Caspar (00:00):

Kashif thank you so much for coming on the show.

Kashif (00:02):

No, it's awesome to be here.

Caspar (00:04):

Yeah. I, I really like your story when I read it, because it reminded me of my own. You're an outsider in an industry where there aren't many outsiders, right? Everyone thinks I'm a doctor, cuz I'm a medicine is like, no, no, no, that's my father. I'm just a businessman in this. And I see myself as a little bit of a disruptor and I, I could see you probably think that too, but how you got into genetics, the DNA Company is a story a little bit personal, right? Cause you struggled with some health conditions and that led you to it. Could you share that story of how you came to where you are now?

Kashif (00:38):

Yes. I came from a completely different industry. I used to sell expensive trinkets to Canada's richest people. That was my business. Like we had the records for the most valuable painting ever sold most valuable antique Patek Philippe watch. That's what I used to do. Nice. And it was in that, that my skill, what I was, what I really enjoyed doing was sort of the, the PR and marketing, like getting out there and talking to people. Right. So I started doing that for other companies and I literally built a PR firm from scratch and being entrepreneur. Like I just can't not do it. So I had to do it. Right. And we quickly became Toronto's top firm. You know, we went from the Canada's biggest companies to literal mom and pop shops. We did quite well very quickly because I thought like the entrepreneur, I didn't think like the PR graduate from school.

Kashif (01:21):

Right. So I had understood what they need, gave it to them. And it was in that journey that I got to my mid thirties, I'm 42 now. And I got sick, like really sick. I, my business partners have to drive me home cause I would be vomiting. But from migraines, eczema, psoriasis, I just didn't, I couldn't get outta bed in the morning. All the typical stuff where you go from like doctor to doctor Google, to finally to a functional doctor who might kind of figure something out, right. The root cause stuff. And it was in that, that I learned in Toronto, the greatest genomicist I believe that's alive today happened to be 10 minute drive for me. Uh, and we started diving deep into my genetics and I figured out what all these environment, nutrition and lifestyle loads were that my genetics weren't designed for. And I wasn't actually sick. I just had crossed the threshold where my body could not cope with all that load I was taking. And that's why nobody could fix it. Right. A few months later, it's all gone. And I have not been sick since I, I don't even catch a cold anymore. Forget about eczema and all that stuff. So it, it was through my personal struggle that I got here.

Caspar (02:24):

Yeah I find so many entrepreneurs do that. They struggle with something. And a lot of times it is their health because a lot of times you're just driven, right? And that drive means sometimes sleepless nights, not eating as well. Not taking care of yourself, not exercising, right. You're just jumping for one meeting to the other. And then your body says enough is enough, right? And depending on your genetics and predisposition, it'll give you something to deal with.

Kashif (02:48):

And you, you ask the typical entrepreneur who hasn't hit the wall yet. Right. They don't think sleep is a good idea. It's like, well, I'm not weak. I'm not gonna sleep extra. I need to sleep two hours. So that, that's what whos my strength. Right? They, they haven't got there and eventually everybody does. And that's when you start to self-actualize and learn what it takes to maintain what you got. Right. And that's kind of what happened to me.

Caspar (03:10):

It's a crazy societal norm, especially for like entrepreneurs and hard workers. It's like sleep when you're dead. It's like, yeah, you'll be dead really soon. Actually, if you keep that up, right, you gotta change that mentality. And I know so many Ariana Huffington and others are now changing that. And we're seeing that that is also something that can trigger genes to, to, you know, go in one way or the other. So there's so many genetic testing companies out there. It seems like a new one comes up every week. That's, you know, for your fitness, for this, for your, you know, microbiome, all of this. What sets the DNA company apart?

Kashif (03:43):

So testing, um, the reason why you're seeing so many testing companies is because the testing side of it has become very easy. Meaning I can literally call Illumina. I'll tell you the name of the manufacturer. Anybody can go, go buy the machine. It comes with the reports built in, right? Because everybody already knows this gene means this, this gene means this, this gene means this. And so that pushed everyone into the direction of what we call genetics. Meaning what does each gene tell you? The trick is, that's not the way the body works. You don't have a bunch of independent genes doing a bunch of independent things. That's like saying music is like 20 separate instruments in separate rooms. It's a symphony, you gotta put them together to hear the full the song, right? So the same thing applies to genetics. What we call functional genomics, meaning how does the body work?

Kashif (04:30):

Let's start there. What does a cardiovascular system do? Where does it fail? What's that first glimmer of the disease. And then what genes instruct getting you there, right? And it may not be the disease itself. It may be again, an environment, nutrition or lifestyle load, which is typically what it is on suboptimal genetics that leads to disease. So that's what we did. We said genetics has done a really good job of solving a really small problem, genetic conditions. Mm-hmm, I'm born with sickle cell syndrome, some rare form of autism, et cetera. They do a good job there and they're gonna find those switches to turn on and off with therapeutics and problem solved. 90% of our healthcare budget is chronic disease, which for the most part we're not born with. And so when you go to these genetic testing companies, you're talking about their websites, they literally will say, we deal with this rare form of cardiovascular disease.

Kashif (05:19):

But for the most part, part, cardiovascular is a lifestyle problem, right? So what they're saying is we don't deal with that. What they, what we've did then we did is said okay, here's the suboptimal genetics, points to 80% chance of Alzheimer's. Why did 20% not get Alzheimer's but the same suboptimal, genetics, what did they do? Cause if you're telling it's not a hundred percent, it's not like sickle cell syndrome again, but it's high probability. Why? Cuz systemwise, there's something failing. There's some suboptimal ability. Something's not wired right. But you need the load to trigger that response to make

you sick. And this is what we worked on. We literally studied 6,000 people, one by one by one, by one, to understand in all these suboptimal buckets, why did some people get sick? And why did some people not get sick? What were the choices they made? And then we understood to how to tell people what to do.

Caspar (06:10):

Isn't there an infinite number of choices though? Like if I'm gonna play devil's advocate, I'm gonna say, you know, and being in medicine, I know this because the days of generalized protocols are completely gone and understanding that one person went down one road and used exactly this type of treatment. It won't work on the next person either. And then you have however many billion there are people on earth having their own, you know, personalized plan that of course I can understand you could peak to under the hood to see what the genetics are showing, but then the choices, every single little one, how, how do you address that?

