Your Guide To Integrative Oncology And Cancer Diagnosis Transcript

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Introduction and Integrative Oncology Overview

Welcome back everybody. I have the distinct pleasure of bringing forth it to you all. As someone who is no stranger to the field of integrative oncology.

He has been a teacher of mine, a mentor of mine, a colleague of mine, a friend of mine, and someone who, has been trodden this path for probably just as long, if not a little bit longer than I have.

And so it's really fun when you get a watch like grow in this field with someone who's seen all the, the popular things come and go and sort of at the end of the day, what settles out is what is most impactful.

And we're going to talk a little bit about that today. We're going to talk a little bit about, why integrative oncology? We're going to talk a little bit today about autonomy for the patient.

We're going to talk about the future of oncology in general and integrative oncology in particular. And so much more. So Sean Devlin, Dr. Devlin, welcome to the summit.

Great to have you. Thank you Nasha And yeah, I agree it's we have a long history together. And it's been interesting to see where we've gone, but, I'm very I'm very impressed with all the work you've done and advocacy work, and education.

And I think the ability for you to reach so many people the way you have has literally saved lives. So kudos. Thank you, my friend. Thank you. Will back at you.

It's huge. It's huge here. So maybe we start with a very light and fluffy topic, which is how do you view cancer? So cancer is complicated, right? In the sense that it's not just like one disease, but it's numerous diseases that have reflective symptoms in patients, on an individual basis.

And disease will show up differently for different people, even though we call it the same thing. so it's very frustrating, I think for practitioners and people who take care of cancer patients with that model because it's, a lot of, amorphous things you try to wrap your hands around.

There's nothing really solid, or clinically succinct that, you know, that you've got you got this taken care of. This is no problem. So besides it being complex in the sense of diagnosis, figuring out what it is, why it got there, but ultimately, what do you do with that information once you have it?

So it's really, it it's one of the few diseases that does require a broad approach that is seasoned and experienced, and also one that requires multiple practitioners at play.

so I'm a big fan of creating a team that's going to honor and respect that patient's autonomy and their wishes, because the diagnosis itself is one step.

And I'll be honest with you, we get that wrong sometimes right out of the gate. So I've had patients come to me and say, hey, listen, I have lymphoma and this is what's happening.

How Cancer Is Viewed and Why Team Care Matters

And we find out, no, it's stage four melanoma. So we've got we have to make a significant pivot, you know, treat those diseases the same. So, all those issues that come up with cancer make it still, you know, as ominous as it's ever been.

A huge, huge I love this because one of the questions I was going to follow up with is, where do you begin with this? And it sounds like one of the first starting points is to bring together your team.

And so who do you like to see on that team? You know, so I'm, you know, I'm pretty I'm pretty open. So I'm not really politically motivated to have any certain people.

But the people I love to have on the team are your traditional oncologist. Radiation oncologist, your surgeons, your oncologic surgeons, usually minded interventional radiologists, pathologists, to be honest.

And, ultimately, on the integrative side, I'm a big fan of what a nutritionist bring to the table what naturopaths bring to the table. and then ultimately other integrative providers or functional medicine providers.

And, you know, usually most teams, if they're fleshed out, there's anywhere between 4 and 8 people on them. And the goal is to have sort of like 1 or 2 kind of chefs that are in the kitchen sort of working things, and the rest are making contributions and a lot of that's with consultation or even like, what we call like a round robin or think tank where we sort of play the case out and discuss how everyone sees it and what best next steps can take place.

I love it. One of the things you and I've talked about over the years is are both of the distaste we have for the concept of tumor board, because even though we know tumor is part of the equation, it needed something to arise in.

And so I like I've kind of thought more about calling it the terrain board or something else. And so this round robin is what you're referring to of like let's take a look at this from a broader view with a few people who have expertise in those more narrow, you know, siloed pieces.

But I think that's really, really powerful. So, you know, you've been at this long enough, and I know you've worked in some very traditional, conventional environments, and I know you've worked in some very nontraditional environments.

But how do you like how do you handle the naysayers, whether it's a conventional oncologist, colleague, or even a family member who's uncomfortable with an integrative approach for the person who you are offering support to, how how do you navigate that discussion?

Well, I think listening is probably the biggest thing that I must do in the beginning. I have to hear from that individual what exactly the issues are.

And a lot of times it does come from other practitioners who may disagree with either philosophy or approach that I've, you know, represented that could be beneficial to the patient.

