Introduction and Guest Background

There are still patients from that, too. Gonzalez. It's time. We're still on a protocol. 30, 40 years later, for patients who are entirely new to the protocol, which I've met a few, and I've reviewed the cases around the world of others.

The immediate thing that's noticeable is that the patients subjectively feel a whole lot better on the protocol than they did before. The quality of life of the patients improves almost across the board.

is doctor talks. Well. I am so excited to have Doctor Andre Williams here. He is a medical oncologist and I'm excited just to kind of hear his journey a little bit.

But at the end, I just want to make sure that everyone knows we're going to dive deep into the Gonzalez protocol. So Doctor Andre, thank you so much for being with me here today.

Oh, yeah. Thank you. I'm privileged to be here. It's something that I enjoy doing and I'm glad for the invite. Thank and so. So tell them I'm always fascinated here.

You started a trajectory. Medical oncology and and hematology. Yes. And then all of a sudden, you know, that's not where you're at right now. You're not on that trajectory right now.

No I'm not. So it was tricky. I will admit it was it was some, as I said to you before we started, that it was a journey that I didn't realize I was on until it was too late.

And probably that's a good thing, because I. I was a pretty bright kid. I was known as a kid who was probably going to get into med school, which I did.

And then when I got old, one of my favorite attending physicians was a hematologist oncologist. And so I thought, hey, I like that and jumped in with both feet.

Enjoyed it. Had to do a Doctor of Medicine and internal Medicine as a part of my journey, and then ultimately finished my hematology postgraduate degree emerged.

Had as a saying earlier, a whole career ahead of me. It would have been wise for me to continue on that path. Actually even ended up getting a an award from the American Society of Clinical Ecology, which, as you know, is a pretty big deal.

So I got flown to Chicago, did all the fancy stuff, sat on a couple of committees and helped to make some, you know, give you the feeling that you're making influence in policy.

And that was that was a pretty good experience. But it didn't feel like I was making the kind of impact I wanted to, because here in Jamaica, where I'm located, it's most people can't afford the kind of chemotherapy and radiation type treatments that are readily available in other countries.

And in any case, most people don't trust them. So it would be you'd be going, I'd be going to work every day for the rest of my life selling something that nobody wants.

And as I'm sure we both know, the success of which is almost random at this point. So that was my journey, and I ultimately ended up looking for a better way.

And I'm just curious, so where you're at, I mean, with the with the chemo, with the I mean with the therapies that you offer as an oncologist. I mean, what kind of impact did you feel that you were making when you were using

those tools?

Yeah. Zero zero impact. And why do you why do you say that? I mean, so for one thing, I, I'm, I'm a Christian. So I believe the doctor patient relationship is more than just selecting the appropriate drug.

It's about selecting the appropriate patient for the appropriate drug or drug protocol. And I think me being able to believe in the likely outcomes of what I'm recommending to my patients plays a significant role in the success that they ultimately have.

Not every doctor believes that, but that's okay because I've experienced it. So let me just switch to my other headphones here one second. Yeah.

Why Oncology Needed a Different Approach

So I decided that I wasn't comfortable selling the same thing over and over without any real evidence that it was helping. And we all know what it's like.

I don't know. Well, so we should be truthful. Maybe you don't, but I worked in the trenches for a long time. Recommending what? What broke everything open for me.

I was recommending to a patient that they needed a particular drug for their breast cancer, and we existed in the public system where health care is supposed to be free.

And so the thought is, you know, she's going to go and access the drug. So she goes off to the hospital. The pharmacy is in the prescription. Unfortunately, the drug is out of stock.

So she has to go outside to an external pharmacy. She has no insurance, and she spends what is equivalent of a month's. The mystic wages on the medication.

And it is only because I told her you need this to stay alive. Now, as a result of staying alive in quotation marks, this lady is unable to feed her children for that month and has to find some sort of alternative plan.

And I thought to myself, nah, this. This can't be right. This is this is not going to end well. You know, there's no way I can see the ultimate outcome of this being good for patients at large.

So the alternative was to figure out, is there anything else that's happening in the world? That's that's a possible alternative to chemotherapy and radiation.

And of course, you know, I need to make it clear. We've started the conversation at a gallop right away, but I need to make it clear that I have nothing against chemotherapy and radiation, per se.

It's just that I believe patient selection needs to be so tailored to the appropriate therapy. And largely, I found that chemotherapy in a patient who is already very distressed and, for example, is a breadwinner for their family is often not helpful to the patient.

Yeah. Because I mean, in in your I mean, I can understand cannot in the public that you're serving, you know they they need to work. Yeah. Obviously if you are then doing it doing chemo, you're putting yourself in a place that now I can't work.

So now I can feed my children or I can, you know, pay my mortgage or I can. Yeah. So those are real, real issues that they can overcome. And it's also like a really difficult product to sell.

Right. Because you're saying to a patient, hey, I'm going to give you this drug, this mental wipe out your immune system. You're going to feel horrible all the time.

It's going to take you three weeks to recover. Certainly your blood can't. And that kind of a thing is going to take three weeks to recover. And then as soon as you recover, there we go again.

Right. So it was I found it hard to be a good salesman for that kind of care. And it's one thing to be selling something to somebody because, you know, it's the best you have.

It's another thing to like me. Find out about the Gerson therapy, which was my first foray into the possibility of peeking behind the curtain and realizing, and there's something else out there that people have been using that actually helps.

And then to, to bring some of the principles. So that in and of itself was a funny story, because I had reached a point where I was literally unable to sleep.

That's how dissatisfied I was with the impact I was having in my current way of doing things. And I remember one night staying up till about 3 a.m., trying to say that there must be something else, and praying, saying, God, you have to show me something else.

I'm looking at my iPad, just scrolling through the internet and I kid you not, iPad blinks. I don't know how it gets onto this web page, and the next thing I know, I'm looking at the girls in therapy.

