Nicholas Gonzalez, MD: An Enzyme Approach to Cancer

Interview by Karen Burnett

Nicholas James Gonzalez, MD, *has been in private practice since 1987 in New York City, treating patients diagnosed with cancer and other serious degenerative illnesses based on his previous research of the methods pioneered by embryologist John Beard, DSc, and William Kelley, DDS, MS.*

Dr Gonzalez graduated Phi Beta Kappa and magna cum laude with a degree in English literature from Brown University in 1970. He worked as a journalist for Time, Inc, where a series of assignments on health care introduced him to some pioneering figures including, notably, Linus Pauling, who inspired him to change careers.

Gonzalez attended Cornell University Medical College where he worked with Robert Good, MD, PhD, then president of Sloan-Kettering. He received his medical degree in 1983. During a postgraduate immunology fellowship under Dr Good, considered the father of modern immunology, he completed a research study evaluating an aggressive nutritional therapy in the treatment of advanced cancer. His nutritional research has received substantial financial support from Procter & Gamble, Nestlé, and the National Cancer Institute. Results from a pilot study published in 1999 described the most positive data in the medical literature for pancreatic cancer.

He is the author of three books: What Went Wrong: The Truth Behind the Clinical Trial of the Enzyme Treatment of Cancer*, a William Kelly history titled* One Man Alone: An Investigation of Nutrition, Cancer, and William Donald Kelley*, and* The Trophoblast and the Origins of Cancer: One Solution to the Medical Enigma of Our Times. *For more information about Dr Gonzalez, his practice, and his books, visit http://www.dr-gonzalez.com.*

Alternative Therapies in Health and Medicine (ATHM): Your background includes an undergraduate degree in English literature and work as a journalist before you became a medical doctor. Would you please discuss your journey to the field of immunology and cancer treatment, and what inspired your move from English and journalism to medicine?

Dr Gonzalez: When I was in college the last thing I ever thought I'd be doing is working as a scientist or a physician. I went to Brown, which had no required courses. I majored in literature and writing, intending to be a writer. My first job after college was at Time, Inc. It was a really nice job: I got to travel and meet lots of interesting people. I had my first cover story when I was 24 at *New York Magazine*. Everything seemed to be going fine. I was working on a book and had a publisher behind me.

The furthest thing from my mind was science and medicine research. I wanted to be Ernest Hemingway, travel the world, write books, write journalism, do novels, all of that stuff that young writers in New York wanted to do. One of my editors challenged me to do some investigative work in medicine and I thought that sounded like the dullest thing you could possibly want to do. I said no about 17 times, but he was pretty persistent for some reason. He thought I'd be good at it.

Without any interest, knowledge, or background in science, I started doing it. I wrote a story on cancer prevention, one of the first big stories on cancer prevention published, and I got to meet some really interesting people doing really creative science. Prior to that point I thought all scientists were nerdy social misfits in isolated laboratories, doing dull, pedantic work, but I began to realize these people were as creative as anyone else I'd ever met in literature and journalism.

I got interested in nutrition as a direct result of my journalism work. Linus Pauling, particularly, was my first interview way back in 1972 when I was just a young journalist, and he really encouraged me to think about science as a career.

When he first suggested that, I thought it was a joke, but he was serious. Other scientists I had met—like Abram Hoffer who first used niacin to treat schizophrenia back in the 1950s—also planted a seed. One day I woke up and decided that's what I was going to do. I was going to go to medical school, at least try and get in. Of course I had no science courses, so I had to give up my wonderful New York apartment, my girlfriend, my journalism life, and my traveling to go live in Queens with my parents (who very kindly put up with me at age 29) to do my premed work at Columbia, to everyone's astonishment.

My journalism friends were taking bets on how long I would last. The longest was about 6 to 8 weeks, but I really enjoyed it and did well and got into medical schools. I wanted to go to Cornell, which was in Manhattan and associated with Sloan-Kettering, the great cancer research center. I was interested in cancer research. The president of Sloan-Kettering at the time, Robert Good, MD, PhD, was already very well known as an independent, creative thinker. He wasn't an oncologist. He was trained as an immunologist and apparently had an interest in nutrition, and he'd been on the cover of *Time Magazine* back in 1972.

A controversial guy, he didn't follow the mainstream path in his career in medicine, but he was a great leader at Sloan-Kettering. I went to Cornell and, during my second year of medical school, Dr Good adopted me as a mascot into his highfalutin research group. I was the youngster on the team, but he treated me like a son almost. He encouraged my initial research forays into nutrition and cancer.

ATHM: Were there doctors or medical professionals in your family before this?

Dr Gonzalez: No. I come from a family of musicians. Four generations, there have been about 12 musicians going back to my great-grandfather, who was a classical musician. My grandfather was a cellist who played at the Metropolitan Opera and a number of really fine orchestras around the country. He came from a family where seven trained as classical musicians, and for four of them, that's how they made their living, including my grandfather's brother who was a well-known violinist. My cousin was a very well-known jazz pianist who died a few years ago—of cancer, ironically—down in Mexico. My grandmother was an opera singer.

There are some distant cousins of my father who were physicians, but I really didn't know them. I was so geared toward the arts; I wasn't geared toward the sciences. Science was just something that nerdy kids did in the seventh grade to win Westinghouse awards but had no social graces. I had absolutely no experience with science growing up. It was all music and literature and poetry and that kind of thing.

ATHM: But you had some abilities that you didn't know about.

Dr Gonzalez: Yeah, I was like an idiot savant. I took to the sciences, did well at Columbia, got accepted everywhere, and just was very grateful. I enjoyed it too, which was surprising. Most people think of the premed work as a grind. For me it was like an adventure, because I'd already had a career that I enjoyed. It wasn't like anyone forced me into it—this whole area of creative science was just so fascinating to me. I was fortunate. At the right time I had the right people, like Linus Pauling when I was a medical student, and Robert Good who was a very creative thinker. He's now deceased, but he really encouraged me. He took time, guided my career, and guided my research interest.

ATHM: Mentors are very crucial to a young career.

Dr Gonzalez: Without a good mentor you end up just leading a mundane life. It's the mentors who really bring you out of that into something really unusual. That's really what happened with me. The right mentor at the right time really makes us in any field, but particularly in the sciences really makes your career.

ATHM: Right. You're best known for your work with pancreatic enzymes and their use in treatment of cancer cells in advanced cancer patients. How did your interest in this treatment develop?

Dr Gonzalez: Here again I have to credit Dr Good. At the end of my second year of medical school, one of my journalism friends called me out of the blue and tracked me down because I was living at Cornell on the Upper East Side. She'd heard about and met this eccentric dentist by the name of William Donald Kelley, who was infamous because of his involvement with Steve McQueen's care—the famous actor who died of mesothelioma in November 1980. This was the summer of 1981. Kelley happened to be passing through New York and my journalism friend was going to meet with him.

