Peer Into The Future Of Cancer Care Transcript

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Introduction and Career Overview

Dr. Stephen Iacoboni, it's such a pleasure and honor to to have you on this segment of Cancer Breakthroughs. I've known you for many years. You're a dear friend, and you've made such a huge impact in the medical oncology field, but also in the integrative oncology field.

So thank you for being with me today. Well, Mike, it's a real pleasure. Thank you for having me. And yes, we've been friends and also work together for several years.

And I'm very excited about your new program and looking forward to participating. And for for the audience out there, Dr. Stephen Iacoboni has been practicing medical oncology for over 40 years.

During that time, he has had over 200,000 patients and encounters. During his long career, he's seen the practice of oncology evolve into his present state from it and from this present state, from his primitive, primitive state.

Back in the 1980s, towards the end of the third decade of his career, he decided to become more familiar and educated with an integrated approach, including naturopathic remedies added to chemotherapy.

To that end, he studied abroad and did primary research on truly integrated cancer care, especially as in overcoming chemotherapy drug resistance with naturopathic remedies.

And I mean this this does not even touch, you know, the breadth of knowledge and training and accomplishments that that you've had during these 40 years.

I mean, you've taught at some of the most prestigious places, gave you kind of add a little bit to to that bio. So so people really understand where you're coming from.

Well, sure, I'll try and be humble about it. That's the most important thing. But I did go I went to medical school in San Francisco, which many people regard as one of the top schools in the world.

And then I did my training in oncology at M. D. Anderson, which many people regard as the top cancer center in the world, certainly in the United States.

And I did my training there and then was offered a professorship, which I did for a period of time. But then I, I got a little disillusioned by the whole process, which was not, in my opinion, patient centered.

It was pharmacology centered. And I have a great interest in pharmacology. But the pharmacology approach in the medical centers is designed to bring new drugs to market.

Not so much if that's the primary goal. Care of the patient is important, and it's of course undertaken. But it is actually not the primary goal. A lot of people don't realize that.

And so I also have a deep love for being at the bedside with the patient. And I couldn't really do that in academia. They want you to let the trainees do the patient work and you sit and read papers.

And I just decided I wasn't going to spend my life doing that. So I went into private practice. And with that also, and that's an interesting point for people to really understand, you know, when they go to places like M. D.

Anderson and you you come with the the understanding or thinking that they have the most cutting edge tools available, and they truly do. But at the same time, their focus may not be solely upon your care.

It may be biased in a way, to really kind of focus more on the development of the drugs and see what the drugs can do.

From Academic Oncology to Patient-Centered Care

You know, due to I'm sure they're funded quite a bit by the the, you know, you know, pharmacy, you know, pharmacological companies to to support these kind of research and studies that they're doing at that location.

Well, exactly. And I don't mean to sound critical. I hope I don't. What I think the finer point to make is that the the mission of an academic institution is to do research.

That's their primary mission. The mission of a doctor out in the community is to take care of the patient. And I had to choose between research and patient care.

And I just fell in love with patient care and, you know, research is hard. There's a great burden on the industry to bring drugs to market and comply with all the regulations.

And so they have to do it. They have to do they invest billions of dollars doing it, but it still didn't filter down quite, quite perfectly to the bedside.

And I my priority was care at the bedside. And so I had to leave and do my own thing. And so I made that choice. But I know what it's like to be at a research institution.

And some of the comments I'll make later about how that impact community cancer care. I'll make some more comments in that regard when we get into that.

Right. And and in addition to then functioning as a medical oncologist, you've also heavily researched the integrative aspect. You were a head of the oncology at a at a clinic in Mexico.

And then also you ran Dr. Forsyth Clinic for a couple of years as well as so you have quite a breadth of knowledge and both areas. Well, I do. I like to think of myself as one of the more important integrative ecologists in the country for the reasons you mentioned.

What happened was a lot of us believed that we would be curing cancer by the year 2000, and that did happen. And I had to ask the question why? And I couldn't get any answers within the confines of conventional medicine.

And so I started casting about for answers. And to be honest, that made me a little unpopular with my colleagues who feel committed to toeing the line and not asking questions.

But it's hard to, to, to, to not meet the needs of your dying patient and in favor of the needs of the industry. And I just was impossible for me to ignore the needs of my patients.