Kashif (06:44):

That was, that was our biggest fear was in our early days, we were highly clinical and high touch, meaning that we never believed that we were gonna scale this out to everybody. We thought that this is more, we're gonna reach more people by charging more money. How else can you, we're gonna, cause we have to train people to think like us, which is very difficult, et cetera. Right? So that's what we work with. Professional athletes, celebrities, executives, because that's, who could afford to pay for that expensive high touch scientific experience. What we started to see, which we didn't anticipate was that there was trends in the suboptimal profiles. So if I give you an example, one of the things I would say where we had the biggest sort of impact is female hormone health. Partly because the experience sucks so bad right now in medicine it's it's like, it's your hormones.

Kashif (07:31):

You're supposed to have problems, right? It's that's the kind of narrative. So we're going this delta value of this. Some something that's so bad to like we can fix it. Um, so in there, we, after going through a few hundred women, we started to see that they always fit in one of six buckets genetically. And we didn't know we were gonna find that and genetics doesn't preach this. Right? Cause genetics looks at the gene. It doesn't look at the system or the person. So when it comes to hormone dominance, are you estrogen dominant? Are you testosterone or androgen dominant when it comes to estrogen toxicity, which is a root cause of so many female hormone diseases, when it comes to toxic clearance, what do you now do with this toxic metabolite? With all those possible outcomes in that cascade, women fall into one of six buckets.

Kashif (08:17):

Every single time, the middle two don't need anything, cuz they're optimal. The outside four needs something, but the they're the same thing. Just one needs a more extreme version of the same therapeutic because they have the same problem. This one just has a more exaggerated version of that problem. So we went from literally, we have a lab in our office and the middle of our office where we're custom compounding nutraceuticals for people to the pill, to the dose, to work on their genetic expression, to understand how do we actually solve this problem at the root cause level. We now have two products for this female hormone issue one on this end one on this end and you need two pills. You need one pill. But we only learned that unintentionally by going through 3000 women, right? And now that has been done for all these various, uh, conditions. We built a AI that can now populate the reports

and speak to the problem as opposed to the genes. So you understand for anxiety, weight, loss, carb metabolizing, you know, uh, acne, whatever you name, all the big stuff. How do you rank genetically? Why are we saying this to you? And then what do you do about it? That's how we now talk.

Caspar (09:25):

Yeah. And I think in, in when people look at personalization, they have to understand also that there are patterns and particles in it. Yeah. Right. So, so when you have these pattern and you have the six buckets that are the patterns, you can then, you know, address those and, and even go further with the particles, but the patterns are essential as well. And, and that, that kind of shows us a lot of where you are generally predisposed to go based on your genetics too, which is something I understand that everyone's gonna get a different treatment at our clinic, but there are definitely patterns for people with different diagnoses.

Kashif (09:57):

Sure. And you start to see that where, you know, some, everyone has their sort of niche and this is what I do. I deal with Hashimotos or here's my protocol or whatever. And it still only works on seven out of 10 people. Right. Right. You're doing a better job than the general primary primary care practitioner that doesn't understand Hashimotos as an example, but how do you then take it to 10 or outta 10. So, and that's where you're saying that those patterns, those sort of profiles or personas, it's the same thing clinicians do. Now you ask, ask a bunch of questions, try to understand and measure. And this sounds like this thing, let me give you this. We can now do that genetically. I can look at a woman or a man and now assume they're genetics based on their body type, based on their hair, based on their skin, based on their behavior and how they move and how their eyes move. We've understood the traits. It's just another way of looking at medicine. It's more personalized.

Caspar (10:47):

Yeah. And speak, speaking of medicine, you know, how has this been accepted by doctors and, and the medical field altogether? Because I know some people are, gungho like, they will just look at your 23 and me and make your whole treatment program based off just that they don't wanna see anything else. And it seems a little bit to one side, whereas others don't want you even mentioning anything about genetics because they're so into understanding, epigenetics are just environment is everything. So what has been the reception so far from the medical field to the DNA company your tests?

Kashif (11:18):

So I understand both of those perspectives and they're both right for the kind of wrong reasons. And I'll explain both and what our experience has been entertaining I would say, meaning that, you know, we'll go to a conference and we're so as an example, right near us, there's a university where that evidence based model that we talk about, it was actually created there at McMaster university. So they actually created how we now practice, like what does the FDA approve that was done here. Right? So we went to a conference there where there was 400, uh, chronic pain specialists. Right. Different, but MDs of different sorts that dealt with chronic pain and we went in there and they said, okay, now we're gonna look at genetics. The first 10 minutes was just like, you know, literally trying to boo us off stage <laugh> by the, yeah.

Kashif (12:09):

By the time we were done, they do this thing where they poll all the attendees to find out what content they like. So they know what to bring into next year's conference. We were ranked the best talk they've ever had in the history of their conference. Wow. Right. Cause for the first time they understood why pain happens, not how do you mask it? How do you go three peel that onion 3, 4, 5 layers more and deal with that root. Cause they started saying, oh, it's that easy. I can just test for this and this. And now understand that five people that have the exact same traumatic accident are gonna have five different outcomes. And now we can figure out why. Right. So it, it, and I've had that experience in this sort of allopathic conventional medical world, which it starts off like, oh sure me, the study show me the this.

Kashif (12:55):

But when we get into the biochemistry that they recognize and say, here's the piece you didn't know, then they're like, how do I do this? I need this in practice. Right? Yeah. It's, it's slightly different in functional medicine where they're out there. Like you said, looking for it. They want it, they need it. But they're disappointed by what they've had to date, meaning the general SNP test, the genetic test I was to talking about, they're taking a thing that gave us this promise of I'm gonna decode your genetics and teach you everything about yourself and keep you healthy. But the tool doesn't actually do that. It scans your genes and only kind of looks at probability for genetic conditions. It doesn't tell you why you would be born healthy and eventually get type two diabetes and why that's different for different people. Right? So, um, that now as we go again to places to speak to functional medicine, integrative doctors, their, their minds are being blown. And they're immediately saying, we need to they're like you said, building programs on the foundation of the genomic findings they now have. Right. So that's, that's what we found.

Caspar (13:55):

Yeah. So let's talk about that a little bit, because you know, as you said, most of the problems we see there, and then throughout medicine are chronic disease sometimes considered preventable disease. Yep. And therefore, if you say it's preventable, a lot of people say, well, then it isn't genetics, which some doctors have blamed and basically it's their go-to in conventional, a lot of patients will say this. It's like, we don't know why this happened. It's just your genes just live with it. Here's a pill. You'll take it for the rest of your life. Hopefully, you know, symptoms, won't get too bad. You'll die, you know, someday. And that's it. Yeah. And that's the end of the story there. And you just say, oh, it's my genes; sucks for me. Right. Yeah. And then you have the other side again that says, Hey, like everything is environment. It's all, all about epigenetics and understanding that. How, how do you play into that and understand where, where does this play a role in preventable chronic disease?