She was excited to do a book about him because he was on the front page of the *National Enquirer* and the *New York Times* being attacked because of his involvement with McQueen—this is 1981, before *alternative medicine* became a catchphrase in every medical center in the country. She thought a book on Kelley would be a real bestseller but she couldn't really make sense out of what he was saying. He was bumbling, talked very softly, and she couldn't understand his long diatribes about science.

She didn't understand him at all. She figured that with me having been an investigative journalist and also having 2 years of medical school under my belt, at least I'd be able to tell whether he was brilliant or crazy, brilliant *and* crazy, or some combination thereof. Initially I said I don't want to meet with Kelley. He's just this crazy eccentric dentist, treating cancer patients with nutrition. She finally convinced me to meet with him and we met at a chiropractor's office out in Forrest Hills. It's the weirdest story.

Within 5 minutes of meeting Kelley, I knew that he was the smartest man I'd probably met next to Dr Good. Kelley was using pancreatic enzymes to treat cancer and I didn't know anything about pancreatic enzymes and cancer. All he wanted was his work properly tested. He said he felt he was doing something valuable and his big frustration was the academicians were completely ignoring him.

He wanted someone to look at his records because, if he was doing something valuable, it needed to be out in the world. I thought that was a very humble approach. It wasn't self-aggrandizement and he was willing to open his files to somebody like me. He already knew I was working for Dr Good—it turned out that Dr Good was one of his heroes. He thought that Dr Good was the one scientist in the conventional medical world who had an open enough mind to give someone like Dr Kelley a fair shake, and that's true. Good had that kind of open mind.

Our first meeting was really quite extraordinary. We were together about 2 1/2 hours and that afternoon, I went up to see Dr Good, and this is how gracious Dr Good was. Here's this guy, the president of Sloan-Kettering, everyone from the Rockefeller family on down, presidents and political leaders calling him, but he made time to see this second-year medical student in the middle of his summer break.

He encouraged me to start looking into Kelley's work. That's how I got interested in enzymes. The next day I was on a plane with Kelley going back to his office in Dallas. I started going through his records and found patient after patient with appropriately-diagnosed, advanced, poor-prognosis terminal cancer, who seemed to have total regression of their disease and long-term survival after being treated only by Kelley.

He opened up all his files, both his successes and failures. He arranged for me to speak to some of these patients and their stories were extraordinary. It was a whole spectrum of patients who had been successfully treated by Kelley: pancreatic cancer, metastatic breast cancer, ovarian cancer, metastatic ovarian cancer, cancers that are notoriously incurable, and here they were, 5 to 10 years later.

After 2 or 3 weeks I gathered several dozen cases together, Xeroxed the records, and went back to see Dr Good. We spent several hours going over all these records on our hands and knees in the president's office at Sloan-Kettering. He said that he assumed they were real because he trusted me, but he'd never seen anything like it. He said, "I can't pull out 5-year-survivors of pancreatic cancer. That's a terminal disease." That's when he said I should really turn it into a formal research study that he would supervise.

It would take 5 years. I finished it during my fellowship after graduating from medical school under Dr Good, after he was pushed out of Sloan-Kettering. Sloan-Kettering presidents are given about 10 years to find a cure for cancer—if you don't find it by then, they boot you out and get somebody else in. Good survived his 10 years and then he went to the University of Oklahoma to set up a bone-marrow transplant research center. Good did the first bone-marrow transplant in history back in 1969. I joined him after finishing my internship. I joined him at Oklahoma for a year and then down at All Children's Hospital in Florida where he also set up a bone-marrow transplant unit.

I was learning how to do bone-marrow transplants—which is about as "conventional oncology" as you can get—but in addition, he was supporting my investigation with Kelley. I went through thousands of Kelley's records, interviewed over a thousand of his patients, and put together a collection of 455 that had appropriately-diagnosed, advanced, poor-prognosis cancer who had done well under his care. Eventually, under Good's supervision, I put it together in a monograph. I wrote up 50 cases in some detail. The monograph had three sections.

First I discussed the theory of Kelley's work—including his use of pancreatic enzymes against cancer—the controversy surrounding his work, and then 50 case reports of 26 different types of cancer. We actually included the medical records proving they had cancer. Most of them were diagnosed at major institutions like Stanford, Sloan-Kettering, or the Mayo Clinic.

In the third part I looked at all of Kelley's pancreatic patients treated between 1974 and 1982. In those days pancreatic cancer wasn't as common as it is today, but Good said I should concentrate on pancreatic cancer because it was one of the two worst cancers there is. He figured if Kelley had any success at all with pancreatic cancer, his work warranted investigation. We found 22 patients: 10 of them came to Kelley once but never did the program—their average survival was 60 days.

Seven did it partially and incompletely for various periods of time, from 4 weeks up to 13 months. The average survival of partial compliers was 300 days. The average survival for pancreatic cancer is 3 to 6 months, so even in the partial compliers, there was significant prolongation of life. Then there was a group of five who complied completely: at the time I finished the study, the average survival was over 8 years.

This included patients with stage IV, biopsy-proven, liver metastases from pancreatic cancer who were alive 5 to 10 years later.

ATHM: Are there any cases that stand out?

Dr Gonzalez: One of those patients I first interviewed in 1986. She'd been diagnosed in 1982. She's from Appleton, Wisconsin and had what they thought was gallbladder dis-

ease. They dragged her into surgery at the local hospital to take out her gallbladder. They opened her up and she had a tumor in her pancreas and a tumor in the liver. They biopsied the liver tumor: it turned out to be adenocarcinoma, the more aggressive type of pancreatic cancer that had originally started from the pancreatic tumor. They closed her up.

She met with a local oncologist who said, "We can give you chemo but it won't do anything. You might live 6 months, a year." She went to the Mayo Clinic. I respect the Mayo Clinic: they have some of the smartest conventional doctors at the Mayo Clinic, the best of the best. They're also honest: if the therapy isn't going to work, they tell the patient that. The oncologist at the Mayo said, "I could give you chemo, but it'd be a waste of time. You should just go on and enjoy your life."

That saved her life because, with no conventional options, she started looking to alternatives. She went to a local health-food store, saw Kelley's 32-page book from 1969, *One Answer to Cancer*, and read it. Kelley put her under the care of a chiropractor he trained who happened to be in her area. Thirty years later she is alive and well.

ATHM: Were you able to confirm that her cancer is gone?

Dr Gonzalez: I'm her doctor now. She's never been back to have a CAT scan so we don't know what happened to those tumors. But I know of no patient in the history of medicine—believe me, I searched the literature—alive 30 years later with a diagnosis of stage IV metastatic adenocarcinoma with liver biopsy confirmed by the Mayo Clinic.

