Cancer Conquest: The Best of Both Worlds

Runtime: 1:37:56

Chapter 1: Introduction 09: to 3:35 I'm Burton Goldberg. I've been studying alternative medicine for 30 years. I didn't believe in chemotherapy, because it was done blindly. 80% failure, 20% success, and of the 80%, 60% did harm…until I met Dr. Scheller, who had three degrees, in pharmacology, in chemistry, and in medicine. Albert's contribution to oncology is the use of various masters. He didn't do everything himself. He used experts in the field, and he developed a test in northern Germany, in a laboratory, that did **gene testing on cancer cells**. **Not only the primary tumor, but also the micrometastases**…those are the serious killers. This film is dedicated to Albert Scheller, a giant of a man, who passed away this year.

1:17 In the year 2002, 476,000 Americans, under the age of 85, died of cancer, making it the #1 disease killer. There is always hope. Even end stage cancers are reversible. **DRIVE** Title: Curing Cancer [the best of both worlds]. I will take you on an incredible journey, exploring integrative medicine: using the best of conventional and alternative medicine in the reversal of cancer. Who am I? For many years, I was a business man, a builder, developer, restaurateur. I knew nothing about alternative medicine. My friend's daughter, at the age of 19, slit her wrist. She was going to a psychiatrist, and frankly being talked to death. It was a holistic physician in California who discovered she was hypoglycemic, a blood sugar imbalance, and when treated, she got well from mental illness. And that set me up on a journey, to discover how alternative medicine can help with cancer, arthritis, heart disease, and other degenerative diseases.

2:36 **DRIVE** Screen title: Curing Cancer [the best of both worlds]. I've called this program, Curing Cancer, The Best of Both Worlds. For not one system alone is as effective as using the best of conventional medicine and alternative. **QUICK INTERVIEW START**

3:01 Dr. Michael Gerber, Gerber Medical Clinic, Reno, USA. You need to use the best of both worlds very frequently, and you just want to use the lightest dose of poison possible, to get the job done.

3:10 Dr. James Forsythe, Cancer Screening Center, Reno, USA. I personally find that combining therapies is the most successful.

3:15 Dr. Wolf-Dieter Kessler, Kessler Klinik, Aurich, Germany. We do not see black and white. Neither conventional, nor alternative medicine is the Bible. We have to use both of them.

3:26 Dr. Dana Flavin-Koenig, Foundation for Collaborative Medicine, USA & Germany. And the best treatments that I have found so far were combination treatments from nutrients and nutrition, and, combining with the techniques that Dr. Scheller is applying.

MAP 1 CHAP 2? Dr. Albert Scheller and Dr. Ursula Jacob, Leonardis Klinik, Bad Heilbrunn, Germany 3:36 – 8:51. Germany map: BG: In southern Germany, at the foot of the Bavarian Alps is Dr. Scheller. 3:41, who every morning, meets with his staff of 10 physicians, and goes over the program for his many patients. Fortunately, Dr. Scheller worked with Dr. Ursula Jakob 3:56 who went to medical school with him in Hungary twenty years ago, and has been working in his clinic for 15 years. She has learned all the therapies and protocols of Dr. Scheller. **4:14** Dr. Ursula Jacob, Leonardis Klinik, Bad Heilbrunn, Germany. Oh you know that Dr. Scheller developed the name Leonardis, Leonard, because of two reasons. First, because of Leonardo da Vinci, and he loves Leonardo da Vinci. I think Scheller was, essentially as him, really, because…BG: You think that he could have been reincarnated. UK: Yeah, yeah, because not only in the science things Dr. Scheller knows a lot about, he also knows a lot about technical things, for example.

4:42 Dr. Albert Scheller: I have a chance, 20% to survival to get better cancer with chemotherapy, OK, 80% failed. If I have a vaccine, who give me 11 or 15% which is very poor, this is 35%. And if I have alternative protocols which gives the patient also hope even with immune correction, with immune modulation, with stimulation what else, again, another 20%. OK and you make it combine it with hyperthermia, let's say 20%, in total, we have an outcome maybe 65%. It's much better than the 20%, which are very poor. You have to combine all together. BG: The best of both worlds. AS: Sure.

Chapter 3?: Healing Breast and Advanced Liver Cancer, Interview with Patient Rhonda Medina, RN. 5:28 – 8:52. Leonardis Klinik, Bad Heilbrunn, Germany. BG: Rhonda, so how did you get here? Well, I'm kind of a reference through a friend of a friend of a friend. They referred me to you, and you referred me to here, and here I be. Getting better, every day. They saved my life. BG: How long have you been here? RM: I've been here since December 20th, and when I got here, I had an enlarged liver, with multiple lesions, and 2 days after I got here and had a PET scan, I **pretty much had liver failure, it collapsed**. BG: Woe. RM: I turned yellow, all the enzymes, all the lab studies, kaput. That's German, because we're in Germany, kaput. (laughs). So the body failed, and the lab work proved all that. So you can see from the lab work that it was pretty extreme. So I made it here just in time. BG: Thank God. RM: And so they reversed it with a lot of their treatments. They did **hyperthermia** for one go around. BG: **Full body**. RM: Full body. BG: With some **low dose chemotherapy**. RM: It was a bumpy month, but it was just a month. And I'm back alive and kicking again within a month. BG: This is astounding. RM: Yeah. The **white cells were non-measurable**. And then they did **immune system building**, and they went from below 500 to up to, into the 30,000, back down into the normal range. BG: And they saved your life. RM: I believe so. The symptoms are going away, the bloating. I had ascites, I had fluid in the liver. The lesions are disappearing, they're having a hard time finding them. I've glad to say. BG: This is wonderful, that's great. RM: Yeah, and that's that. They still have to work with some of the bone marrow, and the **breast cancer** thing is pretty much not an issue, because it's **not there**. I had a couple lumps that came and went, so, I don't know whether that was a hormonal thing, or what. So, **there's balance here**, and they've done remarkable thing. 7:42 picture slideshow.

7:54 BG: And how is the **attitude** and so forth **of the staff**. RM: I'll tell you, there isn't anything better that I've ever seen in a medical arena, than what they offer here. It's **not just the medicines** they put together, they **combine it with every ounce of hope**, and they give it to you with the explanation, and you know they're pulling for you more than you could pull for you, which is a lot. **They're working miracles**, I mean, what else could it be. It's just **the energy behind it**. The chemicals and a few little TLC's here and there, this and that scattered stuff in the States could never in a million years package like this. This is just unique. BG: Thank you. RM: So. BG: You bring tears to my eyes, really. RM: Well, **they bring life**… Your story is…RM: They bring life to people here, and **I've been working in medicine** all my life and I used to count how long a doctor would stay at the doorway, and I think one **time** we made it to 60 seconds. 8:52

Chapter 4: What causes cancer? If you don't know the causes, how can you properly cure it? 8:52 Burton Interviews the Experts: When we ask conventional medicine, well they say the sun and cigarette smoking, and we don't know. But, our doctors know. **What causes cancer**, why to we have this holocaust?

9:12 Dr. Michael Gerber, Berber Medical Clinic, Reno, USA. Well, quite frankly, there are many opinions, but I think the one that holds greatest sway in my experience is **environmental toxicity**. We've been exposed to 100's of 1000's of **chemicals** that haven't been on the planet before a hundred years ago. And the body has decades, and 25,000 year old genetics. The body doesn't really have a mechanism for getting rid of a lot of these chemicals and **toxins and plastics and hydrocarbons and pesticides** that we have in our body. It doesn't have a tool for doing this. And, so, there comes an accumulation of these toxins. And, when you have these toxins, and they are many fold…it's well proven that 100% of us have **styrene**, in our fat, 100% of us have **phthalate**, that's plastics. BG: That **styrene comes from those coffee cups** we use. MG: Coffee cups, packaging, wrap. **Phthalate** (correct sp.). BG: Where does that come from? MB: It's a plasticizer, it's in the food wraps and plastic water bottles. That new car smell, that's phthalate.

10:15 Daniel Dunphy, PA-C, Clear Center of Health. Cancer is an epidemic, and it really ultimately boils down to a mixture of what's in the **environment**, or what's not in the environment, **what's in our food** or not in our food, and **genetics**. But, many, many women are coming in with breast cancer, many men, now a days, as well with different cancers, with **no family history of cancer**, so it's **obviously an environmental issue**, and ultimately, it needs to be dealt with in that way.

10:50 Dr. Ursula Jacob, Leonardis Klink, Bad Heilbrunn, Germany. The main problem is that **you have to look individually for the patients**, and figure out, **what can make this kind of tumor**, or why this patient has a tumor. So we have to look for the micro environment, we have to look for the macro, chemi (test) inside the patient, with this **special kind of blood test**, we have to check out the **dental status** of the patient, and we have to check out the **energy level**, on what energy level the patient is. So we have to look from different kind of aspects, for the patient's health. And then, we have try to

figure out what can help best, to get for example, the patient back to his good energy level, or to get **rid of the factors which can cause cancer in his disease**, for example, **viruses** or **pollution** or **heavy metals**. So we **have normally to check all these things, to treat the patient, really in a good way**. Because, **otherwise, when you only destroy the cancer, it will come back, and this is for sure**.

12:02 Dr. Wolf-Dieter Kessler, Kessler Klinik, Aurich Germany. We have a lot of **radioactive fallout**, and this is very important, **viruses**, a lot of viruses, **pesticides**, and **herbicides**. They are **xenoestrogens**, and an overload in estrogens is resulting in not only breast cancer, but prostate cancer. It's also just bringing you out of **equilibrium with your progesterone, testosterone, estrogen**. If you are not in equilibrium there, then you are producing tumor.

