a really big take home. It's these three pieces that you talked about.

So the, CBD, the cannabis in medicine, the, the ivermectin component as well as the microbiome component. What I want folks to listen to here in that is that, that all three of those are hitting multiple targets, not a single target.

You know, it's not a single cause and a single target. It's hitting multiple at once, which is really powerful. And it adds to that. The power of that stack ability and the power of getting into several entry points, to really support the patient.

So I think that's really powerful that those are things that are lining you up and that have such a reach and will definitely further our understanding, our evolution in medicine and how to best to support our patients.

So with that, the other thing I love that you brought up over and over is just around this podcast that you're doing. So I want folks to know how to learn from you, how to follow you, and how to get as excited about all this is that as you are, because you are going out and seeking the experts in this.

You are an incredible storyteller, but you're also an incredible story collector. So tell us how we can learn more from you and follow you along your journey.

Yeah, and so is my pleasure to tell your story. And you know, when you were telling your story, when we were there on the couch, my mouth was dropped.

I mean, I was just like, Holy cow. And, I was just like, that's incredible. Because we are human, right? We're relational. And so when when we connect with somebody's hearts through a story, then we connect to their minds, and then we can then we can, you know, pivot and educate them to what really is the science showing.

So for me, it's a "Practicing with Dr. Nathan Goodyear" podcast. You can find that wherever you download the podcast we do individual deep dives where I just go, you know, let's talk about Tylenol and immunotherapy.

Podcast, Storytelling, and Closing Reflections

It's trash, you know, and I'll go deep into the science and I love those deep dives. But then I also love to talk to people. So I love to go, you know, and interview, you know really pioneers like yourself.

You know, I mentioned Thomas Seyfried, maybe Paul Merrick and others, many others, Dr. Jason Williams, where I give them the platform to say, here's the innovation I'm doing, but I like to start off by don't tell me who you are.

Who are you? Who is Nasha Winters, right. Because who Nasha Winters is tells me a lot about what takes you. And then that connects with the listeners.

So then now you have a heart to heart relationship. And then when you start to speak the science that heart to heart relationship is set. Now you're speaking to the mind.

And that is the way I think we can build that. And you can find it over at DrGoodyear.com. That's my personal brand website. And yeah you go to the website you go, wow, that's a crazy branded website.

Yeah it's my shirts. You know what they. Are are being is people. I told you this, I went to I went to a conference, came in for dinner that night. There was a couple of shirts on the bed and I said, honey, I hope that's yours.

She said, no, it's yours. Wear it for dinner. I said, oh, okay. So I've been wearing them ever since. It's his signature, but it's also we can always find you in a crowd.

And it's also just shows just the, the, the levity of your being as well is really nice because you get into some pretty heady deep dive discussions, and the shirts are like the reminder to all of us to not take yourself too seriously, which I think it's gorgeous.

Yeah. Oh, what a pleasure. I'm not at all. Yeah, I don't take myself seriously at all. In fact, I'm like, I should take myself more seriously, but I don't know.

It's just me. Incredibly refreshing. And you are. I have a beautiful heart and soul to match, a beautiful intellect and curiosity. And so I thank you so much for your generous time and your offerings to this community.

Thank you, Dr. Nathan. Well, thank you for taking your time and to put this platform out there and to really change, I think the trajectory of medicine for the benefit of patients, you truly are embracing that dual concept of healer and teacher.

So thank you.