It's an extraordinary case. Now, had she been a conventional patient treated with some hodgepodge of chemo, she'd be on the front page of *Time Magazine* or somewhere like that … the publicity machine of the drug companies would be flowing like crazy. But because she was treated by this eccentric dentist who nobody in the conventional medical world liked, she's passed unnoticed except by people like me. She's an absolutely miraculous case and I would challenge any oncologist in America to produce out of their files a 30-year survivor of stage IV pancreatic cancer, properly diagnosed at the Mayo Clinic. They can't. There's no such patient.

Those are the kinds of patients who we put together in our monograph back in 1986, when I finished it under Good's direction. We spent 2 years trying to get it published. Even with Dr Good's support, and his name recognition—he happens to have been the most published author in the history of medicine, with over 2000 articles to his credit and he was friends with editors of journals—we couldn't get it published. The general consensus was that this must be fraud and I must have somehow duped the famous Dr Good. Or, if it's real, it's so controversial that no editor would touch it. They were afraid that their careers would be affected.

I have a collection of nasty letters from editors that were written to Dr Good saying, "How could you be involved with this quackery? It just can't be true." We would, of course, allow any editor to talk to these patients if they wanted. Some of them are still alive. We finally published it 2 years ago as *One Man Alone,* which is my monograph detailing my investigation of Dr Kelley. It was the first academic investigation of alternative cancer therapy in history, as far as I know.

ATHM: What happened with Kelley's treatment of Steve McQueen? It was pretty controversial then.

Dr Gonzalez: McQueen had mesothelioma. He'd failed standard therapy and everybody blamed Kelley like he'd taken a gun and shot him. "Kelley killed McQueen" the headlines read. McQueen had terrible mesothelioma, which was incurable then and totally incurable today. Actually his conventional, genius doctors missed the diagnosis for a year and that's why it ended up metastatic. Then they gave him radiation and immune therapy, which are worthless with mesothelioma. He was dying and then he came to Kelley.

Kelley made one mistake with McQueen—he should never have treated him. He was too high profile. He was reckless, didn't give up his bad habits, and continued to smoke and drink. When he was down in the clinic in Mexico that used aspects of Kelley's work, McQueen was having ice cream flown in—that kind of silliness. But he still lasted a year with terrible mesothelioma. He was dying when he went in to Kelley's office. He was actually terminal. Kelley, the gracious guy that he was, agreed to treat him, but there was an enormous risk involved in taking on a terminal case. Having studied all the newspaper reports, not once did they talk about the fact that by the time he came to Kelley, he was a conventional failure.

When I first met Kelley, he was in a state of depression because, even 6 to 8 months after McQueen died, he was still being brutalized in the press. For some reason, the press just hated the fact that this celebrity who everybody loved had died under the hands of an alternative practitioner. Just unbelievable. All he tried to do is help this guy.

ATHM: Going back even further than Dr Kelley in your influences, let's talk about the English scientist, John Beard. He proposed a hundred years ago that the pancreatic enzyme trypsin might be the body's primary defense against cancer and would work as a cancer treatment. Was that revolutionary considering the conventional thinking about cancer at the time?

Dr Gonzalez: Absolutely. All of Kelley's work was based on Beard. Beard was actually a PhD embryologist, an Englishman who taught at the University of Edinburgh in Scotland. From his embryology research, he went off on a sidetrack and became interested in cancer medicine and cancer research. It was because of his study of the embryonic placenta—the connection in mammals between a growing embryo and the mother's uterus.

In reptiles, birds, amphibians, and fish, the mother lays an egg in the water or on the ground. The embryo matures in the egg and then hatches out. In mammals, we develop in

utero for any number of months. In humans it's 9 months, of course, and that requires a certain modification. As you know, first the embryo has to attach to the uterus, otherwise it's going to pop out. Second, it needs a connection to the blood supply of the mother, otherwise it's not going to have any source of nutrients or a way to get rid of waste.

It's the embryonic placenta that attaches it to the uterus and creates the connection between the mother's blood supply and the blood supply of the embryo. Beard was the first person in history, back in 1902, to make the suggestion that the placenta really was identical to a cancer in its behavior and appearance. Under the microscope, it kind of looked like a cancer. It was amorphous and it behaved like a cancer.

The whole purpose of the placenta was to invade into the uterus, to invade like a cancer invades into an organ. Back 100 years ago, scientists knew what cancer was. They knew it was invasive but normal tissues don't invade. In fact the only normal tissue that's invasive is the embryonic placenta. It invades right through the uterus the way a tumor would. It grows very quickly. It reproduces. It proliferates without restraint. It migrates in the underlying uterine tissue the way a cancer would spread through an organ and then it creates a rich blood supply.

They didn't use the word *angiogenesis* but if the placenta is nothing else, it's an angiogenic organ. A tumor can't grow unless it creates a rich blood supply with the host—otherwise it's going to starve itself. The embryo is the same way. It needs a rich blood supply and it does that through the placenta.

Now 100 years later, molecular biologists have rediscovered the simple fact that Beard had discovered, that the placenta is the ideal molecular biology model to study cancer. All over the world, research groups are starting to study the placenta to try and understand how cancer works.

Beard proposed that but people thought he was nuts: He was an embryologist. What did he know about cancer? He was nominated for the Nobel Prize in 1906 because of a lot of his embryology work, but he was already getting controversial because he made an interesting observation that seemed so obvious, but very often, brilliant observations are what we take for granted. Then the scientists said, "This is interesting." He said the placenta is exactly like the tumor in its appearance and its behavior except for one thing. At a certain predetermined point in development, it changes from this primitive, undifferentiated, invasive, migratory, angiogenic organ to the mature placenta, which stops invading. It's a total change in character that you see in a placenta, otherwise it would just keep invading and kill the mother.

Beard spent a number of years trying to figure out what the signal was. Of course he realized the day the placenta changed its character from this invasive, cancer-like tissue into the mature noninvasive placenta was the day the embryonic pancreas began pouring out pancreatic enzymes. In 1902, when Beard made that suggestion, pancreatic enzymes had already been identified.

That has been confirmed 100 years later and he could find no other correlation. He said since the placenta is virtually like a tumor, and since pancreatic enzymes control placenta differentiation and growth and maturation, pancreatic enzymes must be the body's main defense against cancer and would be useful as a cancer treatment. Then he went from the theoretic to the practical, used enzymes in an animal model, and got a 100-percent regression of tumors using injectable pancreatic enzymes that a drug company provided him. He was not a physician, but physicians both in the United States and Europe, under his direction, began using them in advanced cancer patients and the tumors would regress.