So I asked the simple question, why isn't the chemotherapy working? And I found that there are answers that no one else was really interested in. And so I had to with all due respect to the the illusion that this makes, I had to leave the reservation and go off into the wild.

And that's that's what I did make a talk about that. And so and I want to get into that the chemo, the other pros and cons because obviously it does play a role.

But to understand what kind of role and what the limitations are. And then also immunotherapy, which is more kind of a newer and a direction that medical oncology has has gone.

So during it came to talk a little bit about the evolution of medical oncology. You know, back in the 1980s, what what has changed? We were at that that time and how are we different now?

Well, you can think of the eighties as I think a good analogy would be the history of space flight, which didn't begin until the mid fifties. And it was very primitive.

I mean, we got all excited because you put a dog in orbit for an hour, but within 15 years we were walking around on the moon and a lot of people might not be aware of the fact that medical oncology did not exist as the specialty until the mid seventies.

You know, there was already cardiology, gastroenterology, nephrology, kidneys, everything. The idea that you could kill cancer with with medicine was actually considered a bad idea.

Treatment was radiation and surgery. And then there was a breakthrough in the sixties, not by oncologists because there weren't any, but by gynecologists.

And then some breakthroughs came in the late sixties treating leukemia and lymphoma and then the idea was maybe, maybe we can do this. But there were actually very few medical oncologist in United States, even at the 1975 and the the specialty really didn't get going until the eighties.

And you could say at that time we were putting a capsule in orbit to go around the earth once or twice. And then it's a long way from there to going to the moon and back and the space shuttle and everything else.

And so it's been part of the reason actually why I went into mycology, because it was the frontier and I was right there. I graduated medical school in 79 and it was the birth of the specialty.

And so I've been with it almost the whole way and it's been very exciting.

Evolution of Medical Oncology and Chemo Resistance

But we started out in a very primitive fashion and of course that's had to be refined for the first 15 years or so. I thought, okay, well, we're in the primitive stages.

We'll break out of the land on the moon, we'll come back, we'll have a parade that never really happened. And so when it hadn't happened, within 15 years, I had to ask myself what's missing?

And so do you feel that we are I mean, you're talking about being primitive. And do you feel the tools we are using now? I obviously we've dialed down kind of dosing better.

We've dialed down what kind of frequency and how when to do it and so forth. But do you do you feel, other than that, that there are advances that has been made in that field?

Well, there's been there has been substantial progress, but most of the progress has been either curing early stage disease and and extending the life of late stage disease, but but not curing people with late stage disease.

So if you have stage two or three breast cancer or colon cancer, we can cure that. If you have stage four breast cancer or colon cancer, we can keep you alive for several years, but you're still going to die.

And the same thing with colon and breast. And on the pancreas, we're not able once the cancer reaches a certain stage, it develops a certain extra ability to resist chemo.

And so this gets back to the question I asked at the beginning. How come do you can take a patient with stage four colon cancer, with a cancer in the liver that's led to colon?

And you can give them chemotherapy and make it all disappear on an x ray and in the blood. And in nine months, it's back. Why is that? Of course, the answer is because one fraction of the cells have a native resistance and they grew back.

Just like when you kill Gandhi dandelions in your in your garden, there's always flowers to grow back. And so I asked myself, why did those cells not die?

And why aren't we addressing that? Because that's what causes death. And and I realized that the industry had no interest in addressing that, which I found disconcerting because it was, to me, the biggest problem of all.

And the reason why they didn't want to address it is because they hadn't changed their their model of what they were doing. You can think of the Vietnam War and we were carpet bombing the Ho Chi Minh Trail and all sorts of places there.

And we still lost the war because you can bomb it until there's nothing there's no shrubbery left. But the people are underground waiting for the bombs to stop dropping.

And then they come out again and so there was a form of resistance. We weren't dropped, we weren't addressing. But the industry seemed only interested in more and more drugs rather than finding out what was happening with the drugs.

And what a lot of people also wouldn't realize is that most chemotherapies work the same. I mean, there are different drugs, they have different names, but it's not like antibiotics.

If you're have penicillin resistant strep in your throat. We can choose another antibiotic and it will work. That's not the way it works. For chemo. You choose ten different chemo's and if the cancer is resistant to one, it's resistant to all of them.