12:38 Dr. James Forsythe, Cancer Screening Center, Reno USA. Well you and I know that there are many, many causes. There are lists of, you know, I've drawn up lists myself of over **50 to 100 chemicals**, **genetic**, **environment**, **dietary**, all of those things, poor lifestyle, **lifestyle choices**, smoking, drinking, diet. We know that **smoking, drinking, diet alone probably 60% of cancers, I would say very conservatively**, and then the other are environmental toxins, **chemical toxins**, **viruses**, **parasites**, various microorganisms, such as **mycoplasm**, then all the chemical, **heavy metal toxins**. We have a leukemia epidemic in Valon, Nevada, where they have jet fuel leaking out of the lines that feed the top gun performers out at the Valon naval base. And that **JP8 fuel** is thought to be one of the causative agents of the leukemia epidemic. 16 cases of leukemia in a town of 25 to 30,000 people, when they should have only 1 case, Burton, every 5-7 years.

13:49 Dr. Dana Flavin-Koenig, Foundation for Collaborative Medicine, USA & Germany. There are many, many causes of cancer. And it's a multifaceted activity that goes through years and years of changes in the body that affect the body's balance. Part of it is **genetic**, part of it is **environmental**, part of it is what we are **eating** or what we are **exposed to**, are we involved in **electromagnetic fields**, are we **sitting in front of a computer all day long without protection**. Are we eating properly, or not eating properly, do we have tremendous amounts of **stress** in our lives. (Screen title: Cancer from high stress) There is a multitude of factors, that play a role, many of which we can regulate ourselves. **There are now ways of taking the melanoma and making a specific immune stimulator directly against the tumor cell**. This you can do, or, you can just inject different types of **thymus extracts** or particular types of **immune therapies to enhance the immune system**. BG: So you have good success with **melanomas**? DFK: Oh yes, yes. BG: And that's a deadly, deadly disease, and conventional medicine… DFK: It doesn't have to be. (Screen title: cancer from electro-magnetic fields). DFK: We're seeing a problem, for example, with **immunizations** in children, when they're around these **mobile phones** because the blood brain barrier opens up, and it's letting viruses into the brain. We're seeing multiple sclerosis early. We're seeing more and more problems, because of this **change in the blood brain barrier**. That's just one of many…and we're all sitting at computers, we're all using, the convenience is wonderful [screen title: cancer from electro-magnetic fields], but

unfortunately…BG: At a price. DFK: Yeah, at a price, exactly. A woman with a **mesothelioma** (asbestos cancer), right here, OK, but it's from asbestos. [screen title: cancer from **geopathic stress** (various sources of energy lead to increased vibration, and geopathically stressed locations cause illness)]. Where was she sleeping, in a crisscross, right over where, where, it was amazing. And I saw more and more of this…changing the bed helped them respond to treatment better. BG: So, call in a douser. DFK: Yeah…I thought they were crazy. BG: These are people who water witch. DFK: Yes. BG: And have them come in our house, and see that it gets better…DFK: It works, I couldn't believe this. (Video title: **cancer from water treatment**). DFK: **15:53** The other problem with water, **pesticides, nitrites**, **fluoride**, alas, as I said, my Dad was a dentist, wonderful oral surgeon, and thought fluoride was great, we all did until we found out that **fluoride blocked selenium, and selenium is imperative for protection for our immune system against viral infections, against cancer**. (Video title: cancer from irradiated foods). **16:16** BG: How about **irradiated food**? DFK: Ah…This is a problem. BG: You know, it is another term for sterilizing filth. DFK: Well, unfortunately we getting also into areas of **microwaves**, too, which I also used to think were no problem until I found out that cadaverine, a toxic product that is carcinogenic and we see in dead animals, dead tissues is increased (wikipedia: **Cadaverine** is a foul-smelling molecule produced by protein hydrolysis during putrefaction of animal tissue. Cadaverine is a toxic diamine with the formula $NH_2(CH_2)_5NH_2$, which is similar to putrescine. Cadaverine is also known by the names 1,5-pentanediamine and pentamethylenediamine. Cadaverine is the decarboxylation product of the amino acid lysine). BG: From microwaved food. **16:43** DFK: Yeah. (Video title: cancer from high **stress** level). All of us get cancer cells. They're destroyed, they're made. You have one little cell, and you're **stress** levels are high. It **stimulates the growth of the tumor cells**. **Cortisol stimulates tumor growth**. This has been proven. (Video title: **cancer from parasites**). **16:59** I thought, oh, I don't have **parasites**, I don't have any symptoms. And then I was reading a book on parasites in relationship to cancer and decided well, maybe I should just try to detox myself from parasites, and see if they're anything there. I was completely contaminated. And I thought, my wonderful little doggies, they have parasites too. So, even though I treat them regularly…[screen shot: cancer from parasites] 17:24

Chapter 5: 17:25 Overview of Treating Cancer with the Best of Both Worlds, Collaboration BG **DRIVE**: To enhance the treatment of his cancer patients, Dr. Scheller has created a **network of masters** (Image: Munich, Weilheim, Stuttgart, Landau, Frankfurt, Munster, Aurich, Berlin). 17:40 Munster: I visited the home and office of Professor Giesing, who works in close collaboration with Dr. Scheller. **17:53 Prof. Dr. Michael Giesing, Molecular Oncologist, Munster, Germany**. MG: The basic outcome of a cancer patient is not related to the clinical tumor mass, but it is rather related (video title: **cancer cells left in the blood after removing the primary tumor may cause a relapse**) to very tiny amounts of cancer cells. They are called **micrometastases** (correct sp, also sp. asis), that vagabond, are **disseminated in the blood stream**. The entire world of literature, world wide, tells the same story. Success of therapy, failure of therapy, can be measured through genetic, or genome analysis in disseminated cancer cells in the blood of the bone marrow (Image: micrometastases in the bone marrow). We **follow, by genes, the drug pathways within a cell**. (video title: **Prof. Giesing tests the patient's**

blood to create a genetic profile of the cancer), and detect by that approach whether a drug would work or has worked or not, or whether you have resistance factors. **So we also detect resistance factors, in these cancer cells**. BG: So, when Dr. Scheller sends his patient's blood to your laboratory, you **tell him exactly which chemotherapeutic agent to use for that particular patient's cancer**. MG: Right. The blind therapies, as it is done world-wide have, well (video title: **the FDA says in 80% the chemo is useless**), the FDA says, in 80%, that sort of drug is useless. We know, from our enormous number of patients, that from these 80%, another 60% are **not only useless**, (video title, 60% of the 80% makes the cancer worse), **but facilitate metastasis formation, because the cells have gained resistance factors**. BG: **So the drug can cause cancer.** MG: Oh yeah. Oh yeah. That has been known for decades. And **we were the ones who identified these resistance factors…in those cells that should be treated**. 20:12 And, on the grounds of **Kaplan-Myer diagrams, we found that many resistance factors can produce metastases**. **20:24** So, if you put all that together, the prediction value, that means, will a drug work or not (video title: **Prof. Giesing can predict which chemo drug will work with a success rater of 81%**) at the moment is **81%, measured over all tumor entities that we have studied**. That is a very high predictive value. It's much higher than you would obtain by doing the same sort of study within a clinical tumor. And the reason is (video title: disseminated cancer cells have a different DNA) **disseminated cancer cells have a different make up of genes than the clinical tumor would have**. BG: **So the tumor, and the living cells that sluff off the tumor need different treatments**. MG: So we study in these cells, what kind of DNA operations are there, and **we study which kind of genes transcribe DNA into RNA, and we do that quantitatively. In cancer cells, vs. benign cells, that's the whole story**. And the outcome for patients is enormous. BG: And conventional medicine does not take this into account.

21:48 Dr. Ursula Jakob, Leonardis Klinik, Bad Heilbrunn, Germany. So, the patient who has **stage 1 or 2 cancer, it's not done**, when they are operated, and then said, you are healthy, you can go, these patients think, oh, everything is OK, ready now. But this is not like it seems to be, because you have to check several things of these patients. **22:08** And you know what they always say, **five years, you are healed. This is nonsense**. You are not healed. BG: **Every tumor spreads through the body.** UJ: (Nod) Exactly this, so we have to **check the patients regularly for the immune system and for the risk of spreading micrometastases**.

22:28 Dr. Doris Bachg, MD, Dip. Chem. Biofocus Molecular Oncology and Laboratory Medicine, Recklinghausen, Germany (send blood for chemosensitivity testing). I think that are the question a patient wants to know. I'm cured or not. As so we know from our experience that a tumor patient wants to know every ½ year are there tumor cells in my blood or not, and if we find these cells, they want a recommendation of what to do. What's the best therapy not at this point, in this time point. 22:59 BG: **People send blood from you from America.** How does it work? DB: We **get the sample from the patient, and we isolate from this blood the tumor cells**. And then we do a molecular characterization so that we can say that it's a typical tumor cell from, for example, breast cancer, ovarian cancer, colon cancer. So we can say, if the primary tumor, no, is this is a cell that comes primarily from the tumor, it is really a disseminated

tumor cells. And for the **chemosensitivity testing, we look for special drug targets in these cells**. And, if we have all this information, **we can say what kind of cytotoxic compound would work or not**. So we can recommend to the doctors what is the best therapy.

23:56 Patient Ed Van Overloop, CARE Cancer Support Group, New Jersey, USA. So, I have had a change of heart. I mean, initially, I would have never considered doing chemo or radiation *in the conventional manner*. But since the test has come along, the **chemo sensitivity test**, I've found that it's actually miraculous. They tested me the very first day I arrived at the clinic, and much to my surprise, **the chemo that was proper for me was an ovarian cancer chemo**. BG: Believe it or not. EV: Believe it or not. My **PSA** had gotten up to almost 900 before I left. By the time I got to the clinic, and they gave the very first test, it was **1160**, which is certainly a very high marker. Now, the amazing thing, **after staying three weeks at this wonderful clinic**, the PSA after returning home, now this is just after **3 weeks of treatment, was 49, and since then it's dropped to 13**.

