A Special Interview with Dr. Nicholas Gonzalez

By Dr. Mercola

Dr. Mercola: Hello everyone, this is Dr. Mercola, and today I am here with Dr. Nick Gonzalez, a physician who is focused on the treatment of cancer with strategies that are really quite different than the traditional, conventional approach. He's had really some remarkable results over the last number of years, or decades, I would assume. He'll tell you more about exactly what his approach is. He's located in New York City and has had some really extraordinary successes that we're going to go more into detail. Thank you very much for joining us, Dr. Gonzalez.

Dr. Gonzalez: Thanks for having me and interviewing me. I appreciate the great work that you're doing.

Dr. Mercola: I appreciate what you're doing also. Can you describe to our listeners how this process started with you focusing on treating cancer? Because it's admittedly an area in medicine that even many natural medical physicians are reluctant to approach because of the tremendous potential consequences of going against the system. You know, this is a sort of forbidden area that's rarely addressed -- if you want to maintain your license, at least. I'm interested if you can comment on that, and how you transitioned into what you're doing now.

Dr. Gonzalez: I'd be happy to, and you're absolutely right. The conventional doctors, they accept acupuncture, they accept massage therapy, they accept "spiritual aspects of healing" cancer**.** You get into cancer, that's World War I trench warfare, and you don't go near cancer if you're an alternative practitioner. We go there because the truth is the truth and you have to go where it takes you.

Gonzalez's Work with Dr. Robert Good and Dr. William Kelley

Dr. Gonzalez: My career is kind of unique. I really expected to be a basic science researcher at Sloane-Kettering. I never expected to be treating patients. I went to Cornell Medical College, which is here in New York, and one of its teaching hospitals is Sloane-Kettering. I went to Cornell specifically to start my research career there as an undergraduate medical student.

After my sixth year at medical school, the-then president of Sloane-Kettering, Robert Good—when he died he was considered the father of modern immunology, and the most published in the history of medicine with some 2,000 papers to his credit—kind of adopted me into his research group as the medical student kind-of-protégé guy.

At the end of my second year at medical school, here I was on this track to be a very conventional Sloane-Kettering researcher. I had the opportunity to meet William Kelley,

the very eccentric and very controversial dentist, who had been practicing alternative approaches and nutritional approaches to cancer for some 20 years at that point. I just serendipitously had the opportunity to meet him, and I was not really anxious to meet him because I was really a very conventional guy at that time.

Within about 10 minutes of meeting Kelley here in New York City where I happened to be traveling—I met him through a friend of mine—I realized that this guy was very smart. He'd already been lambasted in the press because he was involved with the treating of Steve McQueen, though he was unfairly blamed for McQueen's death (McQueen died of very advanced cancer, and had terrible terminal cancer when he came to Kelley).

Be that as it may, when I met Kelley he was really reeling from that. His sole motivation was to have his work properly tested because he thought he was doing something valuable, and that if he was, he felt it needed to be in the hands of conventional physicians, which was, in retrospect, kind of an idealistic but maybe naïve approach. The day I met Kelley, I went up to Dr. Good and told him I met this eccentric dentist who had been in the press, and good thing he knew all about the press reports and thought Kelley had been treated unfairly. Good always kind of had an open mind about alternative (medicine) and encouraged me to begin a student project investigation of Kelley during the summer of 1981 after my second year in medical school.

The following day, I flew down to Dallas, Texas, where Kelley, at that time, had his office (Kelley died in 2005, but at that time he had an office down there). I started going through his records, and even though I was but just a second year medical student who happened to complete two years of medical school, I could see right away in Kelley's records there were cases that were extraordinary patients with appropriately diagnosed pancreatic cancer, metastatic breast cancer into the bone, metastatic colorectal cancer—cancers that kill fast, any medical student knows that—who were alive five, 10, 15 years later under Kelley's care with a nutritional approach.

I spent two years and two weeks gathering records in Kelley's office, flew back to New York, and showed them to Dr. Good. On the basis of that preliminary review of Kelley's files, Good encouraged me to do a formal research study, which I eventually developed and completed while I was doing my fellowship in advanced cancer and immunology and bone marrow transplantation under Dr. Good. Among his other accomplishments, he did the first bone marrow transplant in history, which is probably the most aggressive approach to cancer there is, and I was trained to do that, ironically.

I finished my fellowship with Good. By that point, he'd left Sloane-Kettering and went down to All Children's Hospital in Florida, in St. Petersburg, where he established a cancer research division of bone marrow transplant unit under the direction of the University of South Florida. He was getting older at that point already.

I finished my fellowship under him. I went through thousands of Kelley's records, and put my findings together on a monograph, which was divided into three sections. The first section dealt with a theory of Kelley, which I'll talk about in a few minutes. The second section was 50 cases of appropriately-diagnosed cancer under responsible, respectable medical institutions using conventional criteria, the terrible cancer by conventional criteria who were alive five, 10, 15 years later, with tumor regression and long-term survival that can only be attributed to Kelley's program.

The third component, which was an interesting project, the third part of my monograph that would hold the patients Kelley had treated with pancreatic cancer between the years 1974 and 1982 (we just chose those years arbitrarily). Good said I should track down every single patient that entered Kelley's office in that period, because if Kelley could produce one patient report with appropriately diagnosed pancreatic cancer who was alive five, 10 years later, he said that would be remarkable. Because he was president of Sloane-Kettering, he didn't know anybody with an operable pancreatic cancer that was alive five, 10 years later, so if it existed, he would have known.

We ultimately tracked down 23 cases that came into Kelley's office. Ten of them met him once, and never did the program. They were dissuaded by family members or doctors who thought that Kelley was a quack. The average survival for that group (and they proved to be a good controlled group of untreated patients) was about 60 days. The second group of seven patients who did the therapy partially and incompletely (again, they were often dissuaded by well-intentioned but misguided family members or doctors), their average survival time was 300 days.

The third group, initially it was six, there were six patients, we ultimately discounted one because there was some question whether it was colorectal or pancreatic, so I left him out of the final assessment. There were five who were appropriately diagnosed, with biopsies, who did the program fully, all with advanced pancreatic cancer, and their average survival was eight and a half years. It was just unheard of in medicine.

One of those patients (I can use her name because she's given me permission), Arlene, ran a gas station in Wisconsin. She came to see Kelley in 1982, interesting story. She had what was thought to be gallbladder pain, ended up in surgery at a local hospital. They opened up and saw a tumor in her pancreas and a tumor in her liver. They biopsied her liver lesion – it was a poorly differentiated adenoid carcinoma, which is the worst kind, consistent with a pancreatic primary. They closed her up, didn't even attempt surgery, then sent her off to the Mayo Clinic where they reviewed the slide and confirmed that it was stage four pancreatic cancer and gave her six months, maybe a year to live.

She was really lucky to be discouraged chemotherapy. To the Mayo Clinic's great credit, if they know that chemo doesn't work, they're not going to push it onto somebody. In her case, they said "Don't waste your time on chemo. It will just make you sick." She learned about Kelley through a health food store, in her local town in

Wisconsin, underwent the treatment, and she's still alive. I follow her now and it's somewhere to be 29 years -- it was 1982 when she was diagnosed. I know of no patient with stage four pancreatic cancer confirmed at the Mayo Clinic with liver metastasis alive 28, 29 years later.

The Truth about Medical Journals: Why Gonzalez's Book Was Never Published

Dr. Gonzalez: So those are the kinds of cases where I find it quite remarkable, and I put all those together in a monograph form in 1986 where I am able to get it published along with Dr. Good's support. There were two general responses, one there were editors—either trade editors in the regular publishing business or medical editors—who thought it couldn't be true and it has to be fake. They just couldn't believe it.They thought Dr. Good was risking his career.

The other response was from editors who actually believed it, because it was so well-done and in the monograph, we actually had copies of the medical records from the diagnosing hospitals and doctors. Patients gave us permission to use their names, so there's no secrecy, everything was transparent. We even have the names in the original version. The second set of editors believed but thought it was so controversial; it was 1986 to 1987, their careers would be over in publishing, and that the AMA and the NCI would go after them. So we couldn't get the book published. We spent two years. We tried to publish case reports in the medical journals, the whole book, parts of the book, individual case reports, with no success.

Dr. Mercola: Can I interrupt you here, because this is a huge point and many of our listeners, because you're speaking so rapidly, may just gloss over it. Those of us who practice natural medicine are frequently criticized for not publishing our findings. I really never published in journals much before, nothing like you've done, and my justification for it is that it's not going to get published anyway. Here, your anecdotal story, confirms that. We've got—from what you said—Dr. Good, one of the most published authors in the scientific literature at that point and yet he was refused. If the top guy's refused, then how does a general primary care physician ever going to get an article published?

Dr. Gonzalez: They'll throw it in the garbage so fast, you won't even see it. It'll break the speed of light. It'll end up in the garbage so fast it will literally break the speed of light. That's how fast it will end up in the garbage.

Robert Good was at that time, somebody may have succeeded him at that, but he was the most published author in the history of medicine, with literally over 2,000 articles. **{10:00}** He was coeditor/editor of 50 textbooks, and was nominated for the Nobel Prize three times. He didn't win because he was a controversial guy. In fact, there was a book called *Racketeering in Medicine* by Jim Carter, where the introduction talks about Dr. Good, and he discussed the fact that one of the reasons Good was pushed out of Sloane was that he supported people like me, which he did, he would do it. And he was blasted for doing it.

This guy was at the top of his profession: president of Sloane-Kettering, father of modern immunology, and did the first bone marrow transplant in history. Yet, he couldn't get it published. He couldn't get a case report published. In fact, I have a letter. I have it about 10 feet from where we're talking, from one of the journal editors, dated 1987, who wrote to Good. Sir, I have submitted some case reports and a whole monograph to this editor, who was an editor of a very prominent medical journal, a *peer-reviewed journal*. The guy wrote a blistering letter to Good: "You've been boondoggled by a crazy quack guy, don't you see this is all a fraud?" is what it said. And it was just the most extraordinary, irrational letter, when there's nothing snookering, the patients' names were there, the copies of their pertinent medical records were there. These patients were available, any of them could have called these patients, like Arlene Van Straten, 29 years later, she'll talk to anybody, but no one cares, they wouldn't do it, they didn't believe it, they couldn't believe it.

It was very disturbing to me because I come out and I say it. It is what it is. I don't come out of an alternative background; I come out of a very conventional research orientation. And it was astonishing to me. I had some assistant associate professor. I had the president of Sloane-Kettering who couldn't get this thing published because it disagreed with the philosophy that was being promoted in medicine, that only chemotherapy, radiation, or immunotherapy can successfully treat cancer, even though the success rate was abysmal.

The idea that medical journals are these objective and unbiased repositories of the truths about science is totally nonsense. Most of them are owned by the drug companies. They won't publish anything that disagrees with their philosophy. Their philosophy is drugs are good and anything that's nutritious is, at best, worthless, and at worst, fraud and quackery. That's the way they think.

I saw the letters. In fact, there's more than one letter that was written to Good. This particular one, I remember very well because I have a copy of it. It was just blasting me for even having done this project and Good for having even supported me.

