09:30:54

SOAH DOCKET NO. 503-07-4032
LICENSE NO. D-2294

IN THE MATTER OF THE COMPLAINT AGAINST WILLIAM REA, M.D.) BEFORE THE TEXAS MEDICAL BOARD

09:30:54

ORAL VIDEOTAPED DEPOSITION

WILLIAM J. REA, M.D.

May 21, 2010

09:30:54

ORAL VIDEOTAPED DEPOSITION OF WILLIAM J. REA,

09:30:54 M.D., produced as a witness at the instance of the Texas Medical Board and duly sworn, was taken in the above-styled and numbered cause on the 21st day of May, 2010, from 10:10 a.m. to 4:57 p.m., before Cheryl Duncan, Certified Shorthand Reporter in and

09:30:54 for the State of Texas, reported by computerized stenotype machine at the Law Offices of Steve Cook, 13155 Noel Road, Suite 800, Dallas, Texas, pursuant to the Federal Rules of Civil Procedure and the provisions stated on the record or attached hereto.

BOARD STAFF
EXHIBIT NO. 1

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PROCEEDINGS

THE VIDEOGRAPHER: We are now on the record. My name is Adam Meggs, I'm a videographer for Ken Owen & Associates. Today's date is May 21st, 2010, the time is approximately 10:10 a.m. This video deposition is being held in Dallas, Texas In The Matter of the Complaint Against William Rea, M.D. The deponent is William Rea, M.D.

Counsel, please identify yourselves and who you represent.

MR. FRESHOUR: Scott Freshour, F-r-e-s-h-o-u-r, for the Texas Medical Board.

MR. SIMON: Jacques Simon, J-a-c-q-u-e-s, Simon for Dr. Rea.

THE VIDEOGRAPHER: The court reporter is Cheryl Duncan, and will now swear in the witness.

WILLIAM J. REA, M.D.,
having been first duly sworn, testified as follows:

EXAMINATION

(Exhibit 1 marked)

Q. (BY MR. FRESHOUR) Dr. Rea, for the record, if you will, first, please state your full name and current business address, sir.

A. William James Rea. It is 8345 Walnut Hill Lane, Suite 205.

Q. Dr. Rea, my name is Scott Freshour, I work for the Texas Medical Board. I think we may have met before. Is that correct, sir?

A. Yes, that's correct.

Q. All right. You've done depositions before; is that correct, sir?

A. Yes, sir.

Q. What I normally do, Doctor, is I'd like to just cover a few kind of ground rules and common courtesies, if you don't mind, and then we'll get into the substantive material, okay?

A. Okay.

Q. What I ask is -- and I know both the court reporter and the videographer want us, if you would, please, allow me the courtesy of finishing my question fully, then I will give you the same courtesy as it relates to your answer. Can we agree to that?

A. Yes.

Q. As you know, if we talk over one another, we're going to get admonished. So I'd really like to avoid that, because I'm sure Cheryl will correct us on that, okay?

A. Yes.

Q. If I ask you any questions that you don't

understand, please indicate that and ask for a clarification okay?
A. Yes.
Q. I am not a medical doctor, we are going to have some medical terms today. I certainly may mangle the pronunciations. Feel free to correct me. I have no problem with that. But we want a good, clean record and an understandable exchange of terms, okay?
A. Yes, that's fine.
Q. If you need a break at some point, if you would let me know, I believe the courtesy ought to be extended, I don't have a problem. I may need to get to a breaking point, but I certainly will respect that request if need be, okay?
A. Surely.
Q. And with that in mind, Doctor, I would like to go ahead and ask you, you are a Texas medical licensed doctor; is that correct?
A. Yes, that's correct.
MR. SIMON: Scott, before -- I'm sorry to interrupt.
MR. FRESHOUR: Sure.
MR. SIMON: Who's keeping time? Who's keeping time?

THE COURT REPORTER: I do.
MR. SIMON: Okay. Because we have six hours.
MR. FRESHOUR: Right. And if I may pause for a moment, just so we have it on the record, Jacques, we're doing this by the Texas Rules.
MR. SIMON: Yeah.
MR. FRESHOUR: So six hours?
MR. SIMON: Six hours.
MR. FRESHOUR: Okay. And objections by Texas Rules?
MR. SIMON: Yes.
MR. FRESHOUR: Okay.
Q. That's just clarifying a few procedural things between Mr. Simon and myself, Dr. Rea.
Again, you are licensed in Texas as a medical doctor?
A. That's correct.
Q. When was your license issued or how long have you been practicing in Texas, sir, approximately?
A. Well, I think it was issued in 1962, so I've been -- almost 40 years.
Q. Okay. And the other point I'd like to make, Doctor, is, I don't want this to be a memory

contest. So if I ask you something and you can't remember exactly, if you'll indicate "I don't recall exactly" -- or I may ask for approximations, okay?
A. Yes, that's okay.
Q. And have you been licensed in any other states other than Texas in your career?
A. Yes.
Q. And what states would those be, Dr. Rea?
A. Ohio, Illinois and Arkansas.
Q. Okay. And whatever word you want, what is the status of those licenses other than your Texas medical license?
A. They're all active.
Q. Now, have you, besides this -- well, let me ask it this way: Are you privileged or credentialed at any hospital facilities currently, sir?
A. No, I'm not.
Q. Okay. Any particular reason that you don't have credentials, sir?
A. Yes, there is.
Q. And what would those reasons be, generally?
A. Well, I -- when I was 65, I quit doing my surgeries and the like. And so there was really no need to be in a hospital.
Q. And you quit doing surgeries at 65. What's

your approximate age right now, Doctor?
A. 75.
Q. So it's been about ten years?
A. Yeah, that's right.
Q. Okay. In those ten years since 1965, has it just been the private practice and I believe in Environmental Health Center of Dallas; is that correct?
A. Yes, that's correct.
Q. Okay. In that ten years since you quit doing surgery, that's the only medical office or business you've had; is that correct?
A. Yes.
Q. And that's the address you gave us earlier today, that is the Environmental Health Center of Dallas?
A. Yes, that's correct.
Q. Now, prior to you giving up your hospital privileges and that kind of thing, just because you weren't working, had you ever been subject to any peer review or loss of privileges at a hospital facility where you had been credentialed?
A. I think there was one time. It was temporary, they had made a mistake.
Q. Okay. Just generally approximately when

was that and what was the nature of it, Dr. Rea?
A. I don't even remember, it's been so long ago. 30 years ago or something like that.
Q. Okay. And you said it was just temporary. So it wasn't a long-term --
A. Oh, no, just temporary.
Q. Okay. In the other states where you're currently licensed and hold licenses, have you ever been subject to -- or have you ever held any hospital privileges or credentials in those states?
A. No, other than licensure.
Q. Okay. And I know this is going back a ways, but as a medical student and then a resident and maybe you did an internship or a fellowship, were you subject to any kind of disciplinary action in your medical academic career?
A. Absolutely not.
Q. Now, other than the -- and you are aware, obviously, we're here today because there's been an investigation by the Texas Medical Board, correct?
A. I'm quite aware of that, yes.
Q. Right. Now --
MR. SIMON: A complaint has been filed by the Texas Medical Board, it's not an investigation, it's beyond the investigation.

MR. FRESHOUR: Right. And thank you, Mr. Simon. Let me correct that.
Q. You are aware you are subject of a complaint at the State Office of Administrative Hearings that has been filed by the staff of the Texas Medical Board at this time, correct?
A. Yes, I am.
Q. And that's what this deposition is about today, you're aware of that?
A. Yes.
Q. Now, prior -- and I want to take what we've got on board today, the patients that are involved and how we got here. I don't want to talk about those particularly. Have you been subject to any other investigation by the Texas Medical Board that you're aware of?
A. Not that I'm aware of, no.
Q. Okay. Not currently pending, but has there been any previously that you're aware of?
A. Not that I'm aware of.
MR. SIMON: The investigations that you and I participated in, Scott?
MR. FRESHOUR: No.
MR. SIMON: Is that what you mean?
MR. FRESHOUR: No.

Q. Other than what we've got on board at this --
A. Recently.
Q. Right.
Say within the past five years, other than this one, have you been subject to an investigation?
A. No, not to my knowledge.
Q. Within the past ten years?
A. Not to my knowledge.
Q. Okay. Now, you've had a long career, Doctor, so what I'm going to do in these next series of questions is, I'm going to limit it to, say, the past ten years, okay, for the frame of reference.
A. Surely.
Q. In the past ten years, have you been subject to any medical malpractice claims arising out of your medical practice that you're aware of?
A. Not that I'm aware of.
Q. Okay. Have you been the subject of any settlements, or has your insurer or yourself settled any claims with patients before they were filed as medical malpractice claims?
A. In the last ten years?
Q. Yes, sir.

A. Not that I'm aware of.
Q. Okay. Have you been the subject of any civil lawsuits arising out of your medical practice or conduct of your medical practice within the last ten years?
A. No.
Q. Now, Doctor, I want to just go ahead and expand that just a little bit, now. I want to ask that same series of questions, if you can remember back. I'm going to stop it at 20 years. In the last 20 years, have you been subject to any med mal claims that you're aware of?
A. Oh, yes, I was a thoracic cardiovascular surgeon.
Q. And we're going to get to that. But generally will you go ahead and, if you can remember approximately, about how many med mals, say, in the last --
A. Probably three or four.
Q. Okay. And were any -- did you ever have any payouts that you can recall?
A. Yes, I think there were some.
Q. Okay. Do you generally remember what any of the claims were about?
A. Well, you know, cardiovascular surgery is a

very risky deal, and particularly at that time. So it would be whatever was perceived to be the case. I can't remember any --

MR. SIMON: Dr. Rea, the question was if you remember.

A. I don't remember, no.

Q. Okay. Now -- and, Doctor, let me tell you, I have a tendency to jump around. It's not to confuse you, it's just the way the mind works.

A. Okay.

Q. You've hit upon being a cardiothoracic surgeon, correct?

A. Yes, that's correct.

Q. Now, you were trained in that specialty, or that's what you began your medical career doing, correct?

A. Yes, that's correct.

Q. Now, how long did you continue to practice in that field? I know you said you stopped with hospital privilege about ten years ago. When did you stop doing thoracic surgeries?

A. Well, sometime around then. I don't recall exactly. But sometime around 12 years ago, 10, 12.

Q. Now, you're well aware that part of this suit relates to some of your, what I'm going to call

the nature of your current practice, that being what is termed environmental medicine; is that correct?

A. Yes.

Q. Okay. Now, I know you were a thoracic surgeon. About when would you say you -- well, let me ask it this way: About when did you begin generally practicing any kind of environmental medicine?

A. Well, I would say it was probably in the late '60s, because part of thoracic surgery at that time was environmental medicine.

Q. And how do you mean, Dr. Rea?

A. Well, for example, we would see cases of asbestosis, cases of coccidioidomycosis, fungus-type phenomena of the lungs and of the cardiovascular system, and pneumoconiosis, coal miner's disease. Of course, you wouldn't have it around here, but we have seen that. People who were exposed to dust, high levels of dust and things like that. So always from the beginning of the program I did that kind of stuff, and it was environmental.

Q. Okay. Let me -- what percentage of your practice today -- or is the percentage of your practice today as environmental medicine 100 percent of your practice?

A. I would say almost so, maybe 95, you know.

Q. Okay. And if you can, generally when did you really transition out of thoracic surgery being kind of primary and moving into what I'm going to term primarily the environmental medicine in the fashion that you're practicing today generally?

A. Well, I would say that in the '80s, I had a ward over at one of the hospitals, and I had 40 -- I would have 20 thoracic surgery patients and 20 environmental patients in the hospital, as what you would call environmental now. And that went on until the late '90s, and then there would be more environmental medicine than surgery, I would say.

Q. Now, the facility you talked about where you had kind of a thoracic, slash, environmental practice, was that Brookhaven?

A. Yes, it was.

Q. Okay. Now, at Brookhaven, did you ever have any kind of, any kind of peer review action or any action taken against your privileges at that facility?

A. No.

Q. Is that facility still operating today?

A. Yes.

Q. Okay. When did you quit, I guess for lack

of a better term, going to that facility or having patients at that facility?

A. I don't recall when that was. It may have been in the mid '90s, could be, something like that.

MR. SIMON: Didn't it change names?

THE WITNESS: Yes, it changed names.

Q. And what name did it change to, do you know?

A. Well, it changed to Dedman Hospital. And when they decided that wasn't very good advertisement, it became RHD Hospital. And I don't know what it is now. It may be a different name now.

Q. And what motivated or what precipitated your decision to leave Brookhaven when you made that decision, Doctor?

A. Well, they came to me and said, look, we bought another hospital close, small hospital. Wouldn't you like to put your patients there because we could isolate them more and they would not get the exposure and we could do more things to them. Now, I didn't give up my privileges at Brookhaven at the time, because the two were interspersed, okay. And so we had that there for several years.

Q. Now, when you were at Brookhaven Hospital, you -- were you in partnership or working with a

Dr. Alfred Johnson at that point in time in your career?

A. Yes, he was first a fellow, and then he came into practice.

Q. And this is one of those jump-arounds, okay, Doctor? So bear with me.

A. Okay.

Q. We're going to talk a little bit about some protocols later today related to some antigen prep. Is that -- do you generally or -- I don't know if it's you or Dr. Johnson, but you generally followed the same protocols, each of you, in your antigen kind of preparation and formulation, do you know?

A. I really can't speak for Dr. Johnson. It's been several years now since he left and got his own practice, so I don't know how he makes his antigens or what he does. I can't really tell you.

Q. And when did you and he part company, so to speak?

A. Gosh, I don't even recall. I think it's been about eight or ten years ago now.

Q. Doctor, I want to kind of come back to you and some of your training and medical expertise. Are you board certified by any ABMS organization?

A. Yes, I am.

Q. And what, what certification do you have, Doctor?

A. Number one, general surgery; and number two, cardiovascular surgery.

Q. All right. Now, how long -- let's go with the general surgery first. How long have you been board certified?

A. I think it was probably around 1960 -- I think it was '67. I'm not quite sure when I finished my residency, but I took the exams right then.

Q. And on that board certification, being ABMS, are you under what they call the grandfather where you -- or do you have a renewal period?

A. I think I'm grandfathered now.

Q. Okay. Now, on your thoracic surgery, you also said you were also board certified; is that correct?

A. That's correct.

Q. And, again, approximately when did you get that, sir?

A. Well, about two years later.

Q. And, again, are you under a grandfather type of certification there?

A. I think so, yes.

Q. Okay. Now, other than those two ABMS certifications, do you claim any other kind of board certifications, Doctor?

A. I do, but not through the AMBS.

MR. SIMON: ABMS.

A. ABMS.

Q. Okay, Doctor. If you will, enumerate what those board certification are and the certifying organization for me. Could you, sir?

A. Yes, it's the American Board of Environmental Medicine.

Q. All right. And what, I mean -- okay, the American Board of Environmental Medicine, do they certify you in environmental medicine, or what is that certification?

A. That is certified in environmental medicine, which involves several entities, of course.

Q. Okay. And you say -- and I want to be clear on that. It "involves several entities." What do you mean by that, Doctor?

A. Well, I'm talking about immunology, toxicology, nutrition.

MR. SIMON: Disciplines.

A. Disciplines. That would be a better word.

Q. Right. And that's what I was going to say,

the certification is environmental medicine, but -- and I guess this will lead right to my next question. Do you have to take some kind of test or show certain competencies?

A. Yes.

Q. And what are those, sir?

A. Well, it was both a written and an oral exam, just like the other ABMSes.

Q. Okay. And what generally did you have to -- or what areas did these exams focus in on for this ABEM certification?

A. Same that we just talked about, the same disciplines we just talked about.

Q. And those are, just for the record, Doctor?

A. Those would be immunology, toxicology, nutrition and, of course, the environment.

Q. All right. Now, do you have any other certifications from any other organizations?

A. I may have. I'm not quite sure if it's current or not. But it's, I think it's -- well, I'm not sure.

Q. Okay.

A. I don't ever claim them, so I -- you know.

Q. All right. You have been a member, I believe, of -- is it the, is it the American Academy

of Environmental Medicine?
A. I am a member, yes. Now, that's different.
Q. Okay. What is that?
A. Well, it's a certified academy of physicians of -- it's multi-specialty. And it's actually -- 19 different specialties are involved in that, both surgically and medically. And it's been around about 50 years now, and it was founded by both surgeons and physicians to study the effects of the environment upon the individual.
Q. Now --
A. By the way, I did forget one thing on the board.
Q. Oh, certainly, go ahead, Doctor.
A. The requirement for the board, one of the requirements is that you have to already be certified in an ABMS specialty.
Q. And is that -- that's for the American Board of Environmental --
A. Yes.
Q. -- medicine?
A. Yes.
Q. So they require an ABMS certification before you can sit for their examination?
A. That's right, exactly.

Q. And it can be in the ABMS certified areas?
A. Yes.
Q. The American Academy of Environmental Medicine, did that -- and I'm going -- for lack of a better term, is that a -- did that morph out of the clinical ecology or Clinical Ecology Society or association at some point?
A. Yes, I think it did.
Q. All right. So is it fair to characterize what is today the American Academy of Environmental Medicine arose out of what was known, I guess it was in the '60s and '70, as the clinical ecologists; is that true?
A. The Clinical Ecology Society, I think that was true, yeah. It was a little bit before my time.
Q. And that's what I was going to say. When did you join the -- I'm going to just call it the AAEM. When did you join that, Doctor?
A. I think it was around 1973 or something like that.
Q. And have you held any positions with that organization?
A. I have, yes.
Q. And what positions have you held, Doctor?
A. Well, I was the president at one time. I

can't even remember when, it's been so long ago. Maybe 20 years ago or something like that. Just for a year.
Q. Any other positions?
A. I think I may have -- I've been on the board of directors sometimes.
Q. What do those duties entail, being --
A. Board of directors?
Q. -- on the board of directors? Yes, sir.
A. Well, they entail several things. One, they entail planning of the meetings for accreditation, for state licensure, and accreditation association so that you meet all the criteria for the state boards for continuing education. And they also involve trying to help educate physicians about the effects of the environment upon the individual, which of course, as you realize, there's a broad expansion of the knowledge of the environment now and how it affects individuals.
So it would also involve those, those kind of educational things. Helping medical students become educated on these kind of things. We've had a program for 20, 30 years on medical students being involved in the education process.
Q. And are you currently -- do you currently

have any position with that organization, Doctor?
A. You know, I don't recall, but I think either I just went off the board or I went on. I'm not sure which one.
Q. And how do they notify you if you're off or on, Doctor?
A. By letters and everything. But I just don't recall, okay?
Q. Okay. All right. What about -- there's an organization and I've seen it referenced in some of the materials, and I think it's the -- is it the Pan American Allergy Society?
A. Yes, uh-huh, that's correct.
Q. And what exactly is that organization?
A. Well, it's another accredited organization, both nationally and in the state of Texas. And -- for continuing education, for licensure. And it's more dedicated to teaching physicians the techniques that we use like the serial dilution titration, neutralization, intradermal desensitization techniques. But it also is dedicated to educate practicing physicians and residents and students the other aspects of environmental medicine also.
Q. And not knowing exactly how that society is organized, did you ever hold any officer or official

positions with them, Doctor?
A. Yes, I did.
Q. And what were those?
A. One time I was president, and one time I was on the board.
Q. All right. Are you currently, today?
A. I think I am on the board, yes.
Q. Okay. And, again, the duties of the board, would that be the same or similar to what you described for the AAEM?
A. Yes, it would be, uh-huh.
Q. And I think some of the members on there -- correct me if I'm wrong -- are Dr. Sheridan, David Sheridan?
A. Yes, David is on there.
Q. You know Dr. Sheraton?
A. Of course I do.
Q. Do you know Dr. Steven Hotze?
A. Of course I do. He's one of my students.
Q. Do you know Andrew William Campbell?
A. Yeah, but I don't think he's -- I don't think he belongs to that society.
Q. Alfred Johnson?
A. Of course. Alfred was my former associate.
Q. Okay. Alan Broughton?

A. Yeah, Alan was the laboratory guy. You're talking about Alan Broughton, the laboratory man?
Q. I'm not sure. I just know I've seen the name somewhere associated, I think with that society. I'm not trying to trip you up. I'm just --
A. Okay. I don't know whether he ever belonged to that society, but he was -- he had a laboratory that some people used, I think.
Q. What laboratory did he have, do you know?
A. I can't recall what it was. It was out in California.
Q. It wasn't Immunosciences Labs, was it?
A. Yes.
Q. Do you know Aristo Vojdani?
A. I sure do.
Q. Do you know Kaye Kilburn?
A. Of course I do. He's the cosponsor of my conference.
Q. And when you talk about your conference, is that your international symposium on Man and His Environment or -- I'm sorry, I know that's not quite what it is.
A. Yes. No, it's Man and His Environment and Health Disease. And we're having our 28th in two weeks.

Q. And that's here in Dallas?
A. Yes, the world conference.
Q. And that's sponsored by -- or partly sponsored by the -- by you; is that correct, Doctor?
A. Yes, I have organized it. And my foundation, American Environmental Health Foundation, is the one that sponsors it, along with Professor Kilburn, Professor Bill Meggs at East Carolina Medical School.
Q. It's the same Bill Meggs that you've designated as an expert in this case; isn't that correct?
A. Yes, it is.
Q. Are there any other sponsors of -- I'm going to call it the -- can we agree to call it "the symposium"?
A. Yeah, that will be fine.
Q. Because I don't want to keep saying the big, long name, okay? Or it will take us longer today if I have to keep saying that.
A. Yeah.
Q. Are there other sponsors besides the American Environmental Health Foundation that help sponsor that?
A. Well, our clinic also.

Q. Right, the Environmental Health Clinic of Dallas.
A. Right.
Q. And can we agree to call that just "the clinic" for today?
A. Sure, that will be fine.
Q. Great.
You said something -- and we were just talking about the Pan American Society. I'm just going to call them that for short. And we talked about a Dr. Broughton, and you referenced a laboratory. You are familiar with a laboratory called Immunosciences Labs in California?
A. Yes, I am.
Q. Okay. And you use -- do you use that laboratory currently?
A. I think he's back in business, but I don't think we -- he does what we are interested in, okay?
Q. Okay. And when you say what "we" are interested in, meaning the clinic?
A. Yes. When I say that, I mean the clinic and my practice, okay?
Q. And what is he doing that is not of interest to your clinic right now, Doctor?
A. Well, I can't really tell you, because I

haven't -- when he went back into business, I -- he concentrated on certain things, and I think maybe part of it was genetics and part was endocrine or something. It wasn't something that we thought would help our patients, okay?

Q. And you are aware that Immunosciences Labs, for lack of a better term, ran into a little trouble in the state of California on some of their certification and CLIA licensing? Were you aware of that?

A. Yes, I was, uh-huh.

Q. But prior to -- and, again -- well, let me ask it this way: When did you quit or stop sending materials to Immunosciences Labs, approximately?

MR. SIMON: I'll object to that form. We already established during Dr. Holland's deposition and on your own expert's testimony that he did not do business with Immunosciences Labs after that license or whatever it was, certification was revoked. So I object to the form of the question in the sense that it implies that he did anything with that lab at the time when that lab was not credentialed. And that was established already.

MR. FRESHOUR: Okay. I'm going to -- if you would, Mr. Simon, it's "form" unless I ask you

for the explanation. You're supposed to just say --

MR. SIMON: I'll object to the form.

MR. FRESHOUR: Right. But unless I ask for an explanation, you should not articulate anything.

MR. SIMON: I was just reminding you.

MR. FRESHOUR: I understand. And I understand your form objection.

Q. Let me pause here for a moment, Dr. Rea. Mr. Simon, if he objects and says "form," unless he instructs you not to answer, and I'll leave that to him, you'll need to answer my question even if an objection has been registered, okay?

A. Yes.

Q. I'm going to repeat the question.

A. Please.

Q. Do you remember about when you stopped using Immunosciences Labs with your clinic?

A. Well, that was when they shut down with -- I don't know what the ruckus was. But whatever it was, they had shut down for a period of time. And that must have been, what, four, five, six, eight years ago, whenever it was.

Q. And at the time prior to them shutting down --

A. Yes.

Q. -- were you using them for -- mainly for mold antibody testing, is that correct, or were you using them for other services as well?

A. No, we were using them for some other services also.

Q. Okay. Was it -- okay, and let me ask you this way: Was it primarily for the mold antibody testing, or were there other tests? And if so, what generally did you use them for, Doctor?

A. Well, I think it was for more like some kinds of immune tests at some times. Not particularly mold. I never -- just a few occasions used it for mold, because -- we did use some for some patients, but we didn't use it a lot.

Q. What laboratories do you generally use today with -- for the clinic for your testing? Are there any particular labs you like to use?

A. Well --

MR. SIMON: Is that -- object to the form and also to relevancy. Is that part of this case?

You can answer the question.

A. Of course we use Quest and LabCorp. And we have our own laboratory also. And there's a lot of

things we do right there. And then we use [Lab name redacted] and Metametrix. I think that's Atlanta.

Q. Metametrix?

A. Metametrix, yeah.

Q. Thank you, Doctor.

A. I think -- I can't remember any more. I don't think we have any more.

Q. Okay. Well, and the [Lab name redacted] that's not known as XXX commonly in the medical community, the [Redacted]? Is that what you --

A. I don't know what it's known as. We know it as [Redacted

Q. What about Accu -- is it Accu Lab or Accu-Chem --

A. Accu-Chem Laboratory is not in existence anymore.

Q. That was bought out by somebody recently, wasn't it?

A. Yes, it was.

Q. Do you know who bought them out?

A. I think Metametrix did.

Q. I was going to ask you --

A. Don't quote me on that, okay?

Q. But I think we can agree, I think, for some

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reason, I've seen the literature on that.
A. Yeah.
Q. Now, the Accu-Chem Laboratory, that used to be run by a John Laseter, correct?
A. Dr. John Laseter. He's a world class environmental chemist, biochemist, yes. He was at the University of New Orleans for years.
Q. And you -- before Accu-Chem, when they were in existence, your clinic did use them as a laboratory, as well, generally for testing?
A. Oh, yes, because they were the best laboratory for chemical analysis.
Q. Okay. And do you have -- do you have any kind of a business relationship with Dr. Laseter?
A. No.
Q. Did you ever have any kind of business relationship with Dr. Laseter?
A. No. He asked me to be on their board one time, and I think I, I was for a few months, but then I resigned.
Q. And when you say on the "board," the board of Accu-Chem Labs?
A. Yes.
Q. What was your role there as -- on the board, even though it was short-term?