But at the end of the day, I'm not there to win any sort of verbal battle or outwit somebody. My goal is to sort of bring us to a space where we can meet the patient, because that's kind of the goal.

I mean, that patient is the person that we're focused on. And so it's their autonomy that we're trying to, you know, have honor around ultimately the the, the clinician or the family member that's putting up resistance.

I'm going to ask them a lot of questions and maybe even ask if they were in this situation, what would be the course of care that they would pursue and why?

ultimately, everyone gets to choose very rarely when I have been at tumor boards or when I have been in these sort of round robin situations, very rarely does everyone come up with the same answer.

For the patient, it's always different. So I think the patient needs a certain number of options to look at, not too many not to overwhelm them, but enough so that they feel as though they've covered all their bases and that they feel comfortable moving forward with the plan.

But ultimately it is about the patient themselves, not about the clinicians and their recommendations. But what I do is I'm a deep diver. As far as the literature goes.

I've worked with some really phenomenal specialists and have learned to respect and honor, you know, basically big data. Big data to me is something that is always going to be there and it's going to get more, easier to go through as things like, I come on board, we're going to be able to peruse, you know, brand new papers that are coming out, fresh data that's being minted out of conferences, evidence based medicine.

All that stuff is like drinking from a fire hydrant. And when we break it down and make it more digestible, we're put into a space where we can really, garner some, you know, nuggets that are going to help the patient.

But really, I day after day, I'm probably every week I send literature out to my colleagues and say, hey, you know, read this, see what you think you know, whether it's a repurposed drug that I'm looking at recommending or whether it's fractionated chemotherapy or immunotherapy or even lifestyle or diet.

I mean, some people just they they poo poo these things. And my concern is, is that you give simple tools to patients that they're willing to be compliant with that can be very powerful. And, for almost free.

Why wouldn't you do those things? And I get pushback on, well, if they're not eating sugar, how are they, you know, how are they going to put on weight or how are they going to survive?

Handling Resistance and Centering Patient Autonomy

You know, when I have to go all the way back to that and, you know, and I just think about when I'm going to the dentist and there's lollipops for me when I'm leaving, I'm just like.

This is can I. I give dissonance, you know? But for the most part, it's about conversation. And the biggest part of the conversation is listening. that's huge.

And it's, you know, you talked about the autonomy of the patient. And one of the things that you and I have shared a lot over time, our patients and been at conferences where we're hearing and learning, about patients.

And you and I have also been on the side of, of, of having patients come to us who, maybe have chosen a different path than maybe what you and I would have chosen for them had they started with us.

Right. And so whether that was they went headfirst into only standard of care, very devastating, maximum tolerated dose approach that took them to the brink of death, of just not having a functioning immune system or a functioning anything left after kind of being harmed, if you will, to, you know, of saying, okay, well, now I'm ready for an alternative or an integrative approach.

That's one side of the coin and the other side are those who are like, I am never doing standard of care. I am never doing chemotherapy or radiation or surgery, and I'm just going to juice this away and, and pray this away or wish this away.

And we've seen that end. And I think the point is that those are very polarized approaches to this piece. And when I've watched you do beautifully through your career, is weaving together a very meaningful story for that patient to help them maintain their autonomy while helping them make decisions that are based in evidence and not out of either fear.

So kind of a reactive response or kind of blind faith that is also not completely effective. So tell us more about that. Yeah. So you bring up a good point.

I mean really as physicians taking care of patients, there is only one real, goal. And that's to take care of folks where they're at. Right. And it's tough sometimes when you have a patient who has either been through the traditional model and didn't fare well, had a bunch of side effects, or maybe even had progression of disease while

having side effects.

I mean, I think that's probably the worst thing that can happen besides dying of either chemo or the disease during that time. So to go back and to sort of reconcile, some of the issues that come up for these folks.

Number one, a lot of times they feel ashamed, like they didn't do the right thing, like they didn't make the right decision or why didn't I listen to my cousin who told me about, you know, the ketogenic diet or repurposed drugs?

so that's something that I want to get out of the way very quickly because if you're not living in a state of love and honoring your path where it's at, then you've already become disabled on that path.

So critical to me is to reestablish, their faith in themselves, their faith in the decision making and the fact that they are worthy of, you know, getting better.