Kashif (14:45):

So the, the best way to speak to that is like literally my own personal example. Right. Cause I, I went through that exact same dilemma of, okay, so I'm told that I'm brown. So I have a genetic pre predisposition to heart disease. Right. I live in Mississauga, which is a suburb of Toronto and it's a very brown city, Indian, Pakistani, Bangladeshi. Right. Uh, we have the biggest heart center in Canada. And we're told it's cuz that's where all the brown people live. So you need it. <laugh>. So when you look at the genetics of it, we actually have really good hearts. There's nothing wrong with the heart. So it doesn't, so there's no direct, this gene equals a bad heart, but it is true that over and over and over again, that hospital is full of brown people with heart problems. Right? So there's some genetic thing that's it must be genetic because all your kids get it, all your uncles have it.

Kashif (15:34):

Right. So what's actually happening. So that's the first part of the pie that the genetic speaks to it. But now the functional medicine doctor say, no, there's more what's, what's the epigenetic what's, what's the trigger. So now you have to look at not literally measuring epigenetics, meaning looking at a blood biomarker, but what are the loads on the suboptimal genetics? So use me as an example. So as a south Asian mix, like Pakistani, Afghani, Indian, Persian, mut background, uh, I have a suboptimal version of the endothelial lining. So the, in the arteries around the heart, the inner lining, I have a not so good version. So it's more prone to inflammation. Doesn't mean I'm sick. I could ha live somewhere, beautiful life on a beach somewhere, never be sick. Right. I live in Toronto, breathe in pollution. A lot of stress. I don't sleep properly.

Kashif (16:21):

There's a reason why I might get inflamed here. Right? So that's the trigger, the load. I still doesn't mean I have a heart disease. Now layer on top of that, that of the main genes that instruct glutathionization, your detox systems, binding toxins in the blood, sending them to liver to metabolize. I am literally missing two of them. Forget about what version of the gene or what SNP, what variant, I don't even have the gene. Right? And that you won't find that in your consumer testing, it's called, what's called a copy number variation. It's in a whole other test you have to run, right? So I'm, I'm literally missing those gene. So as I go golfing and breathing pesticides, as I go running downtown and I breathe in pollution as I go eat, uh, you know, food in a rush at a food court and I eat, you know, drying agents on bread and pesticides on the vegetables, et cetera.

Kashif (17:13):

I can't clear this stuff genetically. So now it's in my system and it's free flowing in the bloodstream and it's causing damage abrasions to this endothelial lining that was never designed to deal with toxic insults in the first place. And I had the weak version. Right? Mm-hmm. So now what happens when you have inflammation here, all of a sudden your body starts to deploy cholesterol to reduce the inflammation. That's the response. And that's the beginnings of cholesterolemia the disease that gets sort of suppressed. So now for some people, it doesn't, again, lead, it doesn't stop there that it could end there where you just have this kind of elevated level, but you're not being treated for me and my, you know, brown brethren, right? We also don't deal with the inflammatory load well, because our ancestors didn't eat beef. They ate goat, lamb sheep.

Kashif (18:03):

So the B12 that we're getting from the beef that we now eat is our primary meat we don't even metabolize in our guts. We don't have the genes to instruct. And when I go take a B12 pill, how many I call it Hindu vegetarians are told by their doctors, you don't eat meat so take B12. Well guess what? I take it. And I pee it out. I, I can only take, what's called a pre methylated, which, you know, under the tongue sublingual or an IV. So that one thing, you know, all of this stuff I talked about, okay, bad endothelial, not able to detox, inflammatory load, even then it doesn't mean I did get sick, cuz my body should be able to fight the inflammation. I can't fight the fight because I I'm not using the B12 that's in my environment. All I did was I started taking a sublingual B12 and adenosyl as opposed to a methylcolabamin, like a very specific version.

Kashif (18:52):

And I felt different. Like my brain was sharper, these kind of aches and pains I didn't even realize I had, were gone. Didn't need much sleep, et cetera. I have a, of course I'm also supporting the detox. Cuz

what happens is when toxins meet the cholesterol, cholesterol hardens and gets deposited. And that's when it, that lipid transport process becomes more difficult. And that's the beginnings of that blockage that leads to a heart attack. So there's no genetic bad heart in any of us, right? There's four or five systems that are intersecting in one place that if you do all of these things wrong, that's why it takes until the age of 50 before you're actually sick, cause you have to do it for that long. Right? Your body's resilient to a fight, but eventually you're gonna cross that cross, that threshold where you can't cope anymore. And that's why people end up in the hospital heart, 50% of Americans are expected to have some kind of heart disease, right. It's it's mostly rooted in this poor endothelial, the wrong environmental nutrition, lifestyle loads. Uh, and then the inability to clear those loads. It's that combination, right?

Caspar (19:57):

Yeah. And it's crazy how medicine just, you know, points to genes and then just forgets about it. Like those are your genes, go on the pill, don't worry about everything you just said like that. That's not part of what we're, you know, trained to do. Yeah. And, and I do know a lot of doctors that see genetic testing in a way of instilling fear into patients, right? So let's say you have the BRCA snippet, which we all became familiar with Angelina Jolene and her mastectomy, you know, as a way of preventing. Whereas I I've seen, you know, recent studies and research telling its uh, 10% increase risk of breast cancer as opposed to 80 or what it was. The data is always changing. Yeah. But sometimes you can make the case that if you get a, a genetic test back and you see, there are these things that are, Hey BRCA, I have this wrong, I have this off, you know, you start to put the fear and the belief that you will get the disease.

Kashif (20:48):

And the, that the BRCA conversation drives us crazy. Yeah. And I'll tell you why. I literally, we were at this conference in Scottsdale about three, four weeks ago. And we spoke about this and women in the audience were literally crying. Wow. Because they have family members who got mastectomies, done who for the, the first time they now heard, why do things happen? Right. So the clinician who says BRCA red flag, four letter word, cut it off, ask them why mm-hmm. What is this gonna do to me? They don't know. Right. What they know is that there's studies that prove that there's a 10, 20, 80% elevated risk breast cancer. What is actually going on in biochemistry? That question isn't asked. So what is actually going on? Let's that's a perfect example of genetics versus functional genomics. Genetics says, if you have the wrong version of the BRCA gene, you're likely gonna get breast cancer prevent by cutting off your breasts, right.