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A. Physician input.
Q. Did you ever have any kind of ownership interest in Accu-Chem, Doctor?
A. I'm not sure that we did. I think our foundation did. I'm not sure. They may have stopped, but I don't really recall.
MR. SIMON: Did you yourself have any --
THE WITNESS: I don't recall.
MR. SIMON: Okay.
Q. And that's the breakdown. I think Mr. Simon has kind of helped me on that one.
A. Yeah.
Q. I'm asking, did you personally own any interest in Accu-Chem that you're aware of?
A. Not that I'm aware of.
Q. Okay. Now, you also -- we've talked about, and we're going to talk about some more here in a minute, the -- I'm drawing a blank, your foundation.
A. Yes.
Q. What is it, again, one more time?
A. American Environmental Health Foundation.
Q. Okay. Can we agree, for the purposes of today, to call that the foundation?
A. Yes, I think we did.

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Q. Okay. So we've got the symposium, the clinic and the foundation?
A. Yeah.
Q. I'm going to try to keep those straight, okay, Doctor?
A. Okay.
Q. If I don't, you'll straighten me out?
A. Yes.
Q. Do you know, did the foundation own any interest in Accu-Chem Lab?
A. Not to my knowledge.
Q. And when you were using Accu-Chem Lab before they were sold, was there any kind of financial arrangement between the lab and the clinic that you got any kind of favorable prices or reduced rates on your testing costs?
A. No.
Q. Now, I want to go a little bit into -- just generally -- I want to be sure, you don't have any specialty training in neurology, do you, Doctor?
A. Only that I used to do neurosurgery at Parkland Hospital.
Q. You did some neurosurgery?
A. Sure did.
Q. Okay. When did you do the neurosurgery?

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A. Oh, it's in the '60s, late '60s, mid '60s.
Q. Now, you were trained as a thoracic, so how did you come to do the neurosurgery? I just need a little clarification.
A. Well, Parkland Hospital, I don't know whether you're aware, but, it's probably the greatest trauma hospital in the world. And when you're a surgeon at Parkland Hospital, you're trained to go through all the specialties, and that's when I did it.
Q. Okay. And I think that's -- perhaps I'm being a little bit unclear on my question.
Was that during, say, your internship, your fellowship, or were you actually a licensed physician and working at Parkland?
A. Well, it was during my training, but I was a licensed physician.
Q. Right. That's what I'm trying to distinguish, though, it was your training, you weren't there after -- it was like during an internship or a fellowship, right, that you did that?
A. A residency, yes.
Q. Residency, okay.
A. I did six years there of residency after internship.

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Q. Okay. Did you have any specialty -- do you have any specialty training in neurology?
A. I just said, yes, I rotated through several times, yeah.
Q. That was neurosurgery, neurology.
A. Oh, well, I mean, the two are intertwined, yeah.
Q. Okay. What about psychiatry?
A. No.
Q. Radiology?
A. Only -- all of these things you ask, those are all interpretation of our specialty when you have so many long years of training that I have. I have rotated through there and I've worked with the radiologists. I don't have any special certificate of training from that, if that's what you're asking.
Q. Right.
A. And if you ask all of those, that will probably be the same.
Q. Okay. And that's what I'm getting to, you have -- it's fair to say from our discussion today that you feel you have experience in all of those, but you didn't necessarily have specialized training or certifications?
A. I had specialized training, but not

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certification.
Q. Not certifications?
A. Yes.
Q. So just for the record -- bear with me on this, Doctor?
A. Okay.
Q. So you do not have certification in neurology?
A. Same answer, right.
Q. You don't have certification in psychiatry?
A. Absolutely not.
Q. You don't have certification in radiology?
A. Okay, true.
Q. And you don't have certification in allergy?
A. No.
Q. Okay.
A. Although I'm a fellow.
Q. Okay. A fellow of?
A. American College of Allergy, or have been.
THE COURT REPORTER: I'm sorry?
THE WITNESS: A fellow is where you have a --
MR. SIMON: No, fellow of what? She couldn't pick up --

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MR. FRESHOUR: The organization, Doctor.
THE WITNESS: American College of Allergy. They keep changing the name, whatever it is now.
Q. Immunology, you don't have --
A. Same.
Q. Toxicology?
A. Same.
Q. And genetics?
A. Same.
MR. SIMON: And we're talking about formal certifications, vis-a-vis training and experience, correct, Mr. Freshour?
MR. FRESHOUR: Certifications. that's what I asked, yes, sir.
MR. SIMON: Okay.
Q. In your practice, your current practice at the clinic, Doctor -- I guess, why don't we do it this way: In your clinic, how many days a week are you there yourself, Doctor?
A. At least five.
Q. Okay. How many patients do you see a day, a week, a month, yourself, personally?
A. I personally probably see 10 to 15 patients

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a day.
Q. 10 to 15 a day?
A. Yes.
Q. Okay. Now, at the clinic, you're not the only physician; is that correct?
A. That is correct.
Q. Generally describe how, how the clinic is structured. And what I mean by that is, how many doctors do you have? If you have any -- what I'm going to call mid-level caregivers, such as PAs, ANPs, nurses. Can you just generally describe that.
A. Yes. I'll say this, we've shrunk since the economic depression has gone down, as everybody has. But we have about four physicians that are not all full time.
Q. They're not all full time?
A. That's right.
Q. Okay.
A. And then we have our medical assistants who are unlicensed physicians who are waiting to either take their examinations or have decided not to. And I have some of those in charge, like, of my antigens and different areas of practice. So that makes for a very high caliber type of employee. And most of them have been with me for several years.

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Then I have some part-time, like massage therapists or -- of different categories, there. And, then we have, I guess they call them medical assistants. These are people who had two to three years of college that assist us with getting the patients in, weighing them, things like that. And then we have some testers for the antigens, and one physician and several technicians. And then we have several business people, I guess, front desk people who greet the patients and get their red tape going for their insurance or whatever, get them scheduled or that. And then I have a secretary and -- that's about it.

Q. And you said you saw about 15 patients a day, you work about five days a week. Do you work a full eight-hour day, Doctor?

A. A lot worse.

Q. Generally, Doctor, generally how --

A. Eight to ten hours, sometimes twelve.

Q. Okay. And so you more or less have, say, 50 to 75 patients a week you see; is that fair, Doctor?

A. Yeah, that's fair.

Q. So besides you, you've got some other physicians, maybe not full time. About how many

patients, do you know, do they see on average as an aggregate? Do you know?

A. I can't give you a number, but I'm sure it's not as many as I do.

Q. And in that structure of your -- and I'm going to call it your organization, your clinic.

A. Okay.

Q. In the structure of your organization, do you monitor or double-check the work of the other physicians that are present or have any kind of oversight on them, formal or very informal?

A. Informal, of course, because, you know, sometimes they trade patients. Sometimes I never see their practice patients, you know.

Q. Okay. Now --

A. We get a lot of second opinions.

Q. Okay. You give a lot -- you get a lot or you give a lot?

A. Well, both.

Q. Okay.

A. But I mean between them, between our physicians, we get second opinions.

Q. So you confer with each other about patients?

A. Yeah, that's correct.

Q. Okay.

A. That's a good way to put it, confer.

Q. And what I'm trying to get at is there's an informal second kind of opinion in consulting amongst you as physicians at the clinic, correct?

A. That's correct, yes.

Q. But you also do formal consultations for second opinions for physicians that are outside of the clinic?

A. Oh, yeah, sure.

Q. Okay. So that's what you were trying to distinguish?

A. That's correct.

Q. Okay. When you were describing your -- the structure of the clinic, you said something about you have some front desk people kind of on the business side of it. Do you accept insurance, or is the clinic all kind of a cash business? How is that structured?

A. It's cash, usually, the majority.

Q. You don't take any Medicare, Medicaid, anything like that?

A. No. But we treat Medicare patients, but we don't take it.

Q. So how does that work for your clinic,

Doctor?

A. Very complicated. But my business people take care of it, but I think we have to file -- the law says we have to file on certain things, and we do that.

Q. Okay.

A. That's all -- but we don't accept payment or anything.

Q. What percentage would you say, Doctor, of your medical practice there at the clinic is cash only, non-Medicaid -- Medicare, Medicaid patients?

A. Oh, I'd say 95 percent.

Q. And is there any kind of -- in all your years of doing this, is there any particular demographic population that seems to predominate your patient population?

A. Well, it's very, very -- for example, we have Gulf War veterans, we have the people who got -- survived the airplane crash in New York City. We have people who work in factories, who have gotten damaged from the fumes coming from the factories. We've had pesticide sprayers, we've had housewives, almost any profession, really.

Q. Okay. And I guess that was a poorly asked question. Demographically, do you have -- or

gender-wise, do you have a predominant population that is more female versus male or any kind of breakdown you can give me on that?

A. Oh, I think there are few more female than male.

Q. Okay. Now --

A. We have a lot of professional people.

Q. On the patients you see, just generically, and I don't want to talk about the specific patients in the case. We're going to get to those a little bit later today.

A. Okay.

Q. Generally when a patient comes to see you, do you have any kind of a set fee? Do you have an hourly rate? How do you price your services for a patient, say, on an initial visit?

A. I'm embarrassed to tell you, I don't recall anymore, but I think it's $150 for consultation to see them primarily.

Q. And then that consultation, Doctor, is that for a set period of time? Or what is an initial consultation for that $150? What is that?

A. That's history and physical exam.

Q. And that's you doing it yourself, eyeball to eyeball with the patient?

A. That's right, exactly.

Q. And they've come in and they carry in the paper and say, you know, one of your techs perhaps weighed them, measured them, did a BP --

A. That's correct. And they usually come in with a stack of medical records, about this high (indicating).

MR. SIMON: Mr. Freshour, when it's a logical point for you to break, I'd like a moment off the record.

MR. FRESHOUR: Okay.

MR. SIMON: Let me know.

Q. Then we were talking about your initial consultation. The -- so you charge, say, 150 for your initial consultation.

A. Well --

Q. I'm sorry, go ahead.

A. I mean, as I said, I really didn't remember, because I know there are some people that want just one thing and we may charge a lot less for that.

Q. Okay. But they see you. And then if there's anything further that needs to be done, they need to see other individuals in your facility? Perhaps you subject them to some testing or

diagnostic testing. Those are all charged separately, as well?

A. Yes.

Q. Okay. And do you know how -- what's charged, or is that all on the business end?

A. It's all on the business end.

Q. So you really don't know -- without putting words in your mouth, Doctor, is it fair to say you don't really know what your patients are charged, other than for your services?

MR. SIMON: I direct him not to answer. I need a break.

MR. FRESHOUR: On what basis are you instructing him?

MR. SIMON: This is not subject of the complaint here. Looks to me like you're conducting a separate investigation from what the complaint is. And you know the procedure for separate investigation, and we've got to follow that.

The complaint does not take aim at his general practice. It takes aim at particularly five patients. If you want to conduct a separate investigation, you've got to give me notice, you've got to tell me what the issues are and you've got to give me an opportunity to go through the informal

settlement conference. Other than that, what are we doing here?

MR. FRESHOUR: Are you instructing him not to answer?

MR. SIMON: Right now, based on that, yeah. And I would like to talk to you about that, because this is a separate procedure than what it is that's before us all right now.

MR. FRESHOUR: Certify that question, if you would, please, Court Reporter.

For the purpose of the record, no, it's not, I'm just trying to get a feel for his general operation of his medical --

MR. SIMON: Today? Today?

MR. FRESHOUR: Give me a chance, Mr. Simon.

MR. SIMON: Yes, sir.

MR. FRESHOUR: I am trying to get a feel for how his medical practice is operated. It is clearly relevant to the complaint because we're talking about his medical practice with these five patients. That's the scope of this inquiry.

Now, I've got your objection, you've instructed him not to answer. Certify it. I'm not yet at a break point, but as soon as we get there,

10:59:38 I'll be glad to talk with you.
MR. SIMON: Of course.
MR. FRESHOUR: Or if you need to talk to your client.
10:59:45 Q. When it comes to billing patients generally, Doctor -- and we've just gone through, you know more or less what you charge, you're not sure of the rest of the business end -- do you know how the billing is handled for patients? Generally do they
10:59:59 pay up front when they're there, or do you send them a bill? How is that done?
THE WITNESS: Am I allowed to answer that or not?
Q. Unless he tells you not to, you are.
11:00:09 A. Okay.
MR. SIMON: If you know what the procedure is.
A. I know what the procedure is. They do give them the bill after they've been seen.
11:00:15 Q. Okay. And then they either pay there or you work out a payment plan? Do you know how that works, Doctor?
A. I can't really tell you, no.
Q. Okay. Now, in some of the patients -- in
11:00:27 some of the patients that we're going to talk about

11:00:30 in specific today, they get what is termed -- and we'll get into this in a lot more detail, but I'm looking just more or less at how you operate. They get what's called immunotherapy. Do you recall that?
11:00:40 A. Yes.
Q. And they are billed or pay for these immunotherapies that they're provided, correct?
A. That's correct.
Q. Okay. Now, I've seen some of those are
11:00:52 mailed to the individuals, is that correct? Some of the immunotherapies can be sent to them?
A. Yes.
Q. And when they're billed for that, do you know, do they pay beforehand, after they receive
11:01:03 them? Do you know how that is handled?
A. No, I don't.
Q. Do you know who in your clinic determines the pricing or the charges to be made for immunotherapies?
11:01:18 A. Well, I mean, we all usually do, we sit down and we have an overhead that we have to make. And so we go from that angle. But I don't recall all the details of it. Because there's always --
Q. I'm not asking you for the formulation --
11:01:33 A. Yeah.

11:01:33 Q. -- out, just wondering how the charges for an immunotherapy are determined.
A. Well, my costs and then with a modest profit in there.
11:01:45 Q. And that, and that cost, you can determine because, if I -- and correct me if I'm wrong, the -- a large number, if not all the immunotherapies, are being prepared in your own laboratory; is that correct?
11:02:00 A. Yes, that is correct.
Q. Okay.
MR. FRESHOUR: I think this would be a good breaking point. We're about two or three minutes from the end of the first tape anyway. So
11:02:08 we're good.
THE VIDEOGRAPHER: The time is 11:02 a.m. This is the end of tape number one. We are going off the record.
(Recess from 11:02 to 11:10)
11:10:41 THE VIDEOGRAPHER: The time is 11:10 a.m. We are on the record. This is the start of tape number two.
Q. All right, Dr. Rea, just before we went on break, we've been talking a little bit about costs
11:10:55 for antigens. You indicated that most, if not all of

11:11:00 them were prepared in your own laboratory; is that correct?
A. Yes.
Q. Let me ask it this way: Are there any
11:11:10 antigens that you use routinely that are not prepared in your own laboratory, that you --
A. Well, you mean sources?
Q. Let me ask it this way, Doctor: The -- in your laboratory at the clinic, you prepare a majority
11:11:34 of the antigens you use for your patients, including the five that we've got in this complaint, correct?
A. Yes.
Q. Okay. Now, do you -- there's commercially prepared antigens by all kinds of companies, correct?
11:11:47 A. Yes.
Q. So I don't want to talk about the antigens that you prepare yourself, because I would assume you have to have source materials to prepare those, correct?
11:11:57 A. Yes.
Q. And you may get those at some kind of an outside source?
A. Yes.
Q. You don't have those available in your
11:12:04 laboratory, necessarily, yourself?

11:12:06 A. That's correct.
Q. Okay. I want to talk about a commercially prepared antigen. You can probably think of a good example for me, probably --
11:12:16 A. Pollens.
Q. Pollens or cedar?
A. Molds, yes.
Q. Do you use -- the majority of stuff that you use for antigens, the majority of antigens you prepare yourself in your laboratory, correct?
11:12:28 A. Yes, that's correct.
Q. Now, do you have any particular commercial prepared antigens that you use for your patients generally?
11:12:36 A. Yes.
Q. Okay. What are those generally, Doctor?
A. Well, those could be pollen, dust, mold, and...
Q. And is there a particular -- and I really
11:12:52 don't know. Is there a particular company or source you use for those, Dr. Rea?
A. It used to be called Antigen Laboratory, but I don't know -- I think they sold out and changed.
11:13:07 Q. Antigen -- and it may be changed. Are they

11:13:10 located in Dallas, or do you know where they're located, sir?
A. I think Kansas City.
Q. Kansas City -- Kansas City, Kansas or
11:13:19 Kansas City, Missouri?
A. I don't have any idea.
Q. Okay, I'll -- that's fine.
The Metametrix Laboratory that we talked about a little bit earlier, what services do
11:13:47 you generally use from them or ask them -- what services do they provide to your clinic, Doctor?
A. Well, the chemical solvent profiles and the pesticides and the nutritional amino acids, fatty acids.
11:14:08 Q. Now -- and this kind of goes back to some of, some of your, your training and education, Doctor. Is there something in particular that sparked your interest in environmental medicine besides just seeing some -- I think you described
11:14:24 earlier this morning, you know, seeing some fungal infections and I think asbestosis. Was there something else in particular that triggered it?
A. Yes.
Q. And what was that, sir?
11:14:34 A. I had a son who almost died from asthma and

11:14:38 they couldn't help him, and I had to go find treatment for him.
Q. Now, are you aware that I have deposed Dr. Meggs in this particular case?
11:15:02 A. No.
Q. Okay. Are you aware that I have deposed a Dr. Gerald Ross in this case?
A. Yes.
Q. Okay. Dr. Ross, I think did an internship
11:15:16 with your clinic some years back, didn't he?
A. Yes. The --
MR. SIMON: Either yes or no.
A. Yes. It wasn't an internship, though. That's what I was going to say.
11:15:27 Q. What capacity was he --
A. It was a fellowship --
Q. Generally describe, you know, who funded it, that kind of thing.
A. The Province of Nova Scotia.
11:15:45 Q. And he had told me in there -- and I'm not going to ask you for any specific details. He was a patient of yours prior to that, wasn't he, before he came to the internship?
A. Yes, he was. He was.
11:15:54 Q. Okay. And so you're not aware that Dr. --

11:15:59 I think it's William Meggs from East Carolina State is an expert for you in this case? Were you aware of that?
A. Yes.
11:16:06 Q. Okay.
A. I just wasn't aware you had the deposition.
Q. Okay.
MR. SIMON: You asked him if he knew you deposed him.
11:16:11 MR. FRESHOUR: Okay.
Q. Well, I'm going to indicate to you I did depose him, all right?
A. Okay, fine.
Q. And he stated that you had been a victim of
11:16:20 multiple chemical sensitivity. Is that true?
MR. SIMON: Object. Direct him not to answer, because his health is not at issue here.
MR. FRESHOUR: Certify the question.
MR. SIMON: And it is privileged.
11:16:32 MR. FRESHOUR: Certify the question, please.
Q. Well, Doctor, you told me that you work five days a week, a lot of hours, anywhere from eight to twelve a day. Do you have any kind of, any kind
11:17:11 of physical impairment that limits your ability to

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practice as a physician, currently?
A. No.
MR. SIMON: Object --
THE WITNESS: Sorry.
MR. SIMON: All right. It's on the record.
Give me some time to talk.
THE WITNESS: All right.
Q. We talked a little bit about your foundation, Doctor, do you recall that, earlier today?
A. Yes.
Q. What exactly -- well, first let me ask you this: When did you form or did the foundation come into being, approximately, do you recall?
A. I think -- I can't tell you the exact date. I think in the late '70s.
Q. Okay. And what was the, the purpose for you to begin this foundation, generally, Doctor?
A. Well, this is a c.1503 nonprofit foundation designated for three main purposes. One is to educate physicians and the public about the environmental aspects of health and disease. Two is to do research whenever possible and raise funds for, for doing research. And three is to supply some

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products that patients may have difficulty finding to change their homes or change their lifestyle.
Q. All right. Now, you said it's set up as a nonprofit corporation, correct -- or nonprofit foundation, I should say.
A. Foundation.
Q. Foundation, yes, sir.
And does the foundation have any, any officers, board of directors, that type of thing?
A. Yes.
Q. And exactly -- that was a wide open question. Does it have a board of directors, sir?
A. Yes.
Q. Okay. And who is on that board of directors?
A. Unfortunately, we just lost a couple of them due to deaths, Louise Henderson and Professor Joel Butler. And I think Louise's husband was on there for a while.
Q. And are you --
A. Yes, I'm on there also. Of course.
Q. All right. That's the board of directors.
Does it have any -- besides the board, does it have any kind of officers, secretaries, vice-presidents, executive officers, anything like

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that?
A. Well, yes, I guess it does.
Q. Okay. And who are those individuals, including yourself, Doctor?
MR. SIMON: If you know.
A. Yeah, I'm the president.
Q. You're the president? Okay.
A. Yeah. And...
Q. And are you paid or compensated in any manner by the foundation, Doctor?
A. No.
Q. Are any of the board of directors?
A. No.
Q. And I take it, obviously, as a foundation, it would be -- the foundation is required to file tax returns, correct?
A. Absolutely.
Q. All right. And you said one of the purposes was to do research and raise funds for that research. Is there any particular fundraising source you use for the research as it relates to environmental medicine?
A. No. We rely on donors.
Q. And those donors can be across the spectrum, I take it. Could be yourself personally

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contributing or any patients or just people in general?
A. That's right. That's correct.
Q. And the foundation is -- also sponsors the symposium, correct?
A. 28 world conferences now.
Q. Now, I'm going to indicate to you that -- and I know you haven't read this. But Dr. Meggs and I think Dr. Ross both talked about an article on pupillography written by Dr. Ishikawa. Do you recall -- are you familiar with that article?
A. Yes.
Q. And you were part of the contributors to that article, correct?
A. That's correct, yes.
Q. And part of the research for the pupillography article by Ishikawa that you also participated in was the foundation, correct?
A. Part of it. The other part was the Kitasato University and Medical School in Japan, Tokyo.
THE COURT REPORTER: I'm sorry, what university?
THE WITNESS: Kitasato, just like it sounds. Everything is phonetic in Japanese.

Q. The -- you've written a number of books on chemical sensitivity, correct? Four or five volumes?
A. Yes, that's right.
Q. That was underwritten or funded by the foundation, as well, was it not?
A. Yes, it was.
Q. In total?
A. Well, I don't know whether it was in total.
Q. And it -- did that funding include any compensation to you for being the author?
A. No.
Q. Now, the other thing you talked about with the foundation is, it supplies products to change homes and lifestyles. What did you mean by that, Doctor?
A. Well, for example, a long time ago it was very difficult to get silk, like silk underwear, silk shirts, stuff like that. So they would acquire that. Sometimes there are certain bedding that's nontoxic that they acquire, paint. nontoxic paint, things like that.
Q. Now, the foundation acquires that, and I assume -- well, tell me, are the products of the foundation available to the public at large or only to your patient population if they want to use them?

A. The public at large. Anybody can stop in and buy whatever they want, yes.
Q. And now, I would assume, and perhaps even with the five patients that we're going to be looking at later today, they have, they have been given recommendations to live a less toxic lifestyle, correct, generally?
A. Yes. That's part of the avoidance.
Q. And when they -- and if they want to buy or are directed to buy certain products carried by the foundation, does that happen?
A. Not necessarily. I mean, we give them generic what they might, might be able to use. They can get it anyplace they want.
Q. And do you tell them that if they decide to get a product from the foundation, do you disclose that there is -- at least you have some involvement in that?
A. Well, they know that. Everybody knows that. We set it up to help people, so I guess, yeah.
Q. But my question is really specific --
A. It's not a self-dealing thing, if that's what you're asking.
Q. I'm just asking you if --
MR. SIMON: That's what he's asking.

THE WITNESS: I know.
Q. What I'm asking you, Doctor, is, do you tell them, hey, I've got an interest in, or I am part of the foundation, when they go over there potentially to get products?
A. No, I don't tell everybody, no. But we do give them information on the American Environmental Health Foundation, and they would get it in that.
Q. Now, there's also -- as a part of the foundation, and you talk about some of the products now -- changes to the home. What do you mean by that? What are you talking about when you say changes to the homes and products to change the homes?
A. Well, for example, one lady from Brooklyn, I guess we're going to discuss. They found gas in her house, gas leaks, and she was made ill by that. And we recommended that they get it fixed. And that was -- somebody in Brooklyn did it.
Q. Right. And I guess so my question is, something like that is not necessarily -- you're not selling them the gas pipeline to stop the leak, are you?
A. No, I sure am not.
Q. Okay.

A. And particularly in Brooklyn.
Q. We're not going to touch that.
I'm just trying to understand, because the products, you described. But then you said changes to the home, so I'm trying --
A. Well, yeah, you asked that. That's of course one of our big ones, gas leaks in the home.
Q. Okay. But you supply products that they can't get otherwise to help change the home. What kind of product is my question, Doctor?
MR. SIMON: When you say "you," you mean the foundation, correct?
MR. FRESHOUR: Right, the foundation.
MR. SIMON: Because otherwise I object to the form.
A. I want to qualify that, because some of society has caught up with us now. And our getting -- many stores are getting these things in there. So it's more of a convenience now for patients. Whereas, before, it was a necessity, you see. Although we keep trying to stay on the cutting edge of what's new and innovative and get them there first so people can -- hopefully society will --
MR. SIMON: So he's asking you what type of products.