I read that website from from 3 a.m. straight, but till the morning. And as soon as I sense that it was a good enough time to wake up my wife, I leaned over and I say, honey, guess what?

Guess what? We're flying to San Diego in two weeks to be between. And and the rest is, I mean, that's that's where I realized that nutrition critical importance.

That's where I realized that treating the whole patient is so important. That's why I realized that detox is actually a valid part of any good cancer treatment protocol.

And meeting some of the patients who had been on the protocol, the same therapy for years. For example, nothing sells a product better than success, right?

So the journey was I don't know how I ended up on it, but I'm so glad that I did. Yeah, I've I've interviewed Doctor Vicars a few times about the Gerson therapy, and it's such a powerful tool and it's exacted that is to hear you're bringing in high nutrient alkaline foods in large quantities and then opening up your pathways of elimination to move whatever it is that may be interfering with normal physiological function that can drive the body towards a disease.

So yeah, it's a is a really powerful program. Yeah. And you know, what's sad is we I've found that even within the holistic space, which I'm proud to say I'm a member of now, we still have a very place, a very high emphasis only on cancer cell destruction.

And that's so sad because it's only one part of the whole picture. I like to think that there are four different things that must come together for a successful cancer treatment outcome.

The first is, of course, destroying the cancer cells. Whether it is harnessing the body's own ability to do so or externally influencing that. The second, as you said, is high intensity nutrition.

So flood the cells are the nutrients that they need to repair and to heal. The third is adequate detox because we are not I mean, I'm pretty sure that one of the reasons why chemotherapy is not as effective as it could be is because the chemotherapy metabolites themselves, not to mention the damage to the debris from the cellular debris that they have caused.

Both of those in and of themselves are too much for the liver to deal with. So and of course, the fourth thing for me, for any good cancer treatment protocol, has to be an emotional or spiritual component to ensure that the patient

remains grounded and centered and and believes in something bigger than themselves.

And how do you view cancer? Because there's a lot of kind of theories out there in regards to, you know, what is cancer? How does it start? You know what?

Yeah. What what what is your view? You know, from your background. Yeah. So I believe that cancer is an extreme form of autonomic dysfunction, where simply means that the body, as far as I'm concerned, is constantly balancing and rebalancing.

Every microsecond of the day is spent adjusting something at a micro level. So this is, as we all know, occurs when the body reaches a state, whereas unable to fully compensate or what the challenges that has been has been presented with.

And as a result, what it does is it tries to hold the body in the best possible equilibrium. It can, since it's unable to return to complete balance. As a result of that, we have various degrees of extremity.

You know, you can have diabetes, hypertension, auto immune illnesses. To me, at the far end of the spectrum is cancer, which which is a double edged statement because on the one hand, you know, it's it's intimidating because you're saying, well, cancer is the most extreme form of dysfunction.

Well, on the other hand, if we view it simply as something that exists on a spectrum, it means therefore it it must be reversible. And because if we assist the body to get back to balance, then we can expect that it will no longer need to be stuck in that state of cancer.

Discovering Gerson Therapy

And the trick is therefore to not depend on a universal cure, even within the holistic and naturopathic space, to recognize that each patient has arrived at that extreme, probably for a different reason than the next, and to help that individual patient to craft a plan that will encourage the body to heal itself.

And so, because I have and I'm sure you you've seen many times as well, you know, patients come to me and they say, I've been healthy all my life. You know, I've, you know, I'm no.

So here you're kind of looking at it as a spectrum and cancer being at the far end of the spectrum. And, but they themselves view themselves as, as being healthy.

They have energy felt good. They do yoga, they eat organic. And then, lo and behold, they get cancers. What do you feel it is that kind of puts them all of a sudden at the end of that spectrum?

Yeah. So I think think I have a name for those people. I call them resilient resilient cancer patients essentially. So what happens, I think in those cases is that they don't feel the gradual micro shifts away from center that everybody is making in order to compensate.

So for somebody who gets sick easily, who's easily dysregulated, they will feel shifts very quickly because they're used to oh my gosh, you know, my nose is running.

I know what this means. I'm going to have a cold soon. I'm going to have the flu. And they probably have joint pains. But there are, I think, a there's a subset of patients with really good genetics, who are able to make constant micro adjustments to the challenges that they face.

But then like any, any of the proverbial straw that breaks the camel's back. Ultimately everything comes crumbling down because there's this one final insult at the body's just unable to tolerate.

And then everything collapses. So again, I think it's entirely possible for somebody to not ever have been clinically ill and still, for whatever reason, to have a terminal insult.

Then it hits them and pushes them over into cancer. And, and we have, you know, we have kind of different theories as to, again, going back to what cancer is, you know, you have the, the genetic, you have the metabolic.

Yeah. There's your Bible, you have it's a bucket of toxins. I mean, what are when when you look at cancer, I mean, how how do you view it in that way.

Yeah. So it's really all of the above. It's all of the above. And again, because we're all different than our body's ability to respond is going to be different.

And also what tips us over is going to be different. So for example the the metaphysical world, that gray area that we call emotions I personally believe that emotions actually take up physical space.

You know, Nietzsche. Klinger speaks famously about a book he recommends called The Fabric of the fabric of the mind or Fabric of Mind. And it goes into this whole very difficult to understand a world of emotions actually being a mixture of different neurotransmitters.

And it goes on and on. So I think it's all of the above. And that that is why as a society, as a globe, we're experiencing so much more cancer because the the number of insults that the body has to respond to on a given day is exponentially more than when the most exciting thing somebody could do was probably go fly a kite, or make a milk carton with a tie and pull it around.

And now we're in. You know, I don't need to go through the long list of different exposures. We have on a daily basis that challenges the body to respond.

Yeah, yeah, yeah. I mean, the, the, the assault on our our mind, on our emotions, on our frequencies, on our chemical structure. I mean, it just goes on and on and on.