Kashif (21:45):

Or whatever. Some functional doctor may have more advice in that. But that's typically the advice. So what's actually going on the BRCA gene is a gene editing gene, doesn't doesn't cause cancer. What it does. It's a re it's a repair tool that goes around trying to fix other broken genes. If it's not working properly, it's not doing its job of fixing other genes. So it doesn't cause cancer. There's something else, upstream or round stream. That's not working properly. Right. Or maybe overworking that isn't being brought back to sort of this homeostasis optimal level because BRCA is not doing his job. Those are the things we, where we need to start asking the questions what's going on. Cause if you could treat that you can prevent the breast cancer. So I'll give you an example. We talked about hormone dominance. So if you have a woman that is estrogen dominant, meaning in her genetic cascade, she takes progesterone, converts it to testosterone and then to estrogen, which is what all men and women do.

Kashif (22:41):

Some women do that a lot faster, more testosterone, more estrogen. So say she's estrogen dominance. She just produces a lot of estrogen. Say in her monthly cycle, she converts that into estrogen, uh, toxicity. There's two, four or 16 hydroxyestrogen two is nice and clean. Four and 16 are toxic. Some women produce four and 16. So now that's the second layer. Say that same woman is producing either four or 16 and to a high degree, she's estrogen dominant and she doesn't have the, the right detox clearance. So she's not getting rid of that stuff. So it's, it's in the system, right? So during the men cell cycle, it's not so bad because you clear it every month. There's some residual, you know, but for the most part, you're getting rid of it. This is why most breast cancer we see happens in around the menopause age.

Kashif (23:31):

If you really think about it, it's around that time. Cuz that's the time where that woman that's been producing this toxic metabolite that was most likely on their birth control pill for a long time as a you north American 85% chance. She was taking the birth control pill for a long time, which is more estrogen, more metabolite, right? She may be taking hormone replacement therapy, more estrogen, more hormone metabolite. And at the menopausal age, she no longer has a cycle to get rid of it. So what does the body do with this excess toxicity? It stores it in and fatty tissue to keep you safe. Where do women have fatty tissue? In the breasts. Right? What starts to happen when you have this high level of toxic insult next to all this, the glands and everything that were never designed to deal with that.

Kashif (24:18):

And then all the genes go to work, trying to do things and your BRCA isn't working properly to help repair and fix it up. That's the, your recipe for breast cancer. BRCA was like the last thing you know, on that. It's like, okay, now that something's truly damaged, I gotta go fix it. But I'm lazy and I don't work. So I'm not gonna fix it. Right. All of other stuff, it could have been as simple as don't take the birth control pill or take some kind of, uh, supplement to help you clear, right. Or the right hormone therapy. That's reducing your estrogen domaninace and estrogen toxicty. That's the actual cause this was more the bandaid, the BRCA. Right? So that when you ask a simple question, well, why does BRCA have this? That's the answer? Well that's one, there's there's other answers also. That's one of them. Now all of a sudden mastectomy isn't necessary. I think the only solution, right. There's other, so that are all gonna, they're also gonna fix other things, fibromyalgia, crazy menopause, you know, brain fog, joint pain, this estrogen toxicity leads to so much other stuff. Right. So that's the way we think about genetics.

Caspar (25:19):

Yeah. And why is such a powerful question when it comes to health and medicine that people just don't ask enough? And I, I, I think in it's it's a valid question to ask any practitioner, any doctor is to why do I have this condition? Yeah. It's not that I have, everyone's looking for the diagnosis. And then it's like, okay, we got the holy grail of it. We'll just put you on treatment plan for diagnosis X, but no one really stops to ask, well, why do I have this? Is it really my genetic? Is it other things going on? What's going on that led to this. And I think that's what you're learning is the why lets you understand a lot more about yourself and that's exactly what you guys are trying to do. Give you insight to yourself that you didn't have. So you could use that to empower yourself, not to live in fear, like many do, to say, oh the BRCA suddenly correlate that with cancer and my life's over, you know, and go into fear.

Caspar (26:10):

It's BR okay. I have to do certain things that can empower me. So I won't face that in the future. Yeah. But I, I do know a lot of this rests on data, on research and it's, it's evolving, it's changing. I mean, there's so much to learn with in genetics, DNA. Um, how are you staying on top of that? Cause I, as I understand you don't sell data and compare to other companies and kind of, you know, as the pool grows, you learn more and data comes out more, right? That's part of what this is. How are you guys staying on top of that?

Kashif (26:41):

So we're our business. If, if I had to say what, like, what do we do in one word is interpretation. That's what we do. Right? We don't solve any particular problem. We don't make a test. We do, although we do all that, we have reports and tests, but what we truly do is interpret better, right? So we follow all the publications. We are constantly on pubmed and you know, pulling things and learning things and tracking our science team is always saying, Hey, look at this new publication about whatever, right? We then reinterpret that thing to make it actionable, to take it away from a, a genetic causation of, well, it looks like this gene may be causing something. We then start to look at the biochemistry. That's wrapped around that and start to unpack what's going on. You know, simple thing like going back to estrogen toxicity that it's so much more prevalent in women.

Kashif (27:28):

We found a publication that it's an, it's an epidemic in Canada by the way, Lyme disease right now. And I know on the east coast, the US is a big problem. Huge. Uh, so there's this thing that came out that it's so much more prevalent in women. So that's where we start with. Here's the publication, the evidence of something. Now we're gonna figure out what's going on. And what did we figure out is that 30% of these women are being misdiagnosed. They don't even have Lyme disease. They're estrogen toxic and the symptoms are all the same, but there's nothing in the toolkit that points to estrogen toxicity. They're not looking for them. So you, and it's not the clinicians fault, right? The clinicians, here's your bag of solutions. You have to ask questions to pick out which solution to pick, right? And, and this is your you're limited to this bag. So all of a sudden Lyme disease is the only one that fit. So that that's the way we think. We, we, we pull the publications almost daily and we just try and reinterpret the way the body actually works. Then look at what genetics instruct all that stuff. And then all of a sudden we have a new solution for a problem.