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THE WITNESS: And that's what I'm saying.
A. We have nontoxic paints, we have nontoxic pillows, we have nontoxic blankets.
MR. SIMON: Now you have them all over.
THE WITNESS: Yeah.
Q. Now, what is the William J. Rea defense fund?
A. Oh, that's a fund set up to help fight you guys.
Q. Okay. And that's paying for your experts, is that correct, do you know?
A. No, it's not.
Q. Okay. The foundation is paying some of your costs, though, for the defense in this lawsuit, is that correct, or this contested case proceeding?
A. No, that's incorrect.
Q. Okay. And so if it's not being used to defer or defray some of the costs of this, this action between the medical board and yourself, what was it started for, Doctor?
A. Well, you said -- as I understood your question was that the foundation was paying, it was part of the foundation. It's not part of the

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foundation.
Q. Okay.
MR. SIMON: The defense fund has nothing to do with the foundation. that's what he's trying to explain.
A. That's what I'm trying to say.
Q. Okay. The defense fund has nothing to do with the foundation?
A. That's right.
Q. But there is a William J. Rea defense fund, correct?
A. Yes.
Q. And the William J. Rea defense fund -- and we'll call it "the defense fund," if we can agree. How is that?
A. That would be fine.
Q. So the defense fund was set up to help defray the costs in this action, correct?
A. That's correct, yes.
Q. And the defense fund is paying for the cost of the experts that you're using in this case; is that true?
A. I don't recall. I think I paid out of my own pocket.
Q. Is the defense fund, is the -- are you

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getting any kind of compensation or payment for being here today from the defense fund?
A. No, I'm sure not.
Q. So -- and is, is it true that at least some of the contributions are coming from your patients into the defense fund?
A. Yes. We have a lot of grateful patients.
Q. And are you in -- have any position in the defense fund? And what I mean by that, are you the administrator? Do you oversee the contributions, the expenditures?
A. No.
Q. Is anyone associated with the clinic in charge of that?
A. Yes.
Q. Is anyone associated with the foundation --
A. No.
Q. -- involved?
THE WITNESS: Chris.
Q. And the individual involved with the defense fund at your clinic, it is not you; is that correct?
A. That's what I said.
Q. Okay. So if patients are contributing to that, is it fair to say that your patients are not

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only paying for your medical services, but they're also paying some of you legal costs?
MR. SIMON: Object to all of this.
I'm going to direct you to stop answering this because that's, again, on the grounds that I am protecting your due process rights to a procedural investigation by the board into anything else.
MR. FRESHOUR: Certify that question.
Q. Doctor, I want to ask you some general questions. You would agree that by issuance of a medical license, to you or any other physician in the state of Texas, that that's, that's a privilege granted by the state, correct?
MR. SIMON: Object to the form. Calls for a legal conclusion.
Q. You can answer, Doctor.
A. Well, it's -- yes, okay, I would say it was, probably.
Q. And would you also generally agree that by accepting or being issued a license, there's an agreement that you're going to comply with the rules and statutes regulating the practice of medicine in the state of Texas?
MR. SIMON: Object to the form. It

calls for a legal conclusion.
Q. You can answer, Doctor.
A. Yes.
Q. And as a general proposition, Doctor, would you agree that if there are a number of different causes that have been identified that are known to cause a disease, that would be considered multiple causal agents versus a single causal agent, correct?
MR. SIMON: Object to the form.
You can answer if you understand.
A. Yes.
MR. FRESHOUR: Mr. Simon, on what basis do you object to the form of the question?
MR. SIMON: I just didn't understand what it is that you're asking. It's a compound question.
Q. You understood it, didn't you, Doctor?
A. I thought I did.
Q. Okay.
MR. SIMON: If he understood it, of course.
Q. And there's clearly a difference between having a singular causal agent and multiple agents, correct?
A. Yes.

Q. Okay. And "multiple" means more than one, correct?
A. Yes, it does.
Q. Okay. How do you define "chemical sensitivity," Doctor?
A. The adverse reaction to the ambient dose of -- or toxic dose of ambient chemicals, in air, food and water.
Q. So it can be either the ambient dose or a toxic dose of whatever the chemical agent is?
A. Agent or agents.
Q. Right. And, Doctor, I'm not going to play semantics with you, but isn't it fair to say that in most of your patients in general and in these five fairly particularly, that we haven't discussed with any detail yet, is that they were sensitive to multiple chemicals as far as your opinion?
A. Yes, that is correct. That's why they came here.
Q. Right. Now, it is accurate, then, to say that they have sensitivity to multiple chemicals, correct?
A. Yes.
MR. SIMON: Objection, form.
A. But I would have to go through each

chart to --
MR. SIMON: Semantics.
A. Semantics, yeah.
Q. Well, how do you define "multiple chemical sensitivity," Doctor?
A. I don't.
Q. Why not?
A. Because it was an erroneous definition by the guy from Yale in which he said there were no physical signs and no laboratory. Totally wrong. So I never use the term, if I can help it, of multiple chemical sensitivity.
Q. And the guy at Yale, that was Cullen, wasn't it?
A. Cullen, yeah.
MR. SIMON: Cullen.
Q. So you don't agree with the term "multiple chemical sensitivity"?
A. I do not.
Q. But your patients suffer from chemical sensitivity from multiple chemicals; is that fair?
A. Well, generally. I mean, there are some that's just one. But generally that's true. That is a difference.
Q. Okay. What are the symptoms of -- well,

withdraw that question.
Doctor, are you aware that the AA -- the American Academy of Environmental Medicine website uses the term "multiple chemical sensitivity"?
A. Was not aware of it.
Q. What is clinical ecology? Define that for me generally in your own words, Doctor.
A. I can't, because it doesn't exist anymore.
Q. I'm sorry?
A. I said I can't. It doesn't exist anymore.
Q. Anymore?
A. Yeah.
Q. It did exist at one time, did it not?
A. Yes, it did. I've never used the term, so I...
Q. You never used the term?
A. No.
Q. What did you understand it to mean?
A. Study of the effects of the environment upon the individual.
Q. Why didn't you use the term, Doctor?
A. Just wasn't any need to.
Q. Why not?
A. I don't know.

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Q. Did you know -- are you familiar with an individual, I believe it's Theron Randolph?
A. Yes, he's one of my teachers.
Q. Didn't he coin the term "clinical ecology"?
A. Yes, he did.
Q. And before there was -- and in fact, I think we talked about it earlier, the American Academy of Environmental Medicine was the Clinical Ecology Society before it became the AAEM, right?
A. That's correct.
Q. Okay. Were you ever a member of the Clinical Ecology Society?
A. Well, I think -- if the name changed before '74, then I -- as I said, I think I joined that academy in '73, so I don't recall whether it was called that or not at the time.
Q. Have you ever heard the term "idiopathic environmental intolerance"?
A. Rarely, yes. I have heard it.
Q. Do you know what that means in your --
A. No, I don't know what it means.
Q. Well, what does "intolerance" generally mean to you, Doctor, from a medical standpoint?
A. It means you can't tolerate something.
Q. Okay. And isn't it fair to say that your

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patients, at least that you've seen, we're going to talk about in this case, have some problem with tolerance of chemicals, in your opinion?
A. Yes, not idiopathic.
Q. Okay. Well, what is idiopathic?
A. It means you don't know.
Q. And you know -- so you're saying you don't use that because you know why they're intolerant?
A. We're dedicated to find out why people can't tolerate different substances, that's right.
Q. You're dedicated to that?
A. Yes.
Q. And "you" being your clinic?
A. Our clinic --
Q. Your foundation?
A. -- foundation, many other doctors around the world.
Q. Okay. Do you yet have a specific answer in your dedicated research to what some of your patients are intolerant to, Doctor?
A. Yes, we certainly do.
Q. Is that the environment in general, Doctor, or is there something more specific?
A. Well, I think there's something more specific.

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Q. Anything in particular, as far as specificity, or is it different for each patient?
A. It's all totally individual, yes.
Q. How do you distinguish chemical sensitivity from multiple chemical sensitivity?
A. I just said.
Q. Say it again, please, sir. I guess I missed it.
A. That according to Cullen, multiple chemical sensitivity has no physical findings and no laboratory data. Chemical sensitivity has physical findings and laboratory data.
Q. And so the physical findings you're talking about, is it fair to say that they can be a wide and varied and somewhat vague constellation of symptoms in a lot of the patients?
A. Not vague, no. But sometimes it can be widespread. But there are symptoms involved usually.
Q. Symptoms, symptoms?
A. Well, I don't -- the symptoms aren't vague.
Q. And when you say "the symptoms aren't vague," just generally describe, because I'm not a doctor, what do you mean they're not vague?
MR. SIMON: Is that patient specific? Object to the form.

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A. I was going to say we can take these patients here.
Q. Well, I'm not asking you about these patients, though, right now, Doctor. I'm just asking you generally.
A. Well, if you've got runny eyes, you've got runny eyes. If you've got heart irregularity, you've heart irregularities. If you've got bloating, you can see it. If you've got diarrhea or constipation, you can see that. If you've got spontaneous bruises all over you, you can see that.
Q. Okay. So they're not vague because they're observable or you can see them?
A. That's correct, yes, uh-huh.
Q. Okay. And although you can identify those symptoms, isn't it also fair to say that the exact causal agent of those could be varied, as well, Doctor?
A. Absolutely.
Q. Could you distinguish for me how the practice of clinical ecology and the underlying theories -- you're familiar with the underlying theories of clinical ecology, are you not, Doctor?
A. I don't know what you're referring to.
Q. Are there some theories that underlie the

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practice of clinical ecology that you're aware of from Dr. Theron Randolph?
A. Well, I don't do clinical ecology, so I don't know what theories you're talking about.
Q. Well, although you don't do clinical ecology, you did, you were a student of Dr. Theron Randolph, correct?
A. Yes, that's correct.
Q. And he coined the term "clinical ecology," correct?
A. Yes, I think he did.
Q. And there were some theories or -- there were some theories or underlying medical beliefs that he held about what caused these symptoms that were known as clinical ecology, correct?
(Mr. Cook enters the room)
A. So you're asking me to tell what Dr. Randolph's theories were, are you?
Q. I'm saying are you familiar with them?
A. Well, I don't know what you're talking about. I, I could do it if you could put it in the form of modern medicine. I'll be glad to do it. But you're asking me, a man that I studied from at least 40 years ago.
Q. Right.

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A. And it's hard to, hard to say what theories you're talking about.
Q. The theories underlying the terming or the usage of the term "clinical ecology."
A. Well, I can just say this.
MR. SIMON: That was asked and answered. He told you he can't answer the question.
THE WITNESS: Do you want me to or not?
MR. FRESHOUR: Under Texas Rules, Mr. Simon, objection, form, otherwise it's coaching. I'd ask you to refrain unless I ask you the basis.
MR. SIMON: Yes, sir. I object to the form.
Q. So let me ask it this way: You do not know what the underlying theories of clinical ecology are; is that correct, Doctor?
A. I don't know what you're talking about.
Q. What, number one is the theories or the clinical ecology, Doctor?
A. The clinical ecology. I do know this, and I will say this, that Dr. Randolph felt that there were many things in the environment that affected the individual. So it was an environmental problem and it was an individual problem. Now, what you're

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talking about theories and everything, I don't know.
Q. Well, then let me ask you this: You do have an opinion and you have developed some thoughts and theories on what causes chemical sensitivity in your practice, correct?
A. Yes, that's correct.
Q. Okay. And could you distinguish for me how your theories for chemical sensitivities differ from that of multiple chemical sensitivity other than in name itself?
A. I believe I answered that twice now.
MR. SIMON: Answer it again.
A. That people with chemical sensitivity have objective physical findings and objective laboratory tests. People with multiple, according to Cullen, don't have.
Q. I'm not asking according to Cullen. I'm asking you, as you understand multiple chemical sensitivity and you've used the term versus your theories of chemical sensitivity, how they differ other than in name alone as far as manifestation of symptoms and causal agents.
MR. SIMON: Objection, form.
A. Well, I believe I just said, physical findings. You've got a runny nose, according to the

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definition of multiple, you don't have a runny nose. It's all in your head. You've got a heart irregularity, okay, according to us, you can record that with a cardiogram. And you can record it on x-ray sometimes, angiograms. You can record it on all kind of technology. According to a multiple definition, you can't find that. There's no symptoms, no signs. So that -- I still hold to that, okay? And always have. Otherwise you make it into the psychiatric realm or some voodoo realm, which I don't do.
Q. Well, you believe that psychiatry is a bona fide field and area of practice of medicine, don't you?
A. Yes, I do.
Q. Have you ever used the term "allergic depression," Doctor?
A. I don't recall, but we do see patients that are depressed, put it that way.
Q. In general, when your patients come into you, Doctor, do you do any kind of psychiatric testing or screening on your patients generally?
A. Well, we do screening. I don't do psychiatric testing. I either send them to the psychiatrist or the psychologist.

Q. Do you think if a patient articulates suicidal ideation, that they require psychiatric treatment?

A. Well, they require treatment. You know, if I had a busted neck and was paralyzed down on my -- from my neck down, I might have a suicidal depression. But I would say you found the cause, and I don't care what kind of psychiatric care you got, it wouldn't help you.

Q. Okay.

MR. FRESHOUR: Objection, nonresponsive.

Q. Let me be sure that I was clear on that question, Doctor.

A. Okay.

Q. If someone comes into your clinic and expresses suicidal ideation, do you think they should be looked at from a psychiatric standpoint?

A. Sometimes, yes. Sometimes, no.

Q. And how do you make that differentiation?

A. Clinical, human.

Q. So you can tell if somebody's suicidal ideation doesn't require psychiatric treatment by talking to them?

A. Generally you can, yes.

Q. Have you ever looked at your patient population just even in an informal capacity and tried to correlate the frequency or presence of psychiatric comorbidities on your particular chemical sensitivity patients?

A. Well, I had Professor Butler at the University of North Texas who worked with me for 15 years on patients like that, yes. And what we found was that most of them didn't have psychiatric problems. Although there was a small group that did.

Q. And I take it that you're also familiar with the literature that says the opposite by a Dr. Stottlemyer, who I believe is a Ph.D. Are you familiar with that?

A. Yeah, I'm familiar with it.

Q. I take it you don't agree with that, do you, Doctor?

A. No, I sure don't.

Q. Well, Doctor -- and I don't mean to characterize or trivialize. But is it fair to say you don't agree with anybody who doesn't believe that chemical sensitivity is a disease in the manner and method that you describe as a practitioner and in your books?

A. I'm sorry, that's a little too complicated

for me. I wonder if you could rephrase that a little bit.

Q. I'll just withdraw that question, Doctor. We'll proceed on.

I want to kind of change gears a little bit, Doctor. These are more -- this is just kind of general, going back to some of the medical practice in general, okay?

A. All right, sure.

Q. You would agree that you or any physician, regardless of the area of practice, are required to keep medical records, correct?

A. That what?

Q. Are required to keep medical records?

A. Yes. We keep voluminous ones.

Q. And the records, they need to be true and accurate, correct?

A. Correct.

Q. And we could also agree that the records should contain pertinent, relevant or salient findings that you make as a physician, regarding the patient, correct?

A. Yes, that's correct.

Q. And we can also agree that the records themselves cannot be a verbatim of the entire

discussion?

A. That's correct, yes.

Q. Not like they're doing to you and I today, Doctor, your medical record wouldn't look like that.

A. That's correct.

Q. You know, patient Smith said, good morning. Dr. Rea said, now it's afternoon.

A. Yeah.

Q. But you put in the salient and the pertinent facts?

A. We try to, yes.

Q. Okay. And also you would agree that -- and I think you hit on this earlier -- part of an adequate medical record includes a history and physical?

A. Yes.

Q. Particularly upon initial visit and presentation, correct?

A. Yes, right.

Q. History should include things like prior surgeries?

A. Correct.

Q. I think you're going to agree with a lot of this, Doctor, but please say "yes" or "correct" and don't nod your head.

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11:55:46 A. I did say "correct."
Q. I know, but I noticed you started to nod and then said "correct" for the court reporter.
Any description of allergies known to
11:55:55 any kind of medications or medicines?
A. True.
Q. Whether they're a smoker, a drinker?
A. That's correct.
Q. Illicit drug use?
11:56:05 A. (Nods head)
MR. SIMON: Yes?
A. Yes.
Q. Other comorbidities like diabetes, thyroid disease?
11:56:14 A. Yes.
Q. You would also agree that one of the purposes of the medical records is to allow for continuity of care; is that fair, Doctor?
A. Yes.
11:56:33 Q. And what we mean, I think, by that, and correct me if I'm wrong, that means it would allow a subsequent health care provider, normally thinking of another doctor, but even, say, if it was a mid-level, they could at least pick up the medical record, read
11:56:50 it and have an idea of what had been done to the

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11:56:53 patient and what the treatment rational was, what their current perhaps regimen of care and treatment was, correct?
A. To a point, yes, that's correct.
11:57:03 Q. And, again, they can't necessarily know all of the discussion, but it should give them a pretty good idea, correct?
A. Yes, that's correct.
Q. And, again, this is just in general,
11:57:31 particularly I think with your patient population. Do you believe that it's important to have an exposure history?
A. Oh, yes, of course.
Q. And in your particular area of practice,
11:57:49 would it be fair to say that if there wasn't an exposure history, that might be an inadequate record, given the patient population you're dealing with?
A. That might be true, yeah.
Q. Now, if you take an exposure history
11:58:06 generally, Doctor -- and I assume you take them with most, if not all your patients, correct?
A. Correct. And we take it daily, because they recall different things different days.
Q. And is there -- how do you go about
11:58:24 verifying some of the exposures that are claimed, or

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11:58:28 can you?
A. Well, some of them, you can verify; some of them, you can't. Sometimes you can -- like, for example, somebody comes in, they say they've been
11:58:34 exposed to mold, you can sometimes send out mold plates to their house and see if you can culture the molds. If they've been in an industrial exposure, where they work in a job that let's say puts out paint, that they're painting, constantly painting,
11:58:54 you can usually verify that. Sometimes if they work at refineries, which a lot of people from Houston do, you can verify -- like, for example, I've had people come in that worked in the xylene unit. Well, you know they got exposed to xylene if they worked on the
11:59:11 xylene unit. And so on down the line, you know.
Q. And let me ask you just with a little bit of specificity -- I know we talked earlier. Mold exposure, we're getting exposed right now, aren't we, Doctor?
11:59:27 A. I don't know, because I haven't measured this place.
Q. Well, isn't there mold in the ambient air, Doctor?
A. Yes. But sometimes indoors, there are
11:59:38 areas indoors that there are not.

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11:59:40 Q. By and large for the most part, isn't it fair to say that if you go to just about anybody's home, and absolutely if you walk outside, you're going to be exposed to mold today, are we not?
11:59:51 A. Is that a two-part question?
Q. Yes, it is.
A. Okay.
Q. At the house --
A. Outside, definitely, because that's the way
11:59:55 nature disintegrates. Inside, not necessarily. We've measured thousands of houses now, and we have many that have no molds in them and then we have others that have high levels of molds in them.
Q. What does it mean -- and you said a little
12:00:15 bit earlier, and I think just for the record, what do you mean when you say -- you used the term "ambient." What do you mean when you say -- I think it was in connection to an ambient level of chemicals.
A. "Ambient" means your surrounding.
12:00:33 Q. Okay. Is ambient the same thing as a background level, or is that different?
A. No, it's probably a little different. And the background could be just in that particular area; whereas, ambient is surrounding you.
12:01:11 Q. Back -- and, again, that was -- just kind

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of veered off there on the molds for a minute. I just wanted to verify that.

Is there a difference between having a mold exposure and an infection from a mold?

A. Yes.

Q. They're really quite different medically, aren't they, Doctor?

A. Sometimes, yes.

Q. Well, is it -- and I would need you to just make that distinction for me, because I really don't understand, Doctor. You said sometimes an exposure is different than an infection. Can an infection and exposure be the same thing?

A. Yes.

Q. Help me, because I really don't understand what you mean, Doctor.

A. All right, look, you've got mold here, you've got infection -- and the person is healthy, okay, but you've not infection over here, and this patient got too much mold so they have a mold ball in their lungs or they have it in their bronchial tubes or they have it in their sinus or so on. They can have an allergic reaction to it, a hypersensitivity reaction to it, or they can have a flat infection where the temperature goes to 105 and, you know, they

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can die from it.

So, so that's what I'm trying to distinguish for you. Everybody who lives gets exposed to mold. But mold doesn't always hurt everybody.

Q. Now, in the example you just gave, there would be someone who has a mold ball or -- is it hypersensitive pneumonitis, is that what you're talking about?

A. Well, that's one thing. No, I wasn't talking about that, but that certainly occurs with different molds, yes.

Q. Right. But those are the existing fungal infections that have been caused by a mold, but it's different than just simply being exposed, they now have an identifiable infection, correct?

A. That's correct, yes.

Q. Generally if you and I were tested today, Mr. Simon and Mr. Cook, I see he's joined us, if any of us were tested today for probably an IgE antibody for molds, we would probably test positive because of living in the world, correct?

A. Wrong.

Q. Wrong?

A. Right.

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Q. Okay. So not everybody would have an IgE positive test?

A. That's correct.

Q. If I represented to you that Kaye Kilburn in a different case has testified that he doesn't believe in using IgE testing because everybody tests positive, you would disagree with Dr. Kilburn, then?

A. Yes, I would.

Q. Do you use IgE testing for your mold patients, Doctor?

A. Yes.

Q. What laboratory do you use now for that, do you know?

A. I think it's Quest.

Q. Okay. And we covered this, but before they got in trouble, you used Immunosciences Labs for that kind of testing, correct?

A. No.

Q. You did not?

A. No.

Q. You didn't use them at all for mold testing?

A. No, I didn't say that. I said I used them for some mold testing.

Q. Some mold testing?

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A. Yeah.

Q. You're also aware that some of what they got in trouble in California for, was mold, their mold testing parameters? Were you aware of that?

A. I'm not aware of the intricacies of that problem.

Q. Okay. So you really didn't know anything about --

A. No.

Q. -- the problem at all? Okay.

A. Well, I knew they had a problem.

Q. Would you agree that just because you've had a positive IgE test for a mold antibody, it is not necessarily medically -- it is not medically necessary to treat that person for the mold exposure alone, is it?

A. If they had a -- are you talking about a low level IgE?

Q. Well, just a positive -- just generally, generically a positive IgE, meaning it showed that there were some antibodies.

A. Well, not without symptoms, of course.

Q. So it takes more than just the test, there has to be clinical correlation --

A. You've got to be a doctor, yes.

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MR. FRESHOUR: I think this is probably a good break point.

THE VIDEOGRAPHER: The time is 12:05 p.m. This is the end of tape number two. We are going off the record.

(Recess from 12:05 to 12:15)

(Mr. Cook did not come back)

THE VIDEOGRAPHER: The time is 12:15 p.m. This is the start of tape number three. We are on the record.

Q. All right. Dr. Rea, we're back, we've taken a break. We had just talked a little bit with a little specificity, not a great deal, a little specificity about molds. You recall where we ended, correct?

A. Yes.

Q. As a general proposition, Doctor -- and again, this is general, so please keep that in mind when I phrase this question. Would you agree that we as people here today in this office or in the city of Dallas are exposed to many different things, molds, possibly chemicals, pollutants of all sorts, generally? Is that fair?

A. Yes.

Q. And is it also fair to say that just

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because we are exposed -- again, on a general term -- doesn't mean that a sickness or any kind of disease is necessarily going to result from that exposure, correct?

A. Yes, that's correct.

Q. Okay. I just want to explore some of the information that we hit on with molds just a little bit more, okay, Doctor?

A. Yes.

Q. I don't even know. There's probably, what, hundreds of thousands of different molds in the world?

A. Yes, I think there are.

Q. And all kinds of -- they would be genus and species of all different kinds, correct?

A. Yes, that's correct.

Q. And molds -- we hear the term sometimes, and we've heard it a lot recently in recent years, black mold. Are you familiar with that?

A. Yes, I am.

Q. And technically -- and correct me if I'm wrong -- black mold really is somewhat of a misnomer because there's a number of molds that are black; isn't that also correct?

A. Yes.

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Q. Okay. The one that most people think about or the one that's got to the headlines is Stachybotrys, correct?

A. Yes, that's correct.

Q. And -- now, what is a mycotoxin?

A. It's a -- it's the mold's defense that it puts out to stop or kill other molds or bacteria or virus. Penicillin is a great example of mycotoxin. So we've learned to harvest some of the mycotoxins to help us.

Q. Okay. Do you know, do all molds produce a mycotoxin?

A. I think the majority of them do. I think this is nature's way of defending. Some of them are rather benign, others are rather virulent.

Q. Right. And -- so just the generic term "mycotoxin" really doesn't carry a lot of specificity? Could we agree to that?

A. Yes, that's correct.

Q. So if somebody says they've been exposed to mycotoxins, it might mean something and it might not, correct?

A. Yes.

Q. And that would go back to what was the mold species that generated the mycotoxin and a number of

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steps in the inquiry to make any kind of determination if there was medical significance with that mycotoxin, correct?

A. Yes, that's correct.

(Brief interruption)

Q. Now, you can visualize molds if there's a fairly large -- I guess they call them colonies, is that correct, Doctor?

A. Yes, that's correct.

Q. That's where, you know, you look, it can be green, it can be black, it can be red, you just see it, correct?

A. Yes, that's correct.

Q. We had a little bit of a discussion. If there were some mold right now airborne in this room, we wouldn't be able to see the mold airborne unless it was just a huge concentration; is that true?

A. Yes.

Q. And wouldn't it also be true, unless it was just a huge, huge amount, it would be very difficult to see out in the ambient air of the outside? You wouldn't necessarily really see the mold, would you?

