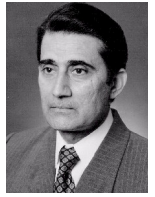


# A Snapshot of Cancer

Majid Ali, M.D.



In this article, I offer simple answers to most of the frequently asked questions about cancer. Those answers are based on extended personal observations—microscopic, biochemical, and clinical—as well as on true-to-life experience with a broad range of cancers. In 1978, I published my first research paper in the prestigious journal *Cancer*. \* A few years later, I was the lead author of *Surgical Pathology*, a two-volume book for pathologists with a heavy emphasis on cancer.\*\* Cancer has preoccupied me ever since, and has been the subject of several previous publications (go to [www.majidali.com](http://www.majidali.com) for details).

Simplicities in clinical medicine are of value only when they allow clinicians to cope with complexities—both in understanding the nature of clinical problems and for designing rational and scientifically sound plans of action. The simplicities in my answers come from my struggle with the maddening complexities of cancer extending over forty years. In 2000, I described that struggle in *Oxygen and Aging* for the general readership. I refer the professional readers to my *Integrative Oncology*, the ninth volume of *The Principles and Practice of Integrative Medicine*.

My work with the oxygen order of human biology led me to the "Oxygen Model" of cancer for understanding the nature of malignant diseases, as well to the "Oxygen Protocol" for treating cancer.

This booklet is devoted to those two subjects. With that introduction, I begin with my simple answers to commonly asked questions about cancer.

**I. What is cancer?** Cancer is a chaotic community of deranged cells which does not use oxygen as healthy cells do, produces large

amounts of toxic acids that devitalize noncancerous cells in its vicinity, grows rapidly, and spreads locally as well as to distant tissues.

**II. How does cancer begin?** Cancer begins with damage to cellular DNA and enzymes under micro-environmental conditions that do not allow the damaged molecules to be repaired expediently. In my view, those conditions are primarily created when the oxygen order of human biology is disturbed. Thus, in my view, *cancer is caused and perpetuated by abnormal conditions of oxygen*. I return to this crucially important issue in the following chapter.

**III. What are the core characteristics of cancerous cells?** Cancerous cells multiply without controls, form tumors, colonize distant tissues, destroy cells, and unless controlled end the life of the person harboring them. Specifically, following are the seven core characteristics of cancerous cells:

1. Wasteful metabolism with deranged oxygen utilization;
2. Production of large quantities of organic acids;
3. Creation of cocoons around them—formed of clotted proteins—to protect themselves from attacks by immune substances and cells;
4. Excessive multiplication that results in the formation of tumors;
5. Generation of abnormal signals by oxygen-derived substances that interfere with the normal communication among healthy cells;
6. Colonization of distant tissues (metastases), by which process they spread their destructive effects; and
7. Abandonment of their wasteful and destructive behavior under certain conditions, and return to a healthful order of oxygen.

**IV. How does cancer spread?** Damaged cells—cancerous and non-cancerous—lose their anchors in tissues and are swept away in health

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\* Ali M, Fayemi AO, Braun EV: Malignant APUDoma of the liver with symptomatic intractable hypoglycemia. *Cancer*, 1978; 42:686-692.

\*\* Ali M, Fayemi AO, Braun EV: *Surgical Pathology Case Studies*. New York, Med. Exam. 1978, vol. 1, 488 pages; vol. II 519 pages.

and disease. Such cells ordinarily are scavenged and cannibalized, and the materials contained in them are recycled. A cancer spreads when the errant cancer cells escape the scavenger cells—or defy them—and find a home in tissues in which the oxygen order has been compromised. At their new homes, cancerous cells continue their destructive behavior of devitalizing healthy tissues, form colonies called metastases, and then leave those colonies in search of new areas of compromised tissues in the body.