And from that, you can understand that the mechanism is not drug specific, but the cancer has developed a different set of armor and that should be addressed.

But since it's not a drug, the pharmaceutical industry felt like they didn't know how to address it. And I thought, well, there's something's got to be done about this.

So that's what I focused on. And it talked a little bit about immunotherapy. And also you have hormone deprivation, as you know, two different therapies that are part of the arsenal as well.

I mean, how how important are they? And and, you know, in the battle against cancer? Well, that is a second part of the answer I was just giving. I didn't want to talk too long.

But what the pharmaceutical industry maybe they were interested in the question I was asking, but they got off on a different tangent, which was the discovery of immunotherapy, which really is like the evolution of airplanes in warfare.

In other words, before the Second World War, airplanes had almost no role in air in warfare. In First World War, they used them a little bit. By the Second World War, airplanes dominate the war.

And so as a whole, new technology and a whole new way to fight a war and immunotherapy is just like that. It doesn't work the way chemo works. And so I think the hope was that we could use immunotherapy to get rid of the cancer, that the chemo wasn't working.

But the problem is it's the same thing. The cancer is still resistant to the immunotherapy. So it works. It works in a different way. But the cancer ultimately was still resistant if you have stage four disease.

The other thing and I want to sound cynical, I'm just stating a fact. Immunotherapy costs, get ready, $200,000 a year or more. And so, again, this is an industry that is making a lot of money and is making some progress.

But no one would consider a cost effective 200 grand a year for everybody. A 78 year old person with colon cancer has a year and a half to live and you deplete their life savings or you deplete Medicare for the extra three months.

Well, I'm not trying to judge the effectiveness of that on a human scale, but I mean, it is a big money deal. And so that's where their focus is. And it would be fine with me if it actually cure the cancer, but it still doesn't.

It slows down. And so why is the cancer not being finish off? And again, we know that if you have early stage disease, stage two, stage three, colon cancer, breast cancer, lung cancer, we could cure you once it gets into stage four, the cancer morphs into a different beast.

And we really need to figure out what that is. And cure people with cancer. And I came upon a rather unique solution to that problem, which I've been using.

And we can talk about that. Yeah. And I that's that was actually kind of my next question is because you as a next step, if you went to Mexico, you've had more freedom in regards to the type of care that you were offering to the patient.

And we're able to explore additional tools that in a medical oncology, in a in a normal medical oncology setting would not be doable. So so yeah, please tell me a little bit about your journey and exploration and what you, what you saw seemed to have an impact and what you what you tried and didn't seem to have the, the effect that you wanted to have or maybe had a limited effect.

But I'll be glad to do that. Back up just a second. Before I went to Mexico, I worked with Dr. James Forsyth in Reno at the John Fawcett, the Forsyth Cancer Clinic, previously known as Sensory Wellness and working alongside Doctor Forsyth.

I learned a lot about integrative medicine and he had he was doing something called insulin potentiated therapy. And the focus of that was lower dose chemotherapy, higher efficacy.

And it had showed a lot of promise. I wanted to see what I could do beyond make it even more effective. And so when I was in Mexico, I was recruited to go there and do that, start that program.

So I was at a place called Chips, which is on the coast of Baja, a beautiful place, very, very friendly people, great food. They did a number of things.

Immunotherapy, Hormone Therapy, and Stage Four Limits

They it was the old Gerson Hospital and where Gerson had perfected his diet and cured a lot of untreatable diseases through diet in the fifties and the sixties.

Quite revolutionary. They carried that out. We also did insulin potentiated therapy there and then they had is that something that I had learned along the way from another group of researchers, which was hyper oxidative therapy, which I think holds a key to a breakthrough in oncology because the fact is, when we were talking about these stage four cancers that can't be cured, you can actually get rid of the cancer.

If you give the patient a lethal dose of chemo, but it doesn't do the host any good if you kill the host in the process of killing the disease. And so in everything everyone understands, I think is watching this, that chemotherapy is poison, it's a metabolic poison, interferes with key metabolic pathways that you need for life.

I like to tell everybody I have a pill I could give you and it'll kill every cancer cell in your body. It does that by shutting off the ability to metabolize oxygen at the cellular level. It's called cyanide.

And if you take it, every cancer cell in your body will die. The problem is, every other cell in your body will die. So that's a nonstarter. But what is chemotherapy? It's cyanide lite.