A. Well, you can see it usually on buildings or grass or pavement where there's a lot. Like, for example, buildings would get colored, you might see

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some black mold growing on that or green mold or so on. But if you look out here, just look out the window, you could not see it.

Q. Right. Just generally to the naked eye, you couldn't look and say, well, gee there's a bunch of mold blowing between, you know, my house and Mr. Simon's house, if we were neighbors? We wouldn't necessarily be able to do that?

A. That's correct.

Q. And as far as it relates to the identification of -- in like serum blood testing, like an IgE, IgG -- I think it's IgM is another one. Am I correct on that, Doctor?

A. Yes, that's correct.

Q. When you run those tests, let's say for a mold in general -- let's use an example, Stachybotrys, since everyone, I think, has probably heard of that one.

A. Okay.

Q. The positive test, a blood serum positive IgE test for Stachybotrys, doesn't necessarily -- is not able to let you quantify or exactly pinpoint the time of the exposure or the extent of it. Is that true?

A. Yes.

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Q. I mean, you can say you've been exposed --

A. That's all you can say.

Q. And I think, isn't it -- the IgE shows a more recent, and an IgM usually is a longer exposure? Or am I wrong on that?

A. The IgE is the hypersensitivity response to exposure. The IgM is the initial exposure. The IgG is the secondary exposure.

Q. Okay. Thanks for that, Doctor.

And we've been talking a lot, Doctor, and what does it mean -- and I think we need to pin these terms down. What does it mean when you say "exposure," what is your definition of "exposure"?

A. Came in contact with.

Q. What is generally from a -- what does "duration" mean when you're talking about exposures?

A. Time of exposure.

Q. Length of time?

A. Yes, length of time.

Q. Okay. And we've already talked about ambient. What does "concentration" mean when you're talking about chemicals? And I think you said a little bit earlier, we were talking about ambient and everything, that deals with the concept of concentration, correct?

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A. Yes.

Q. And what is "concentration," Doctor?

A. Well, "concentration" is the amount that you -- you're talking about exposure?

Q. Right.

A. The amount that you might be exposed with. For example, on, say, benzene you might get one part in one person. You might get a 1,000 parts per million in another person. That would be a change of concentration.

Q. And also when we talk about concentration as it relates to chemicals, you're talking about the amount that the person may have been exposed to in a -- potentially a discrete event, correct?

A. Well, either discrete event or long-term. You could have either.

Q. Right. But right now I'm saying concentration can be defined as the amount that was present at a discrete event?

A. Yes, you could say that.

Q. And there's certainly, again -- and I'm not -- there is also a concentration, potentially long-term, depending on the source of the exposure, where you are and a number of factors, right?

A. That's correct.

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Q. And the thing is, with all of this chemical exposure, there are multiple factors that go in that have to be looked at in making those kind of determinations?

A. Which kind --

Q. Chemical exposures, there's all kinds of factors, concentration, dose, duration. All of those go into it, correct?

A. No.

Q. Okay.

A. If, if you've got exposure, you've got exposure. I mean, then if you want to quantitate it, then the concentration and all of these other things come into it. But let's say you've got an odor -- you know, perfume, you've got exposure, it doesn't matter the concentration. You can perceive it, okay?

Q. Okay. So there is the exposure.

A. Yes.

Q. Because you could perceive it. Let's use your perfume example.

A. Right.

Q. But that alone, because I could smell it -- say, in your area of practice, that alone is not enough to make a medical determination of whether or not I have chemical sensitivity, is it?

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12:26:14 A. No.
Q. And you couldn't make a determination that I perhaps had some kind of -- other than smelling it, that I had any kind of adverse reaction to perfume
12:26:24 with just saying I smelled it, correct?
A. That's right.
Q. And to, to be able to make a further determination, you as a physician, would want to know if you can determine it, the duration of the
12:26:37 exposure, correct?
A. Yes.
Q. And you would like to know, if you can, the concentration of the exposure coupled with the duration, correct?
12:26:45 A. If you can. But frequently you can't.
Q. Exactly.
And there is a relationship between the concentration of the agent, that being -- and the length and duration of the exposure, as far as --
12:26:57 well, there is a relationship between concentration and duration as it relates to making some determinations medically, possibly?
A. Well, it's possible. It doesn't have to be. Yes.
12:27:11 Q. What is a dose response curve?

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12:27:14 A. Well, dose response curve is one of the basic premises of the old toxicology in which, for example, you take a drug or you take a chemical, and the stronger the dose, the more problems you have
12:27:34 until it exceeds the threshold and then you get ill or toxicity occurs. But there are other dose response curves now that have been shown, and these are the J curves and U curves or the hormetic effect which occurs in about 50 percent of the chemicals.
12:27:52 And so you have to take that into consideration also.
Q. Do you know generally, is there a -- is it true that there's no proven dose, no proven dose exposure relationship in your chemical sensitive patients?
12:28:11 A. I guess that's -- I'm unclear what you mean by that.
Q. Okay. Well, let me try to be clear, Doctor.
A. Okay.
12:28:20 Q. Isn't it true that there -- well, let me ask it this way: Isn't it true that in the -- in most or a lot of your chemical sensitive patients that you see, that you cannot pinpoint the duration or the concentration of the exposure that they were
12:28:42 subjected to?

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12:28:43 A. Well, you can usually pinpoint the exposure. But you can't pinpoint the concentration other than grossly. For example, somebody says, I've got a -- somebody just put on a lot of perfume and
12:29:03 they got sensitive to it, okay. Well, you know it was a high concentration for that patient. But you can't always do that. You can just always say they've been exposed, okay.
Q. So you can try, you can try or attempt to
12:29:30 pinpoint the exposure, but it's much harder and it's hard to pinpoint the concentration, correct?
A. Yeah, that's correct.
Q. And is it also hard to pinpoint the duration of the exposure in most of your patients?
12:29:46 A. Well, no, a lot of people can tell you, hey, in five minutes, if I'm exposed to formaldehyde, I always get a runny nose and I always get a headache. Other people tell you that they don't know and it may go on for an hour before they have
12:30:01 problems. A lot of the patients I see have already been problems -- at treatment for years, and a lot of them really know the time of exposure that can occur before they get sick.
Q. Well, and isn't it true that at least in
12:30:20 some of these patients we're going to look at, the

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12:30:23 exposure can range anywhere from minutes to years?
A. I don't -- now, are you talking about the cause of the chemical sensitivity or the triggering? It's two different things, okay?
12:30:38 Q. Okay. I will represent to you that when I talked to Dr. Ross in deposition and Dr. Meggs, they say that the exposure that can result in these people becoming chemical sensitivity can be anywhere from a couple of minutes to years in length.
12:30:57 A. Causing the chemical sensitivity?
Q. Right.
A. Yes, that's correct. That's why I was asking you the cause of the triggering agent.
Q. Right.
12:31:03 A. Triggering symptoms.
Q. Right. And what about the exposure time for triggering symptoms?
A. Well, usually it's acute to within 24 to 48 hours.
12:31:27 Q. And is it also true in these patients that the concentration that they're being exposed to can be a high concentration or a low?
A. Depending on the individual. That's the biochemical individuality response.
12:31:42 Q. And is it fair to say that in at least

these five patients that we're going to look at today, that your determination is it was a long-term low-dose exposure that led to their chemical sensitivity, generally?

A. Well, with the exception of J.S. She had five distinct exposures that were rather acute, although they were cumulative, I think. So -- and if you want to look at it that way, your premise would be right, okay?

Q. And we hit on this a little bit earlier. But the exposure is to a multitude of agents with these patients?

A. Yes.

Q. Chemical agents?

A. Yes, we've seen them. And physical, too.

Q. And I think it's correct to say that in all five of these patients, the records are devoid of any articulation of a specific concentration of any particular chemical. Is that true?

A. I, I don't recall whether that's the case or not. I'd have to go back and see.

Q. And I'm going to go through the patients with a little bit of detail on that, Doctor. But if I represent to you generally that as -- going through the records there was no concentration really

specified for any of the patients from a historical perspective, does that sound right?

MR. SIMON: Object. That was asked and answered.

A. Yeah, I can't say any more than that, okay?

Q. And do you recall that in these five patients that the records don't specify the length of any particular exposure or -- let me rephrase it. The duration to any particular exposure that led to the chemical sensitivity.

A. Yes, there were some.

Q. There were?

A. For example, J.S., she was exposed for about a year in a basement that had a gas leak. She was exposed to the 9-11, she lived right there. So that exposure lasted, what, two months or so, as I understand it. It was acute and then it, the ambient air was contaminated at that time. And there may be -- for example, Liz Qudell (phonetic) had a problem where she lived in a house with -- the house next to it was moldy and she could smell that mold coming in for a year. So there were some timelines in there that did make them either worse or brought them down. I'd say the majority, probably they weren't.

Q. And isn't it also correct that in -- in all of these patients, there is, there is not one chemical that you can specify in your records that actually caused these problems or triggered these problems?

A. No, that's not true.

Q. There's a specific trigger or causing chemical identified in your records?

A. Yeah.

Q. We can go in -- and I'm just asking you, Doctor -- go in and say, for example, on A.R. -- and I'm going to use initials.

A. Yes.

MR. FRESHOUR: And for purposes of the record, Jacques, if we use names, can we agree to just edit them to initials?

MR. SIMON: Please.

Q. A.R., you could go in and say, there it is, she was exposed to -- now I'm going to have to grab a chemical out of here -- xylene on or about this day that caused all the symptoms?

A. Well, we can't say it caused all the symptoms. We can say it caused symptoms. And that's true of some of these patients. Yes, I can tell you those in the charts do show that.

Q. Okay. Doctor, I've marked what's Exhibit Number 1, Doctor, and I think Mr. Simon has probably shown this to you, and I imagine at some point you probably discussed this. This is the notice to take deposition. And attached to that was a request for some records. Are you familiar with that, Dr. Rea?

A. Yes.

Q. Okay. And for purposes of the record, too, Mr. Simon and I have had a discussion, and we agreed that I didn't need you to bring up your books. I'll represent to you, Dr. Meggs had brought them in at a deposition. I think Dr. Ross may have brought them in. I think Dr. Holland had -- or one of the doctors I think had some of them that were my experts. Same thing with medical records, and I think we'll go through those today.

A. I did bring them. They're in my car. But, as you know, there's a mass of records.

Q. And I'm not asking for that.

The records I want to focus in on is, did you bring any records today related to any standard protocols, procedures for antigen preparation?

A. Yes, I did.

Q. All right. And Mr. Simon is handing me a

notebook, and I assume these are the responsive records?

A. That's correct, yes.

Q. Okay. And just looking through these, the other thing I asked for -- and you can perhaps tell me without going through all of these. I also asked for -- if you had had any independent laboratory tests where you sent out any of your preps for -- or your preparations for your antigens to be looked at and broken down by their actual components and concentration. Did you have anything responsive to that, Doctor?

A. I don't think I did. You have to remember some of this has been so long ago that we started this, that we may have, but I don't have the records of it if we do, okay?

Q. And, Doctor, one of the things -- and again, I'm looking through this -- is before Mr. Simon came on the case, I'll make this very clear, I think -- and before I came on the case, I think some of this has been asked for before, perhaps not in -- and it wasn't responded to. So that was one of the reasons I was looking for --

A. Oh, no, I responded to everything that was asked for. If we overlooked it, nobody ever asked

us, because we certainly have it, you know.

Q. Now, my question is, looking at these, and it shows protocol for 1995, these have been in existence since '95 in this very form, or is this in a changed form or --

A. No, in this form. We have -- you know --

MR. SIMON: Do you want to mark this?

A. We followed this very rigidly, okay?

Q. And this is in -- and you say "we," we're talking about the clinic and your lab that you --

A. That's correct, yes.

Q. Now, your in-house lab doesn't have any kind of a CLIA certification, does it, Doctor?

A. We've got some kind of certification. I can't remember which it is, okay. I could call and find out. But I don't -- if it's really important.

MR. FRESHOUR: Well, if we can agree, Mr. Simon, will you just verify what the --

MR. SIMON: I'll verify what the certification is.

MR. FRESHOUR: -- certification is and notify me. I don't need anything more than you to say it's whatever --

A. It's certified by somebody.

Q. Right. Maybe the Texas Department of

Health or something like that?

MR. SIMON: It may be CLIA, as well.

A. I think it might be CLIA, too. We'll check and see.

MR. SIMON: Of course.

THE WITNESS: I know we jump through a lot of hoops for some people.

Q. Now, I think other than that, Doctor, the documents I asked for, I think we've all -- they've all been exchanged.

A. Good.

Q. The question is, this singular notebook, is this the only copy?

A. No.

MR. SIMON: We have one at the office. I can make an extra copy.

MR. FRESHOUR: I think for purposes of the record, what I may do is get this marked and then I can just, when it comes back to me with the deposition, I'll have it there.

MR. SIMON: That's fine.

MR. FRESHOUR: We'll deal with that in a few moments.

Q. Now, Dr. Rea, one of the other experts that has been retained in this case is a Dr. Abadonia

(phonetic). You're familiar with Dr. Abadonia, aren't you?

A. Oh, yes, yes, yeah.

Q. And one of the preparations -- and I'm going to call the preparations antigens -- well, let me ask you this, Doctor: For clarity of the record, what is an antigen? Just generally how would you define that?

A. Well, it's a minute substance -- a part of whatever you're trying to get, a pollen or a food or a chemical -- that will stimulate a response in the body.

Q. Now, generally, Doctor, one of the issues that we have in this case is there's been some concern. And let me ask it this way: You're aware of the board's complaint generally, I'm sure?

A. I sure am.

Q. Okay. One of the things is, there's concern over a use of an antigen of jet fuel. Are you familiar with that?

A. I certainly am.

Q. Okay. Now, other than yourself, are there other physicians that you know that are making this kind of preparation and administering it to patients?

A. Yes, I think there are.

12:42:35 Q. I'm sorry?
A. I think there are, yes.
Q. Okay. Do you know any in particular that are using jet -- I'm going to call it jet fuel antigen, okay? Are you familiar with any?
12:42:43 A. Well, I think Dr. Johnson does, probably. Probably Dr. Ross does. Probably Dr. Fox does. And --
Q. Is that Randolph Fox up in Canada?
12:42:57 A. Yeah, uh-huh.
Q. Okay. How about --
A. And I can't -- I really don't know past that because it's been taught in our courses, so, you know, you don't really know who does and who don't.
12:43:11 Q. And I'm going to represent to you that I asked Dr. Abadonia, I said -- when I deposed him, I asked him, if you're deriving an antigen based on jet fuel --
A. Yes.
12:43:25 Q. -- this is rather crude, I said, well, even if you call it an antigen, isn't it still jet fuel? And he said, absolutely. Do you agree with that or not?
A. No, I disagree.
12:43:35 Q. Okay. Now, I want to be sure of your point

12:43:38 of disagreement. Now, because you are not using jet fuel or because you're using the exhaust fumes from jet fuel is that where you're drawing the distinction?
12:43:47 A. Well, we're using the exhaust fumes from it, and that is not jet fuel.
Q. Okay. The components of jet fuel exhaust, do you know what all is in the, what it is composed of, jet fuel exhaust?
12:44:01 A. No, I don't. You would have to look that up from a chemist. But it's just enough to -- people work around it at the airport all the time, so it must be safe.
Q. Jet fuel exhaust must be safe?
12:44:16 A. Well, it's generally accepted as safe at the doses that we do our extracts from.
Q. And who generally accepts them as safe at the doses that your extracts happen?
A. American Airlines, Southwest Airlines, the 12:44:30 state of Texas, the city of Dallas. Apparently most insurance companies. I guess I could go on and on. The medical profession.
Q. And what do you mean they accept it? They've tested it and said the level you're using is 12:44:44 an acceptable level?

12:44:46 A. No. People working around it. They don't put any restrictions on it.
Q. But you said they accepted yours. And --
A. You didn't ask me that. So I misunderstood 12:44:54 you.
Q. I think we had a misunderstanding.
A. I'm sorry about that.
Q. That's okay. That's why we do this.
The -- okay, you said something that, 12:45:07 you know, American Airlines accepts it and -- now, you're talking about a certain level of jet fuel exhaust that's set by the government or something; is that correct?
A. Well, I guess it is, yeah. I mean, it's 12:45:21 generally accepted in society, put it that way, okay.
Q. And that's an airborne, that's an ambient air standard for jet fuel exhaust, correct?
A. That's correct. And that's where we get our extract, so it has to be much less than that.
12:45:37 Q. I understand. But my question was, what you're talking about is the ambient air standard for jet fuel exhaust?
A. Correct.
Q. Okay. Now, there's a different between an 12:45:55 ambient air standard and what would be a -- the

12:45:58 concentration that may be directly put into the human body by some delivery mechanism such as saline? Wouldn't those be two different things, Doctor?
A. Well, if you don't consider breathing and 12:46:12 absorbing through the skin, so, yes. But, you know, if you breathe the substance, that's going to be the, that's going to be mixed with saline as you go down the bronchial tubes into the lung.
Q. Okay. But I'm saying, the ambient air 12:46:30 standard that you're talking about that is acceptable by whatever authorities is different than administering it to someone under their skin through a saline solution, correct?
A. No, I don't see how it is.
12:46:42 Q. Okay. That's my question. You think they're the same?
A. Yeah.
Q. Breathing it is the same as -- let me ask it this way, one more step further. You believe that 12:46:52 breathing jet fuel is the same as you giving an intradermal injection of your jet fuel antigen?
A. Yes -- well, no, because our jet fuel antigen has much less concentration than that.
Q. Now, let's talk a little bit about that.
12:47:11 A. All right.

12:47:13 Q. Is there an exact description in here? And rather than looking through, you can tell me, is there an exact description here of how you get your jet fuel antigen and prepare it?
12:47:27 A. Yes, I think there is.
MR. SIMON: He can help you find it.
Q. Yeah. If you would --
A. Or there's certainly one of car --
MR. SIMON: Can we mark it so he can
12:47:38 reference it as an exhibit?
MR. FRESHOUR: Yeah, we can mark it and --
A. Well, here's one for car exhaust, and that would be --
12:47:42 MR. SIMON: Let's mark this so the record is clear.
MR. FRESHOUR: Mark this as Exhibit 2, if you would, just the whole thing, please.
(Exhibit 2 marked)
12:47:56 MR. SIMON: And also, the pages aren't numbered so we should describe the page that he's reading from with particularity.
Q. And this is -- what you've directed me to, Doctor, is the protocol for car exhaust?
12:48:09 A. That's correct, yes.

12:48:09 Q. And it says January 1995?
A. Yes, that's right.
Q. All right. Now, before we get into it, I'm taking it that this has been in place since 1995 with
12:48:19 your laboratory?
A. Yes. And probably longer, because we were experimenting with it before.
Q. Okay. Now, my question is, this protocol, although it's directed for car exhaust and you're
12:48:34 representing for purposes of the record and your testimony that this is the protocol that you used to get your jet fuel antigen, correct?
A. Well, the difference would be we don't, we don't do jet fuel right near the airplane as we would
12:48:54 the car. Because jet fuel would be -- like if you were at the airport where the jets were revving up or getting ready to go, you know, as they were just going around. So that would be a much, much longer distance.
12:49:06 Q. So you would be a further distance away from the source?
A. That's correct, yes.
Q. Okay. Bear with me, I need to make some notes, because I can't mark on this page.
12:49:18 A. Oh, all right.

12:49:21 MR. SIMON: Have to get close to the place where it happens.
Q. So -- and again, this is just to be clear, this protocol you use for jet fuel antigen, even
12:50:00 though it says protocol for car exhaust --
A. Yeah.
Q. -- it's exactly the same, correct?
A. And with the exception of collection distance.
12:50:07 Q. Of the?
A. Collection distance.
Q. Collection distance, okay. Which is what we just talked about?
A. Yeah, it's just what we just talked about.
12:50:13 Q. Further from the source?
A. That's right.
Q. Okay. And before I go into this protocol, I want to be sure, are you -- do you have any idea what the general chemical components are of the jet
12:50:59 fuel exhaust that you're collecting?
A. I could get you a list for it, if you like. But I can't, right offhand, tell you all the things, you know.
Q. I take it -- could we agree it's probably
12:51:11 published in some literature?

12:51:12 A. It is, that's what I say, yeah.
Q. By the EPA, or --
A. Yeah.
Q. -- what is it, the agency for toxic
12:51:18 substance and hazard registration?
MR. SIMON: Disease registry.
A. I mean, you never know, but one of them has published it, okay.
MR. SIMON: I believe the EPA does.
12:51:28 A. EPA may, yeah.
Q. And before we go any further, Doctor, we've covered a lot of areas, and I apologize, I think I may have missed this. Is there a difference between an allergic reaction and an irritant reaction?
12:51:43 A. Yes, some people say there is. The allergists say that there is. And there's a lot of semantics that are problems in there, because, you know, you can have a hypersensitivity reaction and it doesn't have to be an allergic reaction. For
12:52:01 example, it could be nonimmune, and then an irritation is like if you start rubbing your hand or your wrist like that (indicating), and say you rub it with some substance, and it just gets locally inflamed. That's an irritant reaction.
12:52:18 Q. Is it a -- say a contact dermatitis, say

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12:52:21 if I -- is a contact dermatitis, is that allergic, is that irritant or what is that, could --
A. It could be either.
Q. That's what I was going to say.
12:52:29 A. Yeah. Or it can be nonallergic and be neurological, so there's three possibilities.
Q. Okay. Now, when I say "source material" when it comes to antigens, do you understand what I, what I'm saying by that, or could you define -- let's
12:53:00 do it this way: Will you define for me what source material is when it comes to antigens? What is source material?
A. Well, source material would be whatever you extracted from the air. Like, for example, if you
12:53:10 wanted formaldehyde or something like that or the jet fuel we're talking about here, or apple, if you wanted to make an extract of apple, it would be an apple or orange, okay. So on down the line. The molds, you do mold cultures and they extract -- they
12:53:29 can extract the source from that.
Q. And diesel fuel would be -- the diesel fuel would be the source?
A. Well, it would be the exhaust.
Q. Exhaust?
12:53:38 A. It is probably a little bit of a misnomer,

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12:53:40 we should say -- jet fuel extract, we should really call it jet exhaust extract, I guess.
Q. Okay. Because you're not -- and I think that's the other thing. For clarity, you're not
12:53:52 taking the liquid gasoline --
A. No way.
Q. -- and diluting that?
A. No way.
Q. You are taking the exhaust or the
12:54:02 combustion product?
A. That's correct. See, it's what, what you would get exposed to like in the dang freeway out there, you know, or at the airport or whatever.
Q. Okay.
12:54:13 A. So that's a little bit of a misnomer, I would agree with you there.
Q. Let's look a little bit now with your specificity here and your protocol.
A. All right.
12:54:38 Q. First off, do you know whether the composition of the jet fuel exhaust is a uniform product? And what I mean by that is that from each jet burning each batch of jet fuel, is it going to be the same or is it going to be slightly different, do
12:55:03 you know?

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12:55:04 A. I don't really know. But I would suspect it would be slightly different.
Q. Because I've at least heard, and I don't know anything about it, that each batch of jet fuel
12:55:15 may be just a little bit different in its composition, the lead there, the octanes, perhaps some of the various other hundred chemicals that make it up.
A. That would be my suspicion, yes.
12:55:28 Q. Okay. And I know I asked you this, but in the materials here, we don't have a breakdown of all of the components that might be found in your jet fuel exhaust antigen, correct?
A. No, we don't, certainly.
12:55:48 Q. I'm going to go -- the first thing says you've got 300 ccs of coca solution.
A. Yes.
Q. And then it, in parentheticals it says, NaCl equal amounts of NaCO3.
12:56:05 A. NaHCO3. It should be.
Q. Well, let me show you what's here, Doctor.
A. Oh, that should be NaCHO -- bicarbonates is what it is.
Q. Okay.
12:56:15 A. Soda bicarbonates and soda chloride.

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12:56:16 MR. SIMON: That's still on the page -- for the record, that's still on the page of the car exhaust extract?
MR. FRESHOUR: Yes, we still are.
12:56:23 MR. SIMON: Okay.
Q. Then it says the second step is 50 percent of each. And it says, unleaded gas exhaust and diesel exhaust. I assume obviously -- and correct me if I'm wrong -- it would be -- instead of 50 percent,
12:56:39 it would be 100 percent of jet fuel exhaust there?
A. Yes, that's correct. Well, you know, it is ambient air so you don't get too close to a jet burner, so there could be other things in there, too. But it seems to work and it seems to reproduce
12:56:56 people's symptoms when you're diagnosing it, that they get when they get around an airplane.
Q. The third step, it says, insert a gas rod into the car exhaust pipe, connect it to the air machine, pulling the exhaust into 400 cc of coca
12:57:11 solution for 15 minutes. Now --
A. Correct.
Q. I want to stop there.
Explain to me very clearly how you catch the jet fuel exhaust.
12:57:26 A. Well, you just have to go out to Love Field

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there and stand behind the fence, and you will get jet fuel exhaust. You can smell it.

Q. Okay. Explain to me, Doctor -- well, let me ask you. Do you do -- I take it you're not doing this yourself?

A. No, but I have done it. So I would know what I'm doing, okay.

Q. Very good.

A. But I am not doing it, okay.

MR. SIMON: So he wants you to explain the process.

THE WITNESS: Okay.

Q. So you're standing at the fence at Love Field?

A. Okay, we've got a collector, okay.

Q. What is the collector?

A. Say this is a collector -- well, it's a, a, you know, a petro-type chemical -- you've seen the chemical flask, and things like that.

Q. Like a beaker?

A. Yeah, like a beaker with a lid on it.

Q. Okay.

A. And the lid has a hose attached to them, one for in and one for out, okay? And you have a rod that goes down so it bubbles through, you're sure it

bubbles through the coca solution. You put your air collector there. And it's a motor, there's a motor on it that will suction -- there's a very mild suction, okay? And the reason those things are not totally detailed, because that's just standard for what you do for most antigens, okay.