Caspar (28:31):

So when you're finding these solutions and I know you guys have health coaches that are available to you also help interpret that what's the extent of involvement in that person's journey to, to health. And how are you working to, to work alongside maybe doctors that don't have this insight yet, or don't speak the language or understand quite, you know, how to interpret this?

Kashif (28:52):

I think the, the doctor part to us was the most important, uh, because what we, so, I personally, in March of this year spent the month talking to 60 functional doctors, one by one by one to ask, not to say, Hey, we have something great. Do you wanna buy it? But to ask them, why does genetics suck? Right? What's your problem? What, what, what do you want from this? And what, what did you expect? What was the experience? The key thing it all came, kept coming back to is make it easy, right? Easy to learn, easy to use. I don't need training. My staff doesn't need to spend their time, all of that stuff,

which I agree if, and this is partly why genetics hasn't sort of, uh, supported clinical work enough other than the genetic conditions, which are just a straight diagnosis because the interpretation was difficult.

Kashif (29:45):

A genetic testing company would give you a genetic report. Here's your results. But if I didn't have the computer up here to understand the algorithm like our team does, then it, it wasn't actionable. It wasn't useful. And all of a sudden it was very underwhelming experience for the patient. So that's where we said that we gotta get away from the genetics. That's what powers our insights. We gotta speak to conditions. That's how clinicians think, right? Give me a lab report that tells me yes or no. And if it's what to do about it even better. So that's what we did. We built the AI an artificial intelligence platform and our science team sat the, and every, this, the 6,000 people I talked about that we studied. We took the insights from those and plugged every single one in. And now all of a sudden our reports don't speak to here's your list of genes.

Kashif (30:35):

We now have to train clinician how to use this thing. We're saying you literally on day one, if you have some basic level experience, you can just read this document and sound like an expert. Right? The other thing we did is we created what we call a cheat sheet, where to the consumer, we don't provide them clinical level guidance because there's no clinician in between. We give them, you know, sleep, lifestyle, exercise, diet, cardiovascular, some general stuff. Uh, but we're not saying we're kind of diagnosing you with fibromyalgia or we see breast cancer coming. We, we leave that to the clinicians. But for that, we created another algorithm, another AI that populates a clinical version, which goes straight to here's their red flags. Here's what we recommend for supplementation and even medication sometimes. And here's a lifestyle and environment recommendations. Cause here's a load that would've caused the problem or could contribute.

Kashif (31:29):

Right? So all of a sudden we, we do have training. We have a course that people like to take just for their own benefit, but you don't need it anymore. And that was the key to the consumer. I would say it's a little bit of the same where the reports are self navigable. Like you, if you have the document in front of you and you want to effect change while we hired Dr. BJ Fogg, who who's the head of the Stanford University, behavioral change lab to say, what are your insights? Here's the genetics, here's the problem? How do we get people to actually change your behaviors, to implement this stuff? So he built that into the reports, very simple, easy ways to take tiny steps towards behavior change. Last layer to that. A lot of people need support and it's not support of I'm going to the doctor twice a year.

Kashif (32:13):

And then in between, there's no one for me to talk to. This is where we think health coach for behavior change. You need health coaching, cuz you need accountability, someone to text and call somebody, calling you once a week, a regular ongoing appointment where there's homework and you know, you have to get it done, right? That's how we found this sweet spot of a certain number of weeks where we can actually get someone to identify the red flag, figure out how to work on it, you know, kind of change their identity and come out of it, a new person, like they believe that this is what they always used to do. Right? And that's how you deal with not masking a symptom with a pill, but changing the behavior. So you're no longer on the path to that disease or condition. You're avoiding it now. That's what we do.

Caspar (32:57):

Yeah. Incredibly interesting. Because as we know, behavior is, is so important to lead you back into a healthy state. And it's not just providing information. I think we have an abundance of information out there almost too much for many people and there's overwhelm, but they're not changing their behaviors based on information. So I think is incredibly important. Now thinking about epigenetics and understanding that, field that side of the coin. Yeah. How consistent are results in a single person across let's say weeks or even months or years, do the results vary based on lifestyle changes after, uh, or altering a person's genotype?

Kashif (33:35):

Yeah. Uh, one thing we find is, uh, and we, it took us time to realize this. So one of the things we did really well is decoded this: mood and behavior. So all the neuro, if I have your DNA, I don't ever need to speak to you to tell you your personality, how you deal with stress, emotion, trauma. Are you irritable? Do you procrastinate? Are you flaky? Are you, do you like skydiving? We know all of that about you from the way your neuro chemicals are processed. Right? So what we started to find again, after doing this hand, holding patients for some time that the, the variance in outcome was based on the cognitive profile, how did they even perceive what we were telling them to do? Right? And there's some people for whom. Now we know when we go talk to them, the first 10 minutes is them gonna be like, this is all wrong.

Kashif (34:30):

These guys don't know what they're doing. And they're gonna find the one tiny thing that just seems 2% off and that's all they're gonna focus on. Right? Then there's people that are just so highly reward seeking that they're gonna overdo it, right? They're gonna throw all their food in the garbage and the family's not allowed to buy candy anymore. And a, you know, like and everything in between. So I would say the thing that we identify that for the most part, when it comes to a condition and a genotype profile, the outcome is the same. If we know what to do about it, right. There's just a different starting point. And some people may much more farther down the path. Some people are starting earlier. That's the difference. The key difference in outcome is here. And we've now learned how to deal with that, which is also something we teach clinicians. You may want to deliver the information in this way. You may want to give it to them staggered or just give it all. They just want it all so they can read it and digest it, digest it. This guy just wants the bullet points. You know, we've, we've learned all that about how people work and now the outcomes are much more, uh, sort of even, and, and effective.

Caspar (35:29):

I'm really interested to know your expert opinion. And based on the data you've seen, do you feel we differ as humans more based on the gender, race, ethnicity, uh, even age let's say, or is it more so environment? Is there a split in that? Do you see one side or the other, how we differ?

Kashif (35:47):

Usually we see both. So, um, so I'll give you an ethnicity example. So insulin response, uh, everyone knows that it's a major cause of a lot of things. Diabetes is the, the primary, but a lot of inflammatory load. And the key thing is manage your starches and your sugars, right? But guess what? For south Asians, myself included, we had the same insulin response from saturated fat, which Western Europeans don't. So if I go on a keto diet, keto diet, I'm gonna feel amazing for the first month because you know, you're all the starch and carbs outta the system, but then all of a sudden my insulin's gonna start going

crazy. Why I don't, you know, I'm not, uh, eating any sugar, right? And on top of that, if you're a slow fat metabolizer, which a lot of south Asians are, all of a sudden, you're converting that excess fat into sugar, which is what you do when you have too much fat.