And so once you come to that point with these patients and there's some trust being built, then you can get them to start to integrate things again in a way that makes sense, because sometimes we have to go back to have the conversation about, you know, second and third line chemotherapy, you know, maybe radiation therapy, you know, other targeted therapies, bisphosphonates, hormone modulation, all these things that they may have already had a taste of that didn't feel so good.

But it's how we do it in the integrative space that allows it to be more tolerable. You know, so that's I think, critical for me. And then on the flip side, when I have somebody who is completely magical in their thought process and believe that doing 1 or 2 small things is going to, you know, eliminate the disease in its entirety, then I have to really talk about where that's coming from, why that desire is, and then putting a new light on it.

Right, a new perspective. Because I have to be honest. I mean, when people say, well, listen, I've eliminated processed foods, I think I'm good to go.

And unfortunately, I know very, very rarely do we see people have a change with just diet alone. But it's very possible to but not likely. So I mean, it's much like saying, hey, listen, you can buy those lottery tickets.

The chances of them paying off are pretty small, but potentially they can. and I really work on stair stepping those people because the last thing I want to do is alienate them, because I don't want to lose them.

And I and I have I've had patients leave like, hey, Doctor Devlin, you seem great, but your plan does not resonate with me at all. I'm going to move on to somebody else, and then somebody else who maybe isn't as straightforward leads them down a path, and they don't have a very good outcome.

You know. I think that's really important. I'd love I mean, this is also why I'm excited that we're having this conversation is you are a frighteningly intelligent human being.

You're that your brain is one of my favorite places to splash around in when I get the opportunity to do so. But you also come from heart and just groundedness.

That is very, very calming for the patient. And I've also gotten to witness that. So I really love that. That's where you started with this. It's like really find out where they're coming from in that moment and get them back into trusting themselves again before you start to talk about all of the other options that are available to them and specific to how they're presenting in that moment, which I think is really cool, that that's the next piece I want to talk about here is a lot of our colleagues out there are really well-meaning.

Colleagues are brilliant. clinicians really love their patients. They're doing what they love to be doing, and they're doing it with the right intentions.

But many of them don't take advantage of the tools or the resources or the method. Geology that helps lead to good clinical decision making to help sort of put our patients on the right path at the right time, at the right dose,

duration, combination.

Those things are so, so important, especially for patients who've had it, who have been failed by a variety of treatments, standard of care or otherwise, and who are now facing kind of an uncertain future.

Precision Medicine, Testing, and Real-Time Adaptation

You are a huge proponent of precision and personalized medicine and testing and investigation. So tell us about how that plays a role into your integrative practice.

Yeah. So I think that I mean, and I've said this in lectures before where I believe all of us, no matter traditional oncologists or, you know, radiation, colleges, interventionists, surgeons, whatever, anybody who cares for a cancer patient is moving to the same space.

And I too am moving there as well. And that place is a beautiful meadow. That is where precision based on ecology and personalized medicine coexist. And we're able to bring the tools to the patient that they need as individuals, not as groups or clumps of people with a given diagnosis.

And that's what's really frustrating, because we're living in a time now where on the lab side, we have technologies that allow us to basically screen the blood for circulating tumor cell DNA, circulating tumor cells.

We can actually take the tumor itself and better understand its genetics and how it expresses itself, phenotypically, like what are its drivers? What are if it's lost its brakes, you know, how does that look?

so we can pivot on that information and take actionable steps to treat the patient directly. But the problem is that, you know, as you know, cancer is a notorious beast.

And it will learn as soon as we start to introduce a pressure to it. and we start to treat it and start to kill it, then it starts to rethink how it's going to live its life in that terrain.

And that's why knowing as much as you can about that terrain and how it's expressing itself, is critical to the treatment. And the only way you do that is you continually dip into the well, whether it be the tumor, whether it be the blood, whether it be their own genome to figure out how best to serve them with the tools that we have, like in real time.

And that's where I think probably AI is going to be like our virtual oncology assistant. That's going to be like, hey, based on the rate of development of this tumor, the thought is, is that there's been enough genomic change or new disease expression that we're going to resample.

So let's recommend that biopsy. Wait. It's only been six weeks now. We need a biopsy right. Same thing goes for blood. So I think we're really in a space now where we're able to do that.

But it's a heavy lift requires a lot of work and manpower and cognitive effort that a lot of people aren't doing it. They go right back to the dividend, chew the Asco guidelines, what the sub colleges are saying, and just follow that cookie cutter approach.