By the end of 1987, we realized I was going to get nowhere, and Good was no longer at Sloane, so we didn't have the power base to arbitrarily conduct clinical trials. Kelley was off the deep end because he thought this project was his one chance to get his work accepted. He saw it wasn't even going to get published, so he literally went off the deep end and stopped seeing patients. I last spoke to him in the summer of 1987. He accused me of being part of the CIA plot to steal his work, and I knew that I had to move on. To this day of course, I would give him credit for his great, brilliant innovation.

It's kind of like Semmelweis, who ended up going crazy during the 19th century after showing doctors they should wash their hands before delivering babies, and no one accepted that. Semmelweis just went off the deep end, and that's what kind of what happened to Kelley, I say with great sadness.

Starting the Alternative Cancer Treatment Practice

I came back to New York with Dr. Isaac, who's assisting me in my research, set up for practice and started seeing patients using Kelley's three-pronged approach (which I will get to in a second) and started getting good results right away.

One of the first patients that I saw, I remember it so well, the day before Pearl Harbor, December 6, 1987. She had been diagnosed with inflammatory breast cancer two years earlier. Inflammatory breast cancer is the most aggressive form of breast cancer. The tumor in her breast was so big, they couldn't take it out. Her doctors thought it was an infection, so time was wasted as they put her on antibiotics, meanwhile this tumor exploded. Inflammatory breast cancer can kill you in two months. By the time they realized it was cancer, it was too big to operate, so they gave her radiation to shrink it, operate on it to get it to an eight-centimeter tumor, and 16 of 16 nodes were positive. It was just unbelievable. They put her on aggressive chemo (this is 1985). They said, "You're going to be on aggressive chemo until you die," and that's the way it's going to be. While getting chemo, she developed bone metastasis, stage four disease, and her doctors threw their hands up in the air.

She started seeing me December 6, 1987. Twenty-three years and three months later, she's alive and well, and after a few years on the program, all her scans are clear. She's just unremarkably well. Here's a woman that was given six months to a year to live AND developed metastasis while getting aggressive multi-agent chemotherapy. Not quite 23 and a half years later, she's alive and well, enjoying her life and just doing so well. We could see that Kelley's approach really worked, and when I report these cases, I'm giving Kelley the credit because he really developed this treatment, this enzyme-based treatment.

Recognition from the National Cancer Institute

In 1993, the National Cancer Institute (NCI), as part of a legitimate effort to kind of reach out to alternative practitioners, invited me down to present cases from my own practice– at that point I'd been in practice for six years. I went down and I presented 25 cases. It was a three-hour session, closed-door, invitation-only. The hotshots from the NCI were down there. Some of them had a chip on the shoulder, but some of them, that guy who shared the meeting, the then-associate director of the NCI, Michael Friedman, were very open-minded. He said, "We're really trying to look seriously into alternative practices."

On the basis of that presentation, the NCI suggested that I do a pilot study with patients with advanced pancreatic cancer. The thinking being is that pancreatic cancer is untreatable and is advanced in a conventional world. Once it's beyond surgical repair, there's no treatment that works, be it chemo, radiation, or immunotherapy. They said, if you can get even three patients to live one year, we'll consider that a miracle. They suggested with a pilot study, it's not a controlled group getting chemos, the group with

an advanced, incurable type of cancer getting the experimental treatment, which in this case, was mine. And they suggested 10 patients. Later, of course, no matter what I did, we were criticized. People in the conventional world criticized me for only using 10 patients. But that's exactly what the National Cancer Institute said I needed: With pancreatic cancer, you don't need a whole bunch of patients, because everybody knows they're all dead within a year and a half.

The Unconventional Financer: Nestle

Dr. Gonzalez: Nestle was willing to fund the study. They got an interest in my work, this international food company.

Dr. Mercola: How would Nestle be behind…It doesn't make sense!

Dr. Gonzalez: It doesn't make sense at all. I'll tell you, it's an interesting story because Nestle—I've joked with their research team, they make 16,000 products, none of which I would eat. I live by my rules, I eat organic, I drink carrot juice, I don't eat chocolates and synthetic foods.

The chief of research at Nestle at that time, Pierre Guesry, an interesting guy, French-born, he had been medical director at the Pasteur Institute, one of the preeminent research institutes in the world. He was the director of it. Nestle hired him as a way to set up a basic science research division in nutrition, which was largely unknown and was funded to the tune of like 500 million dollars —Nestle is a 64-billion-dollar a year company. They have a campus in Lausanne, Switzerland that rivals the NIH. It's on a beautiful rolling countryside near Lake Geneva, with building after building, and they give grants to scientists from around the world to come and do nutritional research. The thing is, if they can add nutrients to their junkier foods, it'll make the junkier food healthy. So that's the business motivation.

Guesry was a pure scientist who was trained as an immunologist, and knew about my work. It was 1992 to 1993, just the same time the NCI was inviting me down. I wasn't that well-known at that time, but he had people looking out for alternative practitioners who might be doing something useful -- you know, business that's kind of interesting. They don't care if it's moon dust, if it works, they want to have a patent on it and sell it. They were actually looking very quietly. Very few people know that they had this research group that scoured the world, looking for alternative therapies that might be useful treating just about anything, it wasn't just cancer. They kept coming up with my name, even at that time.

So the chief of research, Guesry, came to New York and started going through my records, and flew me to Switzerland a few times to lecture to their scientific staff, then just announced they were going to fund my study. There were no strings attached at all, they just want to do it for the sake of humanity. They came up with the money. The NCI supervised the pilot study (it was supervised by imminent researchers). We finished it

around 1999, it was published in June 1999 in the peer-reviewed literature, and showed the best results for the treatment of pancreatic cancer in the history of medicine.

Chemo Drugs versus the Gonzalez Treatment

Dr. Gonzalez: To put it in perspective, the latest chemo drug that's been approved for pancreatic cancer dates actually to 1997, and the major study that led to enthusiastic approval of Gemzar had 126 patients. Eighteen percent lived one year; not a single patient out of the 126 lived beyond 19 months. They were similar type patients to ours, advanced pancreatic.

In our little study we had 11 -- one of them dropped out. We had five that lived two years, four that lived three years, and two that lived five years. And one quit the program and died of a heart attack. The other one quit because she was just tired of living and went off the program, and since she was elderly, she didn't want to keep doing the work. But they lived five years. So in our little study of 11 patients, we have five that lived two years.

In the Gemzar study, with a 126 patients—more than 10 times as many patients—they couldn't get one to live beyond 19 months. So these are rather extraordinary findings. All these patients were approved by a team of really good cancer researchers, so there would be no doubt that they didn't really have pancreatic cancer; they just had toenail fungus. There's no question these patients had pancreatic cancer. They were properly diagnosed and their slides were properly reviewed and all that.

That was the good news, Based on that, the NCI decided to fund a large scale clinical trial, again, of my work in the treatment of pancreatic cancer. Only this time, it would be what's called a phase three study, where my treatment would be used on an appointed group of patients, while the second group would be getting the best chemo available at the time, and we will go head to head, and the NCI said "Are you willing to do this?" and I said yes.

They allocated 1.4 million dollars to do the study—it was going to be run at Columbia University. My friends say "Why did you get involved with something like this? How could you trust the NCI?" Well, my experience with the NCI had been, they were very fair, up to that point, and the then-director, Richard Klausner, in face-to-face meetings with me down in Washington, said he really thought I was doing something realty interesting, and needed to be properly supported.

But unfortunately, about a year after the study was approved, he left to go work for Bill Gates or some private organization. **{20:00}**

On Being Sabotaged by the Academic institutes

Dr. Gonzalez: A new group came in, and they had a completely different attitude, and we could tell—me and my colleague, Dr. Isaac—from our first meeting, we knew something had changed significantly, and all the people that had initially been assigned to the study, who were supportive and believed we were doing something useful, were taken off the study. In fact, one of them couldn't even talk to me, that she'd be fired if she talked to me, if she took my phone call.

I was told by another person who had supported me at the NIH that I shouldn't call him at his office, that he was afraid that his line was tapped, and I should only call him at his home. That's how insane the politics over this clinical study got. I couldn't believe it. I just thought this was just something you'd read about or see on TV, or someone paranoid or crazy would make up. Here I was living it. Coming out of Robert Good's group, I don't say that to impress people, but my background was so pure and conventional. It was so unbelievable to see that the profession I respected and wanted to join could behave like this.

We decided not to quit and to stick it out, and eventually the study was, in our estimation to use a kind word, sabotaged. Turned out the principal investigator at Columbia, who's supposed to be completely neutral, had helped develop a chemo regimen that was being used against us, a conflict of interest that was never declared. None of the geniuses at the NCI and NHI told us that we had to find this out ourselves. Not like any clinical study, there are specific requirements for entry into the clinical study.

Ours is a nutritional program, and when the first protocol version was written back in 1997 (the first protocol versions go back to 1998, 1997), we had a list of specified criteria. First, they all have to sign a consent form. This is a federally-funded clinical study—by law, any subject entered into a federally-funded clinical study has to file and sign a form of consent. It's a requirement. They have to be able to eat. We had no undue expectations. We know what we can do, what we can't do. Ours is a nutritional program. Patients have to be able to eat. If they can't eat, they can't do our therapy. They have to be able to take care of themselves.

This is not like chemo, where you show up to your doctor's office, eat ice cream, stick your hand out and watch TV while they give you chemo, which is what happens at the doctor's or oncologist's office.

This is a program the patients have to follow at home. They have to make their carrot juice. We have coffee enema as part of the program, and they have to do their coffee enemas. They have to take 200 pills a day. They have to do these at home. So all of these were written in the protocol. Initially, the patients that could do it, they started to respond. Then, there was a sudden change at around 2000 to 2001, when the Columbia group had total control of the entry of patients into the study. We were excluded from that process, except during initial months. The thinking was that if we

were involved in the admission process, we'd enter the dreaded bias, whereas if conventional doctors were in control, they couldn't possibly be biased.

Of course, the chief investigator helped developed a chemo regimen that's virtually the definition of a potential bias. He started sending us patients that couldn't eat. We had patients that were so sick we would never have accepted them into our private practice.

They were so sick, they died before they got their supplement order. Whether it was a trick to the protocol, the Columbia team, the NCI, and the NHI insisted that we had "an intent-to-treat provision into protocol." What that means – they use this sometimes in drug trials – is that a minute a patient is accepted into the trial, they're considered treated, even if they never do the therapy.

So John Shibo, who was chief of the study at Columbia, would enter patients that were so sick, we had several that died before they even got their supplement orders. But because of this intent-to-treat provision in the protocol, they were considered Gonzalez treatment failures. Ultimately, 39 patients were entered for treatment by us. Maybe at best, being kind and optimistic, maybe five or six actually did it, the great majority was so sick they couldn't do it.

In 2005, the NIH did a review of the study, and actually to their credit, in writing came out with an official statement saying that so many patients had been entered for treatment with us that couldn't/didn't/shouldn't/wouldn't be able to do the program, that the data would have no meaning -- that basically, an untreated control group is what they had created, instead of a Gonzalez treatment group, that most of the patients sent to us couldn't or didn't do it, and that they were psychologically unsuited. Obviously for a program that you had to do at home, that takes a certain amount of motivation. You have to believe in it, you have to be willing to do the work. People that aren't motivated aren't going to do it.

We were being told we have to treat patients that we would never have accepted into our practice and, of course, most of them didn't do it. The end result is chemo looked better, apparently to the great exaltation of the NCI, Columbia, and NIH – that's what I've been told they've been told they're hoping would happen. They would do anything to make sure chemo looked better. It was actually published in the peer-reviewed journal..