Meaning we're going to kill a lot of your normal tissue, but not all of it. You'll keep breathing and we'll kill the cancer. In the meantime, it's sort of like when we bomb Germany or Japan into rubble.

In 45, the nations were not extinct. They built themselves back. And now West Germany and Japan are two of the most thriving economies in the world. So that's actually what happens in oncology.

You treat somebody really hard, you make them bedridden for a year and they slowly bring themselves back. If they're stage two or stage three, if they're stage four this day bedridden until they die, except that they live a little bit longer, it's not it's not a bargain.

And so what we do is we we take advantage of the difference in vulnerability of a cancer cell to a drug compared to the rest of your body. Yeah, I was saying there's no difference, but with chemotherapy.

So you have 100 cells and you give in a petri dish and you give chemotherapy and 50 of them are normal cells and 50 of them are cancer cells. You'll kill 30 cancer cells and 20 normal cells, and then you do it again and you kill the same proportion and you end up with no cancer, and you have a few cells left over that speak their way back.

Well, I thought, why not find a way to give less chemo with the same benefit, with less harm, and which would be less, less harmful? But we're a benefit. And so like I said, in collaboration with another group, we came upon another vulnerability the cancer cells have that no one seemed interested in the way that I've exploited and been very successful, and we can talk about that.

So because that is the whole idea in regards to like the insulin potentiation therapy is to be able to have a stronger impact with with less chemo. And so you've felt that, I mean, since you were exploring additional means, you didn't feel like the IPT was was enough by itself to to be able to do that.

But there are a lot of variations on the theme. IPT And one of the things about the people who doctor for certain I treated Reno was they didn't want for those chemo under any circumstances.

And so IPT was the right thing for them and for some of the it worked really, really well. For others, not so much, but that was their choice. You know, people I'm a libertarian and people need to decide how they want their own body to work.

Dr. Forsyth has published his results and deserve for anyone to look up to see what he achieved. Some of it was quite impressive. I had some of my own ideas and oftentimes like to rock stars in the band.

You know, the younger one who comes on decides to start their own band, sort of like Eric Clapton left the cream. But I'm not Eric Clapton. I'm just using an analogy.

But I was in contact with the group that was focusing on another vulnerability in the cancer cell that no one in pharmacology seemed to have any interest in which was kind of technical chemically.

It's called the oxidative state of the cancer cell. But I was able to break it down into analogies. That's not that hard to understand and we can get into that if you'd like.

Is so, yeah. So what were some of the tools that Drake's exploring? Because I know one of the ones that you're working quite a bit with was vitamin C and kk3 at 100 to 1 ratio.

And you're I know you were doing that both intravenously and then also you just did that as an oral protocol along with with chemo.

Mexico, Forsyth Clinic, and Integrative Treatment Approaches

So again, the whole idea, if you're going to put something into somebody's body by injection or by mouth, the body doesn't know where it's going. And so it's just going to distribute throughout the whole tissue tissues in the body.

And so when it runs into to a target, that's not something happens. And now it's true actually with monoclonal antibodies. That's the big difference that's getting, again, kind of technical.

But there is targeted therapy in oncology. But aside from that, just with chemotherapy itself, which isn't targeted, it gets to the cell and then the cell has to do something with it. Now, if you can think of a community like a Meridian, Idaho, where the homes are 10 to 30 years old and its trees are tall and people have been living in the homes for a while.

And you may see someone replace a roof here or change some siding there. There's a little bit of repair, but not much now and everything sort of stable then.

That's the way most of your body is living in the adult form the body's built and it just needs maintenance. And then you can think of Caldwell, Idaho, where they're throwing up homes like crazy and you have all this energy going on.

You get rid of the wheat and the corn and you plow it down and you put in plumbing and you have lots of construction workers and lumber and trucks and everything running around and all this business going on.

That's what a cancer cell is doing. And so it takes a lot more energy being spent very, very quickly to run a cancer cancer just a high energy input output entity compared to the rest of the body's just sitting there.

And so when we try to treat cancer chemically, we want to look for things that differentiate the cancer from the rest of the body and then find targets in the cancer that aren't there in and the stable part of your body.

So in in the developed community of, say, Meridian, it's not a lot of activity going on. And so there's not much targets. But if you're building a subdivision, if you run out of lumber or you run out of electricity or you don't have a water supply, the thing shuts down. So cancer cells are running at a much higher metabolic rate than normal cells.

