Don't Skip the Dentist: Reversing Artery Disease with the Bale-Doneen Method Transcript

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Introduction to Dr. Amy Doneen

Everybody. Really, really exciting interview. Really exciting. Guest. Please don't go anywhere. Reverse Heart Disease Naturally Summit is back for you.

But today we bring you Doctor Amy Doneen. And you may know her. You may not know her. But when we're done with this, you're going to say. How did I possibly not know her?

This is a Reverse Heart Disease Naturally Summit and Doctor Doneen in Spokane, Washington, may have actually had hands on with more patients proven to reverse their heart and vascular disease than almost any clinician in the United States.

And I want to introduce her formally, but she will tell us that the goal of reversing our disease is real, and it should be one we strive for. But this pathetic, anemic medical system just waits.

You're half dead. I'm going to stop editorializing. So I am reading Doctor Duncan's biography from an amazing book we're going to talk about. But Doctor Amy Dunning, doctor of Nursing practice, is an international leader.

And that's true in the prevention of heart attack, strokes, diabetes and chronic diseases such as dementia. She and Doctor Brad Bell co-founded the Bell Donation Method in 2001, a medical approach proven to identify stabilize reverse arterial disease.

She and Doctor Bell have been called disease detectives. Man, that is so good. Checking for hidden signs of general disease. She has many academic appointments.

She has a beautiful new facility for her heart attack and stroke prevention center in Spokane, Washington. People fly in from all over the place to see her.

And then, of course, a lot of us are doing telemedicine. She's also my mentor because I'm a graduate in 2015 of the bail donation method. My certificate is proudly in my office lobby and waiting room.

That's true story. Your book. It was in 2015, Oh, time flies when you're having fun and fire with the desire to help people and all. So welcome so much, doctor don't Downing.

Thank you so much, Doctor Khan. I'm so happy to be here. Yes. And as I said, it is not possible to have a summit called Reverse Heart Disease naturally, without having either you or your co-founder and also awesome physician.

He's, just, not available in the same city as you usually, doctor Brad Bell, you are the authentic. You know, you're like the, like the rock that proves that, there Earth is billions of year old because you have seen it.

So let's start right there. I mean, in 2001, you and Doctor Brad Bell set up a collaborative clinic and a method, the Bell donation method, to demonstrate that arterial disease can be stabilized and reversed.

And our skeptics that say that's nonsense. So just just go on a riff and talk about 22 years of experiencing that it's real to stabilize and it's real to reverse arterial disease.

Proving Arterial Disease Can Be Reversed

Absolutely. Well, yeah, that's exactly how it happened. When we started working together 20 plus years ago, it was

a matter of realizing, and you've talked about this over the years, that the tools like coronary calcium scanning and then 2001, carotid IMT started to come into play, which are ways to find disease in the arterial bed before someone has a heart attack to prove that they have it.

So that concept in itself was was landmark. And so that's kind of where we started, was we wanted to find out who had disease and, and who didn't, and then look at the why they had disease and and amazingly treat the why.

See the disease stabilized. So fast forward to around 2008, where we started to collect our data. And at the time we were working with Texas Tech and we had, data in 576 patients that we had been following for about eight years.

And we at the time, we were using carotid intimate media thickness as our endpoint, which can evaluate both the calcified or echo genic harder plaque and also the more unstable plaque.

And so we wanted to see what was happening. And so over that eight year time period and 576 patients, we saw a linear trend down, arterial sickness as documented by the carotid IMT.

And we also saw stability of the plaque burden. And then as we were continuing with our clinical practice, the data was pointing that it's really not the mean IMT that we want to go for.

We want to ask the question, can we actually stabilize the plaque? And so we worked with, Steve Jones at Johns Hopkins and we said, hey, let's let's look at the fat.

Can we actually stabilize the plaque? Can you treat somebody on an individual end of one and take plaque that's soft and inflammatory and over time, actually stabilize it?

And we had enough data in that data set, 324 patients that over a five year time period, in 100% of patients, the plaque became academic and stable. And it was kind of this moment to say.

And even Doctor Jones asked, how are you doing that? That's not normal. That's not normal. And, our answer to that was pretty simple and yet pretty robust.

And that was it's bigger than just our cholesterol, our blood pressure. And if we're exposed to nicotine, it has to do with everything. It has to do with lifestyle, psychosocial stress.

It has to do with insulin resistance, vitamin deficiencies, genetically inherited lipid abnormalities like lipoprotein a so many factors that aren't part of the guidelines.