We filed a complaint with the office of the Human Research Protection (OHRP) at the NIH, which is an oversight group responsible for making sure that federally-funded clinical trials should be run properly. We filed a complaint in 2006, and they spent two years investigating (of course, you know that government takes a long time to do anything) and they found that 42 out of 62 patients had been admitted inappropriately. This has never made its way into the media. Shibo and the Columbia team were able to publish the article leaving that out, the fact that 42 out of 62 patients were

inappropriately admitted. Yet it was right on the OHRP website, which is part of the Department of Health and Human Services of the NIH.

So the study was a total boondoggle, a waste of 1.4 million dollars. Even though I won the grant, all the money went to Columbia. It's all gone. The data, as far as I'm concerned, is worthless, and the NIH and NCI are using it to show that my therapy doesn't work. So that's how this long journey -- just about in July it will be 30 years from when I first met Kelley -- has gone. Although the good news is, we've never been busier in our own practice.

Finding New Hope in Suzanne Summers' Alternative Health Book

Dr. Gonzalez: In October 2009, Suzanne Summers came out with her best-selling book *Knockout,* which was a book on alternative cancer therapies that sold over a million copies. I'm very grateful that she gave us her longest chapter, and I think nine of my patients are in the book with appropriately diagnosed disease, including two pancreatic cancer patients that have lived five, 10, 15 years since diagnosis. Interestingly enough, I never thought that any kind of recognition would come through other than the usual academic channels, and of course that was a disaster. And the recognition we're getting is from a wonderful actress, Suzanne Summers. She had a history of cancer -- you probably know this -- she had a history of cancer herself. She initially did the conventional routine.

She had breast cancer. She had surgery (it's all in her book), then had radiation, which really devastated her and she refused to do chemo, and that's when she became interested in alternative medicine. She's not my patient, but she does coffee enema, eats organically and has her own organic garden, walks the talk, takes a lot of supplements. She does use our enzymes. And she got so motivated that people like us weren't getting the right recognition that she used her fame to write this book that's still selling now, just about a year and a half later.

So that book, interestingly enough, kind of neutralized the publications about the clinical study. The crazy bloggers went wild, but in terms of mainstream, people are taking Suzanne's book far more seriously than the publication about that clinical study. It's completely misleading, for example, they left out the fact that 42 out of 62 patients had been inappropriately admitted, or that Shibo, the chief investigator, helped develop the chemo regimen, or that most patients by the NIH's own evaluation had done therapy when it was later meaningless.

So that's the whole story. We continue to see patients. Our practice has never been busier, and patients have continued to respond. We're doing a book of a hundred cases now, our own cases with patients with appropriate diagnosis. Now that we realize we can't depend on the NCI, the NIH, and the academic community to do the right thing, we're going to do it on our own, and put out a book with a hundred cases with the medical records, and keep up written case reports, just as I did for Kelley, which was,

hard to believe, 24, 25 years ago. Because of people like yourself and people interested in our work, we'll get the word out one way or another.

What you said earlier is completely correct, the idea that somehow, alternative practitioners are these slimy people that aren't trying to get their work out in the world, but when you do try to get to work into the mainstream medical literature, into the scientific community, they'd rather get hit with a truck. They don't want it. That's the last thing they want to do, they'll do everything they can to sabotage it. I tell people now in this National Center for Complementary and Alternative Medicine (NCCAM), I wouldn't send a dog to that group.

They're not there to help you objectively investigate alternative therapies; they're there to undermine it. It gives the illusion that the government's interested in alternative therapies, when in fact that office is being used, as it was in my case, to help undermine promising useful alternative therapies. So any alternative practitioner who wants to work with NCCAM, my attitude is you stay as far away as you can. Take the first train out of Washington and never go back. Stay away.

Dr. Mercola: That's a sound advice.

Dr. Gonzalez: I'm talking a lot. I hope that's been helpful.

Gonzalez's Three-Pronged Approach

Dr. Mercola: No, it really provides a great foundation. I've got lots of questions I'd like to ask you. A basic confusion in the general lay public (not certainly by physicians) is that cancer is like one disease, and of course it's not. It's a variety of different types of cancers. Like any type of approach, there's probably one program that's better suited for a certain type of cancer. So how would you categorize your approach? Is it good for all types of cancers or is it particularly different for pancreatic cancer, or what type of cancer responds best in your 20 years or so of treating?

DG: A lot of people who know about our treatment would think that it's primarily for pancreatic cancer, but that is not actually the case. We've done our research with pancreatic cancer simply because the National Cancer Institute had asked us to do that and Nestle even put up money for animal studies for a pancreatic cancer model that gave fantastic results, by the way. We treat all kinds of cancers.

The First Step: Finding the Right Diet

Dr. Gonzalez: One of the things that amazed me, and amazed Dr. Good back in the **{30:00}** mid-1980's when I was first doing my investigation of Kelley's records, was the fact that he seemed to be able to treat almost any kind of cancer effectively, from brain cancer, to toenail cancer, leukemia, lymphoma, to solid tumors like breast, lung, pancreas, colon, liver, uterus, ovaries, as well as the immune cancers, leukemia,

lymphoma, myoma. It seemed to work for almost any cancer. Now, he treated his patients individually. Kelley differed from some of the alternative practitioners who were treating cancer, like Gerson, who preceded Kelley, who had one diet for everybody. One of Kelley's genius innovations which you know about, because I know you're big on metabolic typing, is that different people need different diets. When I met Kelley, he had 10 basic diets that he used that ranged from pure vegetarian, nuts and seeds, and raw food to red meat three times a day, like an Atkins diet.

He had 10 basic diets and 90 variations that were all on his computer. His attitude was that different people need different types of cancer treatment. His program and our program today have three basic components: individualized diets, individualized supplement programs with large doses of enzymes, and the third component is detoxification routine.

Now in terms of diet, Kelley had 10 days and 10 different diets, and he found that the typical solid tumors -- tumors of the breast, lungs, stomach, pancreas, liver, colon, uterus, ovaries, and prostate -- needed a more vegetarian diet. He had all gradations of a vegetarian diet, one that was 80 percent raw, one that was 80 percent cooked. So even on the vegetarian side, there were all different variations. Some had virtually minimal animal protein, some had fish, some had also red meat.

A patient that developed immune cancers (leukemia, lymphoma, myeloma, and sarcomas, which are connective tissue cancers that are related to immune cancers) tended to occur in people genetically that did best on a high-fat, high meat diet. Again, there are all kinds of gradations in the Kelley world of meat-eating. From almost pure Eskimo-like (the Eskimos are the traditional pure-meat eaters)—an Eskimo-like diet is where people eat fatty red meat primarily with some vegetables to less intense meat diets. There are all gradations. These are people that thrive best when they eat a lot of fatty red meat, but they don't get high cholesterol or die of heart disease. They're like lions and tigers. Lions and tigers eat nothing but red meat, but they don't get any cholesterol problems because their metabolism is suited to using fatty meat.

Then there are balanced people that do well with a variety of foods, both plant foods and animal products, but they don't tend to get cancer. Cancer tends to occur on the extremes, the extreme vegetarians—those are people that tend to be too acid—or extreme meat eaters, they tend to be too alkaline. Balanced people don't tend to get cancer too much. So we continued the individualized diet approach, as did Kelley.

Individualized Supplementation and the Enzyme Protocol

The second component would be individualized supplement protocol. Every patient gets a supplement protocol designed for their particular metabolism, and they're quite variable. For example, our vegetarian patients need completely different supplements from our meat eaters. The vegetarians do real well with most of the Bs, the meat eaters don't do well with Bs. The vegetarians don't do well with vitamin A, but the meat eaters

do well with vitamin A. The vegetarians do well with vitamin D, the meat eaters not as well with large doses, and so on. The meat eaters do well with calcium ascorbate as a vitamin C source, the vegetarians do well with large doses of ascorbic acid. So the supplement protocols are very individualized and very precisely engineered.

Now, in addition to the vitamins and minerals and trace elements, which we prescribe to help with the general physiological efficiency, we also prescribe large doses of pancreatic enzymes. The essence of Kelley's work was based on the work of Dr. Beard, which goes back to the turn of the last century, about 110 years ago. Beard was a professor at the University of Edinburg, an embryologist actually, not a medical researcher, who first proposed that pancreatic proteolytic enzymes are the main defense against cancer in the body and are useful as a cancer treatment.

Now in conventional physiology, today, and then, a hundred years ago, it was known that pancreatic enzymes are needed for digestion, and Beard said above and beyond that, use that as the main defense against cancer in the body and any cancer, and whether it was leukemia or brain cancer, it would respond with enzymes. He did animal studies and clinical studies that were published in mainstream journals, like the *British Medical Journal*, it didn't matter. It was totally ignored when he died in 1924; he died in total obscurity, even though in 1906 he was nominated for the Nobel Prize because of his work, not with cancer, but with embryology. But his cancer work was extremely controversial. He was attacked in the medical journals. Editorials were written against his enzyme thesis; they thought it was too simple, the way they think it is now.

Kelley kind of resurrected Beard's enzyme therapy and incorporated that into his nutritional approach. My average cancer patient would, for example, take 100, 110 capsules of pancreatic enzymes spread through a day and they worked. I'm not crediting myself as being the great genius that discovered this. It's Beard, 100 years ago, and Kelley, 40 years ago, that really showed that pancreatic proteolytic enzymes above and beyond their digestive functions are extraordinarily powerful against cancer. And indeed, they represent the main defense against cancer in our bodies better than the immune system. I trained as a classical immunologist, trained to do bone marrow transplantation.

The Third Protocol: Detoxification

So the second component is the supplement and the enzyme. The third component is the detoxification routine, like the infamous coffee enemas. Kelley found that as the enzyme very effectively started breaking down tumors, you get all these dead tumors floating around in the body, and the patient would most definitely get sick, sometimes they'd end up in the hospital. He saw a way that would help the liver and the kidneys mobilize these dead tumor toxins more efficiently (the liver and the kidneys are the main detoxification organs, particularly the liver).

Ironically, he was often criticized for his use of his coffee enemas (as we are today in our practice) when he got the coffee enemas right out of the conventional medical literature. Most nursing techs recommended them right up to the 1960s. They were in the Merck manual which was a paradigm of conventional treatments right up until the 1970s. There were a dozen articles about the value of enemas and coffee enemas right through 1960s in conventional literature. They fell out of favor not because they didn't work, but because the drug industry took over medicine, so folksy things like coffee enemas were kind of laughed at.

So Kelley learned about coffee enemas from the conventional literature and incorporated them into his program and found them extremely helpful. When you drink coffee, it tends to suppress the liver. When you take coffee rectally as an enema the caffeine stimulates certain nerves in the lower bowels, sets up as a reflex, and the liver starts releasing toxins. The coffee enema seems to stimulate both the phase one and phase two detoxification systems in the liver to help the kidney as well. We have a whole series of things like colon cleanses, and liver flush that Kelley developed that really help the liver and kidneys work efficiently.

So the program is three-pronged.

Dr. Mercola: If I could just insert one point here. We don't want people rushing out to do coffee enemas**.**

Dr. Gonzalez: Right.

Dr. Mercola: I would totally agree with your recommendation, it's just that to warn people that this is not conventional coffee. This is organic coffee, and if you're going to brew it, you might want to use the non-bleached papers, because you don't want to introduce toxins into your coffee enema, and you're certainly going to do that if you don't use organic coffee.