24:53: Dr. Ursula Jacob, Leonardis Klink, Bad Heilbrunn, Germany: **It's really great what is happening in him, but only because of the combination of several treatments**. So, he had a combination of special kind of bone treatments, like **samarium (radioactive samarium-153, relieves pain in bone metastases, kills small metastases)**, he had the **tested chemotherapy**, and he had **immunological treatment**.

25:11: Prof. Dr. Michael Giesing, Molecular Oncologist, Munster, Germany. One of the most amazing stories Dr. Scheller and myself have in common was a successful treatment of a colorectal cancer with **herceptin** (correct sp) (video title: Herceptin is normally used for the treatment of metastatic breast cancer). That was a patient who has metastases from the primary tumor and **we did the routine assay, which drug would work**, and we found herceptin would work. So the patient was treated with herceptin, and all metastases had gone after some while. 25:51 So what is behind that story, **a drug does not ask the cancer cells "Where are you stemming from?", are you a breast tumor cancer cell, or colorectal or whatever. A drug would work, if the cell, the target cell, the cancer cell is susceptible**. So that means **pharmacolgenomics** in target cells. So, Dr. Scheller and other colleagues treat their patients after pharmacolgenomic results, regardless of what the tumor is (Image: micrometastases in bone marrow).

26:32 Patient Ed Vanderloop. Of course that test is what ascertained that I needed an ovarian cancer chemo. I understand **that in this country, a doctor can't give a prostate patient an ovarian cancer chemo**. It's **against the rules**, you have to follow the cookbook, so to speak. And **that's part of why we don't have the success**.

26:50 Dr. Doris Bachg, MD, Dip. Chem. **The disseminated (tumor cells) changes, it must have changes, it must have changed. Otherwise, it would have been able to spread all over the body**. The solid tumor is stayed, in its point or region, but not the disseminated tumor cells, so something must be happened that the tumor cells get the ability to leave that point, and to penetrate vessel walls, and to penetrate other tissues. So,

it's obvious that the characteristic of a disseminated tumor cell is quite from the primary tumor, and also the therapy must be different from the primary tumor.

27:35 Dr. Ursula Jacob, Leonardis Klink, Bad Heilbrunn, Germany **What works on the primary tumor, has not worked on the micrometastases**, and also the pathologists say this, because the pathologists only see a little, little piece of the tumor, or only a little piece of the body, and they cannot say exactly, they can say exactly what kind of tumor it is, but they cannot say in the immunological way, what is working or what is not working on this tumor. **You can see more exactly from the micrometastases, because, they are inside the body and they are all over the body**. So you try to isolate from the micrometastases.

28:12 26:50 Dr. Doris Bachg, MD, Dip. Chem.: **The tumor cell changes all the time, and we have to adapt our therapy to the characteristic of this tumor cells**. And that means really highly **individualized**, that's the **reason why many patients with a standard scheme have no success**.

28:33 Dr. Ursula Jacob, Leonardis Klink, Bad Heilbrunn, Germany. And the problem is, that when you have in front of you, a healthy person, this means, the patient's operated, the patient's separated from the tumor mass, what you can see, also what you can see in a PET scan, but, **you cannot exclude that this patient had micrometastases inside which has the risk for spreading**. BG: And it can come back in 1 year. UJ: Exactly. BG: 6 months, or 15 years. UJ (nod) Depending on the micrometastases. How much they remain inside, and how active they are. And **you test this will a special molecular genetic program.**

29:14 Prof. Dr. Michael Giesing, Molecular Oncologist, Munster, Germany: BG: Professor, **Why Don't More Doctors Use Your System?** In Germany, I can give you a very concrete answer. That is, ***money***. **A physician makes more money, more money, the lousier the situation of the patient is.** BG: Wow. MG: 29:33 You know he makes more money from a patient who is metastasized than before that. BG: **Are you saying, they don't really want to cure cancer?** MG: I have seen many people belonging to the establishment. When they develop cancer, they come to my office, and say "**now you have to look into my disseminated cancer cells**…let the other patient be behind me." I have witnessed stories, if I tell them, they would be unbelievable. BG: Really. MG: From politicians, from well-known journalists, all that sort of stuff.

30:16 James Forsythe, M.D. H.M.D., Cancer Screening Center, Reno USA. We are now **doing the gene test for DNA from metastatic** (correct sp) **cells**. These tests are being sent to Germany for final analysis and are being incorporated in our clinic today.

30:29: **DRIVE** Frankfurt (map view), Prof. Dr. Thomas Vogl, University Hospital J.W. Goethe, Frankfurt, Germany: BG: In Frankfurt, Dr. Vogel, an oncologist, radiologist and surgeon, you will see, is **inserting a catheter directly into the diseased organ for the application of localized chemotherapy**. TV: For this **interventional vascular oncology**, we are performing two types of procedures. What you saw today is to **insert**

catheter in any type of vessel, we can imagine, the insert ports for cerebral tumors, for lung tumors, for rectal tumors, for other tumors. This is one step. So we are inserting the catheter there, then we have the port. BG: I take it, you insert the port for the local oncologist to apply the chemotherapy. TV: In my department, **we also performing the chemotherapy then**. So we have our own beds, and can care for those patients. 31:42 As a second procedure, we also perform **chemoembolization (correct sp, 1 or 2 words)**, which means we **position a catheter in the tumor bearing artery**, and then we directly **apply the chemo drug to a vascular occlusion** [screen text: "vascular occlusion" – the blood vessel is closed], for a vascular shock for the tumor and then remove everything. 32:01 And our, let's say, **our highest level procedure includes a vascular occlusion of the tumor vessel, application of a local chemotherapy**, and this is followed then by **laser induced thermotherapy (LITT)**. BG: So the occlusion is done naturally with substances. TV. Naturally, naturally, we can do it with drugs, chemicals, we can do it also with coils, like I did it with you in that procedure, because it's very fast and very safe. BG: You did use a coil. TV: What we do, we first apply the chemotherapy, and then, at the final stage of applying the chemotherapy, we do the vascular occlusion. **BG: So you close down the blood supply to the tumor. TV: And then we have the drug in our territory of interest for about 5, 6 hours.** So, this **means a reduction of the systemic side effects** [screen shot: "systemic" – affecting the entire body]. This is why so many patients are coming here because **patients with advanced cancer want to have a good life quality** [screen shot: Prof. Vogl's **local chemo has fewer side effects**]. And this is also **part of our collaboration** with Dr. Scheller and Dr. Jakob in the Leonardis Hospital and other hospitals, at least in Europe, increasing also in the US, in Japan or China or wherever, patients are more and more interested in having a good life quality, if they cannot be cured.

33:21 Dr. Ursula Jacob, Leonardis Klinik, Bad Heilbrunn, Germany. UK: This is a very important aspect in the treatment of cancer, mainly in patients who have **several metastases, which cannot be operated,** or sometimes, it shouldn't be operated. For example, when we have a patient with isolated liver metastasis, I would never operate this patient. Because, you make **oxidative stress** situations with the **operation**, with narcotics and all, and **destroy the immune system totally**, and **after operation, it's well-known, that the tumor is spreading more aggressively, in this organ, which is operated**. A very, very good possibility to treat such kind of patients is to make local intervention with chemo embolization or a perfusion of this organ, in cooperation with the systemic treatment and with establishing the immune system. **This means, that you give directly to the organs, in low dose chemotherapy to destroy only the tumors in this place, not to destroy the whole system**.

34:25 Prof. Dr. Thomas Vogl, University Hospital J.W. Goethe, Frankfurt, Germany: **The concentration of the chemotherapy in a locally applied protocol is about 20x higher than in the human body. BG: So it's 2000x more effective**. TV: In a way, but, it's **important to know in what type of tumors you have** to do that. So, for example, if you have a breast cancer patient, and the metastases are here, here, here (head, L/R breast) and everywhere else, you have to carefully review whether this patient is a good patient for local therapy. This is always depending on life threatening situations. **So if the**

liver metastases are compressing the bile ducts, it's a life threatening situation. Then we perform this type of treatment. Or, if a human, or the woman has only liver metastases, then we would perform a local chemotherapy, to decrease the tumors, to downsize the tumors, and this would be followed by **laser-induced thermotherapy (LITT)** [screenshot: laser-induced thermotherapy (LITT) to completely destruct the tumor. But our local chemotherapy, we are most in favor to combine it with **hyperthermia**. 35:26 [screen shot: hyperthermia], and this is a big project we do together with Dr. Scheller and Ursula at the Leonardis Hospital.

35:32 Dr. Albert Scheller, Leonardis Klinik, Bad Heilbrunn Germany. Using **hyperthermia** in various cases. Hyperthermia itself, is a wonderful thing, you know, hyperthermia is something which **makes heat** on the human being, you can do it in different ways, you can make it the whole body hyperthermia, **like you have a fever**. We can make it **up to 41.5 C (106.7 F),** or we can make it local hyperthermia, **we do it with a special machine, who heating up mostly the tumor and not heating up the normal tissue**.

Hyperthermia Staff Member: The patient is connected to various probes and monitoring devices to check for blood pressure, core temperature, oxygen saturation, and a few more things for the whole duration for the procedure. BG: Temperature in the rectum. HS: And the rectal temperature, which is the core temperature. And, so, the patient is monitored throughout the whole procedure. BG: Wonderful. HS: **The reason we do whole body hyperthermia, also local hyperthermia**, in this case whole body hyperthermia, is to **enhance the effect of any kind of chemotherapy**.