Q. Okay.

A. And then you put it there for 15 minutes, and, and go ahead and then you sterilize it with cold sterilization.

Q. I'm--

A. Cold sterilization. That's Millipore filters.

Q. Then it run -- well, so that's the actual collection you just described --

A. Yes, right.

Q. I know you know it better than me. Let me finish my question, Doctor.

A. All right.

Q. We've been doing fair. I think the court reporter will only say fair.

So the little motor runs bubbles through, after 15 minutes you shut the motor off, I take it you, you cap off the tubes or remove them and put a new cap in?

A. Yes, that's correct.

Q. And then you go and you, then it says dilute with 300 cc's of coca solution. I assume you're now back at the laboratory, you pull the top off, you put the solution in?

A. That's correct. So that makes it much less.

Q. Okay. Then you run it through the ceramic Millipore filter?

A. Yes. These are specific filters that I have engaged to exclude bacteria and viruses. In other words, you either -- you know, when you sterilize something, you either have to do it by heat or what you can do here, it's got to be cold sterilized.

Q. Okay. Then you dilute with saline, one-half, this is the concentration. What does that mean, Doctor?

A. Well, then you dilute it with -- where does it say one-half?

Q. I'm sorry -- we're at number six, I'm sorry.

A. Oh, okay, that would be again one-half the volume, you dilute again. So now you're down to very, very small molecules of -- very few molecules

of the substance, because you've diluted it twice, plus you diluted it when you collected it. So you may have diluted it a million times by then, okay? And then -- go ahead, you get this and I can tell you the rest, okay.

Q. Please do, sir, go ahead.

A. So you've got this vial here that is the concentrate -- we talked about concentrations, so I guess I don't have to go over that again. But that's the amount that you've got after you collect it and it's been diluted, okay? Then for patient care after you're sure it's sterilized is you dilute it with four c -- what you call a 1-to-5 dilution, that's four cc's of saline and one cc of the concentrate. And you just keep doing that. That's number one, number two and number three, that would be number 1 to 25, 1 to 125, 1 to 625, and then into the thousands, okay. And that is extremely diluted.

Q. And -- okay. And I'm going to jump for a moment, Doctor.

A. Okay, fine.

Q. So then you take these. And as I understand from reading some of your materials, you would go and you would start with the -- some of the weaker solutions and do then skin testing with this

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going up towards stronger solutions, not the other way? You don't start with a strong and go to weak. You start with a weak solution until you get a reaction?

A. Yeah. Well, we might go weak or stronger, depending on what the skin response is or the patient's response. For example, usually we'll start at number three, that's the 1 to 625, I believe it is.

Q. Yes, sir.

A. And let's say that the patient got a swelling, called a wheal, and the wheal grew, then you would dilute it until you got the right dose. But that's provoking. Let's say the patient had no symptoms and the patient had no wheal, then you would go stronger to find the concentration. That's for treatment only, though. That has nothing to do with the diagnosis.

Q. Right. And we're going to get to the diagnostic aspect here in a bit, okay?

A. Okay.

Q. Bear with me.

Number seven, explain that to me. And, again, if you need to look at it, Doctor, it says, analysis shows no toxic substance. However,

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the electromagnetic imprint still persists as evidenced by skin reactions until number 20 dilutions in some patients.

A. Yes.

Q. What does that mean? And there's another sentence, I just didn't get to that. What does that mean? Or explain that to me.

A. Well, number one is that apparently, as you well know, other people have analyzed it, not ours, but other people have analyzed this technique. And also I think that Professor Fenavitz (phonetic), who is in our group from the University of Texas, who is a physicist, has checked this out that long ago, and felt there was no active chemical in it. And that -- but there is electromagnetic imprints still there. And that's why they react.

Q. Okay. The very last sentence says, this is obviously in homeopathic frequencies. What does that mean, Doctor?

A. Well, when you give a chemical, chemical exposure of any kind, there's both a chemical response and a physical, or a physics response, okay. Now, the physics response is in frequencies apparently. So like you might have 10 hertz, 500 hertz, 300 hertz, or so on, okay. That still appears

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to be there; whereas, the chemical content is gone. And that's why we explain why some people have reactions on their skin.

MR. SIMON: Mr. Freshour, really quick, to clarify the record because you said the attorneys before us did not provide this. It's also the attorney -- from what I recall now looking at the interrogatories and the document demands, the reason why this wasn't provided I remember there was an objection, it was not asked for properly the way you asked for it here. So I did provide it for you.

MR. FRESHOUR: Yes. Sure. For purposes --

MR. SIMON: My recollection.

MR. FRESHOUR: I'm sorry.

For purposes of the record, I agree with that representation by Mr. Simon, just for clarity. And that was also part of the reason that I just a little bit ago asked Dr. Rea to clarify that. So no implication that there was noncooperation between us. It was just an issue that we've resolved and this does it.

MR. SIMON: Okay, good.

Q. Now, let me ask you, Doctor, on the -- this is for car exhaust. This applies to your diesel fume

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exhaust antigen, right, as well?

A. Yes, that's correct.

Q. And I just want to be clear, because several -- it might have been Dr. Meggs. Pardon me if I'm wrong. I don't want to misquote the good doctor. He had a little trouble reconciling unleaded diesel fuel in the way it's labeled because there's unleaded gas and there's diesel fuel. But as I understood it, he had a little bit of concern that I think some of the labeling might have said unleaded diesel. Are you familiar with that in your records?

A. I'm not. But as you know, all of these may be semantic snafus.

Q. Which is fine. I just want to be sure. And I'll represent to you, I think if we look today some places in antigen -- or it might be in the immunotherapy, it says unleaded diesel. But we're talking about diesel exhaust antigen when we see that.

A. That's correct.

Q. Okay.

A. And if we are talking about gasoline, it would be unleaded gasoline fumes.

Q. Okay. That will help.

A. Yeah.

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13:07:55 Q. I want to talk now -- okay, and I think we can finish this up and it will work well. I want to talk about the same procedure for your diesel fume exhaust. It comes under this car protocol exhaust we
13:08:08 just explored.
A. Yes.
Q. And my question would be, to collect the diesel fuel, do you have an engine or a vehicle that's set up at your office? Or what is the
13:08:26 combustion source, I guess is the question for --
A. Well, it would be a diesel, diesel car.
Q. Okay. Now, my question to you is, is that any diesel car? Do you have a specific diesel car where you actually put this glass pipe in, or how is
13:08:40 it collected, Doctor, for diesel exhaust?
A. For diesel exhaust, it's -- this may have been a glass rod originally, but now we just do it several feet away, a foot or two away and collect it just like the jet fuel exhaust.
13:08:58 Q. Okay. So -- and this sounds really crude, and I'm not --
A. Yeah.
Q. Please don't take it that way. I mean, are you at the store parking lot, are you in your medical
13:09:09 office parking lot? Where are you getting --

13:09:12 A. Medical office parking lot, okay.
Q. Okay. So you go out and --
A. That's right.
Q. -- find somebody who has got a diesel
13:09:20 vehicle?
A. Yeah.
Q. Okay. And I take it, then, do you do the same thing for the car exhaust, out into the parking lot?
13:09:33 A. Yes.
Q. And, again, it goes -- same question I asked before, you are aware that there's all kinds of -- there's all different types of diesel fuels?
A. I am aware of that, yes, I am.
13:09:48 Q. There's what they call red diesel, which is -- I think there's a dye poured in it so it can be used off road and not taxed. Some diesels are a higher sulfur content than others?
A. Yes, that's true.
13:10:02 Q. So there's a wide chemical composition of diesel fuels that are used in a variety of different vehicles, correct?
A. Correct.
Q. And, again, we can, I guess, from a rather
13:10:15 crude scientific standpoint assume that the exhaust,

13:10:19 depending on the source of the diesel fuel, may be slightly different at each collection if it's a different vehicle at a different time?
A. That's correct.
13:10:28 Q. Okay. And other than those variations, this protocol is exactly what you do for your diesel collection?
A. Yes, that is correct.
Q. Okay.
13:10:39 MR. FRESHOUR: I think we're at a very good breaking point here.
THE VIDEOGRAPHER: The time is 1:10 p.m. This is the end of tape number three. We are going off the record.
13:10:47 (Recess from 1:10 to 1:38)
THE VIDEOGRAPHER: The time is 1:38 p.m. This is the beginning of tape number four. We are on the record.
Q. Doctor, when we had taken a short break, we
13:38:14 had just gone through some of the -- what has been an exhibit to some of the protocols related to diesel exhaust fume antigens, as well as the jet fuel exhaust antigens. Do you recall that, sir?
A. Yes. I do.
13:38:31 Q. And going through these procedures during

13:38:42 our break, I've flagged a couple of pages and I'm going to just ask you questions.
MR. FRESHOUR: For purposes of the record, I'm going to remove the flags. It's just to
13:38:53 identify them for questioning, Mr. Simon.
Q. Near the back, it says it's EHC-D, which is Environmental Health Center of Dallas, that's the clinic, correct?
A. That's correct.
13:39:08 Q. Chemical listing numerical. Let me show you that. Do you know exactly what that's supposed to be telling us generally, Dr. Rea?
A. I think it's probably tailored antigens for an individual.
13:39:33 Q. Okay. As best you can tell from looking at it?
A. As best I can tell, yeah.
Q. And I want to ask you a couple of questions. Although we're not sure who the patient
13:39:44 may or may not be or the tailoring, I don't think it's necessary for purposes of these questions, okay?
A. Okay.
Q. In there, one of the things -- and I'll be glad to show them all to you. It says north wind,
13:39:59 and then there's a number out there, 0823. Do you

know what north wind means?
A. Yes.
Q. Okay. What does that mean, sir?
A. Well, there's some people who get ill when the north wind blows in, and so we made an extract of it.
Q. And I will represent to you I've looked through this and I didn't see a collection procedure for the north wind. But generally how do you do that?
A. Well, it would be generally the same, except you just collect -- when the north wind blows real hard, you just collect it from there.
Q. Okay. And, again, I would take it that, for lack of a better term, the collection point would be right there around your clinic?
A. Correct.
Q. I'm going to do the same thing. There's a couple of them that I -- one says air, it says air Dallas. It's just collecting an --
A. Probably ambient air of Dallas, I would expect, yes.
Q. Okay. And other one says air office. Is that --
A. It would be for our office, yeah, or

somebody else's, you know, I can't be sure.
Q. What about south wind Richardson?
A. Well, that would be similar to the north, north wind. This would be the south wind coming from the south, probably somebody who lives in Richardson had problems.
Q. What about -- this says coconut, Austin air.
A. I would suspect that would be coconut charcoal that was used for Austin air.
Q. What is -- it says zeolite, z-e-o --
A. Zeolite.
Q. Yeah.
A. It's some -- I don't know what it is, it's some benign substance that people reacted to. Again, probably a tailored antigen, you know.
Q. It says anthracite coal, Austin air.
A. Oh, I guess I made a mistake on that other one.
Q. I'm sorry. It was zeolite --
A. No, I understand. But the one before, it said Austin -- it said coconut, and this one said anthracite. There are two different charcoals that are used through the Austin air machine, which is a filtration device. In some of the air filtration

devices, some of the patients are sensitive to different sources of charcoal. So, for example, if you're sensitive to the coconut charcoal and you do an antigen and it doesn't work, go ahead and use the anthracite coal one, and see if it works.
Q. Okay. So the Austin air is not Austin, Texas, it's the machine?
A. Yeah, I'm sorry, I made a mistake on that one.
Q. Okay. One of them says -- and I'm going to have to spell this. You may know what it is, Doctor.
A. Okay.
Q. It says porcelain, Cerabein ZR luster. Let me spell it for you, Doctor -- and you can look at it, too. C-e-r-a-b-e-i-n. Then a capital Z, capital R, and the word "luster"?
A. I would suspect that that's porcelain used for fillings or teeth.
Q. Okay. And then there's a number of other porcelains, Omega --
A. Yeah.
Q. -- Impress?
A. That's what those are.
Q. So that porcelain is for like dental fillings?

A. Yes, that's correct.
Q. What is -- is it fusaric acid, what is that?
A. Oh, that's a mycotoxin.
Q. Is that from the -- it's from the mold?
A. It's one of the molds, yeah.
Q. Okay.
A. Fusaric mold, I think.
Q. Okay. Thank you.
What is -- is it vanadium?
A. Vanadium?
Q. Vanadium.
A. That's an element like, you know, lithium or calcium or magnesium.
Q. Now, also it shows down here, men's and women's cologne.
A. Yes.
Q. And it shows the source, the mall. What exactly is that, Doctor? What do you mean by that?
A. Oh, we have perfumes extracts and -- men's cologne sometimes seems to be worse sometimes than women's cologne for some people.
Q. Let me ask you this: Could the compositions of -- how do you know what cologne to choose? I mean, that sounds funny, but I'm serious.

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13:45:11 A. How do we know? I mean, of course, number one, the patient usually knows, but sometimes they don't. But what we try to do is get every different type of perfume or cologne and put it in there. You 13:45:23 have to constantly update it because, you know, there are always these new things coming on the market.
Q. And that -- I guess a cologne in a sense is, is it the same as diesel fuel? And what I mean by that is, are there various chemical components 13:45:44 that make up a cologne, do you know, Doctor?
A. I think that there are, because, you know, it used to be all flower fumes. But now there seems to be a lot of synthetics that are involved in these things. That's why I say it's really hard to keep 13:46:01 updating it.
Q. And I guess my question is, because you said -- do you just get like one kind of cologne, or do you mix a bunch together? I mean, how do you determine it?
13:46:14 A. We mix a bunch together.
Q. And let me ask you, Doctor -- this may sound silly, but let me do it this way: You mix Old Spice, some Christian Dior scent, a Ralph Lauren scent, and then you get some knock-off brand that you 13:46:40 would get at the Dollar Store and put them all

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13:46:42 together?
A. Yes, yes, we do. Although we will tailor them. Some people know exactly what brought it, some people blanket, almost every odor bothers them, and 13:46:50 so you mix those. You have a composite. But then we might tailor for -- if an individual, say, works for -- knows that this Dior perfume bothers them, we might make that particular one. Because sometimes at, you know, they're working in a cubicle next to 13:47:09 somebody that insists on being doused with perfume all the time, and they can't work. So you can neutralize them for that.
Q. Let me ask you and kind of go back to where you don't have an identifiable discrete perfume or 13:47:24 cologne. But if you mix, say, those four together, just hypothetically.
A. Yeah.
Q. Let's do that. Hypothetically you mix those together, if the individual reacts, my question 13:47:31 is, how do you know what they're reacting to? Is it all of it, what components? I mean, how do you discern that to make a treatment decision, Doctor?
A. Well, you go ahead and do the neutralizing dose with the neutralizing technique. And if it 13:47:45 shuts off the reaction, that's all you care. You

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13:47:48 don't really care if it is one specific one. In other words, you're trying to help the patient work or help the patient survive, okay?
Q. And I guess my question is, something that 13:48:06 has multiple components to it, let's say, for example -- I'm going to jump back. Let's go to sulphur, the jet fumes, it's probably got -- I don't know all the components. Probably it's got toluene component, it's probably got multiple benzene 13:48:24 components, it's got some aliphatic hydrocarbons --
A. Sure.
Q. -- probably got some hexane, maybe some heptane. You make that solution, that antigen and you give it to them and the individual reacts. How 13:48:42 do you discern, as a physician, if the reaction is to only one specific component? Say, how do you know it's the toluene versus the benzene versus the heptane?
A. We don't care. I mean, all we care is if 13:48:58 the -- let's say it's the airline stewardess, okay, and she can't work because she's -- every time she goes to the airport she gets zapped, okay. Well, you get a neutralizing treatment dose and it works for her. So she's like the other personnel. Then it 13:49:15 doesn't matter.

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13:49:19 Q. And you said a couple of times, and I want to talk to you a little bit about this. You keep talking about a treatment dose.
A. Yes.
13:49:27 Q. What do you mean when you say "treatment dose," Doctor?
A. Treatment dose is the dose that shuts off the provoked reaction. It's the dilution that shuts off the provoke reaction. You know, we said 1 to 5, 13:49:43 1 to 25, 1 to 125, 1 to 625. Let's say that the 1 to 5 gave you provocation of all your symptoms, okay, then the 1 to -- say the 1 to 125 turned off all your symptoms, just they eliminated after you took that shot, that's all you care.
13:50:02 Q. Well, and I guess my question is, if the 1 to 5 provokes and then the 1 to 25 doesn't provoke, that's still -- so you're saying it doesn't matter what component as long as whatever the diluted -- because all the components are diluted 1 to 25, so it 13:50:28 doesn't matter?
A. Yes.
Q. Let me ask you this. I'm trying to understand from a immunological standpoint.
A. Well, this may not be immunological, now.
13:50:41 Q. Okay. Well, let me understand it from a

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13:50:43 layperson's standpoint.
A. That would be better.
Q. It would be easier -- probably better for me.
13:50:47 A. Yeah.
Q. It does not provoke a response, but how -- is provocation different than neutralization?
A. Yes, that's right.
Q. Okay. So just because it does not provoke 13:51:09 does not necessarily equate to neutralization, does it?
A. Generally you're not sensitive, then, if it doesn't provoke.
Q. Then how does it neutralize?
13:51:21 A. Well, it has to provoke. You see what I'm saying? I mean, if you've got a perfume and it makes you sick and you reproduce your system with the 1 to 5, and then your symptoms keep going and you get a 1 to 25 and it turns it off, stops the reaction right 13:51:41 there cold. Say your nose was running, your eyes were running, and it stops it right there, then that's your treatment dose.
Q. Okay. So clarify for me, you've got a treatment -- you're doing these, so -- you're doing 13:51:57 the testing at these certain levels to find out at

13:52:02 what level it no longer provokes. So that's the -- is that the diagnostic phase of it?
A. No, no.
Q. Okay.
13:52:08 A. The diagnostic part is you provoke it. Provoke symptoms, okay.
Q. So at 1 to 5, I provoke?
A. Yeah.
Q. So that's diagnostic?
13:52:18 A. That's right.
Q. You drop down now to 1 to 25, it does not provoke?
A. And the symptoms turned off.
Q. What do you mean "the symptoms turned off"?
13:52:28 A. Your eyes were watering, your nose was running, it stopped it.
Q. Did it stop because of the dose or because it was so diluted it just didn't trigger a reaction?
A. No, no, no. If you got the wrong dose, it 13:52:41 will continue to be provoked. That just happened to be the nature of the physiology of it.
Q. So, so the minute -- okay, so you give me a shot that's 1 to 5, my eyes water.
A. Yeah.
13:52:55 Q. That's the example you keep using. You

13:52:57 give me -- I assume you wait a while, you give me --
A. Ten minutes, ten minutes, usually.
Q. You give me 1 to 25. So now let me stop. In that ten-minute interval, you've given it to me 13:53:10 and seven or eight minutes in, my eyes stop watering, I stop having my symptoms, right?
A. Yes.
Q. Then you give the 1 to 25, correct?
A. Right.
13:53:19 Q. Nothing happens?
A. That's right.
Q. Okay. So you now have deduced, because my eyes didn't water, that that is now the treatment dose?
13:53:28 A. That's correct.
Q. Now that you've determined the treatment dose, I have to do -- do I have to keep giving myself these 1 to 25 shots?
A. For a period of time until you're okay, 13:53:46 until you get desensitized.
Q. And how do you determine the desensitization, Doctor?
A. Well, when you get hit by that perfume mess, you don't have any symptoms.
13:54:13 Q. And, Doctor, I want to go to this antigen

13:54:17 formulation again. What is orris root?
A. It's a root that they used to use in cosmetics.
Q. One of the things you collect to test them 13:54:49 for is fireplace smoke.
A. Well, it's only if they have problems around a fireplace.
Q. And how do you collect that?
A. Really similar to what we've done on the 13:55:00 other. You put a collector in front of a fireplace wood and you, you know, it's either pine wood or hard wood, soft wood or hard wood, so you try to collect them, whichever one they have problems with.
Q. And when they say they are, you know, 13:55:22 allergic to fireplace smoke, do you, before you go in and test, do you have them check and be sure they've got all of the positive air flows and ventilations that are required and they didn't just have the damper shut on the fireplace when they reacted?
13:55:41 A. Well, of course.
Q. How do you make an antigen of stainless steel, Doctor?
A. You soak it in that solution for 24 hours.
Q. In the coca solution?
13:55:50 A. Yes.

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13:55:53 Q. Okay. So you -- so --
A. Any of the metals are that way.
Q. Okay. Let's take stainless steel just as an example, all right, Doctor?
13:56:03 A. Okay.
Q. And walk me through the process. You put it into your coca solution, and it's the same coca solution that's used for the car exhaust?
A. That's correct.
13:56:15 Q. So you've got your coca solution in a beaker, tub, whatever?
A. Yeah.
Q. And you put in stainless steel into it. Now is it, is it sheet metal, is it a metal rod?
13:56:28 What's the source material of the stainless steel?
A. We usually have metal rods because it's something that somebody puts in the prosthesis. So we've gotten the different rods from the companies. And you soak the prosthesis in there, the rod from
13:56:45 the prosthesis. You can get small ones, you know, for like plates.
Q. You just get the plate itself, not the entire prosthesis, obviously?
A. Yeah. Well, there would be no reason to.
13:56:59 Q. Now, if somebody doesn't have, say, an

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13:57:02 artificial knee, an artificial hip, something like that, why do you test them for stainless steel sensitivity?
A. I don't unless they're working around it.
13:57:13 You have to remember, you've got a lot of antigens there. We don't test the same antigens on everybody. I mean, we just have groups of what their clinical demands -- we have a whole segment of people in our practice who have implants, a growing number, and
13:57:29 that's because I'm a cardiac surgeon, and I know about implants, I've put plenty of them in. And so we've developed that, and that's why Ms. E.L. came down, because she's going to have a knee transplant -- or a knee implant. She wanted to be sure that she
13:57:45 wasn't going to be sensitive to it.
Q. So you're testing them for anticipated -- you tested her for an anticipated --
A. Anticipated. But, of course, we do a lot of people who have them in because they complain that
13:58:00 they've got excruciating pain.
MR. SIMON: But her particularly.
A. But her particularly. That's why we did it. It worked successfully. She had her implant in and she didn't have any pain and didn't get allergic
13:58:16 to it.

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13:58:17 Q. What about titanium alloy?
A. Same. See, the difference between -- I guess you're seeing titanium and then titanium alloy.
Q. Right.
13:58:24 A. And one is pure titanium, okay. But if you test them, say, for pure titanium and they don't react, but they put a titanium alloy in there, that's got copper, cobalt, nickel, malignum and several different ones in there, and I've seen where just a
13:58:39 small percentage of them is what they reacted to.
Q. Okay. Well, take me back to the stainless steel -- and I think I got a little ahead of myself, Doctor.
A. All right.
13:58:53 Q. So you drop it in the coca solution. What do you do to get the antigen? Walk me through the process.
A. You'll have to get the process out, but it's the same one.
13:59:04 Q. Soak it for --
A. 24 hours.
Q. Okay, 24 hours, then you -- you --
A. Dilute it down, remove it, dilute it down, sterilize it first, see, you know, through the cold
13:59:15 filtration so that there's no bacteria or virus in

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13:59:20 there. And then you dilute it down. And then you take that concentrate solution, dilute it 1 to 5, 1 to 25, just like the others.
Q. Well, let me ask you -- and this is a small
13:59:31 step in it, but if you've put that piece of metal in there, do you just pour the solution out? Or how do you extract the metal or extract the solution one way or the other without some kind of contact that could introduce a contaminant?
13:59:47 A. Well, they're sterile. The solution -- or the metal is sterile when we do it.
Q. Now -- okay, I need to -- I'm trying to understand, Doctor.
You put the piece in -- now, in that
13:59:59 24 hours, is the entire piece of metal dissolved?
A. Yeah -- it doesn't dissolve, no, it just soaks in there. And whatever electrons or protons or whatever elements come off, come off into the fluid, okay.
14:00:12 Q. Right. Okay, stop right there. This is my next question, Doctor. I guess I'm not saying it very clearly.
So you've got a solution, let's say for example it would look like the cup here of the
14:00:23 court reporter's (indicating).

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14:00:23 A. Yeah, okay.
Q. There's a piece of metal in there and there's a solution, how do you get either the metal out or the solution out without touching it? I need
14:00:31 to know that process.
A. Pour it out.
Q. Just pour it out?
A. Yeah. Pour it in another flask or test tube.
14:00:39 Q. The gold you test for, is that because of dental fillings?
A. Yes.
Q. How about the copper?
A. Well, I think titanium alloy has copper
14:00:56 cobalt in it, or chrome cobalt. Maybe the copper is separate, but it's in there. Some of the other different substances have copper. People are supplemented with copper as a nutrient.
Q. What about the platinum?
14:01:17 A. Same. Teeth, generally teeth, generally fillings.
Q. How about palladium?
A. Same.
Q. Dental fillings?
14:01:26 A. Yeah.