Dr. Gonzalez: Yes, it's got to be organic, and it's got to have caffeine also. Interestingly enough, this is one time when caffeine is good because caffeine sets up the reflex in the lower colon.

Dr. Mercola: Because it's an herb. Coffee's an herb, a natural herb.

Dr. Gonzalez: That's right. It's loaded with antioxidants. In fact, there are recent studies that I'm sure you're familiar with that show that coffee loaded with antioxidants can have an anti-cancer effect and that coffee may actually help suppress cancer. In our case, we're using it not just for that but because it helps the liver work better. You have to use organic coffee, it has to have caffeine, and you have to use a coffee maker that doesn't have aluminum, preferably no plastic, that kind of thing.

You can go on the Internet now and find out how to do coffee enemas. The Internet can be a blessing because you can learn about these things that were previously kind of lost in old textbooks. So you can learn how to do it. You can't just go out and buy junky coffee from your local supermarket, and expect to get any kind of response. So individualized diets, supplements with enzymes, and the third component would be detoxification. So I hope that answered your question.

Is Carrot Juice Recommended for the Gonzalez Treatment?

Dr. Mercola: It does, and of course, I have some more questions with it. One of the other treatment steps prior to your application of Kelley's protocol was the Gerson approach. It sounds like you're using some elements of that, at least with the carrot juice. I wonder if you can comment on that because from my perspective, just generally, there are some concerns about carrots. Most vegetables are good, but carrots happen to be particularly high in sugars, which can break down and metabolize and push your biochemical pathway scenarios that may be counterproductive. But of course it has some benefits, so I'm wondering if you can distinguish or differentiate between those.

Dr. Gonzalez: First of all, we've studied that issue at length. The University of Toronto developed the glycemic index, about 20 years ago now. And it turns out that some of the technology that was initially used was not as accurate as it was. I mean, they were developing a whole way of thinking about food and glycemic index is just basically the way the body's insulin response occurs when you eat certain foods. The way the index is based on it was zero to 100, and even higher, where 100 is like eating raw sugar. It's like eating cane sugar, like eating white sugar. Zero would be like eating a piece of steak, there's no sugar at all.

So basically what the glycemic index measures, as many of your readers and listeners know, it's basically measuring your body's insulin response to food. The thought that carrots have a high glycemic index has been revised. Some people claim now though, that really has sugar in it, which no one doubts, that it really doesn't have that high glycemic index, and interestingly enough, there seems to be a significant difference between cooked and raw carrots. Cooked carrots seem to have a higher glycemic index than raw carrots. And what we find with our patients that do well with a lot of carrot juice, they usually are vegetarian patients, they need a lot, (the meat eaters need less but we still give them some) they tend to tolerate natural sugar as well and their unique metabolism actually **{40:00}** functions best with a certain amount of natural sugar . . . and they do well with it and actually, they function so well that any downside is overridden.

I'm thinking, and I think what you're referring to, is that if you eat sugar you stimulate insulin response. Insulin-like growth factor can stimulate the growth of cells and can actually stimulate cancer cells to divide, and I wouldn't doubt that for a second. But what we found in our patients who drink a lot of carrot juice and consume up to four glasses a day, they don't get much of an insulin response from it; they seem to handle sugars

pretty well. Now our meat-eating patients, they're the ones that tend to get insulin resistance. They tend to respond with an excessive outpouring of insulin, even to low amounts of sugar. We have to be careful with them. We give them no more than two glasses a day and they handle that pretty well.

Again, there seems to be a difference between raw and cooked carrots in terms of the insulin response and their grading on the glycemic index scale. Also, there are certain nutrients found in carrots like pyridoxine and polyene anti-oxidant flacarinol pyrrho____ that are not found in any other food and have a very distinctive anti-cancer effect. So the traditional use of carrot juice actually seems to be well founded. If you use it judiciously, there's no issue in terms of the overproduction of insulin, which theoretically and in practice seems to stimulate cancer cells to divide.

Dr. Mercola: Interesting. I'm not sure, clearly the insulin response is one component, but in addition to that, there are some other variables. If you look at insulin response with fructose, which is probably the most well-documented, pernicious sugar you can have, it has no insulin response or at least relatively, the insulin response is moderate but its glycemic index response is very low. So it really throws the whole glycemic index into question, at least from my perspective.

Dr. Gonzalez: My patients read about it all the time since it has been promoted in the scientific community and the alternative world as well. I don't find a use for it at all for the same reasons that you're suggesting. There are certain foods like carrots that were thought to have a high glycemic index that actually don't, and certain foods like fructose that are pure sugar that don't stimulate an insulin response, which is why it was so heavily promoted in the 1980s although this was a big mistake.

Dr. Mercola: Sure.

Dr. Gonzalez: It turns out it has all kinds of negative effects. It can raise cholesterol and cause liver damage. It's a real problem. You have to be really careful when relying on the glycemic index. Again, we find that carrot juice is really very useful and we have great success when we're gulping down a fair amount of it.

Dr. Mercola: That's why I was interested in your response because clearly anecdotal observations are going to be really powerful, especially in a system or format that is absolutely designed not to publish findings in the scientific method that are valid or really supports this type of approach.

Dr. Gonzalez: Right, exactly. There are some people who use 13 glasses of juice a day. It's not all carrot, these are a variety of juices, but it's really a juice-based therapy. I know Charlotte Gerson well. She's Max Gerson's daughter and she's going to be 90 soon. I know his grandson, Howard Strauss. He's a good friend of mine. I respect what they're doing and they respect what I'm doing. What we do is somewhat based on Gerson. We use organic; Gerson, 60 years ago, was telling people to eat organic. We use some juicing; he used a lot of juicing. He used coffee enemas and we use coffee

enemas. But he had one diet for everybody, which was really pretty strict on raw foods and vegetarian; we have different diets. In our conversations, Charlotte was trying to figure out how our therapy became as effective as it is because it differs from what her dad did. She's open-minded and she listens. In some respect, we look at Gerson as an antecedent, kind of our grandfather because we've taken the therapy into another direction.

Dr. Mercola: I think a big part of that is what you've mentioned earlier but with all the information that was presented, maybe some listeners were overlooking the fact that you used Metabolic Typing, which I re-coined as Nutritional Typing because we made some refinements on it. That there's this very specific dietary approach that is customized for the individual, and is not one-size-fits-all. I think it's clearly a good factor or consideration as to why you're getting such phenomenal results.

Good Health from Different Diets

Dr. Gonzalez: Yes, there's no question. Kelley used a different diet for different people and brought his treatment program [indiscernible] to a different level from previous nutritional positions. He was very wise. When we look at the human species in terms of our past history, humans have adapted and lived in all kinds of ecological regions. The Eskimos lived up in the Arctic where there's no growing season. As I always say in my lectures, there are no fruits, vegetables, nuts, seeds, and grains, but there's fatty red meat. The Eskimo diet was studied extensively in the 1920s and 1930s and even more in 1972 and just recently in March 2011. Right up until a few decades ago, their daily nutritional diet was all meat – 80 percent fat and 20 percent protein. It really wasn't high-protein, it was fat that they lived on as there were no fruits and vegetables. They lived on fatty animals. They craved fat and they ate fat and they were fine. When they were studied by McGill University, they were found to have no heart disease, atherosclerosis, diabetes, insulin resistance, and cancer; they were really healthy people.

Then you get the Polynesians, who were more vegetarian. The traditional Polynesians eat fruits, fish; it's a largely fish-based culture, and they were extremely healthy too. The Maasai in Africa were extremely healthy. They were studied by George Mann of Vanderbilt University during the 60s. They lived on raw milk, not pasteurized, and blood. That's 70 percent fat, but they were healthy – no heart disease, diabetes, or cancer.

So humans adapted to a variety of environments – from the Serengeti plains to the high Andes to the Polynesian islands to the Arctic Circle – where there were different food sources. Humans adapted and it has really changed the genetics. A Polynesian doesn't have the same nutritional genetics as an Eskimo. An Eskimo doesn't have the same nutritional genetics that a Massai has. We have different groups of people thriving on completely different diets and we have to recognize that. People that promote one diet for everybody are mistaken; it doesn't make anthropological, nutritional, and genetic sense.

Unlike most species, humans are a really varied species. We have adapted to, survived, and thrived on different anthropological niches. We have to answer to our ancestry. I

have to eat red meat at least four or five times. I'm not a pure carnivore, but I'm on the carnivore side. I've tried vegetarian diets as an experiment and I lasted about three days. I got so depressed that I just wanted to stop living. If I eat read meat I can work 14 hours a day, and I see the difference in myself in about two days when I switch diets.

So that's very important, and I know that you appreciate that in your own work. Different people need different diets, and that should be the basis of all nutritional therapies today.

Dr. Mercola: Dr. Kelley was a dentist and as you mentioned earlier, he passed away six years ago. For whatever reasons, you disassociated yourself from him 25 years ago. You're a really bright guy, and you're obviously very sharp and clear as can be. You've got phenomenal training. So I'm wondering if you can comment on any revisions, refinements, or advancements that you've taken Kelley's work to.

Dr. Gonzalez: Yeah. We also keep up with the nutritional literature. I read your site all the time because I learn a lot from your site. Once, one of the nice things about going online is all the medical literature is now on the Internet. You can get anything, so it really makes it easy to keep up with the literature. Twenty years ago, I'd have to go to the library to do it.

We refined as needed. For example, 25 years ago, Kelley knew about the omega 3 and omega 6 fatty acids and all that, but a lot of the research on the value of the omega 3s was really done in the last 10 years. Kelley would put people on flaxseed oil and some fish oil sometimes, but it wasn't a big part of his treatment. He never talked too much about it. On the other hand, we realize – I know you do -- that we're very much interested in the effects of omega 3s. This is new research. It's not that Kelley was blind or failing on his part; the literature hadn't been developed the way it is now.

For example, Coenzyme Q10, back in the 1980s I don't remember even hearing about it. I learned about it in biochemistry as Ubiquinone – that's the technical term for it as part of an electron transport train – but I didn't know anything about it as a supplement. I don't even think it was available in the 1980s, and then suddenly in the mid-1990s, everyone was talking about Coenzyme Q10. So we looked into that and we learned how to use that in terms of the different types, even that you have to use it specifically. The vegetarians need different doses compared to the meat eaters.

So we incorporate the new nutritional findings as we can, always using Kelley's model as the foundation. What Kelley provided for all of us is a foundation on how to approach patients nutritionally. It eliminates a lot of the confusion, antagonism, and controversies in the nutritional world. Atkins thought everyone was a meat eater; he was partially right. Keevican and Ornish think everyone should be a vegetarian, which is partially right. The trouble is that they generalize and Kelley said, well, some people should follow Keevican, some people should follow Atkins, and some people would do terribly on those diets.

This gives us a model to work with. What we do is, as new nutritional information becomes available, we try to incorporate it into our program. For example, we find that our meat eaters really thrive on fish oil. I know you recommend krill oil, which you think is also excellent.

Dr. Mercola: Yeah, animal-based omega 3 – that's what it is.

ALA for Vegetarians, EPA and DHA for Meat Eaters

Dr. Gonzalez: Vegetarian patients, interestingly enough, tend to do better on flaxseed oil, which has the alpha linoleic acid (ALA) – a plant-based omega 3. It is thought that the conversion of the plant-based ALA into the fish-oil based eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) is not that efficient. We find that our vegetarian patients actually do it very well and don't use the fish oil or animal-based omega 3.