**V. How does cancer harm the person harboring it?** Cancer cells poison and injure noncancerous cells in their vicinity in several ways. Specifically, cancerous cells:

1. Steal nutrients from healthy cells in their vicinity;
2. Produce large amounts of toxic acids, which directly injure healthy cells surrounding them;
3. Generate an enormous number of free radicals that are toxic to immune as well as nonimmune cells;
4. Denature and clot proteins in biologic fluids, such as blood, lymph, fluid that bathes the brain, and other organs—and so inflict serious architectural damage on tissues;
5. Damage enzymes that serve as catalysts in the body, and so interfere with—or outright block—crucial life-sustaining body function, regionally as well as throughout the body;
6. Eventually damage the DNA/enzyme blueprint of generations of cells, with resulting catastrophic destruction of tissues everywhere; and
7. Unless controlled, eventually cause death by depriving all cells of oxygen by numerous mechanisms.

**VI. How are cancerous cells killed?** Cancerous cells are damaged and destroyed by the healthy immune and non-immune cells by different mechanisms, including cell death triggered by:

1. Direct attack by the natural killer and other types of immune cells;
2. Direct attack by specific and nonspecific antibodies produced as a result of both native and acquired immune responses;
3. Free radicals produced by immune and other cells, which trigger a special type of cell death called apoptosis;
4. Lack of growth factors;

5. Plant-derived cancer-killing substances (cancericidal agents);
6. Cancer-killing substances derived from microbes and certain animal sources; and
7. Synthetic chemicals (chemotherapy drugs).

**VII. Can a cancer cells be coaxed to abandon their wasteful and destructive behavior?** Yes, under certain conditions. This is the most crucial of all questions about cancer, both for the patient and the doctor. I devote large segments of my new book ***Oxygen and Cancer*** to present clinical and experimental evidence to support my view. Here, I wish to state clearly that those conditions cannot be achieved without restoring the oxygen order in noncancerous cells that seek to cordon off cancer cells, as well as in cancer cells themselves.

**VIII. What are the environmental conditions that encourage the growth of a cancer cell?** Every element that threatens the oxygen order of human life favors growth of cancer cells. Specifically, oxygen dysfunction is caused, perpetuated, and intensified by:

1. Production of mycotoxins (toxic substances produced by molds), acids, and other dangerous substances in the bowel;
2. Overload on the liver of synthetic chemicals—pesticides, herbicides, xenoestrogens, drugs, and others;
3. Clotting of proteins in the blood, lymph, fluids that bathe cells, as well as that within cells;
4. Microbial population within the body and that surrounding it—viruses, parasites, fungi, and certain bacterial families;
5. Carcinogens produced by plants and animals;
6. Exposure to various types of radiation; and
7. Damage to immune substances and cells caused by any of the above.

**IX. Why is there so much uncertainty in predicting the behavior of various forms of cancer?** Most cancers arise in "cancer fields" in tissues created during long periods of exposure to influences that cause cancer. These are fields of struggle between mechanisms that restore order and those (carcinogenic) that create and perpetuate disorder. Whether cancer develops in a few years or after many years is determined by the conditions—primarily related to oxygen disorder—that weaken the healing forces or strengthen the carcinogenic influences.

Of course, the integrity of the oxygen order—oxygen homeostasis, in the medical terminology—represents the sum total of the 'health' of the bowel,\* blood, liver, brain, and other body organ systems. The same is true of whether a cancer grows slowly or behaves in a very aggressive way. Some cancers seem to lay dormant for many years before striking out. So, it is not difficult to see why various forms of cancers in different individuals would behave in ways that are nearly impossible to predict.

Thus, what creates so much unpredictability in the appearance and behavior of various cancers is that all of the elements listed above act individually and cumulatively to create the cancer fields—microecologic conditions in susceptible tissues—in which stressed cells lose their bearings and turn cancerous. This is one of the primary reasons why I believe there will not be a drug that will cure cancer.

**X. What is oxygen dysfunction?** The term oxygen disorder appears throughout this booklet. Below, I reproduce some text from my book **September Eleven, 2005** in which I explained what I mean by this term with a simple analogy.