So yeah. Absolutely. So it is amazing that we as a human being is able to survive this amount of is solved to this level and that more of us are just, you know, keeling over.

It's actually amazing. It's actually amazing. Well so I'm Cassius started with them with a person and and how do you how did you start. Because you're still then an oncologist at the time.

How did you start to kind of shift. And that's where the story gets really I tell people that I want Denzel Washington's and our one of those nice famous actors to play me when that time comes because I get back from San Diego, California, 2015, thereabouts.

Several things happen in the space of a year, and number one, and I don't want to get ahead of myself, but number one, I complete module one of garrison training in that same way that that late one in that same year, Nicholas Gonzalez passes away.

Unfortunately, the following year I win the award from the idea award from glass, from Oscar, get flown to Chicago and get exposed to all the essentially get exposed to what my future could look like.

If I follow that conservative career path and decide that's not for me. And guess what I did? I just walked away from the hospital. I just I just said, listen, this is not for me.

Packed up. I handed in my resignation. I had to give them three months notice. So I served the last three months and I finished my hospital career. The I think it would have been the 16th of October 2016 thereabouts.

And by the 17th I was on a jet plane heading to Nevada to train at Frank Schellenberg on Ozone. Walked into that ozone conference not knowing much about it, heard what he had to say.

I saw an ozone machine being used as a demo there and I said, hey, can I buy this? And they said, yeah, that's out of my credit card. So I had a credit card.

I took it back home at me and immediately started putting it to use, I mean, Michael, the rest is just unbelievable because of course I couldn't ever have thought of implementing some of those things within the hospital setting.

So I set up a small private office and small, very small, like it's smaller than the room I'm in right now, and I start putting a few things to use of the coffee enemas and getting referrals of stage for cancer patients.

Hey, is there anything you can do? All right, let's try a coffee enema. At least it might give them a few more days. And then days turned to weeks and weeks turns to months.

And you say to yourself, hang on a second. This is not supposed to be possible. What's going on here? And then, of course, it makes you even more curious.

So to see what's working and why it's working. Ultimately, I signed up for the second module for for Gerson to become a full fledged practitioner, which allowed me to work with patients around the world via zoom and that's when you really start to see that not only is this not limited to the small practice that you have, but it's principles that transcend race and skin color and location, ethnicity, age.

None of those things really matter as much as they did when you were assessing patients for chemo and radiation. So it's just been a steady implementation of the principles that I learned along along the way.

Each time I go to a training workshop, somebody says to me, hey, like, for example, I went to ozone and somebody said, have you heard about Dietrich Linhart?

And I said, well, no, the only thing I've heard about is cisplatin. And, mycin prior to now. So they tell me all about him. I started doing my research again.

It looks like space age stuff to me. I have no idea what autonomic response testing. How does that even work? Jump on a plane again, sweat my credit card and go to train with him, and ultimately end up realizing that this is, again, something I could incorporate into the practice.

And of course, autonomous funds, testing and neuro therapy injections. They are directly implementing a regular regulatory stimulus to that nervous system anyway.

So as a result of that, of course a patient is going to feel and become better marginally with each intervention that you make. And then the rest just keeps on building on itself.

So I try lots of things here and there, make observations. And of course, when you're working with somebody who has opted out of chemotherapy and radiation and has not decided to do in some cases, has the team decided to do surgery?

What you're working with is a patient who has auto selected themself as a really good candidate for natural healing. So they're disciplined, they're willing to go the extra mile, they're focused, they're committed.

And naturally that plays a role as well. So it's been a wild ride. I, I pinch myself every day when I think about like right now I'm getting ahead of myself again.

But right now I'm the only doctor in the world who has both Gerson training and Gonzalez training. But that wasn't obviously not planned. It's just kind of all.

Cancer as Autonomic Dysfunction

I've stumbled into it, and of course, I'm the only doctor who has those two trainings who is also an oncologist. So it opens me up to several possibilities.

I'm I'm just so happy to be able to be in this position. Yeah. That that's I mean, what an incredible asset for people

to have somebody with your breadth of knowledge.

I'm curious, you know, so as you're then helping people, you know, with you have first with Garson and then you brought in the clean heart, you know, the art and and then we're going to talk a little bit more about Gonzalez protocol, you know, which which you also brought in.

Yeah. So that at any point here as you're working with the patient and then you're doing these therapies and, and say, hey, I mean, I, I feel we're doing this.

We're not getting where I feel we should. You probably need some chemo. I mean, does that ever happen. Yeah. Good question. So the first thing I had to learn really early was I had to make a tough decision to say, hey, listen, I'm perfectly capable of supervising a chemotherapy regimen for you.

However, I wanted to have as much integrity as possible. So the first thing I had to do was I sat down and penned a letter to all of my oncology colleagues, and I said, hey, listen, for full transparency, I've decided not to continue with giving chemotherapy because I want patients to know that when they come to see me, they have also opted out of taking chemotherapy.

So therefore I'm asking you to refer to me. Only patients who have either refused chemotherapy are not eligible for one reason or another, or who have had it, and it's not making a difference.

And I'm willing to work with those patients, but I need them to know that they will not be receiving chemotherapy from me. So that's the first difficult decision to be made.

And, you know, I sent out about 14 letters. I probably got two responses. So I still don't know how some of those people felt about that letter. But anyway, I find out sometime after I die, maybe.

So the second thing is, as you said, having the integrity to realize that there's going to be a few patients who present upfront who should have chemotherapy and to be able to say to them, hey, I know you don't want it, but you have a watermelon growing on on your chest.

And as good as I am, I don't think I'm going to be able to make an impact on that in time to save you. So here's my recommendation. Please allow the good doctors to do what they need to do.

And if, if, if they're willing, support you with nutrition along the way or when you finish chemotherapy successfully. I'm happy to help to put you on a protocol to help to rebuild your system.