Dr. Mercola: That's an interesting observation. Do you find that there's something special about flax or you can use chia or hemp?

Dr. Gonzalez: Any of those will do fine. Yeah, I'm using flax generically (50:00) but any of the ALA-containing oils will do, like hemp oil which, again, in Kelley's day was not available. We use flax oil and hemp oil. It depends on what the patient can tolerate better than the other. But our vegetarian patients tend to do extremely well with plant-based omega 3s and not as well with the fish-based omega 3s, despite the feeling in the conventional nutritional science that the conversion from ALA to EPA and DHA is not that efficient; we find it very efficient in those patients. For the meat eaters, they need the EPA and the DHA. They need the krill oil or fish oil based fatty acids. They don't do well with flaxseed. Those are the people who can't make the conversion.

Dr. Mercola: Well, that's a really powerful observation. Thank you for sharing that. I have some other specific questions. Everyone knows, of course, that vitamin D has been associated with decreasing the risk of cancer, but there seems to be some questions, at least to my understanding, on the literature that using high doses of vitamin D for someone who already has cancer may be less beneficial than actually preventing it. I'm wondering what your observations have been on the use of vitamin D.

Vitamin D Supplementation for Cancer

Dr. Gonzalez: I would answer again based on the Kelley model. He was a very good teacher and he said that you always have to approach every nutrient as something that can cause harm or something that can be lifesaving. It depends on the patient, the metabolism, the situation, age, sex, and all that. He would look at every nutrient in terms of who was this patient, the disease does he/she have, their metabolism, and their nutritional or metabolic type and incorporate it accordingly. As you know, particularly in the conventional world, the thrust is in large doses of vitamin D. I had a patient come in recently whose conventional physician had her on 50,000 IU a day for months.

Dr. Mercola: It was probably a vitamin D2.

Dr. Gonzalez: I don't even know because she didn't have it with her.

Dr. Mercola: Conventional physicians, that's what they use – D2.

Dr. Gonzalez: You're right, it probably was. We get people on these large doses. I had a patient with breast cancer – fortunately she's doing fine now – and she was trained in biochemistry. Against my advice and without telling me, she went on high doses of vitamin D and her cancer started to explode and I'm pulling my hair out and I'm trying to figure out what the heck was going on. I checked her supplement orders and she was taking everything.

But what she hadn't told me was that she had gone on with really high doses of D. We immediately reduced it when I found out. She was on like, 20,000 IU a day because she thought it was helpful and her cancer exploded. We took her off all of it for a while until we felt that the excess had been neutralized and excreted and then put her on 2,000 units per day. I've read studies that show that even moderately excessive D, if you use 40 to 60 as a normal range, above 60 can stimulate cancer growth.

Dr. Mercola: Interesting.

Dr. Gonzalez: There's a wonderful, a wonderful site though, on the web, the Autoimmune Research Foundation, that has an e-book. You can access it for free, where they talk about the dangers of excessive supplementation of vitamin D and the rush to over-supplement is going to backfire. Just as it is with every drug, you have to look at every nutrient as following a normal distribution curve of activity, on pharmacology, second year of medical school.

Too low a dose or too high a dose is going to be a problem and often can cause the same symptoms. Nutrients are no different. Nutrients are the ultimate regulators of metabolism and were designed to fit into metabolic processes much more efficiently than drugs – that's what they do – and they also follow a normal distribution curve in every patient. Too much or too little and you're going to have problems.

Too little vitamin D, unquestionably, increases the susceptibility of developing cancer, as 21 cancers have been associated with vitamin D deficiency. Too much of it can make cancer grow. I've seen it in my own practice in patients who, against my advice, have taken high doses.

Dr. Mercola: Finishing up on vitamin D, clearly, we're designed to get vitamin D by exposing our skin to the sun so we're never designed to swallow oral vitamin D. The fact that we can do it is good, but it's really not part of the grand scheme of things. I'm wondering if you've noticed any difference in people who're getting their vitamin D from skin exposure to ultraviolet rays of the sun or safe tanning beds versus oral.

Dr. Gonzalez: Right. We think that sun exposure is the best way to do it, but of course, as you know, you can never have an excess with sun exposure because any excess D is immediately neutralized right in the skin. So with this fail-safe mechanism for vitamin D production in the skin, you literally cannot get toxic from skin exposure. In fact, it's

estimated that farmers in the Midwest will produce 10,000 IU in an hour and they never end up with vitamin D excess and they're out there all summer in the sun. There's a fail-safe mechanism. The toxicity has been grossly exaggerated in the past. It is true that too much D can be a problem but with sun exposure, it seems that whether you are a vegetarian, a meat eater, or balanced, the body seems innately able to regulate the production to exactly where it should be according to innate metabolism. So the body is far wiser than any doctor, including me.

Sun exposure, which is the natural way we get D, is good. Now the Eskimos live in place where there's 10 months of winter and six months with no light. They eat a lot of fish liver and they would eat animal liver. Vitamin D is found in very few foods, and fish liver and animal liver are among the sources. They eat fish liver and they have enough vitamin D from that. They would go through six or seven months a year with 24 hours of night.

You have to select your foods carefully if you want to get vitamin D from a food source. Beef liver has some, but not as much as fish liver. Fatty fish meat like salmon has some vitamin D but as you suggest, the vitamin that's found in many foods is not very efficient. Vitamin D conversion of cholesterol from the actual ultraviolet light is the best way to do it.

Iodine Supplementation as a Defense against Radiation

Dr. Mercola: I've got another question on a supplement or nutrient that's timely because of the timing of this interview. We're still in the process of resolving the Fukushima nuclear disaster, so this whole issue of radioactive iodine is in effect. As a result of that, one of the recommendations, at least for those exposed to the radiation, is to take large amounts of iodine. I was researching that and came across Dr. Brownstein's information and I suspect that you've heard of it, recommending iodine in relatively high doses, 10 to 15mg and even 100mg.

Dr. Gonzalez: It goes up to 130mg per day.

Dr. Mercola: My understanding after having read his book is he believes that it's largely responsible for dramatically decreasing breast cancer, primarily as a result of the change in the conversion of the estrogens. There are three types of estrogen and it tends to convert the estrogen to the less dangerous form, actually the protective form. I'm wondering what your experience has been.

Dr. Gonzalez: There's a long history of people believing that iodine is very important for breast health and I think that's true. My friend Jonathan Wright has long been promoting that. Brownstein has been doing that, and he goes up to 130 mg. Unquestionably, iodine is essential for normal breast health but again, we use a whole program. I rarely, if ever, go to those high doses. Now facing the radioactive exposure, which is a real issue, it has been documented in the conventional literature that if you take a high dose of iodine, sometimes just one dose, that you can block the thyroid absorption of radioactive iodine. Radioactivity seems to really concentrate in the thyroid so that's

particularly susceptible to any problems down the road form radiation exposure. Iodine will do that. Even now with my California patients who really understandably, are semi-hysterical about the wafting over of the radioactivity in the air current, and there is radioactivity in the northwestern Pacific in California, we're telling people to go with the lower doses, like with the Iodoral, 12.5mg per day. We're not going to the 130mg. I just don't think it's necessary. Also, you can provoke hyperthyroidism even with one dose of 130mg. I don't know how he gets away without seeing that, because I've seen that in patients who've done that on their own. Again, just like the one who experimented with the vitamin D. We've seen patients start getting hyperthyroidism from the overuse of iodine.

Dr. Mercola: But it's not part of your protocol?

Dr. Gonzalez: Not high-dose, no.

Dr. Mercola: Twelve milligrams, not necessarily 100, but 12 or 50mg?

Dr. Gonzalez: We don't use that routinely. I use it sometimes depending on the situation. We put all of our patients on iodine but usually on the more standard doses in the microgram levels. They might be taking up to a milligram a day. We find over time that for most people, that's usually enough, including women with breast cancer and I've seen a lot of really advanced breast cancer.

Dr. Mercola: Absolutely. Part of the other reason, too, is he used it for detoxification because of the exposure that we have to bromine, fluoride, chlorine, and dioxins and because these are halides -- they tend to bind to these receptors and by displacing it with the good iodine, you can actually detoxify those toxic elements out of your system. So it has a two-fold approach.

Dr. Gonzalez: Yeah, that's true. We use a lot of sodium alginate as a detoxifying agent. We find that that's one of the best chelators for heavy metals. We use it routinely in virtually our entire practice. We find that it gets rid of heavy metals as well as the halides. So I do agree with him that the halides are a real serious problem and they're everywhere. People are so pleased now. They're not swimming in chlorinated pools but in brominated pools (60:00).

Dr. Mercola: That's 10 times worse.

Sodium Alginate is a Powerful Detoxification Agent

Dr. Gonzalez: I just can't believe it if that's supposed to be an improvement. That's 10 times worse, exactly. These halogens are highly reactive, and they cause all kinds of trouble unquestionably. I agree with Brownstein completely. We use sodium alginate, which has iodine in it, and it's very effective. I tend to – having been trained by Kelley -- like the whole foods approach. I like the alginate, rather than the isolated iodine.

Dr. Mercola: Sure.

Dr. Gonzalez: We always find that nutrients when they're with all these associated co-factors tend to work more efficiently even at lower doses. There's a lot of truth to that.

Dr. Mercola: Where does alginate come from? Is it from seaweed or sea vegetables?

Dr. Gonzalez: Yes, it's a seaweed. We get it from seaweeds. We have a preparation that we put together and it's very effective and that's what we use. There are all kinds of things that help with heavy metals as you know, from chlorella and on down. We find that sodium alginate is terrific. It's an algae and it chelates the heavy metals and the halides. I never use intravenous chelation. We just use sodium alginate to get rid of heavy metals, and it's very effective. You take three capsule three times a day away from meals. You don't have to stay on it indefinitely. We have patients do it for six weeks total, and that will get rid of most of the heavy metals and the halides, and if it's still a problem six months later, we'll have them do it again.

There's so much pollution in the air. A little known fact is that heavy metals can be aerosolized. There are heavy metals in the air. China is dumping tons of aluminum into the air. You don't have to use aluminum plastic bands anymore to get aluminum. All you have to do is breathe and most of us have to breathe. You're going to take aluminum in just from breathing, courtesy of the Midwest and China, from our own industry as well as the Chinese industry, which is totally unregulated.

Heavy metals are a constant problem. We virtually have our entire practice detoxified from heavy metals with sodium alginate every six months. We just find it necessary. Fifteen years ago it wasn't as big an issue, but we've seen the change in our own practice.

Dr. Mercola: What was that regimen you recommended again?

Dr. Gonzalez: Three capsules a day, three times a day away from meals.

Dr. Mercola: Have you actually compared that to alternative approaches, to other algae like chlorella?

Dr. Gonzalez: To be honest, I haven't done a direct comparison. When I found that it worked so well, I never looked elsewhere. I keep up with the literature. Other doctors I know get good results doing other things and I will never claim that what we do is the best on Earth. When I found that it works so efficiently, and it's so inexpensive, that we just have never looked anywhere else. I look at other things like chlorella, but our option is really working so well that I don't really want to change anything.

Dr. Mercola: You said it works so well. Is it documented by hair tests or analysis?