And the consequence of that is that they're burning energy like crazy. And it's not an oversimplification to say that when a cancer cell burns energy, it's not much different from burning gasoline in your car for the few remaining gas consuming cars that are still there out there.

And you burn the gasoline and out of the out of your pipe comes CO2 and other oxides of carbon from the combustion and it's hot and a cancer would be sort of like running your car at very high rpm constantly as opposed to a car like when I even in my truck that gets ten miles an hour in town.

It's an old truck. Sorry, but I don't drive it much and I go on the freeway and cruising at 2500 rpm. So I'm getting 15 miles to the gallon because I'm just cruising in overdrive there are chemicals that the cancer has to generate to cool its engine that the rest of the body doesn't need because the rest of the body isn't running at that level.

And if you shut off the cancer's ability to cool its engine, it will die. And we have identified a whole host of these medicines. So we call a crow oxidants, not our toxin.

It's quite the opposite pro oxidants because the cooling off the cancer cell has is through antioxidants. In other words, a cancer cell is generating a lot of oxidation by burning fuel to build the construction, to run the thing, grow new cells like your child and it and it's burning all this energy and it has to get rid of the waste and it could overheat.

Like in the movie Ford versus Ferrari, the engine shuts down, so it generates huge amounts of antioxidants and it needs those to survive. We've identified the enzymes that generate those antioxidants, and if you inhibit those enzymes, the cancer will die.

And what a lot of people, even identical ecology colleagues, don't realize, if you ask a medical oncologist, how does this drug work? They go, well, it attacks the DNA.

That's true. But that's not what causes cell design. The DNA is damaged and it calls on another part of the cell to repair it. And only if the cell can't if the DNA can't be repaired, will the cell die.

And so if you block that that process, the cell will die. And it turns out that you can give quite a bit less chemotherapy and still get DNA damage if you shut off the rest of the cells ability to repair that damage, the cell will

die.

And so we have found a way to give half as much or a third as much chemo as you would otherwise, causing very little side effect and still get cancer.

Cell death. It's quite revolutionary. Problem is the medicines that we're using are haven't seemed to spark any interest in the pharmaceutical industry.

And so we're left doing it on our own and we are doing that. And I'm very excited about what we're seeing. And the I mean, that the cooling down.

Oxidative Stress, Pro-Oxidants, and Cancer Cell Vulnerabilities

I mean, one of the things that people think in regards to cancer, they they want to make sure that we bring in antioxidants like glutathione on that's a common one that people want to really kind of do IVs and take supplements of.

And from my understanding, glutathione is what is produced within the cancer cell at a high rate for that cooling down effect to help to kind of calm down some of those oxidants.

Am I correct for that? Well, you're entirely correct. So let me back up a minute there. I take a lot of antioxidants, and that's because as far as I know, I don't have cancer.

Antioxidants almost certainly prevent cancer, although no one's actually proven it because you can't put humans in in that kind of a study. But but people who take antioxidants seem to be better off in many respects health wise.

And that's because when a cancer cell is when a cell is trying to turn into cancer, antioxidants will prevent it from taking the step it needs to take to become an out criminal. The antioxidant will rehabilitate the juvenile delinquent and say, don't do that.

Once the cancer is full blown taking glutathione will make the cancer healthier and it will hurt you to do that. And so this dichotomy is sometimes not well understood by certain people.

I have my favorite analogy and again, forgive me, but having been a boomer whose father fought in the Great War and also just because of the way it is, we think of oncology and cancer as a sort of a military operation where killing cancer cells or bombing them with bad things.

When you bomb things, you're hurting everything, not just the cancer. So anyway, on December six, 1941, the United States approach to the Empire of Japan was negotiation.

Well, let's see. In a few days, if you do this, we'll do that will avoid war. And that's what taking antioxidants is. We're trying to avoid war, try to avoid all the difficulty that that entails.

We're trying to prevent the problem. The next day, the diplomats were expelled and instead of talking to the people on the other side of the Pacific about how to make things better, we were shooting at them.

They were shooting at us. The war was on and there was no turning back. And so once you have cancer, you have to forget about antioxidant and turn to oxidation because that's what's happening.