So it's and that, as you could imagine, medical. It's been tough as well because most people, especially now, have had so many questionable experiences with the so-called conventional medical fraternity that what we're having is very polar opposites, and we're almost developing factions within the the world of medicine.

The at large, and patients will come in and very strong opinions as to why they should not receive chemotherapy or even have surgery for that matter. And I think we still have a responsibility as doctors to point a point, a patient in a direction that will best suit them, rather than just giving in to their desires one way or another.

So I've had some tough conversations with some patients who have been adamant that they're not doing surgery. And I said, well, here's the thing. If you're not going to do the surgery, you're not going to be treated by me point blank because you need surgery.

Or if you have this huge breast tumor, for example, or what? I encounter a lot, as well as rectal tumors, which, you know, the risks of, of taking too long to get that started.

So those patients in particular immediately will be flagged and I'll say, hey, listen, this is not the path you need to take. You may hate me, but that's okay and needed to go and have the chemotherapy done or the surgery done.

And then we can always talk afterwards. And so a I've had to almost I remember laughing once and saying I'm kind of like Superman trying to hold the two ends of the train track together so the train can pass over because I get flak from both sides, people saying to me, how could you refer that patient to chemotherapy, chemotherapy, the devil?

And at the same time somebody saying to me, how could you not offer that patient chemotherapy, they're going to die. So it's a wild ride. And I mean, with that, I mean, knowing with your experience, then you, you know, the limitations and you know of of both type of therapies, which is great, you know, the strength and the weaknesses.

And I know that you mentioned kind of in the beginning, you said that, you know, what is chemo done or all of that. And you said, yeah, nothing. But at some point, yeah, it is needed more kind of like it that that emergency, that urgent care.

But there's it's overdone. Yeah. Yeah. I think if we selected our patients better, I have a very, very poignant story that I always tell as it relates to chemotherapy.

I met a lady about two and a half years ago who comes in to see me with sizable breasts, maybe five, six centimeters. And of course, you know, the surgeons, because of the size of our breasts, they're a little bit hesitant to go straight to surgery.

So they say, hey, do some neoadjuvant chemo. The lady walks into my office. It looks really horrible. She's poorly dressed. Her hair is all messed up.

She looks like she's been crying a lot, and her family brings her to see me under. The room is set up so that she's sitting right beside my desk, and her sister is sitting in the background so she can't see her sister.

But I can. So I'm talking to the lady, and my instincts tell me that there's just something not quite right. So desolated is there's something she's not telling me.

So I said, hey, you know, how is how is everything at home, you know? Are you okay? You know, is everything going well with your family life? And I see the sister behind me going like, yeah, yeah, yeah, ask that question.

And the poor patient says to me, listen, doc, I must confess that I live in a relationship where every single night before I go to my bed, my husband tells me that he's going to kill me and my jaw drops.

I said, what? And she said, yeah, that's what I face every single day. For the past year, I've been dealing with that. I said, this is no way for somebody to start a journey of any kind involving any harsh sort of treatment.

So I said, all right, here's my prescription for you. And I take all my prescription pad. And I say, listen, do you have a brother? And she said, yes.

I said, does he have a gun? And she says, yes. And I said, all right, here's what you're going to do. You're going to call your brother, wait till your husband isn't there.

Call your brother to come to the house with a moving truck, and you're going to move everything into that truck and go back to live with your brother and your and your, you know, original family.

And then you come back and see me and we'll talk about chemotherapy. So I tell her to come back in two weeks. Two weeks. I see it in the door open and there's this beautiful lady, well-dressed, looking at a picture of health.

I could barely recognize her, except for the fact that her sister was with her again, and she was saying with this bright smile on her face, and she said, you know, doc, I did everything you told me to do.

It was so smooth. I'm sleeping now, I feel good, I'm reunited with my family and I'm chatting with my parents again. And, you know, I just came by to tell you that I'm going to go up to the hospital to do the chemo.

Of course she is, because now she's in a better frame of mind. And of course, the chemo is going to help her because her body is now geared towards healing.

I love it, I love it, yeah. And and that's the thing is that a lot of times when we, we live a life that is not serving as well. Right.

Transition to Ozone and Natural Protocols

And then we try to fix things with other tools, when in reality it is the life we're living that needs to be fixed. And we can only compensate so much with some of these external tools.

And so, you know, and then we feel upset when we bring those external tools and they're not fixing the cancer or whatever it is when, when in reality, you know, you need to fix the core first, you know.

So yeah, I love that story. So that's perfect. So how then you have the person you have, you know, the clean heart and now Gonzales, I mean, how why did you feel you needed to take that one more step?

Yeah. So not hard to explain. Number one, I was so impressed by the comprehensive nature of the Gonzalez approach. In other words, the Gerson therapy is extremely effective, but it's also extremely rigid.

And I say that I mean, I love both therapies, don't get me wrong. So what we found happening was, for the most part, if a patient presented and up to Gerson himself recognizes that the Gerson therapy is extremely useful for patients with so-called hard tumors or solid tumors or breast, lung, colon, and to a lesser extent, prostate, which is kind of tricky, melanoma, that kind of a thing.

But then you do have a percentage of people who have little things like leukemias and lymphomas, myeloma, and again, possibly melanoma, which can behave either way.

We found long before I joined Gerson, it was already clear that some of these patients did not respond as well as they could have otherwise. And so we knew and I knew that there was still something that I needed to be exposed to to explain that unknown entity of what would help these patients do better.

And the doctor, Gonzalez, wrote a little book called nutrition and the Autonomic Nervous System. Highly recommended. He, of course, builds on the work of several other doctors before him.

Not to waste on price, not to William Duncan Kelly, that to John Beard, not to a passenger. And they realize, of course, that the autonomic nervous system, again, is a center of everything that we're doing in terms of getting the patient to heal.

But that nutrition wasn't just about providing nutrients and enzymes and so on, although it's really good at that. But it had a direct impact on whether the autonomic nervous system remained parasympathetic dominant or sympathetic dominant, which was a source of disease, and largely to patients who are sympathetic dominant, meaning their body is constantly in fight or flight.