Dr. Gonzalez: Yeah, hair tests, urine tests, and blood tests. I had one guy who came in, a Japanese industrialist worth millions and he kept an apartment in New York. He had a nutritionist and told us he eats fish twice a day. In Japan, they had a big mercury leak in the 1950s. There was an epidemic of multiple sclerosis and there's still mercury in the waters of Japan because of this leakage from 50 years ago. Mercury doesn't

degrade; it just sits there. He started eating fish twice a day. He ended up with really significant mercury toxicity that was documented by his fancy conventional doctors in Japan and the fancy doctors that he consulted in the U.S. They didn't know what to do with him. He came to me and he had neurological symptoms. He was afraid of getting MS, of the numbing, tingling, and weakness. We put him on our program, on the alginate.

Within six or eight weeks, his mercury levels – the conventional doctors were doing the tests with the red cells, total blood, and urine – went down to the normal range. When it started going down the normal range, it took about six months to get it there completely. This is a guy who had overt mercury toxicity from the over-ingestion of toxic fish from the Japanese waters that had mercury dumped. He was eating fish twice a day thinking he was helping himself. He was really doing great and he's never had a problem ever since. In cases like that – he came to us with overt heavy metal toxicity – this was a really startling effect. I should write it up but no one will publish it.

Dr. Mercola: Yeah.

DG: We'll put it in our book. Well, the alginate really did the trick.

Dr. Mercola: Could he have taken the alginate with the fish so that proactively, the alginate will bind with the mercury?

DG: Unquestionably. Had he done that, he would have been protected. Whatever he was doing, he was not protected. He was trying to eat healthy. He'd have to take a pretty hefty dose – nine capsules a day – but I think that would have protected him. Absolutely.

Dr. Mercola: So that people who want to apply that proactively, who'd like to take fish, is it sufficient to take it with the meal or away from the meal, too?

DG: What I would suggest, I would take it away from meals. The reason is because it can interfere with the absorption of some useful minerals and trace metals like selenium. So you might want to take it on an empty stomach. Alginate is so powerful and it will leach out. For example, if you take it with a mineral supplement it will very happily chelate to the minerals in the supplement. So you want to take it away from meals.

Any mercury that makes its way into the blood or a tissue, it's going to suck it out. Even if it's on the tissue, it kind of sucks it out. It's quite remarkable. It's usually best to take it away from meals even if you eat fish. I eat fish and I take alginate periodically. What I do is about once every six months, I'll just take it for about six weeks and that's it. Until I figure out a way to avoid pollution in the air. I still have to breathe so I'll be taking in aluminum. I do it every six months.

Dr. Mercola: I was in Florida this year escaping from Chicago's winter when I encountered another physician who explained to me that there are some researchers from the University of Florida who actually looked at the mercury levels and thought that

they were high in the everglades where the fish were contaminated. They thought it was from the coal-burning plants, but they've learned when they studied this more carefully that – they're doing an article on this – it's actually from air currents and most of it was coming from overseas and being deposited back in the United States!

Dr. Gonzalez: Yeah, that's right.

Dr. Mercola: You can't get away from it.

Dr. Gonzalez: People, even doctors, think that heavy metals are like rocks, but mercury can be turned into a vapor. That's the problem with these new mercury light bulbs. If they break on the floor, you're going to have mercury vapor immediately going into the air. It's liquid at room temperature and it can be aerosolized. The Chinese are very efficient turning aluminum – a nasty heavy metal-like substance which is in minerals and rocks – into a dust that wafts around in the wind currents and keeps circulating in the air.

Mercury will float around in the air currents when it's converted into a gas. We worry about it in the ocean, but I'm more worried about it in the air. We don't have to swim in the ocean; we can choose safe fish. But you have to breathe and when you breathe you're going to take mercury in. So alginate helps you survive that onslaught.

Dr. Mercola: Yes, it seems to be one of the hard effects of living in the post-industrial age. Are there any other pearls that come out of your detoxification program?

Coffee Enemas

Dr. Gonzalez: I've done coffee enemas since I met Kelley. I was this really refined conventional medical student, and when I met Kelley I was doing things like carrot juice and coffee enemas, much to my classmates' horror. I've been doing coffee enemas for 30 years now and I think they're important and one of the most effective detoxification tools around. They really work.

Dr. Mercola: So you think it's a good idea for most people to do it proctologically?

Dr. Gonzalez: Yeah, I'm prejudiced. I think the whole world should do it. I was once speaking at a conference with mostly doctors out in Colorado, and there were quite a number of conventional doctors there who were interested in nutrition. One of them got up, and he was polite, but he kind of confrontationally said "Dr. Gonzalez, coffee enemas are abnormal. How can you defend them?" So I looked at him and I didn't know what he expected me to say and I said "I agree with you a hundred percent; they're totally abnormal. When you clean up the world, my patients will no longer have to do coffee enemas and I'll stop them too. Until the world is cleaned up, you have to do extra things and extraordinary things."

Dr. Mercola: That's a pretty solid argument supporting your views. What is your recommendation for an ideal person and someone who's healthy?

Dr. Gonzalez: I drink two pints each morning and each pint holds 10 minutes. I use my time productively. That's when I read journals.

Dr. Mercola: You do it every day? I had no idea.

Dr. Gonzalez: I do them every day, yeah. Every day of the year. I work 14-hour days. I treat very sick people from all over the world. I work seven days writing books, doing research, and keeping up with the literature. It's a lot of work and I don't complain. I love what I do. The reason I'm able to keep up that pace is because I do my program. One of the things that I do religiously – Kelley did them every day of his life. I drink two pints. Each pint you hold 10 minutes. There are two pints in a quart. Half a quart is a pint, 10 minutes, poop it out. Then you do another pint, 10 minutes and you poop it out. They really make a difference.

Dr. Mercola: What do you do to stay productive during that time?

Dr. Gonzalez: I read, I keep up with my reading. You can't do much. You can't run around the block; you're kind of stuck there holding an enema. You get really good at it. I literally couldn't run around the block. I "lose it" without losing it, I should say. I use the time productively. It forces you to read and do useful things.

Prioritizing Anti-Cancer Strategies

Dr. Mercola: Excellent. I think most of the people who are listening would love an answer to this question. You're clearly recognized internationally as one of the leading experts in treating cancer internationally. What would your recommendations be for general treatment strategies for cancer? How would you prioritize them? I think you can shoot up a number of them, but I think the priority would be particularly useful for most people to understand.

Dr. Gonzalez: First thing is clean food. Food is the essence of our metabolism. Everything we are comes from our food. Every cell in our body is made up of things we get from our food. So food should be of the best quality, whether you're a meat eater or a vegetarian – the cleanest food, organic food, grass-fed beef if you can get it, which you can get now pretty easily. The cleaner the food, the better.

In terms of supplements, the single most important supplement for the prevention or treatment of any kind of cancer – from toenail cancer to brain cancer – are the pancreatic enzymes. (70:00) As I've gotten older, I take about eight to 10 three times a day, I take about 25 to 30 a day spread throughout the day in three doses.

Dr. Mercola: So this is not necessarily just for treatment of cancer, it's also for prevention.

Dr. Gonzalez: Yeah, we think – speaking for Dr. Beard and Dr. Kelley – that pancreatic enzymes are not only useful as a treatment for active cancer, but are the best preventers. There are lots of nutrients that help protect against cancer. Enzymes are the best of them.

Dr. Mercola: Now, from a historical perspective – and we both believe in Paleolithic nutrition – we're not swallowing down pancreatic enzymes. Is the recommendation for this really the challenge we have?

Dr. Gonzalez: The cavemen were not getting cancer either, and the reason is because all their food was grass-fed and organic. They weren't prone to cancer. We're in a different world. It's like what that doctor said. It's not normal to take enemas. He's right. It's also not normal to take supplements, and I agree. None of us should have to take supplements.

But in this world, there's no way to maintain our good health without taking a fairly hefty dose of supplements. Even the best organic food is still going to be susceptible to acid rain, which carries pollutants. Like what you just said in the everglades, they're finding mercury in the soil. There's going to be mercury in the soil of organic farms even if you have the best farmer in the history of organic farming. The rain is going to dump mercury into his crops.

You can't get perfect food anymore. You need supplements to help override that. Stress is unbelievable; all of my patients are under stress. The politics, whatever their political persuasion, they're under stress because of the economy and politics and the way that the world is going. Pollution is not getting better; that's a dream and an ideal. Pollution is getting worse each year. We're seeing heavy metal problems in 2011 that I didn't dream about 10, 15 years ago. It's just unbelievable. In my own practice for over 15 years we've seen a change. The world is out to get you. You have to take supplements if you want to maintain ideal health.

Dr. Mercola: Any advice on the specific types of pancreatic supplements?

Dr. Gonzalez: That's an interesting thing and we often get questioned about that. Most pancreatic enzyme supplements are made by maybe two or three U.S. companies. They're all based from a 1951 patent from Ezra Levin, and he was a brilliant guy during his time, but that patent's about 60 years out of date. It used toxic solvents and alcohols, and those were the enzymes that were available when Kelly rose to fame. But what we did during the 1990s when we first started our practice, Isaacs and I developed our method of making enzymes. They made it for us in New Zealand. Traditionally, they've only been available to our patients and we figured they were the best – of course I'm prejudiced – because we see in our practice that they really work.

During the 1990s, we had funding not only from Nestle but from Procter and Gamble. We were able to invest in a big major effort to test different methods of making enzymes and that's when we perfected our method of making enzymes. Traditionally, they've been only available to our patients, but the allergy research group NutriCology now has our enzymes.

Dr. Mercola: What are the characteristics of your enzymes that make them different and better than other ones for its purpose or application?

Dr. Gonzalez: The first thing is they make it for us in New Zealand. Why New Zealand? New Zealand has the strictest laws for raising animals. They've never had Mad Cow**,** trichinosis, none of that. It's the cleanest stuff on Earth or animal products, and our enzymes come from New Zealand.

New Zealand is still the cleanest place on Earth. When we had the money from Procter and Gamble, they assigned a whole team to work with us, including an enzyme chemist. We checked pancreas products, just raw pancreas from the Omaha feedlots, from Australia, and from New Zealand, and we found that the pig pancreas is most like the human pancreas. So most pancreatic enzymes are made from the pig pancreas; they're either freeze-dried or processed. We found that for pigs raised in New Zealand, their pancreas had a much higher content of enzymes than any animal raised in the U.S. You can see the difference. Just the fact that it's in New Zealand means that its pancreas is going to contain more enzyme gram for gram. They're healthier animals and they produce more enzymes. You get more enzymes and you get more bang for the buck from New Zealand pancreases.

Secondly, most pancreatic enzymes are highly processed. In the pancreas, the pancreatic proteolytic or protein-digesting enzymes, which are the main anti-cancer enzymes, are produced in a precursor, inactive form because if they weren't, they'll dissolve the pancreas and you'd end up with pancreatitis and die. So the pancreatic proteolytic enzymes are produced in an inactive precursor form, and it was thought by Levin that in that form, they will have no effect and be useless in terms of digestive aid. In the industry, for example, Nestle uses pancreatic enzymes to help process their chocolate and make it smoother. Leather tanners use pancreatic enzymes. They use trypsin to make the leather smoother. There are a lot of industrial applications for pancreatic enzymes in addition to their use in medicine.