14:01:27 Q. What is a trichothecene?
A. That's a -- the mycotoxin that's put out by Stachybotrys and Ethlotoxin and the Aspergillus.
Q. And so if you are making trichothecene into
14:01:55 an antigen, I didn't see it in there -- and I may have missed it, Doctor. How do you do that?
A. Well, same way. If you put in the mycotoxin and trichothecene, there's only -- you can only get commercially three mycotoxins. You know,
14:02:14 you just, those are your -- and then you take them. Micro food are like a mold.
Q. And all of these we've gone through -- and I just want to be clear because I may not have asked it. All of these antigens that we've just gone
14:02:34 through, you've not sent them out to independent laboratories to break down the concentration or the -- all of the elemental compositions of them, correct?
A. No, I have not.
14:03:32 Q. Now, on a couple of your patients, you -- and I want to talk -- just because we hit on the mycotoxin testing. There's a couple patients that you ran some --
A. Urine.
14:03:52 Q. -- urine, urine mycotoxin testing on,

14:03:56 correct?
A. Yes, that's correct.
Q. And that urine mycotoxin testing was through a Dr. William A. Croft, correct?
14:04:05 A. That's correct.
Q. Now, one of the things is -- and I'll represent to you and I'll certainly be glad to show it -- I've got the results from June of '04 for
14:04:18 patient E.F.
A. Yeah, okay.
Q. And Dr. Croft lists, and he tells the sample was processed, and then he says, no bacterial growth to total 100 mill -- MLS of urine was submitted, and then protein observed within the urine
14:04:39 sample, and he goes 2, 2, 2, and he comes to a total of 4. It says, score of 8 was -- I'm sorry, a score of 8 was given to this urine sample out of a possible 18. Are you familiar with those kind of reports from him?
14:04:52 A. Yeah.
MR. SIMON: We're not asking about that particular report, just in general?
MR. FRESHOUR: In general. But I'm using this as an example.
14:04:58 MR. SIMON: Yeah, because I'd say

14:05:00 maybe you would want to see the document.
THE WITNESS: Yeah, of course.
Q. And I'll get to that.
What is the unit? What does that 8
14:05:07 mean? What unit is that, Doctor? And I'll be glad to show it to you.
A. I was going to say I don't recall.
(Mr. Freshour shows the document to witness)
14:05:21 Q. And my question is just simply, do you know what kind of -- what that unit means, what that 8 means?
A. No, I can't really tell you right now.
Q. Okay.
14:05:32 A. I did at the time that we used him.
Q. Do you use him anymore?
A. No.
Q. When did you quit using Dr. Croft?
A. Oh, it's been probably three years ago,
14:05:44 four years ago.
Q. Okay. Are you using anybody for urine mycotoxin testing right now?
A. Oh, yes. Yeah.
Q. Who?
14:05:57 A. Hooper.

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Q. Dennis Hooper?
A. Yeah.
Q. Out of California?
A. Well, he's in Richardson, Texas.
Q. He's in Richardson?
A. Yeah.
Q. Does he have a laboratory here?
A. Yes, he does, realtime laboratory.
Q. Okay. Is he an M.D., do you know?
A. Yes.
Q. And at the time that you were using Dr. Croft, you were aware, obviously, that he was a veterinary doctor and not a medical doctor, correct?
A. Oh, yes, yes, I was. At that time it was the only people that knew much about molds.
Q. Are you aware that in March of 2005 that the CDC came out with a data sheet on trichothecene mycotoxins? Were you aware of that at all?
A. I believe I saw that.
Q. Yes. And were you aware that in one of those things, one of the entries, it talks about laboratory criteria for diagnosis for trichotecene mycotoxins?
A. I don't recall.
Q. Okay. And I'm going to represent to you it

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said that, selected laboratories are offering immunoassays to identify trichothecenes or trichothecenes specific antibodies in human blood and urine. Then they give a citation at the side, giving a footnote 2 and 3, and then they follow with, however, these procedures have not been analytically validated and are not recommended. Were you aware of that position from CDC?
A. No.
Q. I'm going to represent to you -- were you aware that under footnote number 2, it's like specifically to Dr. Croft and his clinic confirmation of trichothecene mycotoxicosis in patient urine?
A. No.
MR. SIMON: Mr. Freshour, for the record, was that physician that you are reading about from the CDC, was that before or after these patients were treated and after Dr. Croft's labs were rendered?
MR. FRESHOUR: I'm going to let you make that determination, Mr. Simon.
MR. SIMON: Okay. Because I was just wondering about that.
MR. FRESHOUR: Well, and as I told you, that came out -- the date on that was March of

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'05. I think I specified that. But if not, that's what it is.
Q. Is the trichothecene antigen that you talked about in your antigen prep, is that -- you obtained that commercially? Is that one of the ones you obtained commercially, Dr. Rea?
A. Yes.
Q. Now, Doctor, one of the things that you believe or that you advocate is that continued exposure over time, even to low level of chemicals, can lead to the patient's sensitivity at some point, correct?
A. Well, yes, that's a known fact.
Q. And then the -- and that, that goes to what I think has been described, and I think I've read it in some of your literature, is the -- kind of the total load theory; is that correct?
A. It sure could be part of it, yes.
Q. Yes. And I think you've at various times described it as it's like a rain barrel that fills up and then all of a sudden, whatever that last little bit of rain makes everything pour over, correct?
A. That's correct, yes.
Q. Okay. And I guess my question is on that, is, under that theory, is it basically that at some

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unknown level or just at some point people can just no longer handle chemicals, is that in a very crude way what you're saying?
A. Yes. It's like somebody who had a lot of bacteria, and they cut their skin. And let's say that one time you washed it off real good and the other time you didn't wash it off so good. It's the same principle, you've got too many bacteria and the patient got an infection the second time.
Q. In those patients, once whatever the event is that sends them kind of over, if you will, into the sensitivity, is it true that any further addition of any chemical loading would cause them to worsen, in your opinion?
A. Well, in some people, it does, yeah. Others, it doesn't. They recover.
Q. So some -- one day somebody triggers, they feel real bad, then for whatever reason, it passes. I mean, do you see cases like that?
A. Yes, we do.
Q. Okay. And you see the other cases where the people go over the edge and then they're --
A. Keep going on.
Q. -- allergic to everything?
A. Yeah.

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Q. In a person like that, where it seems to keep getting worse, is it, is it true or do you believe that those people, you shouldn't add anything to their chemical load at all because it's only going to get worse? Or how does that work?

A. Well, you don't want to add anything to the chemical load that's of significance because you want to lighten it. On the other hand, there may be therapeutic things that you have to do to help buck up their detox systems or buck up their nutrient systems, and that could add to their load a little bit.

Q. So you add to their load to lessen their load?

A. I said occasionally.

Q. Okay. And so on these patients that we're talking about today where you first gave them, let's say you give them a 1 to 5, they provoke, you give them a 1 to 25, they provoke, it's true that in those situations you have actually added to that person's chemical load, correct?

A. Not if you've been able to neutralize it.

Q. I didn't say you've been able to neutralize it, I said they provoked. So you've added to the load, haven't you?

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A. Okay, yes, I would say. That's why some people you can't test.

Q. So how do you then diagnose they've got chemical sensitivity if you can't test them?

A. Well, you have to go by history and physical. You have to be a doctor.

Q. So -- well, how do you make the determination that they're not a testable individual, Doctor?

A. I -- well, number one, from clinical experience, you can tell. A lot of them are so fragile that there's no way they're going to do it. The other thing is is that you may have to do a probe and test one or two things and see. And if they react and you can't turn off their reactions, you know these -- you can't test right away.

Q. You keep saying turn off the reactions, what does that mean medically, to turn off the reactions?

A. Stop the reaction.

Q. Well, and this is -- and I'm going to go back to it. I'm trying to understand that -- are you stopping the reaction at a dilute level, or are you just giving them such a dilute level that you're not creating a reaction?

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A. No.

Q. And is there a difference?

A. There is a difference.

Q. Okay. Explain it to me.

A. Well, I did. A runny nose, we provoked it. The nose ran. We gave the second dose and it stopped it. That's a turn-off.

Q. Right. But in the scenario I gave you, I said you wait seven minutes, it would shut off before the provocation, you gave it again, it didn't provoke. How do you know that you shut it off or it was so dilute you didn't trigger a reaction?

A. Well, that might have been. But what you do then is you give it to them every four days and see. And if it does stop the reactions or prevent the reactions from occurring, you know that was a turn-off dose.

Q. Well, is it preventing the reaction, or is it just not creating it at that level?

A. No. When you -- like, for example, the patient then breathes it someplace down the line, and if it stops that reaction, then you know you got the turn-off dose. You might not even, you might not even treat it with a second -- or the number two dose because of the fact that they stopped at eight

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minutes.

Q. Well, let's say they didn't stop at eight minutes. Let's say at ten minutes you gave it to them. How do you know it was the dose that shut them off or that the higher dose had finally worn off and the lower dose doesn't provoke? How do you distinguish that?

A. I just told you. The way you distinguish it is you treat them on the number two dose and see if they -- as they go through a few, few days, you'll know whether it's, it can start preventing the reaction or turn off the reaction right away.

Q. Well --

A. By empirical seeing, observing, clinical experience.

Q. Well, let's take -- let's explore that, because I want to be sure I understand really the theory that you're articulating there. So say at a 1 to 25, you say that's the treatment dose, a person doesn't react. You also say you want to stop giving them the chemical load, so if you can't distinguish between whether it's just stopping or too dilute to trigger a reaction, if you give them four days of that treatment, you are in essence still contributing to their chemical load, correct?

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14:17:50 A. Very, very miniscule.
Q. But you are contributing to their chemical load?
A. I would think so, yes.
14:17:57 Q. All right.
A. That scenario is not a very good scenario because what you really do is -- most of these, they are still reacting in the ten minutes. So when you give that second dilution, it shuts it off.
14:18:11 Q. Again, do you know if it's shutting it off or if you give it and wait another ten minutes has the first dose just completely worn off and the second not provoked?
A. No. You can turn it off almost
14:18:23 instantaneously.
Q. And that instantaneous turn-off, should that be reflected in your medical records?
A. No, because that's the technique.
Q. So you shouldn't record in the records what
14:18:33 the reaction was?
A. No, because it's a given. You know. You record the reaction, okay, but then, then you'll have one that says, say, five over three, okay, bang, that, that's the neutralizing dose because there's no
14:18:51 more reaction. That's just a given. Your tester

14:18:54 does that, he knows that, no need to write it down.
Q. Okay. And the reactions you're talking about in these patients, at certain doses -- and I think we can probably use some of the patients, and
14:19:06 we'll get to them today -- you know, at two five, they say it's a headache and they feel flush, then you give it to them at five five and they say, my left elbow hurts.
A. Uh-huh.
14:19:23 Q. Well, if it's, if it's a triggering or provoking dose, why is the symptomatology completely different and it provoked reaction at the changing doses? Shouldn't it systemically or from a symptom standpoint create more or less the same reaction?
14:19:41 A. Well, it does sometimes. But sometimes it's called a switch phenomena because it's a neurological reaction and they'll go to each -- another organ. Well, if that's the case, then you've got to wait until that goes away also.
14:19:57 Q. Well, how do you know what organ it's going to to trigger the reaction?
A. You don't.
Q. What's the half life of hexane?
A. I think it's about two hours.
14:20:08 Q. What's the half life of --

14:20:10 A. Two to four hours.
Q. Okay. What's the half life of heptane?
A. I think much similar.
Q. And when you're giving these antigens, is
14:20:34 there a specific target organ that you're looking to affect or what?
A. Yes, it's individual for an individual patient. It can be any of the neurological -- or any of the organs, major system, musculoskeletal,
14:20:54 neurological, cardiovascular, so on.
Q. So --
A. That's an individual thing.
Q. And given that the half life, say, of heptane, for example, is about two hours, if you give
14:21:10 it in a 1 to 100,000 solution or dosage, how do you know it even reaches the target organ and it just isn't excreted by simply going straight through the system?
A. Well, the patient is hypersensitive, you're
14:21:28 only doing these on people who are hypersensitive. The half life, then, really doesn't have a lot to do with it on these short half lives. I've seen reactions for that same thing last -- if you didn't neutralize it, last for a day or two. Well, that
14:21:42 doesn't have anything to do apparently with the half

14:21:44 life. It has to do with what was triggered in the body.
Q. Well, and could -- and a lot of the reactions that are described by your patients --
14:21:59 A. Yes.
Q. -- when antigen tested, they're fairly subjective, lots of times, right? They're like, my elbow hurts, my head hurts, my eyes feel pressure. Those are subjective, you can't measure those, can
14:22:12 you, Doctor?
A. No, but I can measure the other things. What if they're short of breath? Can I measure that? Not really, but I can observe it. Can I measure with a blow meter and quantitate it? You bet I can. If
14:22:25 I've got some that's got -- they're hurting in the hand and the hand turns blue or their finger turns blue, I can see that there's vascular spasm there. And I can also do a pulse oxygen and it will show it going down in that area.
14:22:41 So, you know -- I mean, it's like everything else that one does in medicine, there are some things that you can objectify and you always have to have the patient have credibility before you take just symptom, symptom responses, okay?
14:22:57 Q. Okay.

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MR. FRESHOUR: And I'm going to object as nonresponsive because my question was, wasn't things like pressure in the eyes and a pain in the left elbow subjective.

Q. That was my question.

A. And I said yes.

Q. Okay. Thank you.

A. But then I elaborated so you would understand what I was talking about.

Q. I understand.

So when you -- and this goes even to a lot of the exposure history. You're taking the patient's word for whatever they're describing as it relates to these subjective symptoms and manifestations, correct?

A. Well, if they're subjective, I'm taking it. Why do people come and pay money to physicians to solve the problem, right? So are they going to lie to me? Well, I suppose one in a thousand will. But on the other hand, most people who take their time and money want to get well. That's the ones I like to treat.

Q. Doctor, would you agree, generally, that we -- and when I say "we," just the public at large -- are still finding out more and more about

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the long-term consequences from use or exposure of chemicals?

A. Yes, I would say that's true.

Q. Okay. And so it's fair to say, although we don't know, even at your dilute solutions, it's possible that your antigens could be contributing to a long-term problem as far as the state of science right now, right?

MR. SIMON: Object to the form. Speculative.

A. Wrong.

Q. You couldn't be contributing? You're sure of that?

A. I'm pretty sure, yes. I've been practicing long enough to know that.

Q. Have you done long-term follow-up studies with your patients that you treated years ago to see if they've had further consequences or manifestations?

A. Yes, I have, yes.

Q. You are aware that some of the components in gasoline and diesel fuel are carcinogenic or teratogenic, correct?

A. Yes.

MR. SIMON: Object to the form in

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retrospect.

Q. One of the things that you, I think tested perhaps one, maybe two of these patients -- and if I'm mistaken, correct me, Doctor -- is lake algae, correct?

A. Yes.

Q. Okay. How do you get your lake algae for making your antigen?

A. We collect them from ponds. We have red algae, blue algae, green algae.

Q. From ponds. I mean, do you own the ponds? Where are the ponds?

A. Out in the country.

Q. Any particular place in the country?

A. Well, a place where there's not any pesticides or anything sprayed.

Q. Where are your ponds, Doctor?

A. East Texas.

Q. Can you be a little more specific? Around Tyler? Marshall? Henderson? Mount Vernon? Sulphur Springs? Where?

A. Lake Tawakoni, near Lake Tawakoni.

Q. Lake Tawakoni.

What's the -- so there's a separate pond for each kind of algae?

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A. There are separate types of algae. There's green algae, blue algae and red algae.

Q. Are they in separate ponds, or are they all in one pond?

A. I can't really tell you that. I suppose that at some certain times of the year they may be in the same pond. They may not be.

MR. SIMON: He doesn't do the collection.

Q. Depending on the waterway, would you agree that there may be different compounds found in the algae, depending on the waterways?

A. Yes.

Q. Okay. So I think generally, do you think that possibly -- I mean, algae as an organism is -- structurally more or less looks the same, is that true? Or do they look structurally different, do you know?

A. I really don't know. I can't --

Q. Okay. So would you agree that probably a saltwater algae is different than freshwater algae?

A. It's possible.

Q. Okay. And you're treating your patients -- when you do algae testing, it's the freshwater algae?

A. Generally I would say yes, unless, unless

14:27:47 they have lived by the ocean and they complained of that particular algae, then we might have them catch it and make a vaccine for them.
Q. A vaccine or an antigen?
14:27:59 A. Antigen, I'm sorry.
Q. I just want to be sure, because I think there's a difference between those two, right?
A. Well, I suppose, yes.
Q. Well, if there isn't, Doctor, you can
14:28:07 certainly explain it to me, because I really don't know.
A. Well, no, I won't go any further than that. There is a difference.
Q. Well, in exploring this algae thing just a
14:28:20 little bit further, do you agree that algae from a lake in Texas probably in August would not be the same as an algae from a lake in -- high up in the Adirondacks in April?
A. It's possible. I can't agree that it may
14:28:38 not be the same. But it's possible, put it that way.
Q. Well, and I guess, then, the -- one of the other things is, that these east Texas ponds that you're using, I mean, how do you know that the ponds aren't being subjected to runoff from, say, a coal
14:29:05 plant or anything of that nature?

14:29:07 A. I don't know any coal plants around there.
Q. Okay. Well, if -- this is around Lake Tawakoni, right?
A. Uh-huh.
14:29:16 Q. Is it in a particular town?
A. No.
Q. It's just out there by Lake Tawakoni?
A. Yeah.
Q. Okay. Are there any farms around there?
14:29:27 A. No, they're all ranches.
Q. Ranches, okay. So cattle, horses?
A. Yes.
Q. Probably do some hay baling out there, have pastures?
14:29:40 A. Yes.
Q. How do you know they're not using pesticides?
A. Because we don't use those.
Q. I'm not asking -- it's your ranch?
14:29:47 A. I have a ranch and then I have neighbors, and I know all the neighbors.
Q. Okay. So let me ask you -- I guess I've got to be real specific, Doctor.
The ponds that you get your algae from
14:29:57 for algae testing your patients are on your ranch?

14:30:01 A. Well, generally. Not always, but generally.
Q. So what other places do you get algae from?
A. I sometimes will do it from west Texas.
14:30:16 Q. Where in west Texas?
A. Well, out there where there's hardly anything, past Possum Kingdom.
Q. Let me ask you, you get a patient from the northeast, who lives in New York City.
14:30:31 A. Yeah.
Q. Mostly saltwater around there, there's some freshwater?
A. Yeah, there's both.
Q. So how do you determine if they're -- why
14:30:42 would you test them with an algae from east Texas, taken in August, if they were exposed to their claimed algae somewhere in New York and you don't know what the body of water was they were exposed to? How does that help you.
14:30:55 MR. SIMON: Object to the form.
That's assuming they are exposed to algae?
MR. FRESHOUR: Yes.
A. Well, how we would do it, number one, we
14:31:02 would have to see whether they were exposed to algae,

14:31:05 and number two, if they were, we might test them here and see if there was a cross reaction, because a lot of them do have cross reactivity, and third, if not, we would have them collect some and make a specific
14:31:20 one for them.
Q. So then the algae for the source of the antigen would come from them and you wouldn't know any way how it was handled, shape, form, nothing, correct?
14:31:29 A. Well, we would tell them how to handle it. Then I wouldn't know for sure. But, again, these are people who want to get well.
Q. When you do some antigen testing, is there any risk or concern that there may be some kind of a
14:31:47 reaction such as an anaphylactic shock?
A. Well, that's the nice thing about this technique we use, we have the largest series in the world of treating anaphylactic shock. And we've never had one from testing.
14:32:03 Q. You have the largest series?
A. Yes. Of people who go into anaphylactic shock with different things.
Q. I'm sorry, I don't understand, Doctor.
A. Well, you may not be aware of it, but there
14:32:15 are people who have to carry adrenaline around all

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14:32:19 the time because they go into anaphylaxis with certain exposures, insects, things, or eating a food or smelling the odor of peanuts or some chemical or whatever, okay. That's dying episodes, okay. That's
14:32:33 a good way to die real fast. And we have treated 150 of those where they've been able to get around the substances by this neutralization technique.

Q. Do you have the underlying data on those 150?

14:32:48 A. Of course I do. It's written up in my book.

Q. Do you have the underlying data that supports what's written in your book?

A. I don't know whether I do anymore. Why?
14:32:55 Would you think I'm lying?

Q. I'm just asking the question, Doctor.

A. No, I'm asking you that.

Q. I ask the questions here, Doctor. I'm not trying to be disrespectful. I'm asking you a
14:33:02 question. Do you have the underlying data for the 150 patients you just --

MR. SIMON: That's asked and answered. He said he doesn't know if he has it down in --

A. I probably do, but I don't know yet.
14:33:10 Q. All right.

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14:33:11 MR. FRESHOUR: Probably a good breaking point here.

THE VIDEOGRAPHER: The time is 2:33 p.m. This is the end of tape number four. We are
14:33:19 going off the record.

(Recess from 2:33 to 2:38)

(Mr. Cook is now present)

THE VIDEOGRAPHER: The time is 2:38 p.m. This is the start of tape number five. We are
14:38:36 on the record.

Q. Dr. Rea, we were just going through a line of questioning that dealt with some provocation and neutralization, then we were talking a little bit about lake algae, and we had a discussion over you
14:38:52 testing some patients for lake algae and the source of the lake algae. And you indicated it was from a ranch in east Texas and it was your ranch, correct? For the most part, there may be a few other sources.

A. Correct.

14:39:08 Q. What is the collection and antigen formulation method you used for your lake algae antigen?

A. Well, we would scoop up the algae and put it in a flask, and then put it in the coca solution
14:39:25 and do just like we do for the other molds.

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14:39:29 Q. And I don't know how far your ranch is from Dallas, but there's a transport period. Is it just in the flask? Is it iced? What's the mechanism and chain of custody?

14:39:41 A. Just in the flask, and it's about an hour.

Q. Okay. It's about an hour drive?

A. Yeah.

Q. Okay. And then you put it through the coca solution. do you -- have you ever tested any of the
14:39:54 algae that comes from your ponds, for lack of a better term, from your ponds for parasites, bacterias or heavy metals?

A. No.

Q. Now, those allergies that are out there,
14:40:13 are those naturally occurring algae, or have you brought in some specimens to create the algae colony growths?

A. No, they're naturally occurring.

Q. Okay. Doctor, you would just agree as a
14:40:52 general proposition that at least some of your medical views that we're discussing here today are at least controversial or disputed by another whole segment of the medical community, fair enough?

A. I would say a small segment, yes, uh-huh,
14:41:11 as is most things in medicine that progress.

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14:41:15 Q. Okay. And were you aware of an article in the -- let me make sure I cite the proper journal, Doctor. A Journal of Allergy and Clinical Immunology in December 6 (sic), did you ever read an article, it
14:41:43 was about multiple chemical sensitivities, a systematic review of provocation studies. Are you familiar with that article?

A. No.

MR. SIMON: December 6 of what year?

14:41:53 MR. FRESHOUR: I'm sorry, it's December of '06.

A. Of '06?

Q. Yes.

A. I may have read it. I don't know. It's
14:41:59 been a long time.

Q. Okay. And they're talking generally about provocation studies, and they've done a review. It included a citation to your work in there. I don't know if you're aware of that.

14:42:10 Are you aware that they concluded that persons with -- and I know you don't agree with this term so don't object to that, Doctor -- multiple chemical sensitivity do -- we conclude that persons with MCS do react to chemical challenges; however,
14:42:27 these responses occur when they can discern the

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differences between active and sham substances, suggesting that the mechanism of action is not specific to the chemical itself and might be related to expectations and prior beliefs. Were you aware of that article or that finding?

A. I think I was. It wasn't a finding. It was just their opinion.

Q. But you are aware of that?

A. Biased opinion, yes.

MR. SIMON: You are aware of the article?

THE WITNESS: Yes, I believe I was, yeah.

Q. And you said it's a biased article?

A. Obviously.

Q. Okay. And it is obviously biased because it disagrees with you or --

A. There's a lot of points in there that it showed people were uninformed.

Q. Okay. I just wanted to be sure the basis that you --

A. Yeah, I wanted you to be sure of that, too.

Q. Okay. Well, I'm very clear on that.

All right, Doctor, you run a number of different tests on your patients that you see for

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chemical sensitivity, correct?

A. Well, sometimes, yes.

Q. Well, let me be sure. I think in most of these patients we're looking at today, and what I've seen, is you quite often use pupillography, correct?

A. Yes, that's correct.

Q. Heart rate variability?

A. Yes.

Q. SPECT scan?

A. I don't use that on everybody, no.

Q. But you do use it in your practice?

A. I do, surely.

Q. And I don't recall, do you recall right off the top of your head, did any of the five that we've got here have a SPECT scan?

A. Yeah, I think one or two of them did.

Q. Sometimes you do a chelation testing; is that true?

A. No.

Q. You don't? Do you use chelation at all?

A. Very, very rare.

Q. Do you recall that any of these patients had any chelation?

A. Not to my knowledge.

Q. Heat depuration?

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A. Yes.

Q. And that's a treatment, not a test, correct, Doctor?

A. Yes.

Q. Thermography?

A. Yes.

Q. And that's a test, correct?

A. Yes.

Q. All right. And this is in addition to the, some of the -- and you always -- not always, but you do a lot of blood and serum testing, correct, on these patients?

A. Yes.

Q. On a number of them, you did urine testing, correct?

A. Yes, some, some.

Q. For specific things?

A. Yes.

Q. But generally you did some urine testing?

A. Yeah.

Q. Did some hair analysis?

A. Yes.

Q. I think in most of them you did -- I guess I have to say it, all of your -- various antigen and testing, as well as food sensitivities, correct?

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A. Yes.

MR. SIMON: Mr. Freshour, when you refer to "them," we mean these five patients?

MR. FRESHOUR: These five generally.

MR. SIMON: The subject of the complaint?

MR. FRESHOUR: Uh-huh. All right.

Q. Now, Doctor, when we talked quite a while ago, we talked about medical records and you need to list things, and talk about things like thyroid, if there's thyroid condition, if there's diabetes, because those are important in helping you come to a diagnosis, right?

A. Yes.

Q. Because those conditions can certainly impact your decision as a physician, correct?

A. Correct.

Q. Now, before we get real deep into that, generally what is a differential diagnosis, Doctor?

A. Differential diagnosis is a person has a set of symptoms, you want to see what, which diagnosis fits, is it something like lupus or something like arthritis or something like gastrointestinal upset, colitis, so on.

Q. All right. And I think we hear -- as

laypeople, sometimes we hear the term "rule in" and "rule out" in medicine, right?