And when you start to see the outcomes still kind of be the same as they were years ago, it's frustrating, right, because there are some people who are really knocking it out of the park by thinking, as you know, they should, that patients are individuals, that have their own personal experience with the disease and their own personal disease.

And that's what we should be treating. You know. When you speak to this, I mean, you're speaking about systems thinking as well because you're moving us out of that sort of algorithmic, linear thought process of you do this treatment until it fails, then you move to this treatment till it fails and you move to this treatment.

You are leapfrogging that with this approach that you're describing, you are shortening what's known as the 17 year gap in the research model. You're shortening the gap of saying, well, instead of waiting for all these things to inevitably fail you, let's get you as close to the bullseye as possible.

In the beginning and recognize that this little guy will change. This is, it metabolically reprograms. To your point, as soon as you put a little bit of input, a little bit of extra pressure into the system, and so that protocol centric medicine of will wait until we see your tumor markers doubling or will wait until your side effects are so atrocious that we just can't continue with this or will wait until the next scan shows, you know, now we're progressing.

You know, that's what we do. And standard of care today is we basically act reactively. We don't preemptively consider. Let's change gears at the first inkling, the first smoldering.

And to your point, we have come to the time and place in our technology and our practices today where we definitely can see those changes happening long before they're big enough to really start to freak everybody out on a doubling time on their tumor markers or on imaging showing progression.

We can start to get examples of that happening. And one of the cool things that we've found is there are certain tumor types or certain genetics of the tumor that also tells us right up front, hi guys.

I'm a I'm a bugger here and I'm going to change really rapidly. So every three months you better be on the on the lookout right. Instead of just saying get on this protocol and we'll see when the treatment fails.

So can you add anything else to that. Because I think that you and I have we have been around long enough to finally witness the potential. And we've seen it firsthand, because you and I are the system singers applying it while a lot of people are still learning about it.

Not yet. Maybe integrating into their practices, but man, it is really beautiful what's coming that will be able to anticipate and respond versus react.

Yeah. And I you know and it's we're in this it's sort of like the fog of evolution of this technology. And a lot of us are, you know, early on we grasped but basically at straws when new technologies came out because we have patients in front of us who are in the active process of dying, and we're looking at any and all options in some of these earlier tests, they weren't as fruitful as we'd hoped they'd be.

and even nowadays, even though I would say the sensitivity and specificity for some of these tests is much higher. it takes getting several different tests from different organizations to really put together that picture.

And you got to remember, these are just like little photographs in a movie you're trying to make sense of. And a lot of times the movie is going to be over before we actually can start to implement some of the things we need to do.

So I think one of the lost art forms is, you know, history taking and physical exam. Right? So I think keeping up with that and paying attention to lumps and bumps, and I'm always asking about any new lumps or bumps or anything odd that you've noticed or, you know, oh, I've had these night sweats.

Oh well, I would like to have known about those. When did those start? Yeah. So I mean, I think integrating all the basic tools that we know of since we were trained as physicians all the way through what technology has to offer.

but it's great to know, like for me, I say, hey, listen, if we can know as much about the tumor, that's fantastic. Resources. If they're limited, I'm going to focus on getting the information about the tumor.

Next is like, you know, the farmer go genomics, the snips, those those pieces of information that can allow me to fine tune and not hurt you with my therapy.

Because the last thing I want to do is introduce a drug to you, which I can guarantee you're not going to process well and you're going to get sick from.

That doesn't make sense. Like, why aren't we doing that the first day to get diagnosed, you know. Exactly. And that's such a strange thing because we will we'll see people go, oh, look, I tested really high for carboplatin.

Understanding NED and Ongoing Surveillance

And yet you go and look at their photo, you know, you know, pharmacogenomics profile. It's like, great. Just because that drug tests really high for you, your genes do not tolerate that drug one iota.

And this could be devastating. And so it's that dance. This is the beauty that we've gotten to to be able to get. So, so specific. And for our patients, which I think is just enormous.

And so another topic that really interests me with you that I've seen over and over is how many patients have you had in your career that came to you after the fact when they, you know, had gotten through their standard of care treatment?

They ring the bell at the end of chemo or at the end of surgery or at the end of radiation thinking they're done. And yet a matter of months or a few years later, they're seeing you with disease burden sort of out of control.

how do you explain this, Ned? Ned? No evidence of disease or this. Any aid. There's no evidence of active disease. How do you explain it to patients who are coming to at the end saying, well, now I'm ready for just, you know, a little bit of something on the side.