36:45 Dr. Albert Scheller, Leonardis Klinik, Bad Heilbrunn Germany. The blood flow in the tumor is much less than the normal tissue. The normal tissue has a complete cooling system. OK. What is usually in the hyperthermia, the blood vessels doing? If your blood vessels heated up**, the blood vessels get dilated, itself, and you can bring the chemotherapy there in a much better way, we have different possibilities to treat cancer. Especially, localized, solid cancer**. BG: Like in the liver. AS: Like in the Liver. BG: In the pancreas. AS: In the pancreas, in the lung. BG: **Where conventional medicine gives up?!** AS: So, yes, that's so. **37:29** And you see, we can make **thromboembolization**, means, we go in the blood vessels where it gets distributed to the cancer, ok, only the blood vessels which serve the cancer, we go in, put the chemotherapeutic drug in, and we close the blood vessels. BG: You **seal off the blood vessels**. AS: Sure. **We seal of the blood vessels, and inside the tumor, we have the chemotherapy. So it gets destroyed**. BG: **So, it specifically in the organ, and not systemically through the body?** AS: That's right. BG: **So it doesn't cause the side effects of chemotherapy**. AS: **Not so much side effects**. There is no, no, without any side effects. But…BG: It minimizes the side effects. AS: Yes, it minimizes it. And the first things, is, you know, if we have cancer, like 70 to 80 mm, we try to shrink the tumor. We talk from downsizing. 38:32 And **if we can downsize this metastases**, liver metastases by the way, or tumor, to a size, let's say 3-4 centimeters, we can **them burn out by a laser. We call it lit, LITT, laser-induced thermotherapy, laser induced tumor therapy** (both), and this is an excellent thing.

38:54 Munich. Dr. Florian Kubitzek Facharzt f. Mund-Kiefer-Gesichtschirurgie, Munich (a dentist and medical doctor, medical oncologist). BG: In Munich, we met Dr. Kubitzek. FK: Most important tool in the diagnosis of **cavitations** is this **Italian made CT scan**. [screen shot: **the CT scan reveals dental infections missed by conventional X-Ray**]. It allows us to make slices of 0.3 mm, that means, more than the conventional CT can do and with this machine, we find all the cavitational alterations of the bone structure. Without any x-ray diagnosis, we are not allowed to do surgery. I think that's the basic principle of medical profession BG: And so, **this x-ray machine**, the patient is in there for how long? FK: 70 seconds. BG: 70 seconds, that thing is over. And there's not, almost a little bit moderation as a panel in a dentist. BG: I've never **seen this device in a dental office in the US**. FK: Meanwhile, they have the acceptance of the FDA and I think there are 2 or 3 machines in the states now. 39:55 (Teeth/jaw models) Models…this one shows us how important the blood supply of all the teeth is. There are the maxillaries and the mandible, veins, arteries and you'll see every tooth has this blood supply, and **this blood supply is disturbed the moment the tooth is dead**. BG: And it's **connected to the meridian system**. FK: The meridian system. BG: **And the nervous system**. FK: Yes. The nervous system we have here, you see all the things. And here you see of **China's meridians, and most of the meridians are running across the face**, and also in the depth, and showing the importance of the connections. And this model shows the whole face, **the whole face is connected with nerve**, and they are in contact with the muscles, and the muscles, they are guided by the TMJ, and that's another **important part of information that, for the cancer patient, that can disturb their whole system**. 40:51 BG: **Is it true, that every cancer patient should visit a biological dentist**? FK: I think that's immensely, tremendously important to have done this. BG: Dr Rowe? in Switzerland says that **95% of all breast cancer patients have a dental involvement**. FK: I can agree 100%. He is quite right. We found the same situation, and **we even found several teeth that are characteristic for the breast cancer patients**. Special are the **premolars, the upper right 4 and 5 teeth on both sides**. And, a friend of mine, he examined known breast cancer patients at the University in Dusseldorf, and he found the same figure. BG: **Correlation**. FK: More than 90% having root **filled or cystic premolars**, and that's more than the average population has. That means there must be some connection between…BG: And yet, **conventional dentists don't look for this at all**, and **conventional oncologists pay no attention to dentistry**. [screen shot: Dr. Kubitzek is both a dentist and a medical doctor]. How important is dentistry? FK: Dentistry is very, very important. And the problem really is that at the university, the **dentists are not taught how important their job is in general.** They learn a lot about being very perfect, in doing root filings, being perfect in doing filings, and stability, and aesthetic are the most important themes in the dental training, and they lose the contact to general medicine**. It was proven that before you start radio or chemotherapy, you have to clean up the mouth**. 50 was a goal, everybody was proud to have and alloy containing 10, 15, 20 metals. Meanwhile, we know it's **better to have only 1 metal in the mouth, better no metal**. BG: Particularly nickel. FK: **Nickel** is a problem, **vanadium** is a problem, **aluminum** is a problem, **iridium** is a problem, **palladium** is a real severe problem in Germany, we have an increasing number of patients that have a problem with palladium, it's a higher number of patients than **mercury** problems

anymore. **Palladium goes to the brain and makes the people confused, depressive, and palladium is in most of the dental materials at the moment. The resin materials are a problem too.** BG: **The plastics**. FK: The plastics, the filing materials. **I think it's fair only to put in the body, you know, that the body will tolerate it.** Of course, **all the situation in the mouth loads the immune system. ***And you will not have any treatment, effective treatment of cancer without immune therapy, and you cannot do any immune therapy without taking care of the teeth**.

43:40 Dr. Wolf-Dieter Kessler, Kessler Klinik, Aurich Germany. I have one case here I could show you that's a **beginning bronchial cancer, and we just found a focalized dental problem**. BG: Can we see that. WK: Yes, I could show you. The area, the whole, you see he develops bronchial cancer on his left side, we know that already. **The x-ray and CT and PET scan didn't show anything**. But we know and the patient knows that he is going downhill, he has had several pneumonias, but the left side here. **It is originating here, in the jaw dental area and is going all the way down**. It is not on the right side. It is on the left side. **That's a very important finding, and we have to do something about this**. BG: It is the blood, coming to the surface there, that's creating the heat. WK: Yes. BG: And that's how he knows that. WK: Right. **The more infection or inflammation, the more blood there is, and the more heat there is**.

44:38 Dr. Michael Gerber, Gerber Medical Clinic, Reno. So you'll see people that have a breast cancer, I'll see 85 year old ladies with a breast cancer who've done nothing with it and it's king of smoldered on for **20 years** and it gets a little weeping or a little blood every now and then, it doesn't cause them a bit of problem. Old guys who have had prostate cancer for 20 years, and a little bother with their urination, but not really much pain, and not much boney destruction. Then there are people who will have a breast cancer and a prostate cancer that will go through them front to back to death in **6 months**, and they're gone. Why is one so precipitous and the other so smoldering? **I think a lot of this has to do with toxicity coming out of the teeth**. And of course, we think the cause, we think mercury is highly related to, from the fillings, remember **your silver fillings are 50% mercury, and their outgassing all the time into your body**. Even old fillings, **even 25 year old filings are outgassing mercury** into the body. And **mercury is a very toxic substance, it causes inflammation, and a lot of people think malignancy, as well as neurological damage.**

45:38 Dr. Dana Flavin-Koenig, foundation for Collaborative Medicine, USA & Germany. This **dentist** at Georgetown University, doing his master's, told me that his father was called in to a young child with **leukemia "they thought"**, many, many years ago they didn't have the tests for leukemia as we do now, but they assumed, because she was dying, it had to be a blood disease, and her gums were completely infected. And they called his father in, to see what he could do to help the child, and he said, remove **all the filings**. And they said, **you're crazy, you stupid dentist, what do you know, you're not a medical physician**. He said remove all the filings, and told the father of the child this must be done. They did it, the child got well, and lived. BG: Yes. DK: So, **he found out many years ago, this was 25-30 years ago**, that he was doing his master's on this. **And his father did this God knows how much longer**, in South America. So we know the

toxicity, and we know now at FDA, that **the leaching out of substances, regardless, is a problem.**