A. Yeah, that's right.

Q. What does that generally mean to you, Doctor?

A. Well, generally it means that there's certain, a certain disease. Let's say you got -- you worry about meningitis and you want to rule out the cause, meningococcal or hemophilus or whatever, and so you can specifically diagnose something or you can say, no, they for sure don't have that.

Q. Now, when you're doing some of the testing -- and I particularly want to talk a little bit about laboratory testing. Quite often, we'll see -- in laboratory testing, you'll see what's called a reference range in the results.

A. Yes.

Q. And my understanding is -- and correct me if I'm wrong -- a reference range is what has been determined looking at a number of individuals that are tested and this is what basically the average findings are for whatever the test may be?

A. Yeah, that's correct, average.

Q. And that's called -- normal population, usually, a reference range, an average population?

A. Average population, not a normal population.

Q. Okay. Average.

And then what you do is -- when a laboratory normally does a test, they do whatever the test is you've ordered on your patient and they send back the results, they list the specific findings, whatever the test is, of that patient. And that's normally compared to what we're calling this reference range or average --

A. Average patient, yeah.

Q. Okay. And that's because that gives you a frame of reference to know, this is what the average patient looks like and here's where -- that just helps you, correct?

A. Yeah, sometimes it does. Sometimes it doesn't.

Q. Okay. And what are you looking for in those kinds of ranges that do help you? And you say sometimes it doesn't. What are you kind of telling me generally?

A. Well, I mean, sometimes, for example, take thyroid, some people will fall like in the lower limits of average range. And, in fact, for them, they might be hypothyroid and they might need some

thyroid supplementation.

Q. What you're talking about there is what we're now seeing a lot of, is this subclinical hypothyroidism?

A. That's correct, yes.

Q. Where you look at a thyroid-stimulating hormone level and it's in the normal range, but it may be towards the low end, and it appears that they've got subclinical hypothyroidism?

A. That's all I'm saying, yes.

Q. Okay. Now -- so you're looking at these average ranges, and you test your patient, and you get the results -- and where I'm really going with this -- I'll go directly to the point. The chelation testing. I'll represent to you --

A. Chelation testing.

Q. Chelation.

MR. SIMON: He said he doesn't do it.

MR. FRESHOUR: Okay. Let me ask my question. If you've got an objection, Mr. Simon, I'll, you know, be glad to hear it.

Q. I'm going to represent to you that in -- and I don't remember the patient. I'll find it if we need to. But one of these patients had a 24-hour urine heavy metal test. Do you recall --

A. Yes.

Q. Okay. And I will represent to you at the bottom of the sheet it was done by [Redacted]. it said that --

MR. SIMON.

Q. [Lab name redacted]

It said something to the effect that these reference are the normal population range that we've established.

A. Okay.

Q. That means that laboratory --

A. Yes.

Q. -- has established what they consider --

A. Do they say normal or average?

Q. I believe they said normal.

A. All right.

Q. And we'll double-check. If it's average, I will certainly correct it.

Do it over 24 hours and get these heavy metal urine results. Then the patient is chelated. It shows what they call a provoke test, ... says at the bottom provoke, meaning they had a chelating agent, okay. Now, my understanding is a chelating agent is a material that is ingested by the individual with the thought being that it will grab

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any heavy metals in the body and flush them out through the urine, correct?
A. Yes.
Q. Rather crude description, but generally that's what it is, right?
A. That's correct.
Q. Now -- and I want to understand, because in this particular patient, I think -- and I'm sorry, I'll find out who it is. One of the determinations you made was this person had heavy metal toxicity.
MR. SIMON: Mr. Freshour, I think we've got to venture into the particulars of the medical record.
MR. FRESHOUR: Let me withdraw the question and ask --
MR. SIMON: Here's what the problem is, that the medical records are in the --
MR. FRESHOUR: Mr. Simon, I withdrew the question. Let me go.
MR. SIMON: Okay.
Q. I'm going to represent to you that the patient had a chelation test and they found abnormal levels after the chelation test, after the provoke. But the comparison was for the chelated patient against the normal unchelated patients.

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A. All right.
Q. Okay. Now, I'm trying to understand how, if that person was first average without chelation, that being your patient, against this same normal range, then you chelate them with an expectation of having higher metal levels removed, how can you use that if it's compared to a reference range of a non-chelated average or normal group? What use is that? Because you would expect higher levels, wouldn't you?
A. Well, you don't necessarily get higher levels. A lot of them, nothing comes out when you do that.
Q. Well, let me ask you, if you're comparing -- if you're going to compare a chelated range against a -- the first test was non-chelated versus non-chelated, right?
A. Yes, that's right.
Q. So if you're comparing to see if what was drawn out of this person, by chelating, it would seem to me as a layperson, make more sense they should be against a normal chelated population to see if it's the same kind of results coming.
A. Well, if that's what you're asking, you're right. But the point is, when it's only -- it's a

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small part of the burden, and it wasn't within the patient's history, physical or complaints. If they had a little bit of, say, mercury or lead come out of them, that would only be what's part of the burden, then you might try to get it out just so you could lower the burden. It doesn't really matter whether it's compared to a normal or not, because what you're saying is, hey, these people have got mercury parked someplace in their body, we would like to get rid of that so we can start treating the other things and take care of it.
Q. Well, and how do you know if it's a burden on them if you're not comparing them against the normal population? Because if you chelated them and they came out with the same results and they're not showing any, how do you know you're relieving a burden?
A. Well, because, number one, you're not supposed to have mercury in you and you're not supposed to have lead in you, you're not supposed to have cadmium in you. So you know that that's part of a burden, always. Some may have symptoms, some may not, but it's still part of their body burden.
Q. Okay. And what I'm trying to do is, as a layperson, understand that if you've got a

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non-chelated to a non-chelated, that's kind of like an apple to an apple. It seems to me when you look at a chelated versus a non-chelated and say the levels are abnormal, that's an apple and an orange comparison.
A. So?
Q. So you don't see anything wrong with comparing --
A. Not in that situation because of what I said. If you've got, if you've got mercury in you, you don't want it in you, I'm going to tell you that. And you don't want cadmium in you and you don't want lead in you, because it's very devastating over the long run. And in these patients -- I'm not sure which one you're talking about here, because I don't recall I chelated any of them -- is that we would do that just to decrease their burden, their total body burden, part of the barrel effect.
Q. Right. But if you say to them, you're burdened with heavy metals because of that chelated result, isn't it true to say that if it's based on that... test in the normal range, it's a self-fulfilling prophecy because you chelated them, you would expect the metals to come out if the chelation works, so, therefore, oh, look your levels

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are abnormal?
A. Only if the metal is there. If the metal is not there, you're not going to have any.
MR. FRESHOUR: Mr. Simon, I wish you would quit with the head and the arm gesture.
MR. SIMON: I'm sorry, I'm just, I just want to maybe -- and I'm going to shut up after this. I guess that the differential between the schools of thought is one is an elective procedure, one is not.
MR. FRESHOUR: Mr. Simon --
MR. SIMON: I'm just bringing it to your attention.
MR. FRESHOUR: I don't need your attention, I need an objection. Quit coaching your witness.
MR. SIMON: I think he knows more --
MR. FRESHOUR: I didn't ask for an explanation.
MR. SIMON: -- than me. I don't --
MR. FRESHOUR: There's no objection.
MR. SIMON: -- think I can coach him.
MR. FRESHOUR: But there's no objection on board. Just if you would, please.
MR. SIMON: Sure.

MR. FRESHOUR: Don't need to explain to me how --
MR. SIMON: Let's move it along, no problem.
MR. FRESHOUR: Okay.
Q. So you don't see any problem with that comparison? That's what I'm getting down to.
A. In certain circumstances, as I've said before.
Q. Now, one of the things you -- several of these patients had was brain fog. You're familiar with that term, aren't you?
A. Yes, I am.
Q. What is brain fog, Doctor?
A. Well, brain fog is like you're under a little bit of anesthetic, you can't think right, you feel tired, fatigued, things just aren't going with enough energy, and so you're sort of fogged over. It's a proper medical term.
Q. Okay. Now, well, let me, if it's a, it is a -- if you say it's a proper medical term --
A. It's in my dictionary, yes.
Q. That's fine.
Isn't brain fog, though, completely subjective? I mean, how do you objectively measure

brain fog, Doctor?
A. Well, most of these people have short-term memory loss when they have it. That's an objective finding. Most of them drop their words. A lot of times they can't remember words. Some of them, they have trouble putting sentences together.
Q. And do you give them some kind of test to determine brain fog?
A. No, other than the SPECT scan or Dr. Didriksen's work, I don't. I mean, I can tell that clinically. You can tell it clinically when somebody is fogged over.
MR. SIMON: What does Dr. Hedrickson (sic) do?
MR. FRESHOUR: I'll ask him about Didriksen if I want.
Q. Well, what's the difference between brain fog and decreased mental sharpness?
A. Probably much the same. Maybe a matter of degree.
Q. How do you get a baseline on somebody to determine whether they've got brain fog or decreased mental sharpness?
A. How do you get a baseline?
Q. Yeah.

A. Get them to when they're clear, when the brain is clear.
Q. Well, they're coming to you, saying they've got it. How do you establish a baseline to say they've got brain fog, Doctor?
A. Well, I just told you some of the things. And then I may send them to Dr. Didriksen, who is a neuropsychologist, to find out what she feels. She does objective tests on them.
Q. Is this the same Didriksen that works with -- used to work with Joel Butler?
A. Yes, that's correct.
Q. Is this the same Didriksen that works fairly closely with -- his name, is it Theodore Simon?
A. Not that I know of, no.
Q. She doesn't work with Dr. Simon?
A. Not to my knowledge.
Q. Dr. Simon does a lot of spectrum brain scans --
A. Yes, he does, uh-huh.
Q. What about lack of mental sharpness, isn't that also fairly subjective? I mean, how do you establish a baseline on that and distinguish it from brain fog?

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14:58:59 A. I think I already answered the question.
Q. Degree, degrees?
A. (Nods head)
Q. Now we talked earlier today and you said
14:59:13 you knew a Dr. Stephen Hotze, correct?
A. Yes.
Q. Are you aware that he also diagnoses a lot
of his patients with brain fog?
A. No, but I would assume he had.
14:59:25 Q. Are you also aware that he attributes that
all to just hormone imbalance?
A. I don't think he does.
Q. Well, do you know if he does?
A. You asked me my opinion. I don't know for
14:59:38 sure. He sends up patients to me that's got brain
fog.
Q. How do you distinguish brain fog that you
see between brain fog that he attributes to hormone
imbalance? How do you distinguish different brain
14:59:54 fogs?
A. How do you distinguish somebody who's got a
sinus infection due to pseudomonas versus one that is
due to a virus? Same way, clinical things and
cultures. And the other way it would be, how you --
15:00:08 if you found what the triggering agents were.

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15:00:11 Q. Well, how do you -- your patients you find
for the most part the trigger mechanism is usually
chemical sensitivity, correct?
A. Well, could be foods that could do it. You
15:00:26 can't say it's just chemicals, no. Sometimes foods
do it, sometimes mold will do it. I've seen pollens
do it, I've seen bacteria do it, I've seen viruses do
it. So I think that your statement is not correct.
Q. Okay. Have you seen hormones do it?
15:00:41 A. Yeah, I sure have.
Q. Are there any other causes that you can
think of for a lack of mental sharpness, besides
bacterias, chemicals, hormone imbalance, the litany
you just ran through?
15:00:57 A. Well, yes, sometimes metabolic. For
example, a diabetic may get brain fog because they
don't have enough blood sugar.
Q. How about somebody who is on thyroid
medication or has a low thyroid function?
15:01:10 A. Yes, of course.
Q. Right. Because you said brain fog includes
things like tiredness and fatigue?
A. Yeah.
Q. Which could also be signs of
15:01:17 hypothyroidism?

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15:01:18 A. That's correct, yes.
Q. Could be signs of diabetes?
A. Right.
Q. Could be signs of another number of
15:01:23 other --
A. Oh, yeah. Differential diagnosis.
MR. SIMON: Let him finish the
question.
Q. Right. And that's exactly what we're
15:01:29 talking about in a differential diagnosis, correct?
A. (Nods head)
Q. You have to establish at least what you
think it most likely is, or hopefully you can say
what it isn't, making it easier to narrow your
15:01:42 universe, correct?
A. That's right.
Q. Now, at least one of these patients that
you had complains of insomnia and kind of low moods,
malaise. And malaise is just generally not feeling
15:02:02 well, is that what malaise means?
A. I would say that's good enough.
Q. As far as -- and a couple of them, I think,
said they had some increased body size. Other than
the chemical sensitivities and those kinds of things
15:02:17 that you gave me, there's a number of other medical

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15:02:20 reasons that persons might have increased body size
and malaise, including things like we've already
talked about?
A. Yes.
15:02:27 Q. Diabetes, thyroid?
A. Yes.
Q. Sleep apnea, I guess, could cause fatigue,
couldn't it?
A. Oh, yes, certainly can.
15:02:36 Q. Obesity?
A. Yes.
Q. Perhaps even cigarette smoking, because
you're not getting enough oxygen, and if it's
damaging the body, correct?
15:02:44 A. Possible.
Q. Same thing goes with, you know, if a
patient complains of shortness of breath, you've got
to begin to look at all kinds of things, weight,
smoking, just a whole litany, correct?
15:02:57 A. Correct.
Q. If somebody is a smoker, what -- in your
general patient population, when you see someone come
in who's a smoker, without knowing the extent of it,
but it looks like it's a fairly long, chronic habit,
15:03:27 what kind of impact does that have, Doctor? What

significance does that carry to you generally?
A. Well, usually that's an environmental insult that damages one of their systems or multiple systems.
Q. And we know what -- and when you say insults systems, you're talking things like the lung cancer and --
A. Lung cancers, emphysema, chronic bronchitis, skin wrinkling, heart disease.
Q. Okay. Now, some of the -- and I'm going to jump back, Doctor, and I apologize for this. When we get back -- we're talking about the heavy metals. There's some heavy metals that naturally occur in our bodies, isn't that true? Like selenium, magnesium. Don't they naturally occur to some level in the body?
A. Those aren't heavy metals.
Q. Okay. What are those, Doctor?
A. Well, they're just minerals.
Q. Minerals?
A. Yeah.
Q. Okay. Now, arsenic is a -- is arsenic a heavy --
A. Well, it's in between. But it's considered a very toxic metal, of course, because you can die of arsenic poisoning.

Q. Right. And there is -- arsenic naturally occurs in the earth's crust, right?
A. Yes, unfortunately.
Q. Right. And there's -- in all of our food and water, there may be some traces of that that's unavoidable, correct, particularly water, in arsenic?
A. Well, it's not unavoidable. But it can be in water, yes. Certain wells are contaminated with arsenic.
Q. Now, I just want to be sure, and I'm going to go back to the chelation example once again. When that patient -- and like I said, I'll find the results before we leave today. When that patient came back and had somewhat elevated levels -- you may not remember right now, and we'll go specifically to that patient here in a bit -- did you sit down and explain to them the significance of that finding in your opinion that they had some metals that chelated?
A. Yes.
Q. Now, in doing that, do you recall -- and I'm going to represent to you that there's the wording at the bottom of that chelation test that they're compared against an unprovoked normal. Did you explain to them what that meant or --
A. I probably did. I don't recall, but I

probably did.
Q. You don't remember, obviously. It was many, many years ago, correct?
A. That's correct.
Q. Okay. But you --
A. I generally do, so...
Q. Right. Because you want to be honest, forthright with your patients, make them have a full understanding of what they're getting, what they're not getting?
A. Yes.
Q. All of that kind of stuff?
A. That's correct.
Q. All right. One of the things I talked to one of your other experts about -- and I think several of your patients here had some hair testing. Are you --
A. Yes, that's correct.
Q. And I think the hair testing, if I'm not mistaken, was done through [Lab redacted] as well?
A. Yes.
Q. Do you, do you know exactly what the chain of custody today is after you take the hair sample from your patients and it goes to the [Labnameredacted] -- XXX for short?

A. Well, I know our chain of custody. I don't know whether we have to have a chain of custody. They're honorable labs. By from our lab where we cut the hair, there's a special kit that you put it in, and it goes directly to [Redacted]. Now, I can't tell you what happens after [the lab] gets it.
Q. Okay. And I'm going to represent to you that I talked a little bit -- I think it was to Dr. Ross, about this.
A. Yes.
Q. When you give a -- get a hair sample from a patient, you need to know, or it's important to know whether the patient has recently bleached their hair, dyed their hair, if they've had a shampoo, what kind of shampoo it was, correct?
A. That's correct, yeah.
Q. Because all of those things can contaminate and skew results for a hair test?
A. Yes, that's correct.
Q. And --
A. In fact, I think we had to use pubic hairs for one of the girls.
Q. Right. And it also makes a difference where the sample was taken from, whether it's near the end of the follicle or close to the head because

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of the way --
A. That's right.
Q. -- hair grows, correct?
A. Yes.
Q. Isn't it also true that when you get back the testing results -- and I'm going to use, for example, it says, hair has some arsenic on it, for example -- or it doesn't say it had it on it, it said it tested positive for arsenic, right? That's what the results says.
A. Yes.
Q. Isn't it also correct that on those results, you can't determine if that was arsenic that was internal in the follicle or external? It doesn't distinguish in the results, does it?
A. No.
Q. Okay. And there's also -- and I don't know, there's certain -- and I don't know if it's arsenic or not, but there's certain organic and inorganic materials that are distinguished when you get a hair result, right?
A. Correct.
Q. So it just says something is there, but you're not sure exactly the source of it, just that it's there?

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A. That's correct.
Q. What is thermography, Doctor?
A. What has been found is that there are nerve points all over the body that reflect the internal temperature of different organs and different areas of organs, and this is a special technique that measures these temperatures in 120 places around the body. And it gives you an idea of what the temperature is on that particular area.
Q. All right. And these are -- these 120 points, and they show it graphically by different colors, is that correct? Is that how it's done?
A. Well, there's two types of thermography. One is where you actually see a green or a red or a yellow color, okay, that's -- and then the other one that I'm talking about, you actually take the temperatures with a probe on the different parts of the body.
Q. Okay. And you use the one that goes to the different probe points?
A. Yes, that's correct.
Q. Okay. And so it gives you -- and are there -- is there a normal or average temperature range you're looking for at those particular points?
A. Yes.

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Q. And that's been established by some research?
A. Yes.
Q. Okay. Now, the -- those reference ranges -- it's not a reference range you've established, it's from some other source; is that correct?
A. Yes, that's correct.
Q. All right. Now, when you see these heat variations, it doesn't necessarily distinguish what the cause of the heat variation is, it just manifests there is a heat variation, correct?
A. That's correct.
Q. And you certainly -- I would assume that you can't take it and put it on a point and say, well, you know, because this point -- I don't even know if it's a point, here on your left elbow has got a three degree fluctuation, that means that you've got a, a liver that's full of heavy metal?
A. They have certain patterns that they've done. You've got to remember, there's 14,000 articles on thermography now. And they do have patterns where there are points for like the liver and the heart and the brain and different areas. I personally don't know those because you have to have

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a regular thermographer read it. And -- but they do interpret it a lot of times as whether the liver is bad or the blood vessels are bad or the brain is not functioning right or so on.
Q. Right. And even if they do that, Doctor, even if they say there's something wrong --
A. Yeah.
Q. -- they can't tell the cause? They can just tell there's something wrong because of the heat fluctuation?
A. Exactly.
Q. Okay. So you couldn't put it on and say, well, the left temple, there's a three degree difference, that means he's got, you know, a, a left side, you know, aneurysm that's growing or something? It's not like that? It's just there's something going on up there? And that's a very poor example, but --
A. Yeah, like, for example, breast lesions, a lot of times they can differentiate between benign and malignant lesions.
Q. Right.
A. When they're real small, you know, before you can pick them up on our mammogram.
Q. Right. But if you go to, say, internal

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organs in particular, you -- say, well, that point correlates to the liver, but -- and it seems off, but you can't tell what the cause of it being off is?

A. You can't tell the cause in any test hardly, except challenge tests.

Q. Except challenge tests?

A. Yes.

Q. And what do you mean by "challenge tests," Doctor?

A. Well, either intradermal challenge, oral challenge, inhale challenge, where you breathe something.

Q. And you do inhale challenges at your office, don't you, Doctor?

A. Yeah, sure.

Q. And when you do those inhalation challenges you put them in a. I guess like a sealed room or little chamber or something; is that correct?

A. We have an environmentally controlled room, then an environmentally controlled chamber inside that.

Q. Okay. And then you send in various, I guess, chemicals and odors and --

A. Yeah.

Q. -- that kind of thing --

A. That's correct.

Q. -- to see the reaction?

A. Yes.

Q. Okay. And on those, do you ever -- do you use any masking agents?

A. Well, no, we don't. We use placebos, but we don't use masking agents because then you're compounding the problem, you don't know what you're dealing with.

Q. Okay. And when you give them a placebo, what is your placebo? Just air?

A. Saline.

Q. I mean --

A. In a flask. We set everything in a flask and have it open. It's all standardized, okay?

Q. Okay. And do you -- so if the flask goes in there, I mean, are all of the materials, are they all the same color? Are they different color? Are they clear liquids?

A. All the same color.

Q. Okay. What color?

A. Well, it's an off-white.

Q. Okay.

A. Or I should say off clear.

Q. Is there such a thing as an off clear,

Doctor?

A. I don't know.

Q. All right.

Doctor, one of the tests you use is pupillography; is that correct?

A. Yes.

Q. And that's a -- and what you're measuring there, I believe, is the autonomic response to the, of the pupils. Is that what it is?

A. Yeah, of the upper area of the head and eyes.

Q. Okay. So what are you looking for when you do pupillography?

A. Well, we -- you're looking for autonomic nervous system dysfunction, which most of these people have. And I think we talked about that a little bit this morning. But what -- this was one of the first tests that you could ever do to objectify autonomic dysfunction.

Q. All right. That was the one -- the study that you and Dr. Ishikawa did?

A. Yes, that's correct, uh-huh.

THE COURT REPORTER: Dr. who?

MR. FRESHOUR: Ishikawa.

THE WITNESS: Again, phonetic,

I-s-h-i-k-a-w-a.

Q. And besides chemical exposure or chemical sensitivity --

A. Yes.

Q. -- there's a number of other conditions or -- that can cause autonomic nervous responses in pupillography, correct?

A. Yes, that's true.

Q. And do those include things such as diabetes?

A. Yes.

Q. Just generally fatigue can cause --

A. No.

Q. -- a different, differentiating --

A. That's up in the air, that's very dubious. Tumors could do it.

Q. Okay. How about stress?

A. How about what?

Q. Stress, just putting someone under a great deal of stress and then measuring their pupil response.

A. It all depends on how you define "stress." You can get a response from that, yes.

Q. How about if somebody suffers from Behcet?

A. Pardon?

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15:16:13 Q. Behcet disease. B-e-c-h-t (sic).
A. Behcet disease?
Q. You can pronounce it better than --
A. I'm sorry, I don't know what you're talking
15:16:22 about there. I just -- I don't know what you're
talking about.
Q. Okay. How about Horner's syndrome?
A. Well, Horner's syndrome says you've got a
droopy eye from the autonomic nervous system. That
15:16:32 doesn't tell you anything.
Q. How about Adie syndrome?
A. I don't know what that is.
Q. Okay. How about MS?
A. Yes, you can have autonomic dysfunction
15:16:49 from MS.
Q. How about psychotropic drugs?
A. Yes, a lot of drugs can do it.
Q. Whether they're legal or illegal?
A. Yeah, I would say so. You get the pinpoint
15:17:01 pupils from the illegals.
Q. Right. And, in fact, one of the articles
cited, I think dealt with a Dr. Fincher, was all
about Ecstasy, I believe, wasn't it, and the response
by the autonomic nervous system? Do you remember?
15:17:13 A. She may have written some section. I don't

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15:17:16 think her whole article is that.
Q. Now, when you do pupillography tests, do
you just have the patients come in and sit them down,
or are they subject to any kind of stimuli or
15:17:27 anything before you test them?
A. Well, these patients are usually on a
controlled diet, safe water and safe air, and we have
a special room that is a faradic cage-type room so
you get less electromagnetic radiation. And then
15:17:47 they're placed in there, and just let them
equilibrate for 15 minutes to a half hour. Dr. Pan
does those studies.
Q. Dr.?
A. Pan.
15:17:57 Q. P-a-n?
A. Yes.
Q. He's one of the physicians at your clinic
that we were discussing in generic terms this
morning?
15:18:05 A. Yes, that's correct.
Q. Doctor, you said, you know, that you put
them in the controlled room and everything. Do you
own any -- or provide for your patients any off-site
facilities that are environmentally controlled while
15:18:23 they're being treated by you?

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15:18:24 A. No, I don't own any. We work --
Q. Go ahead, Doctor.
A. No.
Q. You don't own any. Do you provide any or
15:18:31 do you have a working arrangement with a hotel, motel
or a facility here in town?
A. Yes, we have -- with the Marriott hotel, we
have one building that's environmentally controlled.
And a lot of patients live there.
15:18:44 Q. Okay. And did any of these five patients
live there, do you recall?
A. Yeah, I think maybe they did.
Q. What do you charge them for that, Doctor?
A. I think it's $110 a night.
15:18:59 MR. SIMON: What does he charge?
A. I don't charge anything. But I mean...
Q. Well, indirectly, when you put them there,
they're assessed a charge, correct?
A. Yes, certainly.
15:19:08 Q. And that charge is about $110?
A. I think so, yeah.
Q. So it's with the Marriott, and I assume
there's some kind of relationship between your clinic
and the Marriott to do this?
15:19:18 A. Yes, that's correct.