**A car engine mixes fuel and oxygen to produce energy. A properly maintained engine performs without generating excessive toxic exhaust. An engine clogged with soot produces less energy and more toxic fumes. The basic difference between the two is that fuel is completely burned in the first instance, leaving no toxic residue behind, whereas in the second car incomplete combustion leads to generation of excess toxic residue.**

**Like the good engine, a healthy person uses oxygen to extract clean energy from his meal. By contrast, a human canary with an oxygen disorder cannot do so without producing excess toxic waste which, in turn, causes fatigue and immune weakness.**

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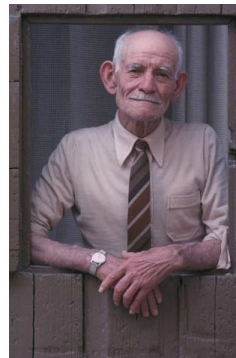
\* Throughout this booklet, I use the term bowel for the entire alimentary tract extending from the oral cavity to the rectum. Hidden microabscesses and mercury load in the mouth are major threats to the oxygen order. Weakened tonality of the stomach, digestive-absorptive dysfunctions in the small bowel, and persistent overgrowth of oxyphobe microbes in the colon are other disruptors of oxygen order.

**The presence of the oxygen disorder can be easily established by doing urine analysis for toxic acids.**

**XI. What is "The Oxygen Protocol" for treating cancer?** The Oxygen Protocol is my term for a treatment plan for cancer that systematically and effectively addresses *any and all elements* that threaten the oxygen order and so promote cancer growth. The Oxygen Protocol for a given person is an *individualized*, broad-based, and integrative treatment plan that has, at its center, an unfaltering focus on achieving the optimal oxygen function in the body. The Protocol seeks to address those issues in cancer cells, as well as within the cells surrounding cancer cells. This is a crucially important subject and I explain its many aspects in various sections of this booklet.

**XII. Is diagnostic biopsy for cancer safe? Doesn't cancer spread via the needle track?**

I have read and heard many naturopathic physicians severely warn their patients against biopsy for diagnosing cancer on the grounds that the biopsy needle will spread the cancer. It is hard to see how any responsible person can take such a position.



How, may one ask, can any cancer be diagnosed without biopsy? How may we know what type of cancer we might be dealing with? And of what degree of aggressiveness? Is the cancer involving the blood vessels? Or lymphatics? How widespread is the cancer in the body of a given patient? I have never met anyone who opposes a diagnostic biopsy who can answer any of those questions. I might add here that neither have I met an experienced pathologist who thought the risk of spread through a needle biopsy can be accepted as a valid reason for not doing biopsy.

There are, of course, some uncommon exceptions to the above. For example, a man in his seventies may make an informed decision to proceed with a full treatment protocol for prostate cancer without biopsy when the existence of cancer is nearly certain. Such a decision may have merit when a prostatic mass on rectal examination has the classical features

of cancer—hard in texture, irregular in surface, and fixed to surrounding tissues—and is associated with a high value of the prostate-specific antigen (PSA) and/or bone lesions on scans. I might add here that very, very few people—in my clinical work—could sustain the motivation for taking cancer treatment for extended periods of time without a clear diagnosis established by a biopsy.

**XIII. When is surgery a good treatment option?** Surgical removal of cancer should not be unduly delayed whenever an experienced surgeon has a reasonable chance of removing all of the cancerous mass. Not infrequently, I have seen persons who refused surgery for months and years during the time the tumor could have been removed completely. Regrettably, on many such occasions, young individuals with cancer had been warned by practitioners of 'natural medicine' that their cancers would spread if they had a biopsy done.

The truly sad cases of cancer—in my experience—have been young persons who ignored clear signs of cancer because they had *heard* that their cancers could be eradicated by diet plans, herbs, or 'energy' therapies. Worse yet are times when an ill-informed practitioner misled a patient in extreme duress. By the time I saw them, their tumors were beyond the point of complete surgical removal.