There's this idea among contemporary scientists, that oh, 100 years ago, people were in caves. No, the pathologists were very sophisticated. Sloan-Kettering already existed. They knew what cancer was. They could distinguish it under the microscope. Many of our histological techniques today are based on what was done 100 years ago, 120 years ago, in terms of cancer biology. There was an explosion of knowledge about cancer biology at the turn of the last century.

Beard was getting these extraordinary regressions, which were published in the mainstream medical journals like the *British Medical Journal* and *JAMA*. I have a whole series of these articles. Conventional researchers at that time thought—the smart guys at the University of Paris, the University of London, Oxford, Cambridge and Sloan-Kettering—as scientists think today, that cancer is caused by some genetic mutation in the cell. What you need to do is find some kind of chemical—some drug—that will kill it. Beard said no. He said cancer is really a natural process that's gone awry and that pancreatic enzymes will control it. This is what really put him over the edge and probably cost him the Nobel Prize.

At that time, as today, it was believed that cancer developed because of mutations in mature cells in whatever organ—the brain, the liver, the pancreas, the intestine, the breast—and they go crazy. Beard said that's not where cancer originates from. He said that during embryonic development, cells of the growing placenta actually break off and migrate through the growing embryo. Throughout the embryo, as it develops, there are these nests of primitive placental cells that stay during our lifetime, and they have the potential to start growing like a placenta in the wrong place. If you have these placental cells in the brain or the intestine, or the breast, and they start growing through some abnormal signal like inflammation, they turn into cancer.

People thought that was just bizarre. Of course what Beard had discovered—which no one realized, because no one knew what they were—were stem cells.

If you read his original book, *Enzyme Treatment of Cancer,* from 1911, he's really describing stem cells. Now if you go into Wikipedia or the library, you'll find that stem cells are attributed to McCulloch and Till from the mid-1960s; that's when they were discovered. Stem cells are really these aberrant placental cells scattered through the body. Now they are useful as a source for replacement cells when tissues are injured or damaged from disease or just age and wear out.

Interestingly enough, a lot of contemporary molecular biologists are beginning to realize that cancer does develop

from stem cells. They haven't made the connection to Beard yet because none of them know about Beard, but Beard had that whole theory 100 years ago. He went a step further and said that, since the placenta is controlled by enzymes, cancer will be controlled by enzymes because the cancer is really placental cells growing in the wrong place at the wrong time. All of this was so bizarre to his colleagues. They just thought he was nuts. He was attacked in the press and medical journals. Part of the problem came from another discovery around that time …

Madame Curie, the beloved French woman scientist with two Nobel Prizes to her credit, the first woman who got a PhD in theoretical physics from the University of Paris, was the first great media star like Steven Hawking today. Around 1905, just when Beard was coming into his own as a scientist, she proposed that radiation was a simple, easy cure for cancer. X-rays had been discovered in 1895 and this was only 10 years out.

She had devoted much of her previous 10 years to studying X-rays and their diagnostic and therapeutic application to human disease. Initially radiation looked so wonderful because she'd radiate a tumor and it would shrink. What they didn't realize is that it would come back more aggressively, and that radiation was extremely toxic.

In fact, Madame Curie tragically died from the results of overexposure to radiation. She was well-known and Beard was this nerdy, frustrated, ivory tower scientist at Edinburgh who didn't know how to deal with the press. He could have cared less. He thought the journalists were morons and was really antagonistic to them.

He didn't help his own case at all. He would attack his fellow scientists. … Understand—he was frustrated. He was one of the first people to say, "Radiation is dangerous. It's not an easy cure." But no one took him seriously, and he died in 1924 in obscurity. It took people like Kelley, on the fringe of medicine, to rediscover his work. If it weren't for people like Kelley, his work would've been lost. It was just saved by threads—some people just serendipitously at different times. During the 1920s, there was an assertive physician out in St Louis by the name of Morse who somehow discovered Beard's work. He used it successfully; he was attacked.

Then the Krebs, father and son, rediscovered Beard's work and wrote about it in the 1940s, but then they were attacked. Then Kelley discovered it in the 1960s and he got attacked. There have been a few people that have kept it alive over the last hundred years. It's just … his work is just absolutely brilliant; forgetting the fact that he figured out cancer 100 years ago, he identified stem cells.

ATHM: How has the reception been for you when you put it out there?

Dr Gonzalez: It's been a battle from the beginning. I began to realize that the scientific and academic community has a very rigid code of behavior—you don't question the prevailing model or the authorities who designed it. I questioned the prevailing model of where cancer comes from and how it should be treated. Kelley's program was all nutritional.

The chemotherapy industry, 30 years ago and still today, really controls the medical research in oncology. It's all geared toward chemo and now targeted therapies and radiation and more fancy radiation. Nothing's really changed.

The reception was bitter then and over the years it's been two ways. We've had a lot of support from mainstream people and we've had nasty attempts to sabotage our work. You're in the middle of a battleground, which is so sad because the battle should be for the truth. It doesn't matter if it's moon dust—if it works, you use it.

A lot of scientists don't think that way. They think that the model they were trained in is the model that should be accepted. Even though we think of scientists as objective, rational, unemotional evaluators of the truth, they're in fact as irrational, emotional, and biased as anybody else.

ATHM: I suppose the funding is a big issue, too, and financial motivation.

Dr Gonzalez: I've heard chemo brings up to, according to one thing I've read, $100 billion a year worldwide. Certainly I've read the minimum: $13 billion. That's not doctor's costs, or surgery, radiation, nurses, or hospitalization; it's just the gross intake for chemo. There are chemo drugs, like Avastin, that cost $10 000 a month.

Kelley's therapy, because it's nutrition, can't be patented and it's cheap. No one's going to get rich using Kelley's therapy, including us.

ATHM: Right. Let's talk about your treatment program. It has three components: diet, nutritional supplementation, and detoxification. So what role does diet play in your therapy for patients with advanced cancer? What are the differences that the diverse diets address?

Dr Gonzalez: As you correctly say, our program has three different parts and they're equally important, although we've been talking about pancreatic enzymes. That's the main anticancer effect, but the program in its totality involves individualized diets, individualized supplement regimens, large doses of enzymes for cancer patients, and detoxification techniques like the coffee enemas.

Diet is critical. Food, the diet, is really the fuel for the body. The body is the most sophisticated engine that'll ever be created and, like any other engine, it runs on fuel. I've always said if you have a Mercedes Benz, you put diesel fuel into it. If you have a steam engine, you put water into it. You don't put water into a car; you don't put gasoline or diesel fuel into a steam engine—it'll blow up. You've got to put the right fuel in the right engine, and humans are no different.

You look at the human body and 100 trillion cells—every one of them runs on nutrition; that's the only thing that keeps it going. There isn't a doctor around with his expensive car that would put the wrong fuel into his car, but the idea that

they've got to put the right fuel in their patients to get them well never even occurs to them.