Kashif (36:45):

So I'm gonna get a double whammy insulin spike, and it's a, it is misunderstood. Like, Nope, this is great for you. So that's a simple nuance where it only happens for one ethnicity, actually two it's, some, some Eastern Asians also, right. Then you have as an example. Um, so, uh, APOE deals with lipid transport, your ability to, and it's known as like a, a gene that's highly implicit in Alzheimer's dementia, uh, stroke because of the blood brain barrier and your ability to transport and clear and, uh, you know, dealing with mutated proteins, making sure they don't cross their blood brain barrier.

Kashif (37:24):

The same result, that is the good version for a Western European is actually a bad version for an Asian. And if you were to take your standard genetic test, every Asian would be told you got the good version of the gene. Well guess what? They didn't, they cuz it, when you combine the other stuff that's going on, it's actually the bad version for them. So there's, there's some phenomenal like that in nuances, which we started documenting for various things, then epigenetically, it's kind of like mismatched to environments. So if you take going back to the Asian example for centuries, it didn't matter where you were. If you were in China, you sat down anywhere, you were given green tea, right? School, home work, friend, whatever green tree, green tea, all day long. So when we study, uh, Chinese people, for the most part, their detox pathways are horrible, cuz they didn't need it.

Kashif (38:13):

Cuz they were getting EGCG from the green tea that really potent antioxidant. So when you talk about epigenetics, all of a sudden remove that genetic expression of I have a constant flow of EGCG, which is promoting glutathione and you know, detox and clearance and et cetera, remove that genetic expression, which is caused by that ingredient. And all of a sudden they they're just not doing it anymore. And why is, why are all these chronic conditions that didn't exist two generations ago in China, highly rampant now like breast cancer, for example, through the roof in China, didn't exist two generations ago. Right? So that's where the expression, if you're talking about like ethnic diversity it's um, it's kind of like taking your ancestral, whatever you were designed for you are, you are inheriting your genetic legacy of your ancestors. You are designed to do what they did. And if you're now doing something completely different, there's gonna be friction. Right. And you can very easily determine what that is by again, learning through your DNA, what you're supposed to do and all of a sudden you're healthy, right? So that's, that's been a big one for us in terms of, and that that's partly why we purposely headquartered ourselves in Toronto, cause it's such a ethnic diverse city. Um, and um, so, and we've done a lot of work with you name the age, sex, race, whatever we've done it all. So.

Caspar (39:35):

With that, do you feel diet should be based more on your background and genetics than let's just say a popular diet like keto or you know, paleo, because you find people that, you know, have great results on a specific diet that's the fad right now. And they lose weight and everything and the others don't and I've always seen, well, it really depends on who you are of course. And what your background is. So do you feel that's the main determinant and how you should eat your, genetics?

Kashif (40:04):

I would say the lowest hanging fruit in terms of outcome from genetic testing is what you're supposed to eat. The easiest you're gonna eat. Anyway, you might as well eat what you're supposed to eat. Right? That's easiest shift to make. Uh, and yes. So keto diet, paleo diet, vegan. Well guess what? There's a gene that determines how well you produce the enzymes to break down vegan proteins like beans, lentil legumes. We have a clinician. Uh, she is in, uh, I think California somewhere and she became a vegan two years ago. Uh, she's been sick ever since she felt amazing. And this is typically what happens when you focus on a diet in general, you're probably also exercising. You're probably also eating a little less. You're probably not drinking the can of Coke because you've just made that shift towards health, right? So you're doing everything a little bit better and everybody feels is great in the first month, regardless if it's matched to you or not, even as a keto diet, if you're not a fat metabolizer, you actually will feel good in the first month.

Kashif (41:05):

It's a second, third, fourth month where you start to feel like crap, right? If you're doing things wrong. So this lady two years, she's thyroid problem, mental health issues, anxiety, all this stuff. We brought it all back to her vegan food. So I'm not saying vegan diet is bad for some people it's amazing. And we can tell you who you are right for her. It was horrible. It was horrible, horrible, but she had the worst version of the genes that break down chickpeas, lentils beans, legumes, which is where she was getting all her protein from. She also had the poor and suboptimal gut lining genetically the ability to sort of detoxify. So she was getting all this irritable bowel type symptomology. It was, it was the compound effect of both of these things, right? So we switched her and she's a keep in mind, she's a doctor that sells our tests and she wanted to learn through the test why she wasn't feeling.

Kashif (41:51):

That was the thing we said, this is it. This is literally what you need to change. There's other stuff we can talk about, but do this one thing. It's like 80% of your problem. She feels amazing now. Right? Same thing on the keto diet. There's whether it's keto, whether it's, you know, low carb, there's some people that just do better on carbs. It doesn't make any sense, but they have the optimal insulin response, optimal carb metabolization. They turn into fuel and glucose really well and they thrive on it and they may be fat, bad fat metabolizer. So they don't, they just, they die on a keto diet. Right. So this is where you know. Genetics can really tell you what you're wired to do. And it, it it's truly, I see that the number one sort of fix that people get into first.

Caspar (42:36):

Now do, would you recommend people get multiple genetic testing and, and let me just throw one out there because I wouldn't say like 23 and me versus DNA company, but what about the DNA company, your results along with a Viome microbiome test to really, if you really wanna get a good understanding of like gut health or just what you should eat, would you say those two would work together or would it be a little bit, you know, oh, I'm not really understanding one says one. The other says something else.

Kashif (43:04):

You're gonna get a little bit of that. But what we, we do believe that the other half of personalization is the gut microbiome. Mm-hmm. So DNA is your cellular function. What is your body wired? Your change, your instruction manual, literally, right? Your gut is your immune system, your gut brain connection. Like it's so much, if you understood these two, you understand chronic disease, right? The root cause for an

individual. What we're finding with, uh, the gut, the concept is needed. It's a bit early in terms of interpretation, the keyword again, and even myself, I've had the Viome map for a while and my results have changed multiple times because they're learning. Right. Mm-hmm. So I just think it's a bit early. There are some gut tests you can do, which again, just like a genetic test, a test for specific condition, there's some gut tests you can do that. Look for candida or really specific things. And, and they're highly accurate. Mm-hmm. The overarching like let's and understand from our gut, how we prevent disease in theory, it's the right thing to do. I don't think the data's there yet. They're getting there and I would bank that Viome's probably gonna be the first one to get there, you know? So, um, we're watching it and I believe one day these two will sort of, there'll be a singularity and you have to have both. And there's your personalized medicine path.