There are exception to this rule as well. A man in his late fifties consulted me for prostate cancer. I had no doubt the best option for him was removal of cancer by surgery *and* the Oxygen Protocol. In young men, prostate cancer is generally more aggressive than in older men. Of course, younger men have longer to live, and the risk of death from cancer increases with age. He adamantly refused surgery, saying, 'My dad died of prostate cancer. His surgeons had assured him the tumor had been completely removed. The same thing happened when my brother developed prostate cancer and had surgery for it. I am not going to have surgery. That is my final decision.' I told him I respected his decision, but I wanted him to be very clear about my advice. Then I outlined my program for him and he began his treatment.

On the second visit, I again stated the

case for surgery clearly. I told him he was a young man and he had also to think of his wife and children. Bad clinical outcome for his father and brother, sad as it was, was not a valid reason for him to categorically dismiss the surgical option. He listened to me politely, then stated his position firmly. He was not going to accept surgery. I changed the subject.

On the third visit, I felt morally and ethically obligated to revisit the issue of surgery. He took my arguments with good humor, then emphatically said, 'But, no thanks.' I promised I would not bring that subject up again, then added that he could do that any times he wished. He thanked me and expressed his determination to closely follow the program (the Oxygen Protocol) that I had prescribed for him. Now, nearly four years since I first saw him, I am beginning to think that *for himself*, he seemed to have been right in refusing surgery. His PSA is lower than before. He has no urinary symptoms. Clinically, there is no evidence that his tumor is growing. The Oxygen Protocol so far is working well for him.

What advice will I give to the next man in his fifties with prostate cancer?, some readers might ask. I will still recommend surgery *and* the Oxygen Protocol. Might my advice change with passing years? Yes, if the long-term results justify. At this stage in my life, I only accept my patients as my true teachers. They are the people who do not lie to me.

I close this section by paying a tribute to the man in the above case history. He is my hero. Men and women like him are blazing a trail. They are opening some new doors of hope—for others with cancer, as well as for clinicians like me. The case of an ill-informed patient who opposes surgery, without any true-to-life experience in treating cancer, is different. He is into self-aggrandizement. The man in my story—and others like him I clinically follow—are a different breed. *They open possibilities by risking their very lives.*

**XII. Is chemotherapy a valid treatment option?** Should chemotherapy be given to a 15-year-old girl with acute leukemia? Categorically yes! At the present state of knowledge and experience, I am not aware of any cases in which

acute leukemia was controlled by nutritional, herbal, or 'energy' therapies for extended periods of time. By contrast, chemotherapy in experienced hands can control acute leukemia in a majority of cases.

Should chemotherapy be given to a 65-year-old man with prostate cancer? Categorically not! At the present state of knowledge and experience, most cancers of the prostate gland in that age group can be controlled for several years (over fifteen years in many of my patients). I have never seen a case of prostate cancer for whom chemotherapy was of benefit even for a few years.

*The crucial point is that each individual requires an individualized assessment and treatment plan.* There is no room here for dangerous generalizations.

On some occasions, I have heard some "holistic" doctors vehemently denounce chemotherapy. How can any therapy be denounced until one has a treatment option that is at least as good as that being denounced? Regrettably, whenever I encountered blanket denouncement of chemotherapy from holistic doctors, it was not accompanied by any data to show that there was something else that was safer and more effective than chemotherapy for the cancer in question.

As for oncologists, they nearly always advise chemotherapy, even when they *know* that the drugs to be used are highly toxic and are *not* known to control the type of cancer in question.

### **I *had* to do something!**

Above is the line that I heard—on occasions too numerous to count—from oncologists defending their decision to institute chemotherapy during my years of hospital pathology work. No one *has* to be given toxic drugs simply because the oncologists will not make the effort to learn how to use supportive nontoxic therapies. Yes, it is true that in many advanced cases the therapies of the Oxygen Protocol described in this booklet may not significantly prolong life. But from long years of experience I know that supportive oxystatic therapies add to the quality of life and are *never* toxic to the patient. At least such therapies do not make a sick person sicker, as chemo drugs often do.

I know chemotherapy does not work for

that cancer, but I did it for anecdotal reasons.