They're the ones who tended, generally speaking, to developed tumor hard tumors, sorry, solid tumors such as breast, lung, colon, pancreas, you name it.

And of course, they're going to respond well to a vegetarian diet because that will help to push them back towards being balanced. But the softer tumors such as leukemia, lymphoma, myeloma, a lesser extent melanoma, they would actually more often occur in patients who are parasympathetic dominant at the other end of the spectrum.

And lo and behold, that's why Gonzalez pointed out that these patients needed to have more animal protein, which flies in the face of almost everything that that has been the status quo for the past 2 or 3 decades.

So, so that was the missing piece for me, the ability to properly individualize the care of each patient that I saw

rather than being prescriptive because I'm coming from the conventional world where we're already following very rigid, prescriptive algorithms for assessing the patient and managing the patient, which has its place but doesn't allow for an individualization.

And so I was constantly and maybe I'm still searching for that ideal way to individualize each patient I see and to make sure that from the get go, the care that I recommend for them is already geared to pushing their body back into balance.

And long story short, is I reached out to Maribeth Gonzalez shortly after that and they passed away and asked, hey, is there any way that I could learn how to do this thing?

That was in 2015, maybe a little bit later? And of course she said no, because at that time all the information had had gone with him. But true to form, Marybeth has recreated steadily worked with several doctors to help get help to recreate and restore the work that he was doing.

And so, in the middle of Covid there 2020 thereabout, I get this email in my inbox. Hey, this is Marybeth Gonzalez. You reached out to us five years ago.

Are you still interested in learning this thing? And I've never responded to an email so fast in my life. I'm like, yes, yes, yes, what do I need to do it?

And to her credit, the training was really rigorous. It was not a walk in the park. And pretty intense, but I managed to to piece together what was required of me.

And so, you know, it's been a pleasure to be able to, to stand, to walk in the footsteps of that, to make everything that he was able to achieve and to to meet the patients that even though he has passed away, so many of them have outlived him, still under protocol, still cancer free.

Subsequently, being able to treat my own patients on the protocol and observing their tremendous improvement and and of course, the final thing is I've been asked to do the case reviews for all the cancer cases that are in existence on the protocol worldwide.

And so I can watch even those cases being managed by my colleagues. I can watch their progress from a distance as well. So it continues to reinforce my belief in what I'm doing.

Do you mind sharing what what that program looks like? I mean, what what are what are some of the kind of the general ideas? So people have a, have a feeling of what they would be stepping into.

Yeah, yeah. So the first thing to note is it ties back into what you asked me earlier about what do I view cancer to be. And so the first, the fundamental principle of any Gonzalez protocol designed for a patient is first, identify is this patient sympathetic dominant, parasympathetic dominant or rarely balanced.

Because when you're balanced you have a lesser tendency to develop disease. Still possible but less likely. So fundamentally it's what we call metabolic typing.

Being able to understand where this patient sits on that spectrum and to be able to design a protocol around that there after. There are three main tenets surrounding how the patient is managed.

The first is an individualized diet plan that matches the patient's metabolic type. So that ranges from on the far. I use the left and right on the far left, extreme vegetarian all the way through in the middle, efficient, balanced, and then out on the other end.

There's an extreme carnivore, and so the patient would be advised to eat in a way that helps to bring their system back into metabolic balance. And so that alone becomes a foundation that is extremely helpful.

The second thing is that even the supplements that we recommend for patients, one way or another, each of them has an impact on the autonomic nervous system as well.

So, for example, very broadly speaking, magnesium tends to be fundamentally alkaline izing.

Why Gonzalez Protocol Was the Missing Piece

So that means that it would involve more of a parasympathetic type stimulus pushing the patient towards being more parasympathetic. So the sympathetic dominant patient would benefit from magnesium, broadly speaking, to help to push them towards center.

Whereas on the on the other side, calcium generally speaking because there are different solves that. You can use calcium generally is acidifying or a sympathetic stimulus stimulating.

So it would push patients towards sympathetic dominance where needed. And so what that then means is when you design a supplement program for a patient, there are two things that are the patient can be assured of every time they swallow that pill, or that to take that supplement, they can be sure that that particular supplement is pushing them in the right direction metabolically.

And two, that's a Gonzalez was extremely meticulous about ensuring that he could identify how much of a particular supplement a patient had in total for the B, and to ensure that the supplements weren't necessarily duplicating the work of another supplement.

The patient was also taking. And that, to me is very important because I we live in a world of social media where the latest one, the supplement, is just a few clicks away at any given time.

And I've met so many patients who are on 15 different supplements, all of which were purported to be cancer fighters and cancer eliminators. And sometimes when you look at it, all of these supplements are, for example, alkaline izing, which is kind of dangerous if the patient has a leukemia lymphoma, because every single one of those supplements is making them worse and worse, and they wouldn't even know.

So it then creates an opportunity for for myself as a doctor and for the patient to be very deliberate about what they're doing with their diet and their supplements every single moment of the day to start doing the thumbs up.

And then, of course, finally, my favorite individualized detox programs, which again, take into account the fact that detox programs are not necessarily going to be the same for everybody.

You don't want a detox program that's intensely colonizing for somebody who has leukemia, lymphoma, again, it's actually going to contribute to them being further metabolically out of balance.

And so by the time we finished designing a protocol for the average patient who, for example, doesn't necessarily have cancer but could just have a chronic illness, we know that within a few weeks the body is going to start reflecting that autonomic balancing that we triggered.

And as a result, the patient immediately calls and say and say, hey doc, I feel so much better already. And it's only been two weeks. And then everybody knows about the high dose pancreatic enzymes.

Everybody knows that story. Discovered first lead author John Baird in the early 90s, and that work was rose to prominence, was subsequently last rose to prominence again with that William Kelly, and ultimately was fine tuned by that to Gonzalez.