How do you explain what this really means? Well, that's a good question. A lot of times the oncologists don't even address this. And that's the issue.

They get to Ned and there's a big party, the bell ringing or whatever you want to describe it as, but they sometimes do literally ring a bell. So my, my take is, is Ned is like that first stop.

Right. That's the first base that you get to to sort of go, you know, listen, I'm going to have a little bit of a breather here, but I've got a plan on how this thing does not come back.

But I think they also need to know, is it gone because we don't have the technology to say that it's completely gone. And people say, well, I had a clean scan and there's no CTCs, right?

There's no certainly tumor cells, no ctDNA. Well, there's errors in sampling, right. And I hate to scare people, but worst case scenario, let's say you have a few cells here or there.

They probably should be addressed some form or fashion. Some therapy probably should be done. The other thing is, is how did you get cancer in the first place?

So what's going on in your genetics? What's going on with the epigenetics that may potentially reproduce that same night, as of which these cancer cells are going to form around.

So whether it's an abusive relationship or some sort of, you know, trauma that's not resolved, they've got to deal with that. you know, maybe it's third hand smoke, maybe they work in a place next to a place where there's a lot of smokers.

I don't know, but at the end of the day, you want to look for all those sources from the get go and make sure that they're removed, because they literally need to be a different person than they were prior to the diagnosis.

And sometimes that's a heavy lift for folks. That's not easy to do. So any deal only means, you know what? We have some breathing room. That's all it means to me.

And I've had patients who are like, doc, why do you want me to treat for another 12 to 18 weeks? I need you to treat for no, 12 to 18 weeks to get rid of anything we cannot see.

And then at that point in time, we'll go into more of a solid surveillance and temper ized approach. But we're not just going to leave it here. And it my general rule of thumb, if it takes us three months to get you need, then you'll be in treatment.

I got another six months. Right. And then at that point time we can, you know, put the brakes on a little bit and go into surveillance mode and or monitor, you know, other therapies, but it is never over.

it's really never over until we've all passed on free of disease on autopsy, you know. Exactly. And as someone who's over 32 years out from that process, it's it's an ongoing process.

It is my life with cancer, not, you know, what I assumed was a life before cancer and life actively engaging cancer and now life with and kind of the maintenance and surveillance piece that you talk about.

I don't go back to the soil in which I got sick. That is the last thing you ever want to do. And so I so appreciate that you highlighted that. It's not just about the tumor, the tumor cell, but it's also the environment that there is inside their body, but also everything they put in on and around them.

And that includes living environments, working environments, relationships, dietary and lifestyle approaches. it's it's you don't get to go back to, you know, binging on McDonald's and Pabst Blue Ribbon.

That's just not what's likely in the cards for you after this. If anything, we hope that you desire to upgrade and to become, you know, a better version of your previous self.

you've kind of alluded to cancer is an opportunity to do just that. And I really love how you describe the No Evidence of Disease piece, that it's like the breathing space to say, okay, now what?

I think that's fantastic. So on the now wet side, I'm super curious because I have like I said, throughout the years I've known you, you've done some really amazing work and sort of the acid base, you know, acid and Alkaline world when you were working with off label drugs in that arena.

I know you've been hugely a proponent of metronomic chemotherapies and off label drugs and a very integrative, vetted therapies. So knowing how to use really innovative, IBS and you've been a fan of mistletoe and therapeutic ketosis and all these other tools of which you have a very, very big toolbox.

Current Excitement in Oncology and the Future Ahead

But I want to hear from you. What are you most excited about currently in practice? What you're currently using that you're like, wow, this is really fun and fun.

Being that sounds kind of a weird word to have when we're talking about cancer, but something that's really lame. You have to realize this is making a difference.

That is fun. I mean, in the field of oncology, this is one of the highest suicide rates among doctors in the field. So we look for these little glimmer moments of what is making a difference.

So what's making a difference in your patients right now? And what do you see on the horizon. Yeah. And and I'll be honest, a lot of the tools that have come out in the past ten years, that involve activation and education of the immune system have been, I think, a game changer for a lot of reasons.

And I would still say that it's immunotherapy that's got me the most excited. I think how it's being used and approaches in its use are, becoming more and more novel.

And I think there are more and more tools in which we're able to sort of attach things to items that are going to engage with the immune system in a way that allows the immune system to be stronger or more activated to that person's individual cancer.