It was thought that you needed the active enzyme, so Levin developed this complicated method of activating precursors like trypsin, and he thought that this was a great innovation for the pharmaceutical companies. The problem was it was very unstable. Pancreatic enzymes digest protein, and enzymes are proteins themselves, so when they sit in a jar in a drug store or health food store, they start auto-digesting and you often end up with a pile of amino acids. In their precursor form, they can last 10,000 years. Bury them with Egyptian mummies and 10,000 years later our enzymes will still be in their inactive form.

Dr. Mercola: So all of your enzymes are in the precursor form?

Dr. Gonzalez: No. We found that for treatment of cancer, for use in humans, you want a certain percentage in the active form and a certain percentage in the inactive form and that worked best. We tried all the different combinations and proportions, and we have to be grateful to Procter and Gamble for giving us all the money to be able to do all this stuff because some of these tests are expensive. We found that a certain percentage should be active, most of it is inactive, and there are studies, a guy by the name of Novak from Hungary, they learned about Beard's work totally independent from me. They started testing pancreatic enzymes against cancer models in animals and they

found that the precursors are actually more active against cancer than the activated enzyme.

One of Kelley's mistakes – he said that we would have to refine the program – was he thought he wanted the enzymes to become more purified and more activated. As I went through his records I found that when he went to the more active preparations, the success rate actually started going down. That's one reason why he ended up so frustrated. We couldn't get our book published, and also his success in the mid-'80s wasn't what it was in the early '80s. He went to a more processed product, more active. It was virtually all active, but it wasn't really active at all and it turns out that Novak has found that the precursors are actually more active against cancer specifically than the activated enzyme. He wrote a paper on that in the literature.

We found that just serendipitously and independently, just before Novak could actually publish. We just observed that on our own clinic and I observed that as I went through Kelley's records. I went through his records year by year, beginning in 1972. I found that the less processed the product he used, the better his success, and then as he kind of got hooked into using a more processed and a more activated approach in the mid-'80s, the success rate went down. We want pancreatic enzymes to have a certain percentage active, but most of them should be inactive precursors, particularly if you use them to treat cancer. At first they'll last longer on the shelf and are far more stable but also, the precursors seem to have the main anti-cancer effect, which is kind of a new finding.

The allergy research group NutriCology has enzymes done according to our specifications. But that would be my advice – get an enzyme that isn't completely activated. More active isn't better in terms of pancreatic enzymes, just like more and more D isn't better than the right dosage. You want the right proportions of activated and inactive.

Dr. Mercola: Excellent. So those were the primary characteristics that distinguish yours from the others?

Dr. Gonzalez: Yes, that it has a precise percentage of activated versus inactive, most of it is an inactive precursor. The other thing with most of the processes that are used to make enzymes is that the pancreas is a particularly fatty organ. As for Levin, who believed 60 years ago that you have to get rid of all fat because it's just inert, now we know that fat is not inert and it's very metabolically active. It turns out that the pancreas' fat has enzymes that work synergistically with the proteolytic component.

All of the enzymes that are made today are basically de-fatted, and they use these toxic alcohol solvents to get rid of the fat from the freeze-dried pancreas. We leave a certain percentage of fat. We find that it works best with about 25 percent of fat, 75 percent proteinacious material. So even in terms of the fat component, if you test a product like Biadin, which for years has been the standard pancreatic enzyme in prescription form, for like one percent fat, they literally de-fat it using alcoholic solvents. We found that that's not the way to go. We also found that if we leave a certain percentage of fat, it's more stable on the shelf. We just tested an enzyme that we've had for five years in

storage, and they're still good and filled with both precursor and active enzymes like it was five years ago. They don't lose activity on the shelf, which has been a real problem even for prescription enzymes – that they lose activity very fast. The FDA has even looked at it. I'm not a big fan of the FDA, but in terms of pancreatic enzymes, they're absolutely right. They came out with a position paper saying that most prescription enzymes aren't really useful because they don't have any activity. The reason is not that the drug manufacturers are lying. As they sit on the shelf, they auto-digest and lose activity. That's because they're too pure and de-fatted. So you want fat, and you don't want them all in the activated form.

Dr. Mercola: It sounds like you've put together a "whole food" enzyme; that's essentially what you've done. There are really no other manufacturers that have taken the attention to detail as far as you're aware.

Dr. Gonzalez: First, the conventional drug people think that we're crazy, and don't care what happens and about what we think. They just hope I get hit by a truck and stop bothering everybody with my ideas. The alternative people, likewise, have not really shown interest. They're starting to get interested and ask questions as you have (80:00) about our enzymes -- what makes them different, what makes them completely different from the things you normally get from the health food stores and drug stores. Keep in mind, again, that most of the enzymes – whatever the brand may be – are made only by a few companies.

For years, Roche made all the B vitamins. Now, of course, the Chinese are making those B vitamins. But there are only a few companies that actually make pancreatic enzymes. They all use the Ezra Levin patent, which was a brilliant patent in its day. He believed it should be activated and should be completely de-fatted. We believe the opposite way.

Dr. Mercola: Have you patented your process?

Dr. Gonzalez: We kept it as trademark. One of the problems with patenting is… Well, it's right there for the world to see. A drug company would change one thing, and this way… what I told you is kind of generic. But you know, I tend to think you have to share ideas. I patented nothing that we do. I think sharing ideas is the way to keep knowledge alive.

Dr. Mercola: I couldn't agree enough. People use these types of enzymes for other approaches other than treatment and prevention of cancer, one of which are inflammatory conditions like arthritis. So would your enzymes also be useful in their condition?

Dr. Gonzalez: Yeah. Although we're known for treating cancer, we do treat a lot of old and new diseases like inflammatory diseases (multiple sclerosis, etc), and even chronic infections. I can't claim to be the first person to do this – even Kelley was doing it. In

Germany, they use enzymes to treat inflammatory conditions like arthritis and find it very helpful to have plant-based enzymes like bromelain and pineapple. So we do use them in our programs for lupus, autoimmune, and inflammatory diseases. I have a patient right now who has terrible arthritis. He had been to Mayo and everywhere. Three months on the program and he told me (I was speaking to him two days ago) that it's about 80 percent gone – the enzymes work. We use other things to help rebuild the joints, like collagen and glucosamine. But we find the enzymes really helpful in autoimmune diseases.

Dr. Mercola: We've also seen one of the new and upcoming nutrients, astaxanthin, one of the types of carotenoids that are phenomenal antioxidants.

Dr. Gonzalez: Yes, very helpful.

Pig Pancreatic Enzymes

Dr. Mercola: But I was thinking of the enzymes, and one of the popular ones in the alternative medicine community is Wobenzym from Germany. Is that closer to the pharmaceutical types?

Dr. Gonzalez: That's closer to pharmaceuticals. I know Ransberger – he's now dead and he was one of the founders of the Wobenzym company. You and I talked about this a number of times. One of the problems with these enzymes is that they use beef pancreas, which are bigger and traditionally from Argentina. And it's cheap. One of the problems is that cows don't have digestive systems similar to ours. Cows are pure vegetarians and have a double stomach. They rely on bacterial fermentation to digest their food. They have very weak pancreas. Their pancreas has a very small component of enzymes. The last animal I would use as a source of enzymes would be cows, which is what the Wobenzym uses.

Pigs are omnivores like us – they have a pancreas very similar to ours. For years, diabetologists would treat diabetics with insulin from pigs! The amino acid homology or sequencing of pig insulin is virtually identical to humans. Similarly, we find that amino acid sequencing of the pig pancreatic enzymes is very similar (not identical) to our enzymes. So pig pancreas is the way to go.

Wobenzym uses beef, which is weak and is not similar enough to humans, so it can't be used. And they use a purified product. They have some kind of freeze-dried pancreas in their product, but primarily processed by that Ezra Levin process. And Ransberger told me – he's the guy who founded that company. He said that he believes that the more activated, the better. And I don't think so.

Dr. Mercola: From a holistic perspective, your products sound like they're far superior. This has really opened my mind and eyes to this whole process. I really thank you for that.

Dr. Gonzalez: You know, I had to become an enzyme chemist, which is not something I thought that I'd initially be back when I was planning my life at Sloane, when Isaacs and I realized that we had to save this therapy, go on our own and find enzymes. When I came back to New York, I lived in my mother's house in Queens before I started my practice. I was doing research, and I didn't have a lot of money. I actually learned how to test enzymes. In my mother's kitchen, I would test different enzymes and pancreas products from different companies. That's how I began to sort out what the problem is—Kelley got more into the more purified, more activated enzymes, and his success rate went down. And I began to see that the less processed the products were, the more they worked.

Dietary Shifts and Exercise

Dr. Mercola: Terrific. So you've given us two really important tools. One is keeping a clean diet or keeping food clean as much as possible, and to use the enzymes and coffee enemas. So are there any other pearls?

Dr. Gonzalez: There are three basic things: clean food, pancreatic enzymes, detoxification, which in this polluted environment is very important. Whenever I talk about diet, patients use different diets. And they'll say, "How can we tell what diet should we be on?" We have tests in our office – we look at blood work differently. We have sophisticated ways of figuring out which specific diet a patient is on. It's something quite simple. Many just love meat – they don't like salads; they don't want to eat fruits. They want to have a big piece of fatty meat for breakfast, lunch, and dinner. They dream about pot roast, and their ideas have been about pot roast with baked potatoes and sour cream on it.

On the other hand, vegetarians will literally gag at the thought of pot roast. It makes them feel sick. If you give a cow a steak, it's not going to eat it. It will starve to death before it eats a steak. If you give a salad to a lion, it will starve – lions are not going to eat grass. People tend to like the foods that they should eat – yeah everybody likes chocolates, but we shouldn't eat that. But we tend to like the foods that we should eat, and it's the experts that screw everything up by telling everybody that we should be vegetarians or on Atkins. People would get really sick. I knew people who were on Atkins, and they got very sick because they were vegetarians. I tried to tell Bob, who's a really good friend, that he should think more like Kelley, but he didn't and that's okay.

So you tend to like the foods you should eat. Keep that in mind. I mean, no one should eat white sugar, junk stuff. It should be organic. If you're eating meat, it should be grass-fed; if you're eating fruits and vegetables, it should be organic. But typical vegetarian type patients, they can eat salad and a piece of fruit for lunch, and that's all they want and they're good for eight hours. They don't get hypoglycemic on that. The meat eaters don't eat like that -- half an hour later, they'll collapse on exhaustion and from lack of

energy, and they need a piece of fat to keep them going. So people tend to like the foods they should eat. Forget about what the experts say. If you want fatty meat, go for it. But if you can't stand it, don't eat it.

Dr. Mercola: So listen to your body.

Dr. Gonzalez: Listen to your body. Your body knows you more than any doctor, including me.

Dr. Mercola: Do you find that people's type will change over time and shift, not dramatically but maybe…?

Dr. Gonzalez: Kelley always made that a warning to me and to the people he trains, that we had to be aware that people could change types. We see that happening, but usually in gradations, like someone who's extremely vegetarian might get moderately vegetarian, for she needs more protein as her body gets more efficient. But very often these are fixed, and it's genetically fixed. Someone who's genetically like the Eskimos will be genetically like the Eskimos the day they're born, the day they die. They'll always eat and need fatty red meat; they're not going to do well with carbohydrates. And a genetic vegetarian like a Polynesian will probably eat veggies and tubers every day. That's what they need. There are shifts, but not dramatic shifts. We don't see a whole lot of dramatic shift in 23 years. I've never seen that.