One of Kelley's genius innovations, among his many genius innovations, is he realized different people need different diets. In the alternative cancer world, the tendency is to prescribe the same diet for everybody. Max Gerson, MD, was one of the great innovators in nutritional cancer therapy back in the 1940s and 1950s. He treated everyone the same on a basically raw foods, plant-based diet. He thought everyone should be on that.

I knew Bob Atkins very well. Atkins was a great diet doctor. He believed everyone should be a meat eater. You have these different people with these different theories. Kelley's genius is realizing the reason there's all this conflict and confusion and these contradictions in the nutritional literature—both in the lay and the professional print at present—and that different people need different diets. There are people who do best on a plant-based diet. They need to eat fruits, vegetables, nuts, seeds, and grains. There are people that do need to eat like an Eskimo. Eskimos are the classic meat eaters: they need red meat two or three times a day. Then there are the balanced people who do well at a smörgåsbord, with a variety of foods: plant foods, fruits, vegetables, nuts, seeds, and grains, animal products, dairy products, fish, poultry, red meat. He had 10 basic diets, 90 variations, and it was all on his computer.

We continue that trend with 10 basic diets; some range from plant-based, raw foods to red-meat based. Raw foods diets are a big fad now, but we also have patients who don't do well on raw food. Kelley was not dogmatic. If the patient didn't do well, he didn't blame the patient. He thought he had to figure out something else.

We've got a lot of experience behind us now, so individualized diet is absolutely critical. The supplement protocols are equally as individualized.

ATHM: So you must have a system to determine which person gets which diet?

Dr Gonzalez: Kelley had his famous 3200-question questionnaire, which covered everything from how quickly your fingernails grow, to how many hours of sleep you need to feel well, to … We don't use that. We get it through a very simple hair test we've adapted to our needs that tells us exactly which diet the patient needs. I will also say that that test is not commercially available but, after 25 years of clinical experience, you just know. Patients with the traditional solid tumors—tumors of the breasts, lungs, stomach, pancreas, colon, liver, uterus, ovary, prostate—they always need to be on a plant-based diet. Patients with immune cancers like leukemia, lymphoma, multiple myelomas, and sarcomas, which are connective tissue cancers, need to be on meat. Balanced people don't tend to get cancer. They have other problems, but they don't tend to get cancer.

From a clinical experience, a patient walks into my office: I know the history: breast cancer in the bones. I know they need to be on a plant-based diet. Usually we call it moderate vegetarian. We'll allow some fish, eggs, some yogurt, but no red meat or poultry, and lots of fruits and vegetables. Clinical experience and the hair test tell me precisely which of the 10 basic and 90 variations we need to employ for each particular patient. We've got it down pretty objectively and very simply.

ATHM: Your supplement therapy includes orally ingested pancreatic enzymes. Some scientists think that these become degraded in the gut, but what has your experience been?

Dr Gonzalez: Completely the opposite. … Beard himself believed he'd have to use injectable enzymes, but actually he was wrong, as smart as he was. It was believed then, and is believed today, that pancreatic enzymes are proteins and they get into the stomach where hydrochloric acid will completely destroy them and they're not going to be absorbed. First, we know in our practice, we only use oral enzymes and they work great because we have patients who get over their cancer very nicely and wonderfully with oral pancreatic enzymes.

Liebow and Rothman were two scientists who in 1975 published a paper in *Science* where they proved that pancreatic enzymes are reabsorbed, intact and active, into the bloodstream. There was a group in Leningrad in the late 1980s that just did a very simple experiment, so simple you laugh when you hear about it. They took pure trypsin, put it into pure hydrochloric acid, and boiled it for an hour. … You could dissolve a piece of cement in hydrochloric acid, and there was no damage to the trypsin. It actually survived being boiled in hydrochloric acid.

As it turns out, trypsin is completely acid-insensitive. It has a way, like an armadillo rolling into a ball, that protects it from acid. It survives all of that in the stomach. Then, as Lebow and Rothman have proven, it's absorbed in the intestinal tract and circulates in the bloodstream. Lebow and Rothman wrote a wonderful review article in 2002 where they proved that pancreatic enzymes aren't destroyed in the gut but are reabsorbed and actually are reused and recirculated in all of us.

So that's just a mythology [pancreatic enzymes degraded in the gut] that not only has never been proven, it's been disproven repeatedly. Lebow and Rothman, even though they are very conventional scientists, have been attacked because their findings don't agree with the prevailing dogma that pancreatic enzymes cannot survive hydrochloric acid or the digestion in the small intestine.

ATHM: How high of a dose do you give your patients of the pancreatic enzymes?

Dr Gonzalez: Depending on the situation, how aggressive the cancer is, and much they have, usually anywhere from 80 to 110 capsules a day. A capsule is 425 mg of pancrease, so it's a pretty hefty amount. You're talking 35, 40, 45 grams a day, spread through the day in six or seven doses. For anticancer effect, they have to be taken away from meals; otherwise they'll spend time digesting food. You want to take them on

an empty stomach so they absorb quicker.

ATHM: Do patients tolerate this well?

Dr Gonzalez: Usually they do. Maybe one out of 50 will have some burning, so we cut the dose down. Mild symptoms: I see a lot of really sick people who have been through a lot of chemo that affects their gut. If they have a history of ulcers, we'll go gentle with it. Rarely do we have a patient who can't tolerate them.

We use a pork-based pancreas because it's more effective in humans but some people are allergic to pork. We have a lamb enzyme that's a second tier approach and it's milder. For people who have a history of ulcer disease, we'll suggest the lamb because it's a little milder. It still works, it's just not as effective as the pork pancreas.

ATHM: What other nutrients does your supplement therapy include? Vitamins? Minerals? Herbs?

Dr Gonzalez: Every patient gets a supplement program. Just like their diet, the supplement program is designed for their particular metabolism situation, health, and profile. We use the vitamins, minerals, and trace elements, again depending on the patient's need. For example we use vitamin C, 1500 mg to 9000-10 000 mg, depending on the patient and disease. All the trace minerals, all the vitamins, amino acids—and we use a lot of glandular products that come from animal glands like adrenals, thymus, ovary, and testicle. We use those depending on the patient's need and we find them very, very effective.

There's an 80 to 90 year history of conventional scientists using these glandular extracts. During the 1940s, cardiologists used to treat heart failure with raw beef heart and it worked, but it's folksy and it was 60 or 70 years ago. They don't do it anymore. They don't even know that it used to be done.

Each of these organs has healing growth factors that will work on like tissue. When you eat liver, it actually helps your liver, if you eat heart, it helps the heart, if you eat kidney—like kidney pie in England—it helps the kidney.

We do use herbs selectively: with a patient with liver failure or liver metastases, milk thistle is useful. Gingko does help with memory despite the attacks. Saw palmetto has an effect on prostate cancers, so we use the herbs the way herbalists will use them depending on the patient's situation.