And so that's kind of how we got to where we are today in the in the two books is to tell that story and bunch of things. Just to follow up, number one, you and Doctor Brad Bell have authored at least two incredible books, one called Beat the Heart Attack.

Gene, I love it. It's out in my office. It stresses particularly a genetic inheritance called NP 21, but it covers your comprehensive risk management program, the baled onion method, and your book, your new book, which is almost a year old when everybody's listening. Healthy heart, healthy brain.

Absolutely wonderful update. An expanded knowledge base, thicker book. These are must reads. But if you know people that were just listening to your eloquent.

I mean, you've had a whole day in the clinic and you're just like, I am on fire because, you know, things that the average clinician doesn't really even think about.

What do you have? Plaque. What kind of plaque? Can we make your plaque friendlier and less dangerous to you so you have a better life? I mean, you're a better life, doc.

I'm a better life, doc, but it's cardiovascular disease. It's often interrupts that. So you're talking about sophisticated. I just want make sure the audience gets it.

Whether or not we make the plaque go away. Like some magical Drano, which is not so easy. We can take higher risk plaque. And that's usually the non calcified plaque, whether it's in the carotid or the heart.

Or we can make it stable, lower risk and largely calcified plaque. And you're using carotid into more medial thickness ultrasound a really simple test but so underused.

And you documented and you see it. I think you said 100% of the academic series. You had, you saw movements in the carotid plaque characterization. So.

Absolutely. Yeah, absolutely. And I want to warn people, if you were to walk into your internist, your cardiologist, your preventive doc, and said, I want a carotid into more medial thickness ultrasound.

It's simple. They're usually going to hear the answer. It's not available, which is so sad and so unfortunate. It's available in my clinic. And you guys have published, you know, on hundreds and hundreds.

It's, you know, basically as invaluable a tool as a stethoscope.

Books, Imaging, and the Bale-Doneen Method

If you're into, you know, precision medicine like you are and I am and the audience is hungry to hear about, I mean, you have a is it expanding in Spokane, at least?

Or still, you're probably the only center in your city offering it. Well, it is expanding is gaining more traction, certainly. But the challenge we have is making sure the data is reproducible.

And it is accessible in pretty much any city. If people know what to ask for, and there's service companies that come in and do that. But the interesting thing is that I want the audience to understand is that 99% of plaque grows in the artery wall.

It doesn't grow in the area where blood flows, where we can just wave at it and see it. It blocks the, blood flow when there's a problem. So using technology that actually looks at the wall of the arteries, such as carotid IMT or coronary calcium scan and other tools that are looking at imaging of of the arteries is very acceptable.

And it's inexpensive. That's the thing. We're talking tests that are under $200, that can be lifesaving. And one of the things you mentioned that I think is important is when we set out to write the first book in 2014, we had a long pause to figure out, who are we writing this for?

Because, yeah, I mean, yes, I've had a busy day, but it's so exciting. We need to talk about this. We realize that we need to write it to the patient.

We need to write it to the healthcare consumer because the health care consumer is going to demand change. So while these scientific thoughts and topics seem complex, they're really not when we articulate them in a way and use patient stories and really understand them all based based in evidence.

And the first book was really looking at ischemic stroke prevention, heart attack prevention. You know, the big guys, right, the leading cause of death and disability and then that was in 2014.

And then come 2017, we realized, you know, I think the bigger benefit of what we're doing. Yes, yes, preventing strokes and heart attacks. But you know, what it is, is protecting all the tiny little arteries, the 30,000 little tiny capillaries that are no bigger than a human hair.

And if we can protect those like the others, which we're going to do by default, by the way, we can we can prevent

the these diseases of aging that claim our independence, like memory loss, vision, chronic kidney disease, peripheral vascular disease, erectile dysfunction, all the things I claim are our quality of life.

And so the second book was necessary to articulate what we have learned between the first book and the second book, leading to the fact that it's really about oxidative stress, looking at all the causes of oxidative stress, treating the why and seeing the disease stabilize.

And it's possible even on people that have had a tremendous cardiovascular history, with stents and bypass, you can actually pause and say, why did you have that first in.

And you know, doctor cons, sometimes it's perceived that it's so complicated. And oftentimes I find clinically that the little things are missed, like the diagnosis of sleep apnea or periodontal disease or an endoderm tooth lesion or lifestyle, which are so, profoundly, you have that covered, hands down.