And there are a number of nutraceuticals that that we use that the cause hyper oxidation to kill cancer cells and one of the things that got me so excited about moving to New Mexico, which is a big deal, was we had a patient there.

I was just consulting and I was going down once a month and there was a patient who had been elsewhere, had a rare cancer that failed everything and was down there seeking a remedy. And we initiated the protocol on her and

his rare refractory untreatable cancer disappeared.

And I said, okay, I'm in. I mean, this is I've never seen this before. This is like going out in the woods 10,000 times and then all of a sudden you see Bigfoot and you go, this is this is totally new.

This changes everything. I've got to learn more. So I was hooked by that and we've learned a lot since then, and I think the process is very promising.

The other thing is that the nutraceuticals that we use in comparison are dirt cheap. I mean, vitamin C and vitamin K and a few other things. A few hundred dollars a month, not $20,000 a month, which is really a lot.

I just gave a patient a drug the other day and we're trying to get the pharmacy. Got it. Still? I'm still practicing. And in my hospital practice, I have to stick with the standard of care because those are the rules.

And I had a patient who was not responding to conventional care. And so there are some research on a new model, a new drug that was pharmaceutical. And I wanted to give it to her and the insurance company denied it.

Everything we do has to be authorized by insurance because. And the interest tonight it it it was thousand dollars for a one hour infusion and I was all set and we went to financial services.

I'm going to put in a plug for Good Shepherd Hospital in Hermiston, Oregon. And they said, Steve, the hospital is going to eat the cost. Go ahead and give her the drug.

And I swear to goodness that that builds loyalty like you can't imagine we gave her the drugs. She did much better. But the point of that is it's $30,000 once a month for these the drugs that the big pharma is throwing around, we're giving supplements.

It cost $800 a month. And so you can see where the money is. It's not it's not in the nutraceuticals. I'm not interested in the money. You know, I should be wealthy and retired at my age, having worked as hard as I have, but I live comfortably.

And that was never I never focused on becoming a millionaire at the age of 50 the way some people do, because that's not why I became a doctor. And and I don't care, because I've talked to a lot of rich, retired doctors on their yachts and they're not miserable, but they're they're not happy, you know, they're bored.

Yeah. You got, you got nobody cares about you if you're out here by yourself with your family. Okay, that's nice. But you know, people ask me, is oncology depressing?

I don't know. It's people are extremely grateful for your being there and I happen to work in an area which is rural and most of the people are religion center.

But I'm not going to name a religion because it doesn't matter. But they have faith and hope and they're grateful for what you do for them. And I'm going to probably going to keep working until I can't get out of bed, you know, because so doesn't matter how much money I have, I can't spend it.

And so the the point I'm making is that we could make a revolution in oncology and save a lot of money. Since Medicare's going bankrupt. And so I'm hoping to do that.

And you and I have talked about other projects that we will collaborate on, hopefully in that regard. Yeah, I'm very excited about those project and I and I want you to kind of give a little bit of a plug.

You've written two phenomenal books. One, yeah. One that directly relates to to your profession and your experience with with patients. Can you just let the audience know?

You know, I just can tell a couple of minutes each book of what they are and how people can find them. Well, I'd

love to. The other thing was, in the process of my work, I thought had something unique to say.

And so I wrote two books now, one that I published in 2010 and another one that I published just a year ago. The first book is extremely popular. It's called The Undying Soul.

And I talked I mentioned how to get a hold of these books when I'm done with the summary.

Books, Faith, and the Science of Purpose

But and it is my first person account of, of being a medical oncologist in the second half of the 20th century and the trauma of thinking we were going to cure cancer and not curing it.

And the underlying theme of that was that in the second half of the 20th century, we thought that DNA held all the answers to the riddle of life, and that the atheist scientists had proven that.

And I actually am very upfront about this, abandoning my faith in favor of science. Maybe one excuses that my parents are both past and my mentors were my professors who are all atheist scientists.

It's not an excuse, it's just a circumstance that might offer some context. But by 1995, I realized that that that fairy tale wasn't coming to the end, that was going to make us all happy.

And so the book is about 1 to 1. Each chapter of the book is my interaction with a patient. And the theme of the book is to contrast the patients who died without faith and patients who died with fate.

So it's a it's a book about death and dying, as well as a book about my own journey towards redemption and recapturing my faith. It's very personal, emotional.