46:37 **DRIVE Dr. Andreas Jordan, Magforce Technology, Berlin.** BG: [map to Berlin] Early morning, Dr. Scheller and I flew to Berlin, rented a car, and visited the Charity University. **I was not prepared for what I saw**. AS: Well, I'm a biologist, not a medical. Here your see a brain tumor patient, and this patient had been prepared already, has been **applied the iron oxide containing nanoparticles** [screen shot: **tumor-specific nanoparticles**]. BG: So, **the surgeon inserted the catheter.** AG: Yes. BG: You then **put these small particles in through the catheter**. AG: Directly. BG: **Directly into the tumor**. AG: Directly into the tumor, **by very conventional methods**. BG: So, that once you put these metal particles into the tumor, the patient will be on the gurney, and be slid into the magnetic device, and that medic device will do what? AG: The medical device generates a **high AC magnetic field**, **which changes its polarity 100,000 times per second**, **and by this very fast change of polarity, the particles get heated**. And the heat, some is very high, in dependent of mass, of little mass of iron oxide particles we have infiltrated into the tumor. **48:02 (dissolving brain tumor)** BG: **And therefore, it kind of dissolves the tumor**. AG: Yeah, so we have good data showing that our **first phase 1 study** was for **glioblastoma** patients**, which is a very aggressive tumor, and all people die, normally**, we have seen that this therapy is **very comfortable, that we have no side effects so far**, and we have **great temperatures in the tumor**, in the range of 50 degrees Celsius (122 degrees F) and more, and during this treatment **some of our patients fall even asleep**, and we have to wake them after 1 hour, which is our treatment time. BG: And **no pain**. AG: No pain. BG: **No burning, no heat**. AG: They have **no headache, they have no bleeding or any other complications,** and we can exactly steer the temperature in the tumor according to the demands of the physician or oncologist. BG: **So you are absolutely vaporizing these brain tumors, almost non-invasively**. AG: Yes. BG: **That's astounding**. AG: Independent, the only thing is **to inject the particles in tumor, and then the tumor is loaded up like a sponge with those particles, and the particles are taken up by the tumor cells, of millions of them, so the tumor cells are not able to get rid of these particles**. **Therefore, you can repeat the therapy as often as you want**. We do it ten times for some patients, or 5-6 times, and you have **again only non-invasive treatments**. BG: How long is the normal treatment, the time length? 49:44 AG: The **treatment time is 60 minutes**, and it depends whether we make a **hypothermia approach**, with lower temperatures, so that we have to **combine it then with radiation and chemotherapy, to enhance the overall efficacy of the combination of treatment**, then, to make the cells weakened, towards the conventional chemotherapy drugs or radiation. **50:08** And we can also do **thermal appellation**, with the same approach, with the same depot of particles we have infiltrating the tumor. BG: What does that mean, thermal appellation AG: Thermal appellation means that **we use higher temperatures which are effective alone** already in the range of 50 to 70 degrees Celsius (122 to 158 degrees Fahrenheit). BG: **And so some patients don't need chemotherapy and don't need radiation, this can do it alone**. AG: Yes. BG: But**, if they do, they could use lower dose** and this would become more effective because of this treatment. AG: Right. BG: **Does this work on all tumors?** AG: This is the most exciting thing, because **it's comparable to radiation therapy**, it

can be adopted by a patented strategy, and by the nanoparticle coding, **we can adopt the particles to almost every type of solid tumor** [screen shot: the magnetic particles in blue are inside the prostate gland and attached to the tumor] and we have treated very different tumors already to get visibility and toxicology and any other things with the therapy. 51:03 BG: **And your success rate is?** AG: And our success rate is, well, we hope, half of our patients are still alive. And according to the literature, with these very aggressive tumors, which have obtained, or which the patients have obtained already, radiation therapy, they were not responsive, they had already chemotherapy, with all these patients, with recurrent tumors, **we have half of the patients still alive, and according to the literature, we would expect three months survival with those patients, and most of our patients are still alive**.

51:37 DRIVE [screen shot: Landau, Germany] Prof. Dr. Dietmar Molitor, Surgeon & Urologist, Landau Germany. BG: In Landau, Professor Dr. Molitor, a surgeon and urologist. DM: **There is a patient with a large tumor. Normally, the surgery is too late.** And then we try to have the **tumor shrinking** [Dr. Scheller shrinks the tumor so that Prof. Molitor can operate.] for this patient, and then I'm able to perform and operation, after the shrinking. He helps me, because the tumor becomes smaller. Tumors have feeds, and arms. They are in the muscle, they are in the intestine, they are with feeds, and fingers. BG: Blood. DM: In the blood, in the vessels, and so on. **And when you have it shrinking, they put the fingers, and the feeds back**, they have a capsule, **and then you can perform the operation. But you have only after the shrinking 8 days.** BG: 8 days. AG: You must perform the operation. BG: Within 8 days. AG: 8 days, **and after the time, the tumor extended again**. BG: To expand. AG: Yeah. BG: **So you get it at the proper time, when it's ripe.** AG: Yeah, then we send the patient back to Dr. Scheller, because he can look which way is the best for this patient **[screen shot: Dr. Sheller uses DNA profiled chemo drugs to remove disseminated cancer cells]**. And if there is a **residue of the tumor, sometimes it will come, then we, the patient comes back to us and we perform and operation again, and we change the regiment of the therapy**. 53:15 And, on this way, **we have 74 patients in the last 8 years. No surgeon would like to operate them, because the tumor too large.** Then he helps me to have a shrinking, then we might, we perform the operation, and after that, we send the patient, to him back. **And all the prognosis for this patient was they will die in three weeks till 6 months. But 58 of them are still alive (58/74, 78%).**

54:02: Dr. Peter Koexck, Radiologische Zentrum, Weilheim Germany. [Screen shot, map: Weilheim.] BG: Not far, from the Leonardis Klinik, is Peter Koexck, who does a treatment using **new and unique radioactive drugs**. PK: **The first aim**, for this **medicament** is **reducing the pain, which is connected to the bone metastases**. The **second aim** is also to **reduce the progress of these tumors, in bones**. BG: And how successful is it? PK: **We're very successful in reducing the progress**. We can't kill very large tumors, because the radiation has only a distance of 1-2 centimeters, and so we won't reach a tumor which has a center of 5-10 centimeters. **We can kill small metastases with this medicament, and so, we can reduce, very good, the progress of bone metastases**.

54:57 Patient Floyd Weston, Prostate Cancer with Skeletal metastases: When I asked them at the clinic, at the Leonardis clinic here, if there was any **hope at all in eliminating my pain**, they smiled at me and said, that's tomorrow. That's tomorrow. [screen shot: **radioactive samarium-153** relieves pain in **bone metastases**.] Dr. Peter Koexck: We **can use it for all types of tumors which have bone metastases which we can find in our bone scans**. Like breast cancer, like prostate cancer. And every other tumor where we can find so called hot spots and as bone metastases. 55:36 FW: It goes right to the site of the cancer. It eliminates the pain you have, you have increased pain for about 4 days, and then the pain ceases completely.

55:48 BG: **Early diagnosis** makes the chances of full remission far higher.
55:54: DRIVE Dr. Bernhard Hoerr, Radiologist, Stuttgart Germany. [screen shot: map to Stuttgart] BG: **A PET scan is an essential tool in the diagnosis of cancer.** BH: The **patient has the glucose inside**. **We have one hour from the injection to the examination time**. And then he comes here inside, and we take him inside there. The machine, the PET machine, and it lasts, I think about him one hour and ten minutes. The brain is 50 minutes. And we have one bad position after another. We can take the whole body, in I think, about 1 hour and 30 minutes, and the legs, in 30 minutes, in an extra examination. And then, you have, in this machine, something like a CT. **You make deep reconstruction**. You have a lung, you have a liver. And the machine has to know this is more tissue, this is less tissue. And you make two pictures from every batch time. And then, you make addition or subtraction from these pictures, and then **you get a PET scan from the whole body. The sugars inside, the radioactivity is inside the patient, you have the tumor, perhaps, and the glucose is coming inside the tumor, and the radiation is coming outside of the patient. And, with these detectors inside the machine, you can detect all the radiations coming outside**. And then we can make more pictures from the whole body, and you see where is fluorine, where is glucose, where is the tumor. And you see it, and **you can make a diagnostic**. BG: Now, the difference between ad PET and a CAT is that with a PET, you put the radiation into the patient. BH: You see, the function of these malign cells, and you can say, well, there must be a malign tumor inside the prostate, and you can operate this. **58:05** BG: **Is it safer to do a PET scan, than a biopsy?** BH: **Biopsies are in 40% negative, rest, the tumor is inside (biopsies: 40% no detection of a present tumor).** You can make a biopsy, like this (pen pushed into to mass example), the tumor is here, you can make a biopsy, you go through the tumor. BG: You miss it. BH: You miss it, but you open it (going through the tumor). **[screen shot: opening the tumor releases cancer cells into the body]** And you had nothing, of the tumor, only the good tissue, and the bad tissue is hurt. BG: Yes, beautiful. That's very, very interesting. BH: And therefore, in German, it's "naehnadel im heuhaufen", you don't find a needle inside a haystack. BG: Haystack. BH: the PET scan, you find everything **better than ACT** or **MRI** or **ultrasound or biopsy**. **If you had not a PET scan, in the primary therapy, on the therapy of the metastases, it is like blind flight**. BG: Good news for surgeons. BH: **You can make all operation and you look inside the patient and say very good, you have no cancer**. **You can see with a PET scan, very much earlier, without surgery**.

59:24 Dr. Dana Flavin-Koenig, Foundation for Collaborative Medicine, USA & Germany. If you look at a normal PET, PET study, you don't get the uptake of the molecule, the sugar molecules that you would do in a normal cancer situation. **In Prostate cancer, it's different**. However, it does take up the eleven Choline [screen shot: C11-Cholin-PET mit Bildfusion; C-11 Choline PET (eng.); PET: Positron Emission Tomographic Evaluation] a substance which has an affinity to prostate tumor cells. What he's been able to show in patients, for example, when he's compared a normal PET and you didn't see anything at all for the cancer, and then he would **give eleven Choline and he would then take a new PET, and you could see exactly which lymph nodes were infiltrated, where the tumor was, and when they operated on the patients, they could remove just those lymph nodes to eliminate *all* the cancer that you could never see in a normal PET scan**. BG: And they don't do this anywhere else in Germany? DK: No, they call it experimental, the **insurance companies don't wish to pay for it yet**, because the say "oh, this is just research". This has saved many, many patients' lives.