That is the second sentence that I commonly heard from oncologists at the hospital. That statement is equally silly and reprehensible. It is interesting how oncologists regularly ridicule holistic practitioners for being anecdotal, and yet accept the logic of anecdotal experience while administering poisonous chemo drugs for types of cancers that do not respond to chemotherapy drugs.

I have also seen some oncologists employ scare techniques to intimidate patients and force them to undergo chemotherapy. That is equally deplorable. It is hard to see how an oncologist can force a highly toxic—and of very doubtful efficacy—drug therapy on an unwilling patient.

The matter of a person with cancer rejecting chemotherapy is a different—and an important—concern. Many people have witnessed cases of horrible toxicity of chemotherapy—including deaths from such complications as kidney or liver failure—in their family or friends. They have an understandable distrust of chemotherapy.

### **XV. How does a patient know when the right advice about chemotherapy is being given?**

This is where the American medicine *utterly* fails persons with cancers that are beyond complete removal by surgery. We desperately need a new class of clinicians who devote their lives to the study of cancer and who can help the patient make an informed decision without compromising themselves. At present, there are far too few such clinicians to provide optimal advice to even a fraction of persons who need that.

How does one proceed? By doing due diligence. What is the basis of the advice against chemotherapy given by a holistic practitioner? What kind of formal training has the practitioner had in treating cancer with his 'natural' therapies? What sort of true-to-life experience she/he has had with the type of cancer in question. Regrettably, most such practitioners are not even familiar with the basic terminology used in classifying cancer. To them, a cancer is a cancer. That is a sad example of a little knowledge being dangerous. Again, a person with cancer should know that no two persons ever have *identical* cancers in *identical*

microenvironments.

#### **XIV. When is radiotherapy the right choice?**

My answer to the question of chemotherapy furnished above fully applies to radiotherapy as well. In general, toxicity of radiotherapy is not as difficult to reverse as that of chemotherapy. On the other hand, when cancers return following radiotherapy, they tend to be far more aggressive than those that follow chemotherapy. Advice on inclusion of radiotherapy in the treatment plan must also be obtained from clinicians well-versed with short-term, intermediate, and long-term consequences of the treatment.

#### **Author's Clinical and Research Work**

At this stage, the readers are likely to want to know about the author's background so they can have a framework of reference for critically evaluating the information presented in this booklet. That is especially needed for considering my case for "thinking oxygen" in understanding the nature of cancer, as well as for the validity of the "Oxygen Protocol" for treating cancer. I make a strong case for addressing *all relevant* metabolic and toxicity issues concerning the cause and behavior of cancer. Equally important is the matter of the light in which my guidelines for therapy should be integrated with surgical, chemotherapy, and radiotherapy options. *There is no substitute for a knowledgeable and experienced clinician when one seeks medical advice for a course of action for a potentially fatal disease.* Thus, all information presented in this volume is furnished for educational purposes only. Following is my professional background.

During my 29 years of work as a hospital pathologist, I conservatively estimate I assumed the responsibility for diagnosing over 75,000 malignant neoplasms and followed the clinical course of many of those cases. (The real number of cancers was probably close to 100,000.) That experience was rewarding. It gave me a clear sense of the biology of diverse cancers, as well as the clinical outcomes achievable with the main-stream therapies. During the last two decades, my colleagues at the Institute and I participated in the clinical management of over 2,000 cases of cancer. That experience has been



disconcerting, largely because it was not possible to clearly delineate the long-term efficacy of our integrative therapies. Most of those patients concurrently received therapies that put in jeopardy oxygen homeostasis—chemotherapy, radiotherapy and others—that countered the integrative oxystatic therapies which we prescribed. That created a moral and an ethical dilemma: How can anyone ask a person with cancer to discontinue traditional therapies unless one has a plan that is superior to what is being used?

Another all-too-common problem has been the financial burden of integrative therapies on patients, since insurance carriers nearly always refuse to cover such therapies, seriously compromising the continuity of care.