But and using genetics to be very precise in our drug selection if we need it in our lifestyle, suggestions. And really looking at the end of one, that individual wonderful patient, couldn't be more excited to hear that from you.

So there's so many areas that you and your, copartner doctor, Brad Bale, have innovated in these two books. And I just want to quote from your your most recent book, and I love this.

And I would, you know, going to paint this in my lobby to find out which patients are in cardiovascular danger. You need to look at their arteries, not just their risk factors.

You can steal this for me because I use the short form called test, not guess. I didn't create that. I picked that up. It's not trademarked. But you said in two you're looking at arteries and for people listening that say, look at you know, these screening companies or my local hospital will do a carotid ultrasound, but you're talking about a specific test looking at their Tara wall.

There's a difference from the typical insurance covered carotid ultrasound that an internist might order. And what you and Doctor Bell are offering at your advanced heart attack stroke prevention clinic.

Right. Absolutely. Yeah. Oh, absolutely. You know, the like I said, the plaque grows here in the quality of the plaque is assessed here. And so to use a test that just limits, our vision at blood flow, we're not going to see what's going on with the quality of the plaque itself.

You know, one thing, going back to what you said on test, not guess I love that you've had that. And I, I think of that often because it's an expression.

It's a statement that you've had for several years and it's really, really good. But, we had a paper published last year that really challenged the current system, putting people in two categories, because that's what's done right now.

Primary prevention means someone has not had a heart attack or stroke. Secondary prevention means they have. And that's it. So our our call out is to say let's put people in three camps.

Primary prevention means we've looked we've looked at all the areas we can safely and effectively get to the carotid, the coronaries, the aorta, the arteries of the top of the leg.

We've looked and we don't find any plaque. Well, that we want our goal for a lifetime for that patient is to remain in primary prevention like you. Secondary prevention are people who we look and they've have plaque in their arteries.

They probably don't know it because no one has come to me in 20 years and said, Doctor Tony, I think I'm growing fatty streaks in the wall of my artery.

No, because you don't feel it. But if someone is secondary prevention, then what's our life goal? To make sure they don't get in that third chair, which means they've had a heart attack, they've had a stent, they've had a stroke to prove that they have plaque.

And in that population, which we claim to be tertiary, we want to stop recidivism because the disease can be stopped. So if we simply say and ask ourselves, if you're listening to this, well, I wonder if I'm in the first chair or the second chair.

I know I'm not the third chair because I've not had a heart attack or stroke, but the only way, you know, if you're primary or secondary in the way we define it is you've got to, as you say, test not guess.

Right. Well, wonderful. And then again, you guys have a method, you know, that you've developed, you've published, you've written about it. The bailed online method.

You use this acronym called Ed Frog in both books. It just so that everybody knows, just tell us the bullet points of what that stands for. Yeah, absolutely.

So it's an acronym that really kind of ties in what our method is. So, education is number one. That's the e to educate ourselves. And the evidence based and everything that we do and share the knowledge and educate our patients on what really causes, a heart attack or stroke and share that educational knowledge.

Number one. Number two is disease. That's what the D stands for.

Womenu2019s Heart Disease Red Flags

Look for disease. And if someone has plaque monitor it on a regular basis. So that we know the plaque is getting safer, it's healing and that's what we want.

So the F stands for fire or inflammation. Or more recently we've turned to oxidative stress. That really is is a key factor. So fire monitor the inflammatory labs on a regular basis.

And then the R is huge. The R stands for root causes. Looking at all the reasons why someone might have plaque. And like I said earlier, maybe it's sleep apnea.

Maybe it's periodontal issues. Maybe it's psychosocial factors, maybe it's genetics, maybe it's lipoprotein a maybe it's air pollution. All of those root causes that have a cause and effect, look for them and lay all the cards on the table and treat them.

The O stands for optimal goals, and that means individualize. It's not aggressive. It means what's best for you might not be best for someone else, and really be individualized in your care and the care that we give.

And that's possible. And then the G stands for genetics. We use genetics for a lot of reasons. We use pharmacogenetics to understand how someone is going to metabolize treatment.

And we use genetics to identify lifetime risk of things like heart attack, stroke, aneurysms. And we set screening guidelines based on that. So and we also use genes to look at how people might best, receive lifestyle advice.

Even so, yeah, it's really, an acronym that we're an architecture that we put evidence based medicine into and use that directly in our clinical practices.

Yeah. And people that are listening will want to get one or both these books and study this method, because you can understand it even if you're, you know, a lay member of the public concerned or known to have heart disease may be primary, secondary, tertiary.