Caspar (44:22):

Yeah. It's really interest. I'm sure Naveen and Momo and everyone over there are really happy. You just said that because I mean, I do think if you think about it, you have your genes, of course, that are yours. And you wanna know about who you are, what, what was passed down to you, what your inclinations are, your, your kind of pros and cons of your coding and informational structure. And then you have this whole other, you know, society within you basically of, you know, your gut microbiome and there's so is so many different, uh, you know, forms of DNA in that itself.

Kashif (44:54):

Yes. There's more, more DNA, more foreign DNA in your body than your own. Right?

Caspar (44:58):

Right. We, we forget that. We forget we are human earths basically that have other civilizations within us they're constantly changing. And, and that kind of creates the health just as I believe we create health on earth based off our own health. So it's like, you know, macro micro, all that. Um, so it's, it's, it's really, I, I find it an amazing tool. Now, what are the limitations you're seeing where we are right now with this? Because it sounds all wonderful, but it does seem like it's still early. As you said, even with the microbiome testing, what, what are the limit you are seeing and trying to address right now with, with DNA testing?

Kashif (45:36):

Uh, I think that, uh, the genetic therapeutics are that's the frontier that needs work. Mm-hmm. And, and, and I'm not saying in terms of see, when, when we do is health coaching, what we're understand why diabetes happens, why cholesterolemia happens, why breast cancer happens, and it's kind of coaching away from those behaviors. Uh, and if you are already sick, it's reversing the disease. But when it comes to the hardcore genetic conditions, there's a lot of companies doing a lot of good work on building therapeutics for those conditions. We have a few of them we're not there yet. I think CRISPR is gonna be a big one in terms of like gene editing. Like, for example, going back to the one I said again, sickle cell, right? If we could just splice that out of the gene and replace it with a good version, you don't have the disease anymore, in theory.

Kashif (46:24):

And it made it work at a Petri dish. It's a, how do you, now that translate that into the human body where the body adopts it from head to toe. So Goldman Sach, so the entire healthcare industry in North America, or, sorry, the US is 4 trillion dollars, the Goldman Sachs put on a report, I think last year saying

that the coming genetic therapeutics, industry on its own is projected to be 4.8 trillion by 2030, so bigger than the entire healthcare industry, because it's so precise. If all of a sudden you can take something that alters your genes to absolutely get rid of the disease as a possibility, why are you waiting for the disease to get sick and then treat it? I'm sure it's not gonna be cheap on day one, but it's, it's it, that's where that's the direction things are going.

Caspar (47:11):

Hmm. Now speaking of the way things are and where we are right now, I I'd wanna ask you this because I get asked this a lot. You know, speaking of COVID the virus itself, mRNA technology and vaccines, have you seen any changes on your end, in the data we're seeing in just DNA genetics based on, on any of these factors so far?

Kashif (47:34):

So the, I mean, the work we did there was more in terms of the, the severe response. So COVID the virus exists. I mean, we can get into another hour discussion about why it exists, right? There's lots of opinion, but the, the fact that there's something out there that makes people sick check, that's true. Right? What happens when someone's in the hospital? Is, are they there being treated for COVID? No they're being treated for respiratory inflammation or cardiac inflammation. Those are the two things where if you cross this threshold where you can't cope, you need acute care. Right? So, um, what we learned and this happened very early days, like March 2020, everything shut down by April. We were already speaking on podcasts about this, that we think we understand why certain people go to the hospital and some people walk around with no symptoms. Mm-hmm.

Kashif (48:28):

And we, we actually, uh, queried our own customers because we already had their DNA to find out of those people who actually got sick. And then we gave them the right supplementation. How did they do et cetera? So we understand who's already at risk of respiratory cardiac inflammation, regardless of the trigger, COVID is the trigger, COVID is the thing that, again, pushes you pass your threshold where you're no longer cope and now you're sick and now you need to go to the hospital cause you can't breathe or your heart's failing. So this is why there, I don't know what the exact number is. I was listening to a podcast the other day, it was something like 96 or 98% of deaths or with a comorbidity, you know? Right. So it's, it's the comorbidity that, that is unfortunately puts you into the ICU. Yeah. But it's true. That COVID is a highly aggressive trigger that gets you there.

Kashif (49:14):

So if we understand that and we can identify genetically who all these people are that have greater risk of severity, we could potentially mitigate and reduce that system failure, where all of a sudden you're better cope. So a 20 year old person with a that same cardiovascular suboptimal profile and a 60 year old person with the same suboptimal cardiovascular profile are not gonna have the same outcome because they haven't had the same load. They've had 20 years of exposure. This person's had 60 years. So they're already at the tipping point, right? This person can probably handle a lot more. So that's the work we did. Uh, we actually worked with IBM to help build this like AI platform where you could query and, you know, look at your body type and stuff and try and understand better what your risks are. Um, the, at that time almost immediately, the narrative became, we need a vaccine, which is true.

Kashif (50:12):

If you have a viral, you know, thing that there's, okay, we need some kind of, uh, sort of, um, end, end game to it. Like, how do we get rid of this thing? So the work we did, we did with a lot of executives, a lot of athletes, a lot of people that were sort of paying for service, we'd never pushed to get it into sort of mainstream healthcare. Cause we could see the friction, right. But even today, people are coming to us for this type of work.

Caspar (50:37):

Would you then recommend a vaccine based on genetic profile?

Kashif (50:41):

Uh, so if we look at, first of all, there's hardly any time has past to see what the outcome is, but if you look at past problems and what the problems have been, um, we look again going back to glutathionization, methylation anti-inflammatory response, uh, the cardiovascular responses happening in some young men.

Kashif (51:03):

And being able to predict who those people are. Right. Who's gonna have the, the documented cases of what the negative outcomes have been, as opposed to the vaccine causes this. It's the vaccine does something that your body wasn't ready to handle, which then takes you over the threshold. Same thing as we talked about COVID and I'll, I'll give you example this whole, uh, sort of debate over do vaccines cause autism, right? There's certain states where I know a doctor in California who just advised a parent to spread the vaccines out and lost his license. Hmm. Right. For just not saying don't take it, but just spread them out. Right. Mm-hmm. So pharma companies are right. That they've tested the active molecule in every way, and it doesn't do anything wrong other than treat that, that whatever it's meant to treat. But the parents are also right.