Dr. Mercola: Well, that's an important observation. Those are really some of the most powerful truths that we can discern from people like you, who have dedicated their lives to carefully examining these variables and have come up with something. I really appreciate the opportunity to share these truths you've uncovered for us. Are there any other pearls you want to suggest, specifically the priorities on how to know how not only to treat, but prevent cancer?

Dr. Gonzalez: There's so much information about exercise helping protect not only against heart disease, but also cancer. Even conventional doctors are starting to recognize that. Having said that, I know a lot of us hardly know how to do formal exercise, but activity is important, even if it's just walking. We tell all our patients – even our advanced cancer patients – to walk even for just 20 minutes. Walking is one of the best. Exercise really helps – it's as important as a good nutrient, and it's really very useful. And it's not only about eating clean food – leading a clean life sounds like a cliché, but we should also lead a clean life in terms of your homes and work environment as much as possible. My office was built as a non-toxic office. Even the paints used were non-toxic, and at home it's the same way. It's make the difference.

The Dangers of EMF Exposure

Another big problem is EMF exposure, or exposure to electromagnetic fields. With cellphone towers going up everywhere and Wi-Fis and wireless phones and wireless

computers, we're subjected to an extraordinary amount of electromagnetic field pollution. This didn't exist the way it does today in Kelley's space. He never mentioned it – he didn't know about it, didn't think about it. He didn't have to. I actually have to have a sub-meter to check around my apartment. Electromagnetic pollution is something we really need to think about.

I had a patient with leukemia. I felt I wasn't doing as fine as I should have. Kelley always said, "Your success will kind of make you feel self-satisfied, but your failures **{1:30:00}** will keep you up at night." And that's true. This was a woman in her late thirties when she started with me. She did well, but she didn't die, which was good. But she wasn't getting better either. She lived in a metropolitan area, near a major airport or one of the major radar centers in the country. She could look at her window and see a cellphone tower.

I insisted to have someone go to her house, and she was like living on a toaster oven that's so electromagnetically active. We tried to do things to neutralize it. Finally I had to tell her to sell the house and move out, and she moved. That was one of the most extraordinary experiences I've had – her life didn't normalize until she left that house. We had it checked by an expert. As soon as she moved, the kids started sleeping better, and her husband felt better. The whole family did better. Electromagnetic field pollution is becoming the next great nightmare we have to deal with.

Dr. Mercola: Sort of the industrial pollutant of the 21st century, especially with cellphones. And it's becoming virtually impossible to avoid exposure to it. From my perspective, one of the more exciting innovations is, getting back to simple basics and foundations, is grounding or earthing, or giving yourself back to the Earth. Some technologies do that. I wonder if you have any experience with or comments on it.

Dr. Gonzalez: Well, Stephen Sinatra is one of the core proponents of earthing, and he's a professional friend. I never claimed he's a close personal friend – he's a professional friend. I know the story of his son and all that. The smartest man in terms of EMF (I'm going to go out on the limb here; Clint Ober, I respect what he and his group are doing) is David Stetzer.

Dr. Mercola: He's out there in Canada, isn't he?

Dr. Gonzalez: In Wisconsin. David Stetzer has a website, http: //www.stetzer.com. He said there are problems with the earthing system. One problem is, Clint Ober developed a lot of this in Europe, where they have different electrical systems from what we have here. In the US, a lot of corporations, companies, and governments… they know they have to ground things – the reason that we have grounded outlets is if we didn't, computers would explode. They're all grounding it into the ground, and they Ober made the mistake of assuming that the earth is this infinite reservoir of endless electricity that we keep dumping into the ground. He said that that's wrong – sometimes, depending on your soil, you can actually plug that like the earthing cord and you'll get electricity

coming back at you from the ground. I found that in my own apartment. It actually happened when I experimented with the stuff. As much as I respect the group that did that -- they were correct about EMF pollution, and it almost killed Steve Sinatra's son -- in my own apartment, even though it's properly grounded and it's been test-grounded through experimentation, it's actually feeding electricity to the unit. New York City has so much electricity ground from all buildings that are dumping their electricity right into the ground. And it's like a hotwire of electricity. And Stetzer was the first guy to point this out.

I have a patient in Texas that uses the earthing thing, and she's doing great. She had arthritis, but the pain was better. I told him where she lives, and he said, "That's a sandy area, and electricity isn't going to be transmitted through it." In a place like New York City where it's granite and the rock is filled with cat ions and anions are going to transmit electroenergy very quickly, he said there are nine million people dumping their electrical use right into that granite, and it's going to come right back to the Earth. The first time I slept on that thing, I went through the roof, and I felt like I plugged my finger into an outlet.

Dr. Mercola: How do you determine if you're in an area that's congested and there's a lot dumping?

Dr. Gonzalez: Stetzer said that the way the US electrical system is set up, there's going to be a lot of problem, but some places like Texas are going to be safe because of sandy soil. Electricity is transmitted very nicely through water that has minerals in it – any natural groundwater is going to have minerals. A place like New York that has groundwater and is surrounded by water and has granite with ions is going to transmit very nicely. I will call Stetzer – he's a great guy. You can get his phone number on the Web and you can speak to him. I know a lot of people, and nobody knows more about EMF electricity than Stetzer. This guy knows everything about this stuff. That's something you might want to look into.

Dr. Mercola: I definitely will. So you mentioned exercise as a tool, and I exercise myself. I'm a firm believer of it. It seems that one of the mechanisms is that it sensitizes insulin receptors and secondarily reduces insulin levels. I'm wondering if you find value in monitoring people's levels and seeing if dietary intervention or exercise is able to change them, or if it's a useful tool for cancer treatment.

Dr. Gonzalez: We don't do it routinely. First, insurance companies won't pay for it if you do it routinely. They start questioning why you do it.

Dr. Mercola: Why, it's a cheap test. It's only 10 dollars.

Dr. Gonzalez: Yes, yes. We've done it. Indeed, literature shows that when patients exercise regularly, their insulin metabolism is normalized. Insulin resistance tends to

lessen if they have that. They're not prone to hypoglycemia. No question that it helps. We find that whether vegetarians or meat eaters, exercise helps both groups.

Dr. Mercola: But you find that testing insulin is a useful tool to monitor cancer patients?

Dr. Gonzalez: Yes, the answer is it would be. We don't do it routinely ourselves. There are other tests that we use.

Dr. Mercola: Okay. Any other pearls that you have for cancer approaches?

Dr. Gonzalez: Yeah, we've talked about a clean life and electromagnetic fields. There are a lot of supplements that have protective benefits, like selenium, vitamin E, and even good old fashioned vitamin C. Some of the usual doses vary from meat eaters to vegetarians. I think just some of those basic nutrients are very helpful. I think we've covered a lot of ground – it's hard to be really specific in terms of how much vitamin E you should take, because people need different amounts. Vegetarians may need it in different forms. So the doses and portions that we give vary according to a patient's health and disease history. But some vitamin E, vitamin C, vitamin D…

Dr. Mercola: Do you find some of the lipophilic or liposomal vitamin Cs helpful?

Dr. Gonzalez: I've read about them, but I've never used them, so I have no direct experience. This doesn't mean that I think they don't work, but I haven't been, at this point, convinced to start using them. We might someday change and become motivated in that direction. I don't use them, so I'm not really an expert.

Structural Therapy

Dr. Mercola: Any last words of wisdom?

Dr. Gonzalez: Yeah, one thing we haven't discussed is structure, which is very important. Kelley said in his book in 1969, *One Answer to Cancer*, that majority of cancer patients have some prior history of significant neurological trauma, like major whiplash. If we find that to be the case, structural therapy can be extremely helpful. It has to be done properly, and someone must know what he's doing. But you know in conventional medicine, they don't mention structure. It's all orthopedics, you know, just repairing broken bones and all.

You know, the nervous system is housed within a bone structure, and if that bone structure isn't in normal alignment, it can cause stress to the nervous system. The nervous system does control everything, and if it isn't happy, your body is not going to work well no matter what nutrition you take. So very often with patients that have had history of neurological trauma, there are certain types of cranial osteopathy that I think is a superb technique, chiropractic that I think are really effective. It can be very helpful, and I've had patients that stabilize when they get proper body work. They improve

substantially. So making sure your structure is in good working condition is important, because your spine and skull house the nervous system. When your spine and skull are under stress, it puts stress on the nervous system, which controls everything from the top of your skull to the bottom of your toenails. If your nervous system isn't happy, no matter what you do nutritionally, you're never going to function ideally. I've seen that over and over.

I've had a patient with 30 years of migraine and headache, to the point that she was going literally nuts. She had been to the Mayo clinic, everywhere, and they were just putting her on drugs. Life wasn't worth living. I could have died when I took her history – turned out she had three motor vehicle accidents, and that was when the migraine started. I could put her on all the detox and nutrients, but what she needed was a good structure. I sent her to someone I trust. After the first treatment, her headaches were 50 percent reduced. That's something nutrition wasn't able to do because that's a structural issue. That's another issue, like environment pollution. It sounds a little esoteric, but it's very important to make sure that your structure is working properly. If it isn't, if you have a history of major trauma, try to find a structural therapist.

Dr. Mercola: I'm trained as a D.O.

Dr. Gonzales: I know you are. Kelley was a dentist**.** This is something I'll tell you: that's one of the advantages of being a dentist. He was interested in TMJ work before he started getting involved in cancer. He was very much attuned to structure. He was trained to do cranial osteopathy way back in the 1950s when it was first developing. I learned from him, and certainly not from my orthodox training, when it comes to the value of structure, because I never gave it two seconds' worth of thoughts during that time. I learned that it's really important and can make miraculous changes. It goes along with nutrition. When people get a bad structure, they should have proper alignment.

Dr. Mercola: That's right. I actually get weekly chiropractic assessments when I'm at home, and I'm a believer in that. But there's a range of different quality of chiropractic physicians, and you want to find someone that's good and who's going to provide great service.

Dr. Gonzalez: Yeah, some are good, while some are a disaster. You have to know what you're doing. Word-of-mouth is usually the way to find someone good. A bad structural adjustment causes more trouble than when you leave it alone. But good structural adjustment can change someone's life.

Dr. Mercola: Absolutely. I thank you for everything you're doing. Now, if our listeners and readers would like to learn more about your approach, what type of research can you recommend, e.g. your website, books, etc?

Dr. Gonzalez: My website's in place – it's http: //www.dr-gonzalez.com. We're doing a series of books, and the first two are out: *The Trophoblast and the Origins of Cancer*,

which discusses Dr. Beard's work from the perspective of 21st century molecular biology, and *One Man Alone*, which is my original monograph of my investigation of Dr. Kelley that we could never get published 23 years ago. I finally re-wrote it, put in an introduction, and updated it, but it's basically that book – we finally made it available. You can get those on Amazon, through our website, or our publisher, New Spring Press. The third book is going to be a big masterpiece about how they sabotaged the clinical study, much like *War and Peace* in a lot of ways. *(Laughs)*

Dr. Mercola: Well, terrific. I thank you for your willingness to share your insights and for all the work you've done in advancing the field and providing a really valuable resource for people to use in their search for optimal health.

Dr. Gonzalez: I appreciate that, and I really appreciate your website. Isaacs and I read it regularly, and I appreciate all the work you put into it.