And the whole principle is that high doses of pancreatic enzymes will send simply an off signal to the cancer cells, reducing the signal that they use to multiply and to invade tissues to create new blood vessels for themselves, to evade immune surveillance.

And that kind of a thing. So absolutely brilliant when you put all those four things together in the right patient, very critical in the right patient, it's going to be very difficult for the patient to not get.

Well, you know what I mean? And so can I talk to Libby? You. Yes. Everybody. Now regards to pancreatic enzymes. And I know a lot of doctors know, but it may not be that all the listeners know.

So you're saying that it kind of turned the off switch on the cancer for its multiplications? And I know the theory came in relationship to when a fetus develops in the womb, the pancreas starts to produce these enzymes and various mass. It grows, you know, stops.

So it becomes like a limiting factor when the pancreatic enzyme source was, you know, is being produced and the fetus. So is is that the only that's the kind of the main function you're feeling that the pancreatic enzymes has.

Yeah. I mean we know they're going to have naturally are going to help in digestion as well. But the story begins with that to John Baird, who spend all this time looking at embryos for some weird reason, paid off in the long run.

But a very interesting job. Yeah. Awesome. Yes. Looking at embryos, they in there and he discovered that the placental cells which initially are part of the whole package, are within the mom's womb.

The placental cells are trove of, as we call them. They had very similar properties to cancer cells because their job was to anchor themselves into the maternal womb, the mother's womb, and provide that source of blood supply and nutrients for the developing fetus.

And of course, to do that, they have to be able to invade deep into the tissue of the womb. They have to be able to avoid immune surveillance, meaning the mother's immune system can't destroy them because that would defeat the whole purpose in some pregnancy complications.

That's exactly what happens. Interestingly enough, they both secrete beta hCG, some very interesting similarity. They both attract blood flow to themselves, angiogenesis.

And of course they are. They both multiply very rapidly as you mentioned. And so he quite by accident, it seems, recognized that there was a specific time where the placental cells just suddenly stopped doing all of that.

And as you correctly said, it happened to be the same day that the fetal pancreas, the baby's pancreas, secreted its first dose of enzymes. Now, when you think about it, there's no need for a fetus in the womb to have pancreatic enzyme because they're not having any food for another several months.

And yet it was just consistent. I think memory serves me right. It's probably around 56. I hope I'm remembering right. Everything just suddenly stopped and it happened to be the same.

The that the fetal pancreas secreted its first enzymes. So he of course, like any good scientist, made an extrapolation and he said, hey, I wonder if the fetal enzymes is actually the signal for telling these to send ourselves to stop.

And indeed, it turned out that that was the case. And then he took it a step further and said, but the center cells really behave just like cancer cells.

In fact, it could very well be that in some strange way, cancer cells are actually left over to central cells that are dormant in the body somewhere. So he decided to see, hey, I wonder if this would help with cancer.

And do you know what might call it? They had at the time they had preparations of intravenous enzymes that they were using and they were seeing, according to his reports, which were actually well written, they were seeing tumors literally just dissolving.

Yeah. And you would think that it would be good to be able to have that available to the world at large. But like any

good therapy, it had to go through its own rigorous rollercoaster ride.

Despite being published repeatedly, it fell out of vogue for a little while, and the simple reason is that one person gave the use, for argument's sake, a dose of five pancreatic enzymes and considered at high dose.

Another person would use 50, and the person with 50 would get these tremendous results, and the person using five would say, well, you know, I didn't get the results.

They couldn't be that good. And it was just a simple matter of dosages and in some cases, how the enzymes were extracted and prepared. So that's all William done on Kelly and after Gonzalez several decades later, realized that that's where the issue lie lay.

They ultimately decided to be hyper focused on quality control, getting the right preparations of enzymes at the right dosages. Their results began to speak for themselves.

And so, again, we have this legacy that has been left behind by the world at large to be able to to embrace, if we're willing, says a slow march towards getting the world back in touch with this vitally important principle.

I mean, a lot of people I'm sure are listening. They're thinking, well, I just need to add pancreatic enzymes in my protocol. How important is that to have somebody to guide you through this process?

Yeah, yeah. So I think whether Gonzalez protocol are nuts, there are intricacies of managing a cancer patient or a chronic disease patient every single step of the way for example, I spoke about how much how intricate it is to assess the patient, first of all, adequately, metabolically type the person because you don't want to be putting all your efforts in and going in the wrong direction.

That's the worst thing you could do.

How the Gonzalez Protocol Works

So, for example, I've met patients who are alkaline, who are parasympathetic dominant both by history and by the type of cancer that they present with.

And they're all vegetarian. I'm saying, do you have any idea how much harm you're causing yourself right now? So right away there's that's something that you would need, a trained physician or a trained practitioner to be able to highlight for you.

Well, then the second thing is the body is in a constant state of flux. Every step of the way, there's this delicate balance between the nutrients going in and the toxins coming out, and the enzymes are doing the work, and then the autonomic nervous system is adjusting, and it's not going to want to adjust too quickly because it doesn't want too many rapid shifts.

And then what tends to happen is somewhere in that dynamic relationship, the toxins into the bloodstream. And they're floating around for a little while.

And you know what that means. The patient feels like garbage, and they'll call you and they'll say, hey, I don't think this thing is working because all my joints are hurting me, or I'm nauseous, or I'm throwing up, or I'm having diarrhea, or I have a headache or I can't think straight.

And all of those are symptoms of essentially a detox crisis, which we which we know, but patients often don't. And so, you know, they run into trouble.

And the other thing is patients sometimes have personal preferences. So you'll have somebody who will say, I really love doing the juices, and I love the supplements, but I'm not a big fan of the coffee enemas.