ATHM: What is the detoxification component of your therapy and why is that important?

Dr Gonzalez: That's probably the most misunderstood component—even among alternative doctors—though that's starting to change, because even alternative doctors now are getting interested in detoxification. When you put patients on an aggressive program like ours, every tissue and organ in the body starts repairing and the enzymes start attacking the tumor. That is great, but as the normal tissues repair and rebuild, a lot of toxic debris is going to be released.

We all live in a toxic environment. There are over 79 000 chemicals being released into the environment—even if you eat organically, there are heavy metals and pesticides in the air. In New York City, there's mercury in the air pollution. You breathe, you're going to get mercury. You breathe, you're going to get hydrocarbons. There are pesticides in the air where I live that waft in on the wind currents.

There's no way to avoid that unless you can figure out how not to breathe, but most of us have to breathe. You take in these thousands of chemicals, and they get stored in the cells like a ticking time bomb—and most of us didn't grow up on organic. I used to have Twinkies for lunch when I was in college, like some kind of idiot. I have very good genes, otherwise I'd have been sick as a dog. When I met Kelley and went on this nutrition program, it was a revelation.

I had a lot of toxic junk in my body and as the body starts repairing on our program, every cell in the body starts dumping these stored toxins. Hydrocarbons, pesticides that might have been there since childhood, broken-down cell particles, heavy metals, all that stuff gets dumped into the bloodstream and filtered in the liver. When tumors break down, cancers are very abnormal. Cancer cells produce all kinds of mole-

cules and enzymes that are foreign and toxic to normal, healthy tissue. You break down cancer cells; that's wonderful, but then you've got all this dead tumor waste that is notoriously toxic.

Even conventional oncologists realize if you break a tumor down too fast, you can kill a patient with chemo. This debris from the repair of normal tissues plus that of tumor breakdown can overload the liver. Kelley developed, and we use as well, a series of procedures that very efficiently neutralize and help us excrete all this junk. The most famous (or infamous) of these is the coffee enemas.

Kelley was viciously attacked over the use of coffee enemas, but actually it always frustrated him. He got them right out of the conventional medical literature. They were in the Merck manual right up until the 1970s. When I was doing Kelley's project, I actually called the editor of the Merck manual and he sent me a whole mass of information on coffee enemas. They were in the nursing texts and medical textbooks, right up until the 1960s and 1970s.

They seemed to help the liver work better. Kelley also had a liver flush. (There are all kinds of liver flushes on the Internet now.) We start all our patients on a 5-day liver flush. We use juice fasts, we use colon cleanses. For most of us, our colons are filled with all kinds of toxic junk and abnormal bacteria. You want to clean all that stuff out. There are those naturopathic-oriented researchers from a hundred years ago who believe all disease begins in the abnormal colon. Of course with the overuse of antibiotics, and the disruption of the normal flora in our gut, it's a big problem today.

We also have fasts and detoxification baths. The skin's a detox organ. The body gets rid of toxins through the liver, the intestines, the kidneys, or even through the skin. We have these baths, like a salt and soda bath. You just lie in it for 30 minutes. It's sea salt and baking soda or kosher salt and baking soda: it just draws out toxins through the skin. I've had patients where the bath water turned brown when they did that, just from the junk coming out of their body.

We use all these different procedures—simple things like skin brushing that, as hokey as it sounds, stimulate lymphatic drainage. We have a couple dozen procedures we can use depending on the patient. Even those are kind of individualized, but everybody does coffee enemas at my practice. Whether their problem is toenail fungus or brain cancer, everybody does them, including me. I do all these things. I always tell patients to never trust a doctor who doesn't live by his rules: We live by our rules, Dr Isaacs and me. She's doing a liver flush this week and I am also.

Gerson used coffee enemas 60 years ago and he said if patients don't do the coffee enemas, this program won't work because they're going to die from autointoxication from the dead tumor.

ATHM: That's a strong statement.

Dr Gonzalez: The tumor will poison them. You really need to get rid of that stuff. Having followed alternative medicine now for 40 years, I've seen that a lot of the alternative practitioners didn't really see the benefit of detox. They thought it was, even within the alternative world, crazy. They would load their people with vitamins, minerals, and trace elements. They do well for a while and then start getting sick. Kelley said the reason is they're not detoxing, and what happens is the nutrients are stimulating repair, which is wonderful, but then the cells start dumping all these stored toxins and people get sick.

Unless you have a way to manage that and expedite the release of those toxins, people are going to feel really lousy and won't be able to stay on the supplements. One thing we do is cycle on and off the supplements. They take them for 20 or 25 days at a time and break for 5. During the 5-day break, the body rests, cleans out, and usually we have them do one of the major detox procedures like a liver flush.

ATHM: Do you recommend fasting as well?

Dr Gonzalez: We do recommend it generally. We have different fasts that we use. We have a citrus fast, which we use for our acid patients: it involves drinking nothing but citrus fruits for 2 or 3 days. Then we have a carrot juice fast: carrot, apple, or celery juice. Eating nothing but carrot, apples, and celery: that's for our more alkaline patients.

ATHM: Could you please describe some of the results of your studies using enzyme-based cancer therapy with your cancer patients? Maybe describe one of your best cases.

Dr Gonzalez: Oh, sure. In 1993, when I was just beginning to get well-known, the National Cancer Institute (I believe out of good intentions the people who were there then are no longer there now, they've all gone on in the industry) invited me down to present cases. I presented 25 of our cases. I hadn't been in practice that long, a little over 5 years, so I didn't have 10-year survivors. But I had patients, with pancreatic and metastatic breast, who already were responding. I presented a series of cases at an NCI 3-hour session headed by the associate director at the time, Dr Michael Friedman.

Based on that, Dr Friedman suggested I do a pilot study of my work with patients with advanced pancreatic cancer. He suggested pancreatic cancer because it's the worst—if I could get anybody well, that would be something really that we'd have to take seriously. Pilot studies are small studies on patients diagnosed with a cancer for which there is no conventional treatment. They're called, technically, Phase-II studies. Sometimes they have a control group, but most often they don't. The thinking is that if you can show any response in one of these terrible cancers, then that would lead to a larger study.

He suggested 10 patients—we eventually had 11. Now Nestlé, the chocolate company, had gotten interested in my work, and the chief of research, Pier Gessery, had become very interested in my work himself. He was a renowned researcher, had been head of the Pasteur Institute before

going to Nestlé, and he got Nestlé to fund the pilot study. We did that and we had an eminent group of oncologists supervising it so no one could say, "Wasn't done right," or "This patient doesn't have cancer," and all of that.