As you just laid out a beautiful structure there. But you do want to study this, because it's very thoughtful. And it's

actually in the medical literature, the doctor, don't need and they'll have taken the time to publish this so that doctors around the world can read, learn, and put this into practice.

And they have huge training, numbers that they've, accomplished. We'll talk about that in a minute. So another innovation that I give you guys credit for is really emphasizing what you guys call red flags.

And again, we can't go over every one. But you specifically stress, you know, red flags for unknown heart and vascular disease in women. And just mention a few of them that you think the listening audience might not ever even have considered.

Oh, absolutely. So thank you for asking that, because February is Women's Heart Month, so it's nice to specialize on that. But red flags are they don't have a cause and effect.

Here's an example. So if a young woman experiences migraines, we know that she has a significant increase risk in her lifetime. As of also suffering a stroke.

We don't know why though exactly is the pathology of the migraine. Is it the fact that it's affected her sleep pattern? But we know that migraines are a red flag and that individual needs to be treated and evaluated for cardiovascular risk?

Another one for women would be preeclampsia. You know, pregnancy is a wonderful time to it puts the body under stress. So wonderful stress. But it tells us a story.

So if a woman has preeclampsia, if a woman has hypertension or high blood pressure during pregnancy, if she has diabetes during her pregnancy, those factors when the pregnancy is over are sometimes forgotten.

But do you know any of those factors? So just increase the risk throughout their lifetime of diabetes, sustained hypertension, blood clots in the legs and even strokes.

And so it's using these red flags and the knowledge and like you said in our books, both of them, they are written to the public. So a whole chapter on all of these unique red flags.

Insulin Resistance and Oral Health

And it's just and people should not feel guilty if they have a red like maybe it's an autoimmune, maybe it's, you know, any sort of, arthritic condition that we need to recognize might place people on increased, risk.

So I think just knowing that is very helpful and recognizing and not being afraid to look in the mirror and realize that we all have risk, and to get treated effectively.

Absolutely. And, you know, one of the ways you identify a red flag for silent atherosclerotic disease is you guys are focused on a couple of things most clinicians aren't.

And one is certainly insulin resistance. And you still order an old test called a two hour oral glucose tolerance test. Shrug. The very thing we tell our patients not to hear sugar, water and then monitor, you know, their blood sugar for two hours, maybe their blood sugar and their insulin levels for two hours of blood.

I mean, tell us why you hold on to what many clinicians would call maybe even an how date test. And sure, what do you find in your clinic by doing that?

Yeah. Great question. One thing I will say is insulin resistance is is beyond a red flag. It's actually a root cause. And one of the most common root causes that we see are is missed when we see patients for the first time, especially those with known heart disease.

So how do we diagnose it? Well, we have options. We can look at a fasting blood sugar. And if that's elevated but

not in diabetic range we say, gosh, you probably have some pre-diabetes.

If someone has an A1, C or a three month average of blood sugar, which is often advocated for, that can be a indication that they have prediabetes. But why do we put people through the agonizing test of drinking 75g of glucose, and then testing both the one hour and the two hour, blood sugar?

And like you say, insulin oftentimes as well, it really gives us an indication of not only how long someone has been insulin resistance, it really gives us a real life example of how an individual's body responds to that glucose load.

And really, doctor DeFranco has done most of the work for this and way back, even in 2010, he he looked at what is most predictive. Is it the fasting, the A1?

See the one hour and the two hour? And really the one hour? By the time it jumps up to 150, there is a 13 fold increased risk of that, that that individual is going to be flat out diabetic over the next 7.5 years.

And by the time the two hour glucose gets above 120, not 140, there's also a significant risk that there's data cell decline and and it really is a true fact that the sensitivity and specificity of A1 C levels is about 50%.

So someone could have a normal A1 C and that's a three month average, I should say challenging that pancreas is the best way we can uncover this and make sure that they never.

I consider a personal clinical failure if one of my patients was ever to become diabetic. We have 20 years to identify it before someone, before the beta cells get so wiped out that they're type two diabetic.

So it we really have this wonderful window window of opportunity. And it's so often not done. Excellent. So we've talked about you know you go way beyond the usual approach to looking at vessels.

You go way beyond the approach identifying root causes. You go way beyond the approach for these subtle red flags and sometimes testing for them. You really have talked probably more physicians about the oral cardiac connection, the health of the gums, the health of root canals, the health of, cracked teeth.