1:00:24 [screen shot: Aurich, Germany] Dr. Wolf-Dieter Kessler, Kessler Klinik, Aurich Germany. BG: In a small village in northern Germany, Dr. Kessler has trained a staff of 17 nurses and technicians to become, what I consider, **the finest team of diagnosticians in the world**. **We have a lot of heroic procedures, today, in cancer. You could fill up the bones with Chemotherapy, for instance, you could instill iron oxide into the brain, but you still don't know why the patient has cancer**. **01:01:05** So, in order to **find out what the root cause is**, we have to use **functional medicine**, which has been developed especially in Germany over the past 50 years. 01:01:17 BG: What does that mean, functional medicine? WK: **Functional medicine** is involving the time factor, **other than conventional medicine, you would find out how the organ works**. 01:01:31 BG: **When a patient comes to you, what is the process, going through your clinic?** WK: Well, first of all, we do a **physical,** and usually, we have to do a physical. We check the **lymph nodes**, and **heart beat**, whether there is a **pulse** missing, have pulse deficit, do an **ultrasound** [screen shot: ultrasound view]. This is the kidney, and that's the gall bladder. Stop: the gall bladder has no stones there. That's the gall bladder here. Exhale. And that's the prostate coming up here. BG: **And then, all of this is recorded for you in your file**. WK: Yes. BG: **As to what exists at this time**. WK: Yes. 01:02:18 And then we do **thermography**. Thermography is clearly showing differences in the right and left sides. **Especially, in beginning breast cancer, seven years ahead you could see it**. See these two [thermography **female chest mapping**]...we have here in the left breast, we have this focus here, in the upper quadrant, here, and you don't have this here (on the right breast). I give you another picture of it. That is a premalignancy. A clear premalignancy picture. It's coming up here (screen focusing). It is very clearly here, it is not over here. It is not here in the right breast, it is only in the left breast. [screenshot: **thermogram** image]. **The thermogram tells you, at a very, very early stage, that there is something going on**. Plus, when you start treating, you can see how that changes, to the worse, or to the better. 1:03:15 **Mammogram**. **The mammogram, to me, compared to the thermogram, is like watching the moon through a binocular**. You know, that's about how I feel it. It doesn't tell you where you are. It doesn't tell you the difference of the right and left side, except there is a major thing going on there, and it doesn't tell you how you treat.

Whether you are able to eliminate the early changes of the tissue. **The more often you take a mammogram, the higher the risk that you actually produce cancer. 1:03:51** [screen shot: **iridology**] BG: **What are you looking for, doctor, in the eye?** WK: I'm looking for **constitutional factors. Each organ is relating to a special site in the iris.** And, when we check the iris, we could find pigments, or weak spots in the iris, that give us hints where to treat, and what to treat. Ah, **some substance missing of the iris. That is a clear sign of a beginning pancreas cancer or already a pancreas cancer. We are looking for these deep holes. This is another sign here, that is a carcinoma of the bile system, there, there is a closed duct, closed up, plugged up by cancer**. You see the deep sign in this area here, and you see the pigment in that area, and you have a reflex vessel here. [looking at iris chart]. **That is a pigment of the pancreas projected on the kidney, so I have a causal chain. I have to treat the pancreas, in order to get to the kidney. I could deduct that from the iridology.** BG: **But the wonderful thing is, is that you use this as one tool, you don't rely on it alone.** WK: Yes. BG: **You have 7 or 8 or 9 or 10 different tests to vector in and find the patient's problem.** WK: Yes. The whole **ideas is that alternative medicine must be standardized**. It is very difficult to standardize it. But if you **put several systems against each other, then, you get a clear picture of what you are dealing with**. 01:05:28 **Electrodermal screening**: And after that, we go to electrodermal screening, we **use the acupuncture point as an information** center. We **not only find out which organ is diseased, but we also find out the causal chain**. Which organ has passed the hot potato to the other organ. **So, not until you know the causal chain, you will be successful. So, we are testing here, over 40,000 toxic substances. Including pesticides and herbicides, viruses, bacteria, environmental toxins, all kinds of environmental toxins.** And, **it's the combination of toxins, which is so dangerous**. A very harmless virus, all of a sudden, could be very toxic, if it's combined with PCB, atrazine and a certain radioactive element for it, for instance. We have several systems that we hold against each other. BG: So when you do this electrodermal screening, how can you tell by putting a probe on an acupuncture point what's going on. How does that work? WK: It is **a resonance procedure**. If you are resonating to a certain toxin, and you have a certain testing device, we know that you have actually accumulated that toxin. 01:06:47 **Ondamed.** There's another system that's very important, that's actually a basic tool that we use here, is the Ondamed. **The Ondamed is the most innovative biophysical system on the world.** And, it looks like science fiction. You would scan the patient from top to toe, and find out the blocked sites. You could then use **neurotherapy with procaine, go into those spots and revitalize these tissues, or use the specific frequencies of the Ondamed that you find out by pulse test**. And**, the frequencies that you find out, there, with the Ondamed, all relate to a certain organ.** If you find out, let's say, 260 Hz, it may be the gall bladder frequency, and you know, the patient comes here with a cancer, let's say, with a prostate cancer, and **you have a gall bladder frequency. So that is a strong approach. You know now that you have to treat the bile system, the gall bladder, the bile system, in order to get to the disbalanced prostate metabolism**.

01.08.03: Dr. Michael Gerber, Berber Medical Clinic, Reno, USA. It's nice to be able to do, as Germans do, Germans do **electrodermal screening on chemotherapy agents to see which ones will benefit the patient most**. So that's very helpful. **1:08:14** Another

German invention is **dark field microscopy** and also the live cell therapy or the dried, looking at dried blood under a microscope, and from this, you can get a really good idea of who has a lot of free radical damage. [screen shot: dark field microscopy]. Now, there are lots of blood tests that you can tell about free radical damage, that, you know, **cancers are very dirty**. They put out sore infections. **They put out a lot of free radicals, and you can really see this free radical damage under the microscope. And you can see nutritional deficiencies. You can see folic acid deficiency. You can see fatty acid deficiencies. All these are very clear under the microscope. You can tell if people have a lot of fibrin, which is the stuff that plugs up the blood vessels. You can see all of these quite readily.** And, if somebody hasn't had the heart attack, or the stroke, or the cancer, you can say, heavenly days, we need to do some work here, this is not normal blood.

01.09.07 Daniel Dunphy, PA-C, Clear Center of Health, San Francisco USA. This sample here is from a **patient with breast cancer**. You'll notice, in this slide, for instance, there is a **crystallization going on of red blood cells.** This is a typical red blood cell. This is a red blood cell in the process of degeneration, and, these are crystallizations that are occurring up here, in here, over here. BG: And what does that mean? DD: Well, this is **a fingerprint of cancer**. I've been observing this clinically for 15 or 20 years. And, what I'm interested in are patterns that occur over time. This is a live sample here, of a patient who had breast cancer seven years ago. And of course, when I look, I look with a mind towards understanding how viable the cells are. This is a neutrophyll, for instance. BG: **Now, this is just from one prick of the finger**. DD: Yes. BG: **In a drop of blood. DD: A small drop of blood is reflecting the whole picture of the body**. Now this was a large spore, form. This being a red blood cell, and the spore was present in the patient who I already knew had cancer. I don't use these for diagnosing, but I **use them for tracking**, and I **start reading this for information about the cancer itself**. Cancer needs to build an infrastructure to grow into, and it puts out these little rootlets, and grows into it. And it's very vulnerable. And that's why hyperthermia or high heat therapy is combined with low dose chemotherapy in very advanced cases to try to save the patient. By not killing the cancer, and killing the patient often times, but **regulating the ability of the cancer to grow, and building, simultaneously rebuilding of the immune system of the person, detoxifying and allowing them to fight the cancer on their own**.

01.11:18 BG: James Forsythe, M.D. H.M.D., Cancer Screening Center, Reno USA., you did **a study on a nutritional supplement for cancer treatment**. JF: Yes, we've got a study, that's ongoing, and was started in January of 2004, and we hope to accrue eventually between 250 and 300 patients on this study, to make it statistically significant. Now, at this point, we have **160 cases, in which we have data collected, and these are all stage 4, advanced cancers, of various types**. The study was started with the sponsorship of both the manufacturer and the distributor of poly MVA. **Poly MVA** being a natural food supplement. Designated by the FDA as a supplement, not a drug, which can be used for whatever my boards tell me I can use it for, which is basically, I have free reign, under the homeopathic board, to **use it in cancer patients as an adjunctive therapy, not in place of chemotherapy, but in addition to, or alone, if patients do not want to take chemotherapy**. BG: **You used it for end stage cancer?** JF: Many of these

patients, Burton, **were told not to do anything more**, just to go home, **get their affairs in order,** basically, make up their wills, go out and take a cruise, whatever the doctor may have told them. In other words, they were basically…BG: **They were given a death sentence**. JF: They were given a death sentence, the towel was thrown in, you're on your own, basically at this point. BG: What kind of product is it? 1:12:56 JF: The polyMVA, Burton, as developed by Dr. Merrill Garnett (book title **First Pulse**), a research scientist, and a dentist, who worked at the University of New York, on Long Island, on Stonybrook. He was interested in going for the unique property of the cancer cell, which basically is low oxygen, tension prevalence, and the tendency to only metabolize simple sugars, glucose being the major one. By going after this dual complex of the low energy cancer cell, for anaerobic metabolism, and the fact that they use only glucose, **he was able to develop a product that would get into the cancer cell, steal the electrons away, and cause the cancer cell to self electrocute. BG: And conventional doctors don't recommend special diets**. JF: Yes, this is very interesting, because if anyone was not a believer that **cancers love simple sugars, then why is the PET scan so effective. The PET scan, which stands for positron emission tomography, is totally based on the fact that cancer cells have an increased number of insulin receptors on their cell surface. That lights up the cancer like a neon sign. So, you can find cancer anywhere in the body, just by giving this radio tagged glucose material.** So, it can find a cancer if it's in your neck, in your great toe, or anywhere in between. BG: In your bone. JF: Or your bones. Right, it's for **soft tissues and bones**. BG: **So, if anybody doubts that cancer patients shouldn't eat sugar, this is the proof.** JF: This is certainly one of the biggest proofs we have. **And, a very important point here is that conventional doctors, even with this proof, Burton, still do not recommend special diets for their cancer patients.** In other words, a sugar free diet, or a South Beach type diet or even a modified Atkins diet would be perfect for them.