We studied 11 patients in the pilot study, adding a patient when one dropped out. We had five patients who lived 2 years, four patients lived 3 years, one died at 5 years from a heart attack, and another one lived almost 5 years and died for other reasons. To put that in perspective, the most prominent drug for the treatment of pancreatic cancer—gemcitabine, the brand name is Gemzar—was approved by the FDA in 1998 based on a study of 126 patients, not one of whom lived longer than 19 months. They didn't have anybody live 2 years out of 126 patients. We had 11 patients and five of them lived 2 years…

ATHM: What happened next?

Dr Gonzalez: Based on that, in 1998 I met with NCI's director at the time, Richard Klausner. We met down in Washington, and he agreed, based on the preliminary data of the pilot study, to support a large-scale study. (The pilot study data wouldn't be published in a peer-reviewed literature until June 1999. It was published in *Nutrition and Cancer*, which is a conventional, peer-reviewed journal, but we already had the preliminary data that showed that we were getting significant responses.)

Meanwhile Nestlé decided they would fund some animal studies. I know people have mixed feelings about animal studies, but you can learn from them. They were done at the University of Nebraska under Parviz Pour, one of the world's experts on the molecular biology of pancreatic cancer. He'd actually developed a mouse model for pancreatic cancer in which no chemo drug has ever been shown to have any effect. He was going to use the worst model to see what our enzymes did. They showed significant response. In fact, the article from that study was published in *Pancreas*, which is the research journal for the pancreas. Dr Pour wrote in his summary that this is the first time he'd ever seen any response from anything in this model.

That was published in 2002. Unfortunately, as you know, the big large-scale study that Klausner approved in 1998 turned out to be a total disaster. Again, it was going to involve patients treated with pancreatic cancer, but it was going to be a controlled study in which my therapy would be compared to the best available chemos and be run out of Columbia University in New York. When it first was developed, we all thought—Dr Isaacs and I, the alternative community—this'll be a groundbreaking study, the first time the conventional and the alternative doctors would come together for the benefit of humankind. But all those idealistic things, which should govern science, and should govern all of us in the sciences, unfortunately don't. The initial team assigned to this study, I absolutely believe, was interested in doing a fair, honest, and honorable study. I still know some of those people today.

But Dr Klausner, about a year later, went off to run a foundation and the new team that came in—from the day I met them—I knew that we were headed for trouble. It was almost as if they couldn't believe that the NCI was supporting a study of something as crazy as my treatment. I don't know what they were really thinking, but that's the way it came off. As the study began to deteriorate in a morass of meaningless data, Dr Isaacs and I thought we could quit and walk away but then we knew that would be used against us. *You see the alternative guys, they don't have the guts to stick through a real scientific study*.

We were going to stick through this and make sure that it was run properly, or we would scream and holler to let people know that we knew they weren't going to run it proper. Unfortunately, it wasn't run properly from the beginning.

It turned out that in 2000, the NCI insisted that Dr Isaacs and I had to be removed from any decisions about patient entry into the study. When we first developed the study under Klausner, it was agreed that we should be involved with Columbia in selecting patients because at that point I'd been investigating this therapy since 1987, almost 17 years. But in 2000, he said no to having Isaacs and myself involved in patient selection. Everybody had this dreaded bias. They're always afraid the alternative guys are going to be biased.

But not the conventional doctors. They're all pristine, pure. It turns out the chief investigator, John Chabot of Columbia, helped develop the chemo regimen and was involved in the development of the regimen being used against us. This was a conflict of interest that should have precluded him from serving as principle investigator because in any research study, the chief investigator is to be free of any attachment to any of the treatments being studied.

In fact the whole reason the NCI wouldn't allow Isaacs and me to be involved—not just as principal investigators, but even involved in any way in patient selection—was because we helped develop one of the therapies, yet they put a guy in charge who helped develop the chemo regimen. We have the papers and literature proving he was involved in its development. We didn't know this and no one told us. We had to find it out ourselves.

From the beginning, patients were approved at the Columbia site who didn't meet the criteria of the written protocol. They were far too sick to do it, and we had no veto power at all. Our program is nutritional—we know what the limitations are. We're not magicians. Very often really advanced pancreatic cancer patients can't eat and if they can't eat, they can't do our treatment.

That was written into the protocol: the patients had to be able to eat. Regardless, repeatedly patients were entered who were too sick to do the treatment, too emotionally unstable, or unsuited to follow through. A couple of patients were entered with diagnosed mental illness. Mentally ill patients can't follow a patient program like this. We protested and objected. In fact it was written in the protocol that patients with active mental illness could not be entered. Their rationalization: "They're on medication, so they're not actively sick. They're on medication because they're mentally off."

Unfortunately there was also what's called an intent-to-

treat provision written into the protocol that we objected to. Intent-to-treat is a real trick that can be used in a bad way in a clinical study like ours. It meant that once a patient was approved—remember we had no say in the approval of patients—they were considered as treated, even if they never took a single supplement.

We had patients who were so sick they never took a single supplement. We had one patient who quit the study after several weeks, went off and got chemo because he couldn't do our therapy, and he died. He was considered a Gonzalez treatment failure even though he was doing chemo. Out of 39 patients who ultimately entered into the study to be treated by us, we estimate maybe six of them actually did it for any length of time. The majority did it briefly, a few days … but they were all considered Gonzalez treatment failures and we objected.

Then we began to realize that patients were not only being entered in violation of the entry protocol, but that there was no signed consent, which is required by law … any clinical study has got to have informed consent.

Even the United Nations, and the World Health Organization, have come out very strongly that any research anywhere in the world has to have significant informed consent. This was under the aegis of Columbia in our study; we had nothing to do with it. Dr Isaacs and I discovered that patients were being admitted who hadn't been properly consented. Now that … that's just plain carelessness.

ATHM: Was there anything you could do?

Dr Gonzalez: Dr Isaacs' sister is a well-known nephrologist who was head of the review board at a major Midwestern medical school. She told us there's this group in Washington, the Office of Human Research Protections, that is the oversight group for all federally funded studies. If there's mismanagement, they investigate.

In June of 2006 we were totally disgusted when none of the errors were corrected—so many patients had been entered that were just not suitable; we filed a complaint with them.

Even though no one in the Washington academic community has much love for me or for alternative medicine, they read hundreds of pages of data that I gave them and opened up an investigation. Two years later they found that, out of a total of 62 patients entered in the study (including the chemo patients), 42 had been improperly admitted, which was two-thirds of the patients. This was all done by Columbia. Their findings are still on their website: based on that, the FDA got involved.

Now the FDA is not considered any friend of alternative medicine. They have a long history of trying to get supplements off the market and so on. We had a completely different experience: people are dumbfounded when I tell them. Because this was an NCI and NIH clinical study, it had to be approved by the FDA and they approved this within 2 months. They can delay it for years.