We did have the pleasure of interviewing Doctor Doug Thompson. Dentist is a graduate of your male Dineen program, as well as, starting up his own integrative dental network.

As you know. So we've talked about it, but, I mean, very few clinicians have your experience, and yours is greater than mine. That patient with, you know, on fire with inflammation.

And really, you can't get it under control. How often do you really say, Eureka! We found it by cone beam tomography, by advanced periodontal evaluation.

I mean, how often does that come up? Is it a fairly frequent event that the mouth is the source of the fire? Yeah. And they're all intertwined. So, you know, you look at periodontal disease and 70% of people over age 50 have some form of periodontal disease.

And if we equate periodontal disease and understand that it's really a chronic bacterial infection, that certain bacteria that live in the gum line and they have, they have names AA, PG, TFT, these dangerous bacteria actually have data to demonstrate that they can cause, plaque in the artery wall.

And we had a paper published in 2017, that really looked at that. And we used a model called the Arthur Genic triad to, to demonstrate this for the first time to show causality.

And it's not part of the problem. And I'm sure Doctor Thompson mentioned this, too. The old way to diagnose periodontal disease is visually an exam, which is important, but it's if your gums, depths or, you know, bleeding and over three centimeters or millimeters of centimeters, millimeters, then you have periodontal disease.

But if you shift gears and say, well, do I have any of these dangerous bacteria? Because those are the ones that we have the data to show the causality.

And then to your question about, and endo Doncic abscess, Doctor Pesce was the first one to actually publish that. And he looked at, patients in the, in the, emergency room who are having a heart attack, like having a heart attack, 222 of them, in fact.

And he asked them and got their permission to to analyze the the clot, the thrombus that was blocking the flow of blood. And he asked them and evaluated them.

While, you know, in the E. R., do you have any mouth pain? You only teeth that hurt, sensitive, cold, whatever. And the answer was no. So what he found is about 50% of these people who were in for acute MI had and or Doncic bacteria within the clot itself, suggesting that an endogenous lesion could be the causal factor of a plaque rupture.

And subsequent thrombus. So I don't think any hospital that calls himself a heart hospital, is doing a good enough job. Unless they are partnering with an oral health specialist to evaluate and or lesions with 3D imagery, so that we really can see those.

And also working with an oral health specialist to understand the bacteria in the mouth. Wow. Powerful statement. I want to circle back. Again, you have a turning method and obviously you're seeing, important advances in arterial health cooling down the fire, converting to more stable, calcified plaque in heart and carotid arteries because you're intervening and your program does depend on pharmacologic agents, things like statins, things like blood pressure medication.

You've got very tight goals for people at risk. Now, one of the unique things of the Bale Dunning method is that you still use a diabetic drug that many people have never heard of, called pioglitazone in some patients, and many people have heard of metformin, or everybody's going crazy right now about ozempic.

And the reason why do you hang on, to pioglitazone? And I know everything you do has a scientific basis, but what have you seen in your patients by using that very inexpensive oral antidiabetic drug?

Yeah. One thing I like to say is that all drugs are poison. So if we don't have to use them, we won't.

Treatment Strategy, Training, and Clinic Policy

But in some people that have insulin resistance, to the degree that even an optimal lifestyle is not going to keep them safe, and there's still residual inflammation from the insulin resistance.

What pioglitazone does is it sensitize the body to use the insulin. It's an insulin sensitizing. So, it reduces diabetes risk by 72%. And it also has data that it can stabilize the necrotic core of plaque.

And that was done by coronary angiography, and coronary imaging to show you can actually stabilize that plaque if you if insulin resistance is one of the root causes while we have it, it's not it's not safe for everybody because you can get some fluid retention.

So, if someone has a heart muscle that's enlarged, we're not going to use it has to be properly selected. For sure. But when we look at other technologies like the GLP ones, which is the one you just mentioned, Ozempic or we look at, metformin, which is a great drug as well.

We and we use that, we use we use that as well oftentimes. But when we're talking about truly treating the insulin resistance, pharmaceutically pioglitazone really has that ability to do so.

And part of it is it can store, even the conversion of, of a secretory muscle cells to trap cholesterol within the artery wall. So it has these benefits that are really, really powerful. Wow.

So just going back to really my first point, if anybody has any doubt that heart disease, plaque and carotid disease, black and sexual organ disease, plaque and peripheral artery like disease plaque can be at least stabilized to lower risk and maybe actually diminished.