1:14:55 Dr. Dana Flavin-Koenig, Foundation for Collaborative Medicine, USA & Germany. Patients that eat, for example, a lot of **sugar, sugar products, and the refined carbohydrates, like white flour**, etc. BG: And alcohol. DF: And alcohol, of course, they are having **a more acidic environment**. **Parasites, funguses and bacteria, the pathogenic bacteria grow preferentially in the acidic environment. Parasites are notorious for living in the intestines in patients, with funguses, often together in patients that eat high carbohydrate, refined carbohydrate, and high sugar diet.** [fingers between each other] This is a normal cell with the receptors for insulin, and when you eat sugar, it goes into normal cells. This is a cancer cell with the receptors for insulin. There are multiple receptors, much, much higher. **So the first preference for a tumor cell, when you eat sugar, you're feeding the tumor cell.** That's one point. The red meats, in general, with arginine are not recommended. If you're going to eat any meat at all, stay on the beef area, but please, please, please consider organic beef. Not beef that is full of hormones, full of pesticides, full of antibiotics.

01.16.13 BG: Dr. Ulrich Friedrichson, Pshyco-oncologist, Leonardis Klinik. Dr. Scheller believes the **mental state of the patient is very important**. **Everything she heard was BG: negative** UF: **you're going to die within weeks, or if you're lucky, within month**. BG: Well, actually, with what happened to her, and the way she was

treated, the answer is yes, you were right. UF: (Laughs), Right. BG: She was very right. UF: Right. That is what she was told, and BG: **She was given a death sentence by her doctors**. UF: Right, definitely. And, the way we **started treating her** here was on one side, **to make her believe that there are other possibilities to treat a tumor, without killing herself**. BG: She can beat it. UF: Yeah. **We talked about weak cells, tumor cells, as weak cells, and immune cells and healthy body cells as strong cells, and said, well, if I am that strong, I can help you fight my cancer.** BG: It's part of **visualization.** UF: Right. And we started out then, thinking of her you have to **think about your tumor cells, kicking them out, and cleaning your body up**. BG: Like the old Pac Man picture. UF: Right. And the first few times she didn't understand what we were thinking about. And, one day she came and said well, I think I got it now, my two kids, they are gown up now, but they are messy. And, I have to go in their rooms and clean that up. **And that cleaning up, that's me inside**. **I'm cleaning up my body from the tumor cells.** BG: Fabulous. UF: And so, every time she's getting a treatment, or she got a treatment, she was visualizing that **she is going into her body looking for the messy places where those tumor cells are, and packing them together in card board boxes and throwing them out**. Give them away. And, the metastases on the skin, there was the dirty clothes the kids are leaving when they come home over the weekend. So, they are just, ah, she is just rubbing those off, and every time the yeast was on it, she was throwing them out, and that's when she said she felt it cool, and that was a part of the visualization, and the first time, she said, it's a little bit warm, and when she did the visualizations, well, it's getting cooler, and that was every time **when she went in the rooms of her kids, she opened the windows, and she really felt that clean air inside**, and getting the fumes out, and that was swiping those tumor cells away, by the yeast, and that's why she felt cooler, it was fantastic. BG: Wow. UF: It was fantastic, great, and I said well, **you do it, you do it**. **The medicine is helping you, but you do it.** It was really great. BG: That's terrific. UF: Yes. BG: What else have we not covered that we should cover, in your specialties? UF: That we **can even measure, by laboratory data the activity of natural killer cells, and T and B cells, in the immune panels**, that if we **treat people with psycho-oncological methods, that the activity of those immune cells will rise**. We can measure that in the laboratory.

1:19:47 BG: So, if you're like me, you'll be asking, **how come this treatment isn't done in America?** I went to Reno to meet an old colleague of mine, Dr. James Forsythe. [Cancer Screening and treatment Center; James Wm. Forsythe, Board Certified Internal Medicine, Oncology & Homeopathy; Earlene M. Forsythe, BSH, MSN, APN]. He was a major contributor to my cancer book. [An Alternative Medicine Definitive Guide to Cancer: Cancer can be Reversed. This book tells how, using clinically proven complementary and alternative therapies.] **There is a stranglehold by the American Cancer Society, the National Cancer Institutes, all the official cancer societies**, the surgical ones, the medical ones, the medical oncology groups, ASCO – the American Society of Clinical Oncology, there is very little presented at their meetings on natural therapies. BG: Pay no attention to the immune system. JF: [Shakes head] Poster sessions…they don't go into it.

1:20:29 Prof. Dr. Michael Giesing, Molecular Oncologist, Munster Germany. Two years ago, **I gave a report to the NCI Board of Directors, in Rockville Maryland**. And I remember they were sitting very…BG: The FDA, in Maryland MG: Yes, but it was the National Cancer Institute. BG: Oh, I see. MG: They were sitting, a couple of very illustrious people, from NCI. And **I gave**, as I do it often, **a very normal report of what data we had**. And, at the end, **the Chairman of the Directors said,** well **if that is true, there is going to be a revolution in oncology**. I went back to Germany, but I have thought that over, very often. Here, you have individual people like Dr. Scheller, whomever, who are very much in front of oncology. But these are a few clinics, a few people. **What we need is major, clinical institutions in the United States, I would even like under the umbrella of the NCI to make it very official, they should test the system, try to treat after pharmacolgenomic data in disseminated** cancer cells, or leave it (don't use the data) and observe what happens to the patients. [screen shot: **The National Cancer Institute never took Prof. Giesing up on his offer**]

01:22:04 Dr. Dana Flavin-Koenig. Foundation for Collaborative Medicine, USA and Germany. There are **many diseases that don't have to be deadly**, but if you're **limited** to only using chemo, **only following the protocol that has been designed 10 years ago, or 5 years ago, for 2% of the patients, you're not reaching them**.

01:22:18 Daniel Dunphy, PA-C, Clear Center of Health, San Francisco USA. **And there's a single-mindedness that I was referring earlier in medicine, which has to do with simply focusing on the cancer, not on the person. And in the process, losing the person as well as killing the cancer.** BG: So you **treat the person who has the cancer**. DD: Yes. BG: **Not the cancer itself**. DD: **It's a lot more work**. Yes. It's a lot more work.

01:22:40 Dr. Wolf-Dieter Kessler, Lessler Klinik, Aurich, Germany. **Conventional medicine does not know about it, because they are not taught**. And, one thing for sure, **people want to stay blind, for ego, for their image, they want to flow in the mainstream medicine**, but **if you become a patient yourself, that's the time, not later than that, that you start thinking**. BG: That's how you got into this integrative medicine. WK: Exactly [**wounded healer**], because I'm a patient myself, and I cannot understand, that there was not answer to my problems.

1:23:13 James Forsythe, M.D. H.M.D., Cancer Screening Center, Reno USA. **Most traditionally trained oncologists are very narrowly focused. They see a direct path to the treatment protocols, and they are unwilling to accept any alternative therapies, from any side**. Many times, an oncologist, if a patient comes in and tells him they want to be on a certain diet, or supplements, they will often turn **them away, or roll their eyes, and leave the room, and they treat them very poorly, and they don't respect their wishes**.

1:23:40 Dr. Dana Flavin-Koenig. Foundation for Collaborative Medicine, USA and Germany: Well, **this medicine could be practiced anywhere in the world if people would open up their minds, and learn, and look and the data, and see the results**

that we're getting. The problem is that many, many of our colleagues are **so skeptical, and so closed minded that they don't wish to even look at the data for confirmation**. And, unfortunately, **there are many, many people out there in the world who are utilizing cancer patients for example, just for profit**, they are not there to help them, and **we are there to help them, but how do you differentiate**.

1:24:14 BG: **Why don't they do this in the United States**? Prof. Dr. Thomas Vogl, University Hospital J.W. Goethe, Frankfurt, Germany. **Many countries, patients with metastases, they are, nobody's interested in them. Cause you cannot get a big success, for example**, if you have breast cancer, and if you want to cure the patient for the first treatment, this is OK. But in the metastatic patients, doctors are not so interested in. BG: **Right now, it's available here in Frankfurt.** TV: Yes, Frankfurt is an international place. BG: It's easy to get to. TV: Yes, It's easy to get to. And thanks, to our good collaboration to a lot of American sites and oncologists, interesting, **most of the patients are finding to us by the Internet.**

01:24:52: Daniel Dunphy, PA-C, Clear Center of Health, San Francisco USA: When we **declared war on cancer in 1972**, it was very **characteristic of the culture to declare war on something if you don't like it, and basically, it doesn't work with cancer**. I would contend that it works in a small percentage of cases. **That philosophy has gotten us nowhere, but killing a lot of patients**. BG: **Why do you think it doesn't work?** DD: **Because it is orientated towards selling a lot of chemicals, rather than curing patients.**

01:25:23 James Forsythe, M.D. H.M.D., Cancer Screening Center, Reno USA. **If we know of nothing else from the AIDS epidemic, that cancer is caused by a dysfunctional immune system**. And this became abundantly clear in the early 80's when we saw all of the young people dying, especially young men, of all of these horrible types of cancer, when, ordinarily, these cancers were never seen in this population age group. **So, studies from the 80's and onward, and even before that, have shown that the immune system is vitally important, to fighting cancer, and to keeping the body's defenses at a strong level**. BG: It's **not taught in medical school, is it.** JF: No. I went to the University of California, San Francisco, one of the top 10 medical schools and we heard nothing about this concept as far as I can recall in 4 years of medical school. BG: And, in all the years since you've been out of there, which has been, what 30 years…JF: Well (laughs) BG: And we've learned so much, they haven't done anything about it. **Why, what to you think is going on in these oncologists' minds?** JF: I think there are several things. For one thing, **because they haven't been taught about it in medical school, they're afraid of it, they don't think it's real, the terms you get are it's not scientific, it's never been scientifically proven, it's not true science, it's never been subjected to a controlled scientific study**. BG: That's interesting. JF: You get all this **verbiage**.