Not only did they approve it, but they never interfered, never tried to obstruct the way people think … They approved it quickly, took a hands-off approach. Then when the OHRP found that it had been mismanaged, they were almost legally obligated to get involved because they had approved it.

They conducted their own investigation. They never even contacted me. I learned through my friends in Washington that the FDA was involved. I said, "Oh boy, where's that going to lead?" Well lo and behold, about 8 months ago I learned that the FDA had concluded their investigation and substantiated our charges and it's right on their website. They actually conducted a site visit at Columbia. They reviewed my charges apparently and they found that the principle investigator—John Chabot, he's named right on their website—didn't follow the written protocol, didn't keep accurate or complete records.

The whole essence of clinical trial management is you keep accurate and complete records. They vindicated us. We've got two major federal investigator groups, who are not known to be friends of alternative medicine, substantiate our charges: the study wasn't run properly.

ATHM: Where did you go with it then?

Dr Gonzalez: You have to document. Taking on the NCI, the NIH, you have to really document and I did. I documented from beginning to end. It's a story of science gone awry at the highest level of the academic research community. I think anybody reading that will come away with this … some belief that maybe these esteemed scientific guardians of the truth may be less deserving of the esteem that's often given them.

Interestingly enough you asked about case reports. There were two forewords: one was by Dr Paul Rosch from the Academic Scientist perspective. Sarah Cooper wrote the first foreword and she was actually a patient of Dr Isaacs. She had applied to be part of the clinical study and Chabot had originally approved her. She gets to New York and she had a great attitude and was really enthusiastic. She met with Chabot and she had flown in at her own expense having been told she'd been approved. He said, "Maybe you could have surgery and that would cure you, so I'm not going to let you get into the study."

She had biopsy-proven pancreatic cancer, proven at the Mayo Clinic. She'd met with three surgeons and they said even if she had surgery and chemo, she might live 15 months. He wouldn't let her in the study. She was devastated because she thought, incorrectly, the only way she could get my treatment was through the clinical study—but we could still take on private patients.

She became a private patient of Dr Isaacs using this therapy that we use together. We didn't charge her because she'd been through such hell. She was diagnosed in February 2001, with pancreatic cancer poorly differentiated, the most aggressive form of pancreatic cancer there is. It hadn't gone into the liver at that time but she never had surgery, chemo, and radiation; only our therapy.

She says in the foreword that she's had 11 birthdays she never thought she'd have and watched her grandchildren grow

up. It changed her life. She's writing a book about her situation. She runs a nutrition course at her local church—she's very devoutly religious—and she's nearly 12 years out. Again if she were a conventional patient, they'd be holding press conferences.

We've also got Arlene Van Straten, Dr Kelley's patient from 1982. Stage IV pancreas diagnosed with biopsy of the liver, confirmed at Mayo … actually this month, it's 30 years. She's alive and well watching her grandchildren go through college.

ATHM: So what is next for you?

Dr Gonzalez: We're doing a book, two volumes, of 120 of our own cases. Ninety will be cancer, 30 will be other types of things like multiple sclerosis, chronic fatigue, Lyme's, which we treat—but 90 cancer patients. I finished 75 of them and even reading these cases brings tears to my eyes to see what these patients were facing and how they got well. They did all the work; they deserve all the credit. Our therapy got them well, but they did all the work. I really have such respect for these people. It's a joy writing up these cases.

ATHM: Are you optimistic for the future of the medical community becoming more receptive to new ideas and new treatments for cancer?

Dr Gonzalez: I think the only thing that's going to make a difference is people demanding it. What I have seen in my own 25-year career is that there's a greater interest in alternative. People are demanding organics—Whole Foods, whatever people say bad or good about Whole Foods, they provide organics and they're taking over the world. There's one being built 200 feet from my apartment in New York. They're taking over. That's good because people are demanding it. When I was in practice 20 years ago it was hard to get organics in some places. Now in any small town in America you can get organics.

There's been a change. People are going into different oncologists' centers with one of our books and saying, "I want you to work with Gonzalez. I want the … " When the doctors won't do it, the patient throws a temper tantrum and walks out. Sooner or later you beat them in the marketplace. That's one of the great things about the free market in its ideal sense: The best rises to the top, and the worst disappears. Competition. … In terms of scientific truth and finding the real answers, a friend of mine said: Cancer medicine is like a self-perpetuating industry. Could you imagine what would happen if pancreatic enzymes really were found to cure cancer and that was the end of it?

ATHM: What would happen if all of those resources and doctors and researchers were working on other problems instead?

Dr Gonzalez: They don't even realize that they're on a treadmill and this is all they know. They're making a good living doing it and people call them doctor and they get to travel to Monte Carlo for conferences and all that. They get benefits and health insurance and the government work that pays really well these days. I don't think it's even conscious. If you ask them, are you against a cure for cancer? No. But when it comes down to it, emotionally they just can't accept someone like me because it's so foreign to what they believe.

There was one point in the clinical study when everything was obviously going crazy. There was one oncologist from Columbia who said, "Things aren't going well, but we know you say you have patients in your own private practice … Why don't you present some patients out of your own private practice at the next session," because we have these meetings every 3 months at Columbia?

We asked how many cases; he said 10. We put together 10 cases, wrote up case histories. We … blotted out any identifying information, put it together in monograph form, really worked our tails off to do this and had multiple copies made. I don't know, there must have been 10, 12 of them at the meeting. Isaacs and I distributed and they're going through this—these are appropriately diagnosed patients with stage IV pancreatic cancer that have been with us 5 and 10 years, doing beautifully.

Instead of saying "Wow," they got angrier and angrier. There were 10 or 12 people in that room. The oncologist who asked me to do it said, "Wow, these are great cases," and everyone else looked at him scornfully and he shut his mouth. Not one of the other people at that meeting, not one of them, said a word about it. Not "Thanks for doing this, these are great cases," just the one guy slipped and then he shut up because he realized that wasn't the right thing to say. … It's unfortunate that it happens instead of what science should be, the rational, unbiased, unprejudiced, unemotional evaluation of data for the benefit of science, and truth and for patients, ultimately. What we saw in our 10-year experience, it just wasn't going to happen. That wonderful, mystical, coming-together-of-minds for the benefit of truth, science and patients—it wasn't going to be.

ATHM: Are you working on any new projects right now that you would like to tell us about?

Dr Gonzalez: … Our practice has never been busier. We're doing our writing. We're always refining our programming; we never sit still with that. We spend so much time with patients; it's a 7-day workweek. We love it.

In terms of research projects, we're avoiding that until there's a change in the character and quality of the academic scientific world, which I don't see happening right now. That 8-year study took thousands of hours of time, thousands of hours of work, and tracking down the errors and getting the documentation and trying to get these government investigative groups involved. I don't want to go through that again. … We have absolutely no optimism that another study would be done any better.