You'd say not true. I've seen it hundreds, if not thousands of times. Right? Oh, it's very true. I mean, it's very true. We can identify plaque. We can understand why someone has plaque, we can monitor the plaque activity.

And if we treat the why, we see the inflammation go down and we see the disease stabilize. Those are my expectations for my patients. And if I don't see that, it's pausing together and say, what are we missing?

Have we looked at the bacteria in your mouth or how is your stress? How's your sleep? Have you had a cone beam X-ray? Do you have some inflammation from a tooth?

Do you have gut dysbiosis really taking the mystery out of this whole thing and identifying the why? And that probably the biggest thing I would say is the standard of care is missing so many of the whys, and they're not that complex.

And complicated. Yes. Lipids matter. Yes. Blood pressure matters. Yes. Don't expose your body to nicotine. All of those are important. But there's so much more right?

Tell us where one are clinicians watching and says, I want to sign up and take the bail down in method course. What's the website for that? Oh, thank you for asking. So it's just simple.

It's baledonen.com and it's bale donen donen.com. And there is an online version as well as a library. Yeah. And we're starting since Covid taught us how to talk online, we're now doing hybrid so people can come if they want to come or they can watch.

And it's a 17 hour CME, and a C program because we invite all specialists to come at our last one we just had in Houston last month, we had a pediatrician.

We had several dentists, hygienists, cardiologists, internal medicine, family practice, a doctor of nursing practices a are in PS it bringing to the table.

Everyone comes with a different knowledge base. And to think that one specialty or one backdrop is going to treat such a grand disease that affects 30,000 miles of vessels, we're going to miss the boat.

So we welcome everyone to the table and we learn from one another. And I think that's important. Actually, I believe the rarest job in America is to be a preventive medicine clinician.

There's so much opportunity. So I'm not worried that you're draining my competition, I welcome it. It's such a need, from all the specialties you mentioned.

And the fact that you integrate dentists in your audience is fantastic. I want to come see you in Spokane. Number one, do you do telemedicine in some states?

Oh, absolutely. Yeah, we do, but I want to come visit you. What's the website for your clinic? So the website is the prevention center.com. Okay. That's pretty simple.

Am I going to wait six months to get in to see you? Because you're such a big kahuna? Well, there is a waiting list, but sign up because six months happens like that.

And I will say one of my colleagues and interventional cardiologist jumped ship like I jumped ship about eight years ago. And, that interventional cardiologist is now your colleague in your clinic.

And, what a wonderful thing to see. I briefly own the trademark prevent, not stent. And my hospital got so mad at

me I didn't renew it. But Doctor Pierre is pretty much living the same, path, career that I do.

And I just got to finish up with the last, you know, remarkable thing about your clinic. If it doesn't work, what's your policy that you've almost never needed to activate?

But I want people to understand how confident you and Doctor Brad Bale are. So just tell everybody, Amazon like policy at your preventive clinic. Yeah.

So we are a fee for service clinic. And and so if someone was to have an arterial thrombotic event, a heart attack, or in a scheming stroke on our watch, we would give them back the moneys that they paid to us to prevent that during that year.

And it's not a legal issue. We do follow the standard of care. We just don't think it's good enough. So, and it's a partnership. So, working with patients and knowing that we've got skin in the game as well, it really increases that compliance.

And it also improves the care that they're getting because they deserve to be healthy. And they, they, they work hard to be here. So I respect that. And out of the thousands of patients you and Doctor Bale have taken care of, you've actually had to activate that policy like under five times.

Right? Yeah, I think it I think it's two actually. And both people are fine. And one, the one that I have was a very unique, interesting situation where I won't go into.

But he never did, cashes, check. He's he's a dentist and he has a framed on his wall. So, so that was one. Yeah. Any celebration where I grew up in suburban Detroit, we call the policy like that.

Hotspur. So, as you know, you can't be any more confident in your ability to help people than to actually offer what you offer. So I know you've got a long day.

You probably got work to do. You got charts to do. I don't want to keep you any longer, but I think the audience is just been blown away, that there is this force for over two decades, two books, academic papers, thousands of patients.

And, they need to go out there and buy those books right now and study this up. And I would say that they're very well invested money. Thank you. Thank you, Doctor Khan. It's an honor to be here.

Thanks for doing what you're doing. Well, we fight the same fight in different parts of the country, and God knows we need more soldiers on the ground with us.

Absolutely. All right. Have a great day. You too. Thank you so much.