Fortunately, there has also been a subgroup of about 60 self-selected, well-informed, highly-motivated, and strong-willed individuals who assumed the *primary* responsibility of the control of their own cancers. They have been under our care for two to twelve years. Though limited, my experience with this small subgroup has been richly rewarding. In this chapter, I share my views of the biology of cancer and responses to integrative therapies based on insights they gave me, as well as on personal pathologic, clinical, and research findings. In my effort, I have looked at the problems of cancer through the prism of oxygen homeostasis because, as I explain below, oxygen drives *all* host defense responses to malignant neoplasms. To elaborate that view, I reproduce below some text from a previous article:

The long-term outcome in unresectable cancer is primarily determined by how well oxygen homeostasis can be achieved and maintained. The benefits of soy and other phytochemicals, with or without therapies that modify specific molecular and genetic pathways, are often substantial in the sense that such therapies can alter the behavior of cancer cells for variable periods of time until oxystatic therapies begin to take hold.

#### **Chemotherapy's Score Card**

Some readers might think I am biased against chemotherapy. The oncology industry continues to claim progress with chemotherapy drugs. The real story of cancer treatment with

## 7 - A Snapshot of Cancer - Taken from the book OXYGEN and CANCER

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their drugs has been—and continues to be—quite different. Consider the following two quotes—one from a 1986 issue and the other from a 1997 issue—from *The New England Journal of Medicine*:

We are losing the war on cancer...The main conclusion we draw is that some 35 years of intensive effort focused largely on improving treatment must be judged a qualified failure [vol.314, page 1226].

In 1986, we concluded that 'some 35 years of intensive effort focused largely on improving treatment must be judged a qualified failure.' Now, with 12 more years of data and experience, we see little reason to change that conclusion [vol. 336;page 1569]

It is important to point out that the data which the *Journal* refers to in both reports (from the same lead author) concerned national statistics in the United States, not merely those of any single hospital, county, or state in the Union. However, the articles did point out clearly improved outcomes with chemotherapy given to children and adolescents for some types of cancer.

In 1986, I recall an oncologist-friend angrily dismissed the *Journal* report on the ground that the report had not included the then-recent advances in chemotherapy. After the 1997 report, none of the oncologists at our hospital wanted to hear about the *Journal* statistics.

Why do oncologist *never*—to my knowledge—look for nutritional deficiencies in their patients? Why do they *never*—again to my knowledge—consider nutrient supplementation for their patients who are nauseous and tired following treatment with chemotherapy drugs? Why do they vehemently oppose clinical nutritional medicine? Why do they not test their patients to detect toxic metal overload? When heavy metal toxicity exists, why do they not consider chelation therapies to reduce that load? Why do they *never* look into the critical issues of the bowel and liver toxicity in their patients? Why do oncologist resist, directly or indirectly, a patient's own efforts at spiritual healing?

Clearly, oncologist do not dismiss nutritional, herbal, detoxification, and self-regulatory

approaches because they have tested them and found them lacking. The real reason is they lack professional courage. They are afraid they will be labeled charlatans and loose esteem in the eyes of their peers if they pursued any of those critical issues. That is a sad state of affairs. I hope some of them will accept my challenge and test the Oxygen Protocol for treating cancer presented in this book, with or without concurrent traditional therapies. I know they will discover that focus on oxygen homeostasis will significantly improve their clinical results.

### Cancer Is O<sup>2</sup>-Related

I end this article by underscoring the two *critical* phenomena that cause and perpetuate cancer:

First, all events that cause and perpetuate cancer are *oxygen-related*. Second, all events that cause and perpetuate cancer are *oxidation-related*.

I shorten the above two statements into: Cancer=O<sup>2</sup>—the first O standing for oxygen and the second O for oxidation. I might also state here that O<sub>2</sub> is the symbol of molecular oxygen, meaning two atoms of oxygen linked together.

Oxygen is the ultimate molecular Dr. Jekyll and Mr. Hyde. I devote a chapter to that subject in this book. Oxidation is loss of energy—of electrons, in the scientific terminology. For example, when a flower wilts, that is because of degradation of its substance due to oxidation. When cut grass decomposes, that is oxidation, and so on.