I don't do those as much. And so they run into trouble because they're not detoxifying. And then they say, well, you know, this thing is not working. So it's absolutely vital for somebody to be guided, especially in 2024 when, as we mentioned earlier, the amount of toxic challenges that we face on a daily basis is so different from what, for example, doctor Max Gerson in the 1930s had to face or even Doctor Gonzalez in the 1980s and 90s and early 2000, he was treating patients with greater success, largely because there was just so much less to think about in terms of toxins.

Yeah, yeah. And and that's a thing also is that, you know, when we're looking at some of these therapies that were very successful, let's say in the 80s.

Yeah. And we're doing exactly the same thing, and we're not getting the same result. And is that a recognition that we're living in a different world?

Yeah. We're we and we we just have to take into account for that. Oh yeah. Oh yeah. And yet and yet the principles stand the test of time. Because if we're diligent enough, as you know, with being persistent with the therapies, over time, the patient, they may make smaller incremental changes, but they do get better.

Yeah. Just requires more patience, more effort and more determination. And so it is just important for patients to know that you can't just take you get a step away from the medical mind.

American Medical mindset where they take a pill and the symptom goes away. Yeah, it's not that way where we repair, we're rebuilding a car or we're doing it from the beginning at that.

Yeah, it takes time. Oh yeah. What have you seen. So you've been doing this for about five years now right. Oh yeah. So 2021 for Gonzalez. So yeah runnable for years on what are we seeing.

And this I know it's a short period of time especially when you deal with a program that is say it's a longer journey. Yeah. What have you been able to experience so far.

So I've noticed two things. One, I wanted to highlight again what I said earlier really quick, which is there are still patients from that to Gonzalez.

It's time who are still on a protocol 3040 years later. So they're still around and I'm being asked to help some of them, for example. So that's one too, is that for patients who are entirely new to the protocol, which I've met a few, and I reviewed the cases around the world of others.

The immediate thing that's noticeable is that the patients subjectively feel a whole lot better on the protocol, and they did before long before we start to talk about remission and and the cure of the disease and whether there's any residual disease and imaging and so on.

Long before we talk about that, the quality of life of the patients improves almost across the board. And then you start to talk about outcomes. One of the most successful stories I've seen so far is somebody who is readily willing to share, share his experience as a gentleman with irresistable pancreatic cancer who by the time he came for the Gonzalez protocol, had already been opened up, closed back, and they realized we can't do anything.

And I think maybe 4 or 5 months had already passed since then. So he's already at that kind of extreme end of what you're expecting in terms of less, in terms of survival anyway.

And despite this, he starts a Gonzalez protocol and within a few months he is back mountain biking against his doctor's orders. Of course, that's the other flipside to this kind of thing, which is that patients feel better.

So much so quickly that they immediately begin to think that they're invincible. And of course, he goes on to live them. Don't want to miss school. It's roughly 18 months post starting of the Gonzalez, and that's false diagnosis, to be quite frank.

Ultimately sadly became very poorly compliant for the same reasons I mentioned. He just became super confident, began to cheat here and there. And we, we realized subsequently wasn't really doing the detoxification exercises as he should have.

So he he pretty much became less than compliant as a way I like to express it and unfortunately ultimately passed away but passes away at 18 months. Post died post commencing in a Gonzalez protocol, which means it's almost a total of 2320 to 23 months post diagnosis.

Thus not that's no joke about pancreatic cancer, and that's the one that I like to talk about. Not because I'm just trying to find my best case and present, but because that's just super impressive across the board.

Yeah. So I mean, whether or not is my best case, that case wasn't managed by me personally, but I managed I was responsible for reviewing the management of that implemented.

And we recognize that the management was as best as he could have done, but the patient just became too cocky towards the end. Unfortunately for my own patients, my favorite story is a 74 year old lady with neuroendocrine tumor.

This diagnosed in the groin and she comes to see me not because she had this diagnosis of a new and the current tumor, but because she was found to have something a small mass on her pancreas.

That's actually why she came to see me now in the course of working her up, as I mentioned before, doing her metabolic typing and that kind of a thing, I recognize.

Hang on a second. This lady's parasympathetic dominance, her body's usually alkaline. Whoever was seeing her prior to me had insisted that she needs to be on a vegetarian diet.

So she comes to see me on two years into a vegetarian that she feels like crap. She has this cancer diagnosis. She has a whole ton of other symptoms that are in line with the parasympathetic dominant type picture. So lots of allergies.

She was kind of having issues with her emotions, always finding herself more depressed than anything else, always lacking energy. So I said to her here, understand that you're concerned about the pancreas, and I understand you have this diagnosis of cancer, but let's focus on getting the whole personal well.

And she agrees. The first thing I say to her is, guess what? You are going to start eating a whole ton of meat. And her face lights up and she says, I love that.

But my doctor says I shouldn't. And I said, well, guess who's your doctor? No. So she agrees and she starts a protocol and I interview her maybe four weeks in there about and say, how are you doing?

And she says, I feel great. She said, I have not had this much energy in years. I used to hate being on this vegetarian diet and I can't get enough meat now, and I'm not putting on weight even though I'm eating all of this meat.

And of course her numbers and everything are getting better as well. She's sleeping deeper. She's able to do a lot more. She's not having any more allergies.

She's very effective around the house, helping her granddaughter and her daughter her whole life. Just turns around. And of course, she gives me this glowing testimonial that's on the Gonzalez Protocol website now.

And she is 74 years old with this diagnosis. So she goes back to see the doctors about the pancreatic mass and she says, hey, guess what? I don't think I need to do anything about this month.

It's going to take care of itself. And the doctor said, no, actually, we need to do a biopsy. And she says, no, I'm I'm

not doing a biopsy. And they say, no, but if you don't, you're going to die.

And she said, well, my doctor told me that my body is going to get balanced and I'm going to start doing a lot better, so I'm not going to die. She is now.

I think she is approaching.