01:26:49 Dr. Dana Flavin-Koenig. Foundation for Collaborative Medicine, USA and Germany. **There are many articles coming out where they're saying that chemo is not helping at all, and the way they are doing the chemo is not helping at all.** The

improving and perfecting it, not through 1000's of tests on patients, but by looking at the blood tests to see which chemo, if they need it, will respond. BG: That's the work of Dr. Giesing. DK: And Dr. Scheller. Exactly, this is why I'm collaborating and working with them. (****Can't do large scale studies on individuals****)

01:27:17 BG: Do you think **doctors are using chemotherapy because there is a big profit involved in it?** James Forsythe, M.D. H.M.D., Cancer Screening Center, Reno USA: Well, there is **certainly more profit in giving the chemotherapy, than there is in giving alternative therapy**. And I think, there's **less explaining to do, there's less time involvement**, time is money to the doctor, because he can only see so many patients a day, and if he ends up spending half hour to an hour with each patient, he's not going to make as much if he can see 20 or 30 patients a day. So he's...and it's easier to explain, **this is the protocol, here's a slip, this is what the FDA recommends, this is what the National Cancer Institute recommends, this is what we're going to do, we'll see you next week**, and **this is your schedule**. As opposed to sitting down with the patient, spending that time, **telling them about all the options they have**, all the supplements they have, the dietary things**, that's not a winner for a doctor in terms of what he generates in terms of income**.

01:28:19 Dr. Michael Gerber, Gerber Medical Clinic, Reno, USA: As we like to say, **you don't get cancer off a door knob, so you've got to change your terrain, you've got to change your environment**. BG: **The terrain is like the, the soil of the body**. MG: The soil of the body. If your body is the type of soil that lets cancer grow, and if you have a little genetic potential, and you have a little stress, then you've got a problem.

01:28:39 James Forsythe, M.D. H.M.D., Cancer Screening Center, Reno USA. And here's another **thing that Medicare forces you to do**. **They will publish a list of only those drugs**, say if you have colorectal cancer, **that they will approve for** colorectal **cancer**. Now, if I'm on your third or forth line regiment and you still want to be treated, and there's still hope for you, I may want to go to a fifth or sixth line treatment protocol. BG: They won't let you. JF: They'll let me, but you as a patient will have to pay for it, which, often times, is not realistic, because they're very expensive.

01:29:10 Daniel Dunphy, PA-C, Clear Center of Health, San Francisco USA: When a doctor, **oncologist sees their patient, many times, their experience with cancer is, they're gonna die**. Matter of fact, **they're framing it, many times will tell people, you've got three months to live**. **Cancer is, unfortunately, a disease of victims**. And **the victims tend not to scream to high heaven**, if they are not getting their treatment (effective healing). **It's like, shut up, take it, and die**.

01:29:36 Patient Rhonda Medina – Reg. Nurse, Breast Cancer, Liver Cancer. For them to tell you that you have this, and, you know, **we'll give you a few months, but we'll try and make it a longer few months,** if you take this, and that's what they can offer you, and people say, well, I guess I'm lucky to live a few more months, and **they buy it, because they have no choices**. And **you want to trust your doctor,** that's why it perpetuates, is because you have to trust that somewhere, they're going to put something

1:30:04

together to save you, they've done it before. BG: **Most people think, well, if it was any good, my doctor would know about it.** RM: Right. BG: That's not so. RM: Yes. And you're a good person, and your doctor's going to try really hard, because you deserve to live. But then, **it becomes the routine of what they can give you legally, you know, without losing their license**.

01:30:21 **Ed Van Overloop**, CARE Cancer Support Group, NJ. **I almost think it equates to murder**, the way some of the patients are left go. I experienced it with my own Dad, I experienced it with my brother's wife, and many family members. **When you become 4th stage terminal cancer, it seems like they give such excesses of chemo and radiation that, that alone is enough to kill you. Very few people survive.** I have found, statistically, that in or Northern **NJ metropolitan hospitals, that it's only between 5 and 10% tops that will survive.** BG: **End stage cancer.** EV: Of end stage cancer. BG: **And at Leonardis, from what I was able to talk to the doctors and find out, it's between 80 and 90% depending on the cancer**.

01:31:09 Patient Rimma Raude, Breast Cancer, Liver Cancer. **They give me from 8 months, to a year and a half. That was the death sentence**. To treat you in another way, this is protocol, this is it, and **nobody interested in what is going on with me**. **They don't interest, they don't care.** The only people who cared about me are my family, and this clinic. And Dr. Scheller really cared. **Now, my liver is free of metastases**. It's completely free.

01:31:42 Patient Prof. Heinrich Bauersfeld, Colon Cancer with widespread metastases. So he looked at it, and the help he uses, and **my picture is clean**. BG: Congratulations. HB: Yeah, and that is **due to this clinic's excellent treatment**. BG: Leonardis, and Dr. Scheller. HB: Yes. And these 3 months, these 1 and a half months, from October onward, have apparently caused the disappearance of this damn thing.

01:32:11 Patient Evita Spreianbarth, Breast Cancer, metastases in liver and lung. With this treatment, for example, today **I have a chemo and I'm expecting my girlfriends to come to visit me and I want to go out with them and eat in a restaurant**. BG: Of course. ES: So if you have this treatment, **in a regular clinic, with the standard, you cannot think about it 2 weeks to do this**. BG: So when you have, it's **done differently**. ES: Very differently, **very special to my cells**. For example, **they check my sensibility for the chemical things they want to give me, because each body is reacting different**.

01:32:47 Dr. Dana Flavin-Koenig. Foundation for Collaborative Medicine, USA and Germany, with Walter Schaetzler, thyroid cancer metastases in lymph nodes. Unfortunately, the university **didn't seem interested in testing that chemo, they gave a general chemo that is applied, it is an older chemo, just to see if it would do something, and then Mr. Schaetzler** then had lung metastases. Then I said, at that point, you must take everything, and the university must give this other chemo. **And, indeed they did, and the lung metastases disappeared and the tumors disappeared**.

01:33:13 Patient Claudia Berkmuller, Breast Cancer and **Multiple Brain Tumors** (DK translating). They put her **on a natural treatment for support for her immune system**, but in addition, I found a new treatment that I tested on her, that was **used for primary brain tumors**, a plant substance, and she began to feel better, and, she said, I saved her life. Which is a really, I'm absolutely delighted, I feel like a guardian angel. It worked, it worked beautifully, and **all of the 30 metastases are gone**. I always said, when I didn't have Dr. Koenig, I didn't live. She's my angel, yes. She's really my angel. BG: That is fabulous.

01:34:01 Patient Prof. Heinrich Bauersfeld, Colon Cancer with widespread metastases. **Don't go to classical oncologists. Go to these people, and trust them. Trust them**. BG: Wow.

01:34:07: Prof. Dr. Thomas Vogl, University Hospital J.W. Goethe, Frankfurt, Germany. According to my experience and my knowledge, I think **Dr. Scheller's department and hospital is one of the leading hospitals in the world**.

01:34:15 Patient Floyd Weston, Prostate Cancer with Skeletal metastases: **To me, it's been very, very shocking** to come from a great country like the United States and to ascertain, that **this technology is available, and it's never been made available to Americans. It's tragic**.

01:34:34 Dr. Dana Flavin-Koenig. Foundation for Collaborative Medicine, USA and Germany: **What we're seeing now, is that *we can* cure cancer, utilizing conventional medicine *and* alternative medicine in combinations and in ways that we never dreamed possible before**, where every single substance plays a role in curing the patients of their cancers and eliminating all of the toxins, all of the side effects. **The conventional medicine is enhanced, but we are selective with it. We are using it in a way that is defined just for the patient's specific therapy.**

01:35:18 (voice) Daniel Dunphy, PA-C, Clear Center of Health, San Francisco USA: **It will be the patients, in the end, who make this happen. Not the oncologists. The oncologists' life is not on the line. The patient's life is on the line. And it will be the patients who demand that the technology be used. It will be the oncologists who acquiesce or don't acquiesce to the patients' demand, and, they will be fired. Because the patients are not going to stand for it.**

01:35:48 [screen shot: "You must be the change you with to see in the world." Mahatma Gandhi]

01:36:59 Burton Goldberg Closing: **The bottom line here is that there is always hope. Even end stage cancers are reversible, using the system of both worlds**. I hope this documentary will change the way America treats cancer, and how it may help you stay alive. God bless.

1:36:22 Credits:

Dr. Albert Scheller
Prof. Dr. Michael Giesing
Prof. Dr. Thomas Vogl
Prof. Dr. Dietmar Molitar
Dr. Andreas Jordan
Dr. Dana Flavin-Koenig
Dr. Florian Kubitzek
Dr. Bernhard Hoerr
Dr. Wolf-Dieter Kessler
Dr. Peter Koeck
Dr. James Forsythe
Dr. Michael Gerber
Daniel Dunphy PA-C

PET scans images, Philips Electronics, Positron Corporation, Dr. Bernhard Hoerr
DNA 3D animation, courtesy of the National Human Genome Research Institute
Photos of Rhonda and The Leonardis Clinic, by her sister, Melinda Sue Norin
Logistics Tricia Rose
Filmmaker Stefan Sargent
Producer Burton Goldberg

www.curing-cancer.com
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If you have or suspect that you may have cancer or a health problem, you must consult your health care provider.

End: 1:37:56