Kashif (51:54):

That that's the day my kid changed. Right. They took all this stuff and they've never been the same and they were fine before. So what happened? What happened is in that serum, there's heavy metals and other things, you know, the adjuvant that's with that delivers it. And if you have no Glutathionization pathway like myself, and you're given four or five of these things at the same time, when you're three years old and you're neurologically so underdeveloped, right. Then all of a sudden these free flowing chemicals and toxins and insults are in your blood wreaking havoc to your cellular structure, that you may not have the detox ability to clear and may not have the methylation response to reduce the inflammatory response you're getting, which leads to neural inflammation, which is literally brain damage. And then you have these kids that are then bucketed into their autistic.

Kashif (52:50):

They weren't born with anything. They were literally neurologically damaged because of some, and it may not have been a vaccine. It could have been some chemical, it could have been a renovation in the house, whatever they didn't have the genetic capacity to deal with it. And that's why you see the numbers from one in 10,000 to one in thousand now to one in 60 kids are expected to be autistic. It's not be because this disease is spreading and there's some genetic strain. That's it's because the load is so much more mm-hmh. You can't go anywhere and not be exposed to things that kids were not designed to be exposed to at that age. Right? So that's, that's why you have so much more of this. You,

you go to school and you're playing on the grass and there's chemicals, pesticides. You go home and sleep on your mattress covered in fire retards.

Kashif (53:33):

You go eat potato chips and all of it. It's just too much. And all of a sudden there's certain kids, not all, one in 60, as we now know that just can't coat, and they're gonna get this sort of neuroinflammation and damage. So goes back to that question is a vaccine bad. No, it, it hasn't. It had a good purpose though. The vaccine, those kids took, you know, we no longer have these 18th century diseases. Right. But that kid needed a different protocol. Mm-hmm. Right. And it's not every kid. It's, it's a few, but that's where you get major problems from these few, which we could deal with in a different way. If you looked at it differently.

Caspar (54:09):

And is that what you'd like to see happen is, is people actually getting that genetic profile to understand you, you are at a higher risk and this vaccine should be spread out based on the science of you. Not on the general science of everybody, cuz there is no one size fits. It's all. And that's kind of what we're doing. We're saying, Hey, in general, this is absolutely safe. And you have to say, the numbers would substantiate that, but you can't tell a parent who has an autistic child who got it because right on that day that their numbers, Hey, you're, you're insignificant. You're not part of that.

Kashif (54:41):

Yep. And that it's, it's a little bit of everything. It's a little bit of the earlier you understand your genetics the earlier you know what to do. There's no more guesswork. So imagine having your child's instruction manual in your hand, how they behave, how they think, how they deal through emotion, everything. There's a second thing of now, what do I give them? Do I give it to them or not? Do I spread it out, et cetera? The third thing is, you know, if a doctrine prescribes a statin, they tell the patient take CoQ10. Right? So what else should I be doing to reduce the risk? And let's not pretend that there is no negative outcome, instead of saying this thing doesn't cause this it's scientifically proven. You can prove that in a kid that has the right profile for whom yeah.

Kashif (55:25):

They're not gonna get it. And you know who to select to be in that trial. Right. But if you do know that for some kids or some adults or whatever, the problem we're dealing with, it is a problem. If we know what the problem is, we probably know what to provide alongside to prevent that problem. So that's just deal with it and admit it and work forward so that it works on 10, outta 10 people, not seven outta 10 people just like we, why we give CoQ10 to people that take a statin. Cause it depletes your storage, your energy, everything gets screwed up. You need it. Right.

Caspar (55:56):

I'm really hoping that is the future of medicine. Cuz that is what we believe is personalized medicine. And that is not leaving any person behind to say, sorry, you weren't part of the, you know, one size fits all and it, it greatly impacted you. Kashif, what are you, what are you excited for next in, in genetic testing? And what's coming up next for the DNA company?

Kashif (56:16):

Well, for us, what's truly exciting is that we believe we were going this modality of us being like an Intel inside chip of personalization, meaning that everyone in healthcare and wellness knows that personalization is coming, but they don't know where it's coming from. Mm-hmm. Whatever we're doing, we can do better. Uh, but we don't know where to start, right? So we're saying that's the work we've been doing in the background for the past few years. Then we, where all these major problems from something as simple as acne or fitness, all the way up to breast cancer, we can personalize whatever you're doing, the protocol, the diagnosis, the whatever, right? So selling tests and helping people is sort of the front end of our business. All of what we learn is the ability to then partner and sync up with whomever is in health and wellness and already doing something great.

Kashif (57:05):

And making their experience personalized from talking to LA fitness and saying let's make a truly personal, personal training program, right? It's actually personal all the way up to talking to the companies. Like for example, like Livongo who makes a diabetes app and saying, let's take your tech, but match it to better protocol that's personalized. That's uh, what we're working towards. Uh, it required going through what we did, which is understanding the insights document and then building the AI machine to now allow other people to plug into that's where we truly think we're gonna change the way people think about personalization.

Caspar (57:39):

Yeah. I'm excited for it because I really do think these are the solutions we require. We're past the days of the generalized protocol, the trial and errors, right? The understanding maybe this will work for you. Maybe it won't in four weeks, we'll put you on something else. We'll do this and that. And really getting to the core of who we are, you know, what, what makes us up? What's the information within us that shows us, you know, the choices to make that are best for us. Yeah. That that's really exciting. So where can people learn more about you and, and the company pick up the test?

Kashif (58:10):

Uh, so the DNA company.com, we try to keep it simple. <laugh> so just go to the DNA company.com. There's really only two products on the website, the test and a $5,000 coaching program. And that's there because we have a lot of executives and stuff. It's the one it's kind of like just rip me apart and put me back together. That's what that program is. We usually take a few months with a person there's other things we do that aren't on the website and that's where once you get the test, you speak to a coach, they'll start telling you about if you even need other things. Um, we actually built a matching system where, you know, whether it's a supplement or, or a, a non, an organic mattress that doesn't have chemicals or whatever to teach you what you actually need. And then those things are available too. So yeah. So DNA company, The DNA company.com the test is right there. Once you get it again, a coach will help you learn, start to learn all the other things you can potentially do.

Caspar (59:03):

Amazing. Thank you so much for this Kashif, wishing you, you and the company, all the success in the future.

Kashif (59:08):

Oh thank you. This was awesome. Talking to you.