### The First Dimension

Sometimes ago, I saw a woman in her late sixties with lung cancer that had spread to her liver. I recognized the probability that the cancer had actually seeded many other organs. That is what we pathologists nearly always find on a careful study when such cases come to the autopsy tables. She was accompanied by her younger sister and a younger brother, a pastor. They all gave me broad smiles and told me they had recently heard me on WBAI-FM Public Radio in New York for three hours during its fund-

raising. Doing a radio thing is one thing, caring for patients with dangerous, widely spread cancer an altogether different. Their smiles made me uncomfortable. I tried to keep my discomfort to myself.

The patient's internist had referred her to an oncologist for chemotherapy. The family had not done that. I told them we could do many things to control her cancer, but it was important for them to let an oncologist outline for them what might be done for her in that field. Their faces stiffened. That did not surprise me. It is not uncommon for patients and their families to fail to hide their disappointment when I first raise the issue of chemotherapy. They come to see me as a 'holistic' physician to avoid chemotherapy, not be told to consider such therapy. I sidestepped that issues, and asked the patient why she had ruled out chemotherapy. 'That's our firm decision,' the pastor-brother spoke before the patient could. It is a warning signal for me when a family member opposes a form of therapy before I can find the sense of the patient on the subject. So, I politely repeated the question, looking deep into the patient's eyes that time. She smiled broadly. Among physicians, such smiles are considered a form of denial.

I spoke about the difficulties of controlling the type of cancer the patient had with our Oxygen Protocol. They listened to me attentively. Then all three smiled again. I decided to outline the components of the Oxygen Protocol, and the revisit the issue of chemotherapy after that. I consider it my moral, ethical, and a *human* responsibility to assure that persons with difficult cancer learn about the chemotherapy option from oncologists, not me. So I explained the Protocol at length, then returned to

chemotherapy.

"We have been reading some of your books since before this problem was diagnosed," the pastor-brother said, when I finished. "It is our shared decision not to take chemo. We have seen the devastation of those drugs first hand." He looked at his sister. She nodded, her face again breaking into a knowing smile.

"When we know our programs can do much better than chemo, we say so," I said reassuringly. "But sometimes the situation is not clear."

"What would you do if you were the patient?" the pastor had asked the expected question.

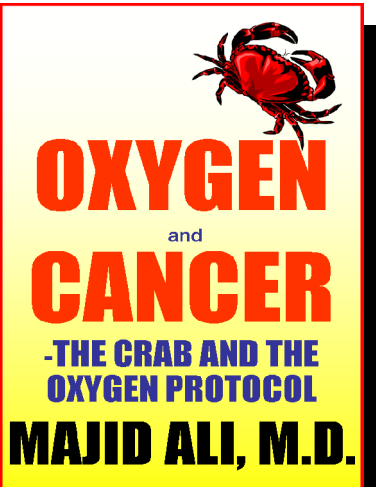
"I don't know. I really don't know what I would choose if I *actually* I faced this difficult situation."

"What would you have liked to be your options?" the pastor pressed on.

"I know spiritual healing would be my first dimension," I tried to verbalize something I had thought hundreds of time. "The Oxygen Protocol would be the second. Would I take chemo as the third thing? It's hard to say. Perhaps..."

"That's it. Your first dimension is also our first dimension. We are here for your second dimension. Those two dimensions are enough for us."

I looked at the patient. She had the sweetest of the smiles I had ever seen. I stayed with that smile of the first dimension for a while. Then the pathologist in me raised his head. I thought about revisiting the chemo issue with the family during the next visit. But her divine smile sublimated that thought rapidly. I knew I was looking at the most beautiful African American woman my eyes had ever fallen upon. The ugliness of chemo simply did not belong there then.



The book cover features a red crab at the top. Below it, the title "OXYGEN and CANCER" is written in large, bold, red letters. Underneath, the subtitle "-THE CRAB AND THE OXYGEN PROTOCOL" is in smaller, blue, bold letters. At the bottom, the author's name "MAJID ALI, M.D." is in large, bold, black letters. The background is yellow with a black border.

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