I think, one of the cool things is being done now. There's several, interventional radiologists doing it, but that's intra tumor immunotherapy. it's a it's a mixed bag, of course.

I mean, sometimes it's too late or you just can't do enough and enough time. But I've also seen some cases where they're taking, you know, advanced stage cancers and putting them into remission.

That's exciting to me. The other thing that I think's fun is that all the new targeted therapies and small molecules, there's a lot of things that are coming out.

but along the line of true integration, it's being able to run either in tandem or parallel. you know, things like cryotherapy, hyperthermia, low dose chemotherapy, repurposed medications, ortho molecular tools like dose dense vitamin C, oxidative therapies.

All those things have a role in the treatment of these patients. but again, they're not alone. You know, they're going to be done in combination with other known tools, whether it be hormone modulation, whether it be certain forms of radiotherapy.

I think a lot of times, you know, everyone thinks radiation and they just think, oh, Madame Curie. And it's just people getting holes burned in them. That's not the case, right?

I mean, it's a very fine tuned science. some of the brightest minds practice, radiation oncology. And I think, there's a place for radiation oncology.

So a lot of stuff that's going on now involves those sort of tools. But ultimately, at the end of the day, I believe that it's going to be patient empowerment, through self-knowledge and learning more about where they are on the spectrum and being able to sort of follow their own journey in real time.

And that's empowering, because at the end of the day, I need a patient who is not scared. I need a patient who's completely empowered and has general working knowledge of what they're doing and why they're doing it, and ultimately that's going to get them down the road way farther than just being scared and timid and worried about when the next shoe is going to drop.

And the fact of the matter is, if you get cancer in 2024, there's a good chance you'll be alive in five years based on everything that's happening between now and then.

So people don't think about it. But like, I think like I've news I read in her to, you know, now just got approved for what? You know, you don't have a high expression.

You have no expression. Hey, we're going to consider in her too So and these are new kinds of drugs that may have a real influence on how patients do and if they're tolerated.

Fantastic. It's just another tool in the toolbox for folks, who eventually do run out of tools. But when you use them in a wise and smart way, and also a way that's being supported, I do see patients do very well, you know.

It's I mean, did you ever think that five years ago, ten years ago, 15 years ago, we would be having these conversations that there's actually hope on the horizon with regards to kind of a repurposing or re-envisioning standard of care and a truly integrative approach with very well vetted, evidence informed, quote unquote alternative therapies.

Yeah. No. And I'll be honest with you, the sad part is, is we've had patients that I know probably would be alive today if we had the tools that we had today to deal with them then, you know, and we've had some I mean, just cases that broke our hearts open and people who really struggled to survive and had the means to basically do anything to survive, and that didn't pan out for them, you know.

And I want that day, I want that day when we can look at a patient and go, yeah, we got this. It's not it's done. You

know, we got this all in the bag and know it for certain because I think we're getting there, you know?

And the fact is, a lot of wonder for research is being done currently at some really big institutions. And I have some great faith that they're going to be able to bring to the marketplace some game changers.

Absolutely. Game changers. You know, and I have a you know, we know Ctca I kind of had some hope for, you know, but, you know, city Hope came in and bought those guys up.

And now they've put a lot of money into research. And even though it's a little bit of a tagline, this integrative medicine concept, at least they're using that tagline.

And I hope they dive deeper into that side of it. Yeah, yeah. And that's just it, as I think that there is, we finally are getting some of the much needed financial resources to go into some meaningful research, while the rest of us are sort of still applying it at the bedside, because, I mean, that's that's the reality at the end of the day, as you and I are like, well, if it's got evidence informed behind it, I'm comfortable using it, you know, until the research finally catches up from the evidence based, studies to have this, because that is good research, that is good science, that is good medicine as well.

And as long as it's not causing harm and it's stabilizing, supporting or enhancing somebody's outcomes, we're all in. And it's folks like you. Sean, that are just leading the way on this.

I mean, you have trained I'm sure there'll be a lot of patients that will be listening to this who have had your care in their care at some point along their life, along their journey, and they may not even realize it, because that's how prolific you are in teaching others in this arena, which I think is really powerful.

So your legacy moves on through so many clinicians and through their patients. But I'm also very excited and hopeful, like you, because you and I have been at this for a long time to see that things are, in fact, changing.

And I would like to think that you have had a very, very big hand in in that. So, Sean, thank you so much for all you do and for bringing your wisdom and your passion and your purpose to all of us.

Awesome. Thank you. Nasha