It's an easy read except that it'll make you cry. And everyone has raved about it. It's out of print, but I have my own supply and people can email me for a copy.

The other book is a lot like a book that Eric Metaxas published a year ago. He published many books. One of them that he published was is Atheist Death.

And my book carries the Longest Supper. Those means I was on his podcast a year ago. He was we had a really good time together and you could look it up.

If you want to go through his podcast, you'll find my name there. It's called Telos and it is the scientific basis for a life of purpose, meaning the the science.

It's the science of purpose. Now you may say, Well, that's silly. Why would you have to have a science of purpose? Most people aren't scientists. They don't deal in hard science, which is why it was so easy to manipulate them during the epidemic with bad science like quarantining healthy people, that's never been done before and it didn't work out so well.

We recovered. I know that in the beginning drastic measures were necessary, but over time they should have let up in a little bit. That's my opinion. A lot of people now are coming around to that and there's actually strong data.

Sweden. You've heard of Sweden, right? Yeah. And South Dakota where they did. Yeah. And Florida where they didn't quarantine and the economies didn't crash.

And you didn't have to print a bunch of money that had no substantial basis for people to keep living. And so that's one thing. So the point is most people don't realize that if you talk to any college science professor in a secular setting, that is to say, not a Christian school or a muslim school or a Jewish school, they will say that.

The fact is the fact is that science has shown that there is no God of Abraham. The God of Abraham means Allah,

Yahweh and Jesus Christ, that everything that goes on is a chemical reaction that's perfectly understood by all the smart people.

And I actually believe that in 50 years ago, when they sequenced DNA and said, this is it, it seemed plausible. Now we know that that's just a fat lie.

And they may have thought that for a time, but they should have figured out that it's wrong and they should reverse their point of view, but they won't because they're entrenched.

They have their their their own paradigm and they won't let go of it because then it would threaten their doctor, their careers. God forbid that you would make a sacrifice for the common good, even if it costs you a little something.

And so the book tells us, well, it's the science of purpose. And the scientists who say purpose is apparent, it's not real. When when the wolf pack goes, it gets something to eat.

They're not actually being purposeful. They're just responding to chemical signals in their brain. They're motivating them like machines to go put food in their stomach and shut off the chemical process, tells them they're hungry and they're just chemical machines.

So that's pretty macabre. But actually they go so far with all this talk about A. I., it's even worse. They go so far as to say that when you, the human being, fall in love and the most precious things that have ever happened to you, the kiss of your mother when you go to bed as a child and when you kiss your child goodnight in their bed, that's all.

Just a chemical reaction. And that we could build a machine that feels everything that you felt and you're nothing special about you. There's no God. God is a fairy tale.

That's what they're teaching as a fact. And the fact is, it's a lie. It's proven false. And my book explains why they do it, why they're wrong, what the answer is.

And so if you want to know about the meaning of life from not a religious point of view, but from a scientific point of view, to help you give you the faith you need to keep your the the intellectual or the scientific or the philosophical basis to maintain your faith so that you don't doubt it.

And when someone says your belief is a fairy tale, you say, oh, no, actually, your, your, your scientific atheist is a is a fairy tale. This book will tell you everything you need to know.

So the way to get either of those books is to go to my website, which is stepheniacoboni.com I know it's hard to spell all that, but Stephen is with ph and it's iacoboni.com But you know how Google is.

If you misspell it, it'll still get you there. And then you'll see a video of me and a trailer and podcasts and all of the endorsements. I got the endorsement from the top intelligent design person in the world, Stephen Meyer, who runs the Discovery Institute, and I am affiliated with them and a member, but I'm on an advisory board with them and you can email me through the website, ask me questions and order books.

Well, Dr. Iacoboni. in Order to both books actually, yeah. But you have to email me too to. Yeah it's for the first one. Yeah. No. And I read both, they're both spectacular.

So yes I really urge the viewers to, to take a look at them and read them. So, Dr. Iacoboni, thank you so much for sharing all this information. I know that this will be extremely valuable for people, understand their own journey as they are considering what kind of treatment that that may benefit them the most.

And and you brought forth so much information and help for you now at the said 200,000 patient interaction that that's not a small number. Thank you so much, Dr. Iacoboni.

Thank you, Michael. God bless you. Thank you. Thanks.