
# Letter to the Editor

## Re: "Cancer Care: Conventional, Complementary, Alternative?"

I read the article by Dr. Barbara MacDonald in the Aug/Sept 2018 issue of the Townsend Letter with great interest.[1] She gave a good breakdown of the design flaws in the recent article assessing alternative cancer treatment in the *Journal of the National Cancer Institute*,[2] and also made an excellent case for why she advocates proceeding with some form of orthodox therapy for the majority of cancer patients. Based on my own experience working with an alternative cancer therapy, I felt I could add a little information for practitioners about the pitfalls of working in this arena.

I met the late Nicholas J. Gonzalez, MD, in 1983, while he was in the middle of his investigation of the work of William Donald Kelley, DDS. Gonzalez had found a remarkable number of patients with documented terminal cancer who had thrived under Kelley's care.[3] Kelley's regimen involved dietary changes, oral nutritional supplements with large amounts of pancreatic enzymes, and detoxification including coffee enemas.

Gonzalez and I came to New York City in 1987, where Gonzalez set up a practice to recreate Kelley's methods. I completed my internal medicine training, then joined Gonzalez, starting to see patients myself in 1993. While we always had tremendous faith in what we were doing based on Kelley's results and we started to see remarkable outcomes ourselves, we also found that there were a few patients who swore they were completely compliant who nonetheless did not do well. We therefore advised patients who had conditions that could be cured with standard modalities such as surgery, chemotherapy, or radiation that they should do those treatments. It would be a shame for someone to pass up a chance at a cure to pursue something that was experimental.

However, in the early years of Gonzalez' practice, he would also see occasional patients who insisted that they wanted to do a natural-only approach, that they felt it was their right to try, and that they would rather die than get surgery, making such a compelling case that he would decide to treat them. A few of those patients did well. Most of them, however, turned out to be problem patients. An example that sticks in my mind is a patient who had cancer of the larynx, which can be cured by radiation or surgery, but with inevitable alteration of the voice. This patient's career depended on the ability to speak, so a passionate plea was made and the patient was accepted. After four months on the protocol, examination by an otolaryngologist showed that the lesion on the larynx had shrunk by 40%. The patient then opted to discontinue more than half of the supplements prescribed and to cheat extensively on the diet. The patient's spouse explained all that in a call a few months later; the patient was on the phone but unable to speak due to regrowth and progression of the laryngeal mass. The patient was then politely but forcefully referred for radiation, since the voice was gone and radiation could still be curative.

Gonzalez had patients who refused curative surgery who reported that they were taking all their supplements but were not buying enough of the products

to be doing so. In two cases, friends called more than a year after patients died to inform Gonzalez that the patients had been smoking cigarettes or drinking a pint of vodka every night. We finally concluded that for a certain number of the patients who refused orthodox therapy, their real agenda, based on their actions, was not a fervent belief in the power of nature to heal. It was a desire to deny that they were ill. They would try to appease their loved ones, made frantic by their refusal of standard medical care and by their deteriorating condition, by saying they were pursuing a treatment under the direction of a physician. Meanwhile, they would not be following through with the treatment prescribed.

Denial and noncompliance are not confined to cancer patients who refuse potentially curative orthodox therapy, but my experience tells me that more patients in that group exhibit those behaviors. The potential legal ramifications of these patients' poor outcomes are tremendous for the practitioner involved in their care. An informed consent document may or may not protect against malpractice litigation, but disgruntled patients or family members can also file complaints with state regulatory agencies, giving them the opportunity to go on a witch hunt, if they feel so inclined. This is not fearful speculation on my part; it happened to Gonzalez in the 1990s. I have written in a previous Townsend Letter article about those times.[4] Given our reluctance to have a patient refuse a curative option to pursue an experimental treatment they might or might not actually follow, and our horrendous experience of dealing with malpractice cases and state medical board investigations, Gonzalez and I decided to refuse to accept new patients who have curative options they have not received. As I continue our work after his death, I also continue that policy.

Gonzalez and I have been criticized for that decision by other practitioners, mostly naturopathic physicians, who claim they "turn no patient away." MacDonald's statement in her article that "a licensed naturopath who focuses their practice in oncology is not bound by a standard of care like medical oncologists are" helped me understand the perspective of those critics. I hope this letter will help explain my perspective, and that it will be helpful to others as they decide how they want to operate their practice.

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**References**


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3. Gonzalez NJ. *One Man Alone; An Investigation of Nutrition, Cancer, and William Donald Kelley.* New York, NY: New Spring Press; 2010.
4. Isaacs LL. In memoriam: Nicholas J. Gonzalez, MD. *Townsend Letter.* 2016, Jan;390:14-19.


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