Patient Outcomes and Case Examples

Oh, well, she's probably past two years now. And every January. Yeah. Oh she's. Yeah, she's coming up to two years now on the protocol. She doesn't I had to beg her to go back and have the doctors evaluator again read that I got sickness and she's adamant that she doesn't care what they say.

She's not doing it. She did a Pet scan and the mass was not metabolic on that active. So it's probably actually another neuroendocrine tumor anyway. So it should improve with everything else that she's doing.

And this lady just looks at a picture of health at age 74 a man. It's unbelievable. And the stories are the stories are more or less the same across the board.

Now to be clear, the patients need to be there. Performance status to begin with needs to be good. So it's not to say that it's a solution for every person with cancer.

There are some criteria that we'll use to determine whether this patient has what it takes to actually sustain the protocol to begin with. So again, like I mentioned before, if somebody with a huge tumor on their chest or somebody with a rectal mass that's about to close off their their colon, it's not an ideal candidate at all.

But having said that, those are extremes of presentation that are not very common. And in a reasonably selected patient, one can expect pretty good outcomes.

I love it, I love it, and how how can people get Ahold of you? UI? Where where do they and do you work with people all over the world, or how does that work?

Yeah. So, you know, I'm a I'm a clinician through and through. So at first I was very reluctant to to use video conference to see patients. But in the world we live in today, it's it's tough sometimes to ask someone to fly halfway across the world just to be properly examined.

And I've also found that because the the protocol is so comprehensive, if I can get enough information in general to adequately, adequately, metabolically type A patient, then video conference actually works pretty well.

So as it stands now, I do see patients across the world. If possible. I'd still love them to come to Jamaica and spend some time with me a few days. I can get a few things that I might not be able to tell over zoom.

Sometimes I, you know, my instincts tell me, hey, I just want to see they have a scar on their back. I want to examine. It's kind of a thing, but I found that for all practical purposes, most people want to be managed at a distance.

And it's entirely possible to do so. So I do a lot of that now in terms of how people get in touch with me. I have my practice is known as taxable wellness.

It's TSA to UVA wellness. To shuba means to return to God or to return to your best self. And I think that all our efforts are directed not just mine, but yours as well.

Michael, we instinctively want patients to be able to return to the best version of themselves. And I think I what I've started doing now is I don't just evaluate the patient for the Gonzalez protocol, but I listen to the story, look at the medical reports and so on.

And then I try to recommend the therapy that I think is best for them, because of course, I'm like a Swiss Army knife right now. The possibilities are endless for what I could recommend.

So a patient who comes to see me if I cancer diagnosis once they're reasonably eligible for a therapy, would either be considering the gruesome therapy, the Gonzalez protocol, or I do have a protocol that I use for my patients locally, which requires ozone treatment, some IV vitamins, lots of coffee enemas, lots of emotional work.

Interestingly, I've found that I'm getting pretty good success with with those patients being treated that way as well. But that requires, of course, six weeks of spending time in Jamaica with me.

Yeah, I am really enjoying what I do right now, as you can tell. So now you can sleep at night, as I was saying, but I sleep, you know, I don't want to say I sleep like a baby because if you think about it, a baby doesn't really sleep throughout the night.

It's, But I sleep really well. I enjoy heading into office in the days my only challenge now is, is trying to be able to replicate myself. It's not very straightforward, as you could imagine, and I think to humbly say, I humbly submit that that's probably what most of us struggle with.

As pioneers in this field. It's it's hard to, to find people who share our, our, our values, not just our abilities and to be able to serve our patients, you know, in a broader way without having to have that contact with every single patient.

What I'm doing, like you, is I'm doing a little podcast called Healthy Reasonings as a quick advertisement there for people who want to hear my thoughts on various things.

I'm sharing most of them here, but from time to time I'll remember something. I say, hey, I should do a podcast on that. And my mom called me today and she had this picture of something that the gardener wanted to use on her lawn.

She said, is this safe? Of course, it had this really nice name, but then in the ingredients you supply for seed said, you know, mom, I don't think that's the best thing for you to use.

So these are things like those helped me to, to get material for my for my podcast. Thank you. Thank you mom. I'm curious also. So here because you exist in this kind of medical oncology world, what are your colleagues saying?

I mean, do you have any have you had any feedback and a pushback, anything in regards to what you're doing? Yeah, I'm not going to lie, I what I had was radio silence for several years.

Luckily I work. I should have mentioned I work with my wife. She's a registered nurse. So that makes it a little easier to to I mean, I'm not entirely alone.

So we we do what we can together. And I know that she has my back and vice versa. Over time.

Working Globally and Final Thoughts

What what I've noticed is happening. And of course, I have no animosity towards anyone, to be clear. But what I've noticed is generally I think the public is noticing that conventional medicine does not have all the answers.

And slowly but surely purely conventional doctors are also noticing the same thing. So every now and then I get a referral here and there. Hey, you know, this patient who I've not been able to get any traction with, could you take a look or.

I have a friend who, you know, I, you know, I'd hate to see her go through chemotherapy. Could you take a look at her and tell me what you think? So luckily, I didn't burn. Burn?

I hope I didn't burn any bridges in the years gone by, because the communication lines are now open again, and

there's at least an openness to have me look at some of the patients and I'm happy.

Yeah. That's wonderful. Well, like Andre that this been a pleasure. And I'm so, so excited. You know the the work that you're doing and the, the people that you're helping there.

There's so many people out there that that need this help. And I'm so excited that you stepped into those shoes and and. Yeah. And and offer that opportunity for people to deliver a long, you know, vigorous life.

You know, quality of life is is so crucial. And we know that, you know, even though chemo shrinks, tumors, we know that it doesn't really bring a lot of quality of life.

So thank you so much, Dr. Andre. Thank you. I mean, we need each other. So I'm glad I got this opportunity. Thank you. Thank you for tuning in to Doctor Talks.

We hope today's episode has enlightened and inspired you on your path to optimal health. Each day is a new opportunity to make choices but empower your wellbeing.

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