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15:19:19 Q. And I assume that your clinic gets some
kind of either monetary portion of that monies or
something from Marriott for whatever this agreement
is?
15:19:30 A. That's correct.
Q. Okay. And is there any average length of
stay that your patients have there, or is it all
dependent?
A. This is all dependent. But some people
15:19:42 just get so well, get so good there, I can't get them
out. Our problem is we line up patients that we want
to get in there -- or who want to get in. We don't
recommend -- or we don't force them in or anything.
They do that on their own. So we've had some there
15:19:58 up to two years. And others -- our average we like
is two to three years weeks, get them out.
Q. And in that two to three weeks, are they
coming back and forth to your clinic for treatments?
A. Yes, every day.
15:20:13 Q. Okay. Now, you said they're
environmentally controlled rooms. And I'm talking
about at the Marriott.
A. Yeah.
Q. What does that entail generally? What do
15:20:25 you mean when you say that, Doctor?

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A. Number one, no pesticide. Number two, no carpets. Number three, special nontoxic paints. Number four, electric, all electric. And number five, the beds and the mattresses are environmentally sound without any foam or the contamination. Same as with the furniture. And they're maintained with nontoxic soaps and so on.
Q. Okay. Now, just so I understand about those, let's say a patient has been there, two weeks, three weeks on an average stay, patient leaves.
A. Yeah.
Q. How do you ensure the integrity of that room for the next patient? What steps do you go through to maintain its integrity?
A. Well, we have specific protocols for cleaning them.
Q. Such as?
A. Well, as I said, nontoxic soaps. We use mostly elbow grease, no deodorants, anything like that, and obviously you change the sheets, you change the bedding and all that.
Q. Well, let me ask you --
A. No pesticides, no fragrances squirted in there, things like that.
Q. And let me ask you, does the Marriott do it

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with their own hotel staff, or do you know who does it?
A. No, no, we have to do it with our own, because we have to have control over them so they don't mess up, which is an easy thing to do.
Q. Okay. One of the tests you use is heart rate variability, correct?
A. Yes, right.
Q. Okay. What is -- what do you mean by "heart rate variability," Doctor?
A. The weller the heart, the more it will vary in response. So, you know, if you get into some stimulus -- well, it can go real fast, it can beat in a different way that's normal, it can pump in a different way that's responsive to the stimulus. The person with a damaged heart, the more they got damaged, the more shrinking is the variability of the heart. And that's sort of now become a well established valuation of the autonomic nervous system going to the heart.
Q. And are you familiar at all with the task force of European Society of Cardiologists and the North American Society of Pacing and Electrophysiology position on heart rate variability and its applications?

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A. No. What year was it?
Q. It was in -- I'm talking about the 1996 position paper. Are you familiar with that?
A. No, that's a long time ago. I would expect it's outdated by now.
Q. Well, I'm going to represent to you that Dr. Meggs actually cited to this during his deposition.
A. Okay.
Q. Are you aware that that publication at that time said there was only two clinical uses for HRV?
A. No, I'm not.
Q. Were you aware that they said it was only -- one use was to assess risks after an acute MI and to look at symptoms related to the development of diabetic neuropathy?
A. No. But that's old literature, and I wouldn't --
MR. SIMON: That's a position paper, Mr. Freshour, not a peer reviewed article?
MR. FRESHOUR: That is -- as I said, it's an article from the European task force of European Society of Cardiology and the North American Society of --
MR. SIMON: Position paper?

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MR. FRESHOUR: -- Pacing and Electrophysiology.
MR. SIMON: That's a position paper.
MR. FRESHOUR: It's what it looks like to me.
A. Okay. And this was in '96?
Q. Yes.
A. Well, it's changed a lot since then.
Q. Okay. I understand that. But do you understand my question that -- were you aware of that?
A. I wasn't aware of it.
Q. And you weren't aware either that this is a paper that Dr. Meggs cites specifically in his expert report?
A. No, I wasn't.
Q. Okay. Dr. Meggs is one of your experts, correct?
A. Yes, he is. Excellent guy.
Q. You trust his opinion, don't you?
A. Pardon?
Q. You trust his opinion, don't you?
A. Well, I trust it to a point.
Q. Well, there's certain things you don't trust him on?

15:25:20 A. Well, you know, I don't know how you -- if you know how medicine works. But we take everybody's opinion and we synthesize it. If it fits the case, we use it. If it doesn't, we don't. So that's all
15:25:34 I'm saying.
Q. You talk about a SPECT scan a little bit earlier. Do you recall that, Doctor?
A. Yes.
Q. What is a SPECT scan?
15:25:49 A. A SPECT scan is a specialized scan that can have one, two or three cameras. And what you -- we happen to have a three-dimensional one that Dr. Simon works with. And it reads 3-D. You give technetium, which is a radioactive substance, and you can measure
15:26:12 different areas of the body like the brain, and the stomach and so on. And you can show function on it and -- in contrast to a CAT scan or MRI, which shows anatomy.
Q. Okay. Now, isn't it also true that
15:26:33 abnormalities that are shown up on a SPECT scan can be caused by or attributed to conditions such as depression?
A. Yes. You can show a depression pattern.
Q. OCD?
15:26:45 A. Yeah.

15:26:46 Q. Schizophrenia?
A. I believe there is a pattern for that.
Q. Alzheimer's?
A. Yes.
15:26:51 Q. And I believe that drugs cause like -- drugs, methamphetamine, cocaine cause a particular pattern, as well, correct?
A. Yeah, I think you're right.
Q. And when you're looking at a SPECT scan,
15:27:04 are you looking for a hypo or a hyperperfusion in your field of practice, Doctor?
A. Both.
Q. It can be either?
A. Yeah, there can be areas that are hyper and
15:27:15 areas that are hypo.
Q. And have you ever seen Dr. Simon's normal views that he -- his baseline studies?
A. Yes. We have them all over the clinic.
Q. All right. Now, basically in the SPECT
15:27:38 scan, as I understand it, it's a continuous image, isn't it, Doctor? It doesn't just -- it's just not a single shot in time?
A. That's right, it's (indicating), like that. Cut after cut after cut.
15:27:51 Q. And it goes for a number of minutes, as

15:27:54 well, right, it's --
A. Yes, it does. I don't know what the time is, I've forgotten.
Q. So if, if you're looking in the medical
15:28:02 records and you've got just a single shot in time, that's not representative of the entire SPECT scan, true?
A. Well, I wouldn't say that wasn't true, because he picks out, he picks out the ones that are
15:28:13 representative and sends them to us.
Q. Now, when a patient gets a SPECT scan, I guess then my question would be, do you get the entire -- I don't know if you call it the film or the entire picture or just certain pictures from
15:28:27 Dr. Simon?
A. We just get the three-dimensional pictures. We don't get the whole run, because it wouldn't do us any good.
Q. Why not?
15:28:35 A. Well, number one, I'm not an expert on interpreting SPECT scans. And number two, it would take a long period of time to analyze it if I knew what I was doing.
Q. Do you know if the use of a SPECT scan has
15:29:02 ever been struck in a court in a chemical sensitivity

15:29:06 case?
A. Oh, I'm sure it has, because it's been used hundreds of times, and I think probably one or two times it has.
15:29:19 Q. Are you aware of the position of the Council on Brain Imaging as to the use of SPECT scan?
A. I don't even know who they are.
Q. Okay.
A. So I guess not.
15:29:31 Q. So you're not aware?
A. No.
Q. So -- and I guess my second question is, so you're not aware that they said -- the Council on Brain Imaging studies came out and said, you cannot
15:29:41 use a SPECT scan to diagnose chemical sensitivity? Are you aware of that?
A. I'm not aware of it.
Q. You disagree with that, I take it?
A. Well, I never diagnosed chemical
15:29:50 sensitivity on a brain scan.
Q. Did you use it as part of your diagnosis?
A. Well, of course. But that's not how I diagnose it. So it would be immaterial, wouldn't it?
Q. I don't know. Would it, Doctor?
15:30:02 A. Yeah.

Q. Would you need a SPECT scan?
A. I like to have SPECT scans, of course.
Q. So is it immaterial or not, Doctor?
A. Well, that depends on what you're trying to do with the patient.
Q. Well, you're the one who said it might be immaterial. I'm just trying to figure out --
A. Well, I don't do brain scans on all patients.
Q. And on those you do, you order it for a reason?
A. Of course, yes.
Q. So you do have some reliance on that?
A. I do use it as part of my treatment, yeah.
MR. SIMON: Diagnosis?
THE WITNESS: Well, both.
MR. FRESHOUR: Let the doctor answer, Mr. Simon. There's no objection on board.
Q. Can you tell me, do you know what the predictive value and the negative predictive value is for a SPECT procedure, Doctor?
A. No. Simon would know that. I don't.
MR. FRESHOUR: I think we're at a good stopping point.
THE VIDEOGRAPHER: The time is 3:31

p.m. This is the end of tape number five. We are off the record.
(Recess from 3:31 to 3:39)
(Mr. Cook did not return)
THE VIDEOGRAPHER: The time is 3:39 p.m. This is the start of tape number six. We're on the record.
Q. All right. Doctor, when we just got done, we were going over a number of different tests you use and some statements on the SPECT scan, and I want to be clear on the SPECT scan. And you mentioned a Nancy Didriksen earlier today. What does she have to do with the SPECT scans that you do in your practice, Doctor?
A. Nothing. She's a neuropsychologist and she has a battery of tests that will objectively show certain areas of the brain that may be dysfunctional.
Q. Do you know, has Ms. Didricksen ever testified in a court case that she -- when she finds patients with chemical sensitivities sent from you, she anticipates they already have it or you wouldn't have sent them to her, and she expects them to have chemical sensitivity?
A. I'm sorry?
Q. Ms. Didricksen, are you aware -- has

Ms. Didriksen ever testified in a court case that when she has a patient referred from you, she expects they've already been diagnosed with chemical sensitivity when they get there?
A. I don't know. You would have to ask her that.
Q. Okay. So do you ever send a patient to her that you haven't already determined to be chemically sensitive?
A. Yes.
Q. When was the last time you sent her a patient?
A. I think last week.
Q. So you're still using her --
A. Oh, yes.
Q. -- all the time?
A. She's very competent.
Q. Doctor, a while back we were talking about differential diagnosis, and we went through a couple of different, you know, conditions that can cause certain symptoms. I want to talk about some of your patients -- and I think several of them in this particular case, the five, came in and they had either sleep disturbance or some anxiety or depression. Do you recall that generally?

A. Yes.
Q. And suffered from fatigue and sleep disturbance. Do you remember that?
A. Yes.
Q. I think even a couple of them said they had some lethargy, inability to concentrate, memory loss. Do you recall that?
A. Yes.
Q. Now, when we get to differential diagnosis, isn't it true that there are those symptoms, such as sleep disturbance, inability to concentrate, lethargy, fatigue, sleep disturbance, those are also symptoms of certain psychiatric conditions such as depression, correct?
A. Could be.
Q. And they could be some kind of a nonspecified -- or unspecified anxiety disorder, correct?
A. Could be, yeah.
Q. Now, one of the treatment -- I guess treatments you use is what we call heat depuration, correct?
A. Yes, uh-huh.
Q. Now, I'm not to be derogatory, but that is basically a sauna-type therapy, correct?

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A. Well, it's part of a sauna-type therapy. It's part of it, yeah.
Q. What is it? Then explain to me what heat depuration therapy is in total.
A. Okay, number one, the goal of this is to help the autonomic nervous system get balanced again. The second goal is that about 2 -- let me say this, almost every patient we get don't sweat, which is a function of the autonomic nervous system.
And it also is a function to help the detox systems work better. For example, you might want to get more passes of the blood through the liver so you can detoxify it, or through the lung so you can detoxify it. Only about 2 percent of the toxics come out from sweating. So that's a second -- a tertiary issue. And what we do, we have specially constructed heat chambers that are non-outgassing and no particulates, so you can contrast some of the public saunas which have redwood or have formaldehyde in it or pine or so on like that.
The second, they are meticulously kept clean so that the individuals don't breathe in other people's toxics or stuff when they come out. Thirdly, the patient actually does exercise, if they're capable of it, for 15 to 20 minutes

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beforehand. Thirdly, they do the heat therapy with adequate amount of liquids at the same time. And then they get massaged to help break out some of the sequestration of toxics in the body.
Q. How does massage help break up the sequestrations of the toxics?
A. Well, one of the first responses, when a pollutant goes in the body, is that the connective tissue and the muscles grab them. You may have tight shoulders or tight back muscles or tight leg muscles. And it's been shown, both in animals and humans, that one of the responses in the body is to sequester the toxics so it doesn't kill the individual initially, you see. So a lot of patients that we see have been sick for some time, 5, 10, 15, 20 years. And they have gotten hard areas in their muscles and fascia that -- where the toxics seem to be sequestered. And I have biopsied some of those, and definitely this is true.
So that is your heat therapy when you -- when it's done. You do it for no more than a half hour. You start off very gradually, 10 or 15 minutes, depending on how sick the person is, and try to work up to 20, 30 minutes of good sweating.
Q. Well, let me ask you, there's a couple of

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points. You're saying that when the toxics go into your body, they sequester and you get tight muscles. I mean, do they aggregate in a distinct hard spot, like pile all up in your arm?
A. Sometimes they do. You've probably experienced it, everybody does. Like when they get into something, their neck spasms or a shoulder will spasm. This apparently is a way to slow down the toxics so the liver and kidney and lung doesn't get it all at once and it can handle it.
Q. And you say "this apparently." Do you have -- have studies shown that it actually is aggregating in this area?
A. Yes, I do.
Q. You've done the studies or other individuals --
A. Well, other people have done them, and I've done biopsies and shown it, yes.
Q. And so explain to me how massaging a hard spot releases the toxics from your body.
A. Well, what it does is open up the blood flow, microcirculation. And if you've got a severe muscle spasm like this and it opens up like that, then you get a normal physiology that's then able to be maintained, and the detox systems work better.

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Oxygenation works better in that particular area and can detox due to the oxygen that's librated. Or it can pick it up and send it to the liver or lung and get detoxed there.
Q. Well, are there particular spots in the body that are more susceptible to this aggregation?
A. You know, it's hard to say, because you can't do brain biopsies, and you don't do heart biopsies, okay. So you don't really know whether they sequester there. The only thing you can do is presume. But you can -- with the skeletal muscle, you can actually show it.
Q. With a biopsy?
A. Yes, correct, yeah.
Q. Okay. So I'm still not quite clear. So through aggregating it in your muscles and you massage them, how is that releasing them from your body?
A. Well, number one, you're relieving muscle spasms, which relieves the aggregation, okay. Number two, you're relieving fascial spasm, which makes up 40 percent of the body, okay. And number three, you are delivering more oxygen to that area because the oxygen supply, because of the edema on the small blood vessels that shut them off, open up. And then

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15:49:09 the blood can go through.
Q. Well, if, if this muscle spasm occurs because the body can't handle the toxics, if you're massaging to release it, aren't you then overloading
15:49:24 the body, since it couldn't handle it?
A. Well, you have to be very careful. And you don't do that initially on a sick patient. You have to wait until their detox systems have gotten better before you do that.
15:49:35 Q. Let me ask you, if most of your patients don't sweat, why are you putting them in a sauna? Won't that kill them if they don't sweat if they're in a sauna?
A. No. You teach them to sweat. Remember, I
15:49:47 said you do graded temperatures, where you may only go in five to ten minutes at first, and then you go to 15, and then maybe 20, and then 25, 30.
Q. Well, how do you teach someone to sweat? I thought that was an involuntary thing with the human
15:50:02 body.
A. Well, sweating has to do -- apparently it's a very complicated thing. It has to do with the heat centers in the brain and also the peripheral blood circulation. And the -- these go to the autonomic
15:50:21 nerves. And what apparently you're trying to do is

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15:50:24 balance out the sympathetic and parasympathetic autonomic nerves so that things can work normally and go back to efficient function. And I say "teach," because it seems to be that's what you do. In other
15:50:38 words, you can't radically do it or, like you say, you can wipe them out.
Q. Well, how do you -- how are you able to ascertain the efficacy of the sauna therapy?
A. Well, we did several blood levels -- and
15:51:10 published this, by the way -- and of the chemicals in the blood before sauna, during sauna and after sauna. What you see is you see them at this level, say, okay, in the blood. And when you start doing the sauna, they go up like this (indicating) and then
15:51:30 they come down, and they'll either go away or they'll get much lower than before. And we did a whole series of patients, measuring those.
Q. And you published that?
A. I published that in a peer review journal,
15:51:45 I also published it in my book.
Q. Do you have the underlying data for that?
A. I did, yeah. I don't know whether I've still got it. We did this about 20 years ago.
Q. Now, did you do blood testing on any of
15:52:19 these patients to quantify if it was working? Any of

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15:52:22 these five.
A. I don't recall. I don't think so.
Q. Have you been doing any routine blood tests on any of your patients besides the study you did 20
15:52:31 years ago?
A. Well, I do chemical levels, yes.
Q. Do you do blood studies?
A. That's what I said. I do chemical levels. For example, I may do a xylene, toluene, benzene and
15:52:44 so on. But I do it now before and after treatment because I don't -- I want to keep the expense down as much as we can. You see, our foundation funded that in the past.
Q. I looked through these five patients. Why
15:53:01 do you give them glutathione?
A. Because glutathione is a great antioxidant and it detoxifies chemicals.
Q. How does it detoxify chemicals?
A. Well, there's two sulphur, I think two
15:53:17 sulphur molecules on the end of glutathione, and I think they grab the toxics and hang on to them and put it out of the body.
Q. Do you think, or that's what chemically happens?
15:53:27 A. No, that's what happens.

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15:53:28 Q. Do you know that or is that --
A. I do know that, yes.
Q. Is it a hypothesis, or have you proven it?
A. No, no, other people have proven this. I
15:53:37 mean, all our data and everything we do is a composite of the world literature and our experience.
Q. Why do you give your patients niacin before they go into the heat depuration?
A. Well, we don't for everybody. But some of
15:53:54 the people that can tolerate it, it dilates their vessels and helps them sweat faster.
Q. Creates a flushing effect on them, doesn't it?
A. Yeah, it does.
15:54:03 Q. Have you ever told anybody that that flushing effect is the toxics coming out of their body?
A. I don't recall. But usually not.
Q. Have you ever told them that?
15:54:12 A. Well, I don't know. I don't remember.
Q. Well, is it true that if they get a flushing feeling after taking niacin, that toxics are coming out of their body, medically?
A. No.
15:54:23 Q. So have you ever told anybody that?

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15:54:25 A. Not to my knowledge, I haven't.
Q. Okay. Do you ever -- I believe I saw some of the -- do you ever do any kind of testing of the sweat on these individuals to see if anything is
15:54:42 flushing out of their body?
A. We have, but I haven't for years. Like I say, we didn't have enough money to keep on doing it.
Q. Okay. Have you ever said that you could smell it on their breath after a sauna?
15:54:54 A. Oh, you can smell it more than on their breath, you can smell it coming out of them.
Q. Well, then how do you -- I guess then the question is, if they're sweating it out, how do you ever establish or -- how do you make a determination
15:55:12 that they're at a normal level? I mean, is there something that you can correlate it to or compare it against?
A. Yeah, when they've got their energy back and they can navigate through society.
15:55:26 Q. So it's not any -- you can't say it's an objective level, it's more just a functional, subjective level; is that true?
A. No, it's not true.
Q. Then what's the objective criteria you use
15:55:39 to determine --

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15:55:40 A. Energy, energy is the objective criteria. If you can't walk across the room and now you can run down the hall, anybody can tell the energy has improved.
15:55:50 Q. What besides being able to run down a hall do you use as an objective criteria?
A. Well, that they can now work and remember, and -- if they have short-term memory loss. That they've got their heart irregularities under control,
15:56:06 that they don't have muscle spasms anymore.
Q. So you can cure heart irregularities with your treatments?
A. I don't believe I said that.
Q. You just said their heart irregularities
15:56:20 were gone.
A. That's right. But you asked me how I would know objectively. And I'm saying in some patients if their heart irregularity is gone, that's how you measure objectively.
15:56:31 MR. SIMON: He didn't say he treats heart irregularity with his treatments.
Q. What's placebo?
A. Pardon?
Q. What is a placebo?
15:56:42 A. Well, you know, that's a good question.

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15:56:45 What we think of placebo is saltwater and usually water, something that nobody is supposed to react to.
Q. What do you think a placebo is?
A. I just said.
15:56:56 Q. You said "we," I didn't know if that was you.
A. Environmental Health Center, people in environmental movements around the country, the 5,000 physicians that do this.
15:57:17 MR. SIMON: Try to use you, try to use you, limit yourself to you.
THE WITNESS: Okay.
Q. Doctor, have you read the -- I'm not sure, I think it's the 2009 CDC report on exposure to
15:57:30 chemicals in the human population? Have you seen that?
A. Yeah, I've only briefly gone over it. I haven't had time to really digest it. It's too new and I've had too many things to do, you know.
15:57:41 Q. So this may not -- you probably don't know, but are you aware that the first sentence of the executive summary under the heading, interpreting the data, states, and I quote, the presence of an environmental chemical in people's blood or urine
15:57:56 does not mean it will cause disease or effects? Are

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15:57:59 you aware of that?
A. I'm not aware of it, but I wouldn't have any argument with it.
Q. Okay. That was going to be my next
15:58:05 question.
So the mere presence of somebody with chemicals is not enough to -- for you to decide to treat them; is that true?
A. Yes, that's true.
15:58:19 Q. Okay. Doctor, if -- this is a pretty basic question, and if I've asked it before, I apologize. I don't think I have.
If you don't know the exact causative agent of a disease or the exact chemical causative
15:59:02 agent for a particular patient's chemical sensitivity, how do you make treatment decisions?
A. Well, with difficulty, of course.
Q. Beyond that?
A. Well, you mean if there's no positive
15:59:18 laboratory data?
Q. I'm just saying if you don't know the causative agent. Let's say, for example -- we'll choose any of these patients. Let's choose, I don't care, A.R., for example.
15:59:29 A. Okay.

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15:59:30 Q. She says she's exposed to, I think -- wasn't it A.R.?
A. I'll tell you, a better example would be --
MR. SIMON: Let him ask the question.
15:59:39 A. -- would be J.S.
MR. SIMON: Doctor, wait, let him ask the question.
Q. A.R. comes, says she's had a pain exposure some 15 years ago, she's had problems after 9-11. She's got a thyroid condition. She takes Adderall. She says she's sensitive to everything, and there's a fairly long litany of exposures. How do you decide what's the causative agent and how you treat her?
A. Well, at this, at this stage, you can't,
16:00:12 you can't decide what the causative agent is. All you can do is try to decrease the total load and get the triggering agents that are predominant and try to either neutralize them, get, get rid of them, or treat them with nutrition, and take care of the
16:00:35 problem that way.
Q. Well, when you say treat her total load, if you don't know what the agents are or how long she was exposed to any of them, the duration or concentration, how do you get rid of the load?
16:00:49 A. Well, you go by past history of people who

16:00:53 have had the problem, and her total load is increased. For example, we know that natural gas leaks can cause people to see one of them. Ensure she gets in a place with no natural gas leaks. We
16:01:07 know that pesticides are a big offender in all of these people, so you get her in a place where she has no pesticides. We know that drinking water can cause problems, both the chlorination and if it's well water, could be arsenic or public water supply. The
16:01:23 last I saw in Dallas, there was 32 different toxic chemicals. If -- you make sure they have organic food and as chemically free as possible. Therefore, you're going to decrease the load, and sometimes that will help them.
16:01:42 Q. Well, that's great you're going to decrease their load. But let me ask you this: How do you, as far as, say, natural gas leak, all you've got to do is stop the leak, it stops the exposure. So why does she need treatment from you other than getting a new
16:02:00 gas line, perhaps?
A. Well, because if she lives in a gas house, the gas has about a 10 percent leak in most houses and you can't stop it all.
Q. Okay. Looking through this, do you know
16:02:09 what she was exposed to? Natural gas, as far as you

16:02:16 could tell?
MR. SIMON: We're talking about A.R. right now?
MR. FRESHOUR: Yes.
16:02:21 MR. SIMON: Okay. If you need to --
A. I'm looking here. I --
MR. SIMON: If you need to look at the actual medical record, you've got to see those, that's another ballgame.
16:02:30 THE WITNESS: No, no.
A. I don't recall that she was, no.
Q. Do you know if she was exposed to any pesticides that she articulated?
A. She lived in New York City and had lived in
16:02:41 some apartments that were pesticided, yes.
Q. Do you know that she was exposed to those pesticides, or are you just extrapolating because she was living in an apartment in New York City?
A. I think I -- well, I asked her about it.
16:02:56 Q. Did you record that in your medical records?
A. Probably did, yeah.
Q. How long was she exposed to the pesticides?
A. I don't recall.
16:03:02 Q. What concentration were they?

16:03:03 A. Well, you know I don't know that.
Q. Okay. What about other things, what was her drinking water source? Was she buying bottled water or was she drinking city water?
16:03:14 A. I think by the time she came to us, she was doing plastic bottled water.
Q. Okay. And plastic bottled water can come from a whole variety of different sources, correct?
A. Yes. Plus the fact that the plastics can
16:03:28 contaminate her.
Q. All right. Did you test her for any of the chemicals found in plastics?
A. I think we did, yeah.
Q. How long had she been drinking bottled
16:03:46 water, do you know?
A. I don't recall.
Q. Are there different kinds of plastics, hard plastics and soft plastics?
A. Yes.
16:03:53 Q. Aren't their chemical compositions
21 different?
22 A. Yes. One has got dilates and the other has
23 got -- mind blank, I can't remember.
24 (Mr. Cook enters the room)
16:04:07 Q. Why did -- I'm going to represent to you

that you've prescribed her immunotherapy for -- and it says unleaded diesel. Why did you do that?
A. Because she was reacting to it.
Q. Did she come in and describe to you any sensitivities and, specifically, to diesel fuel, when she presented to you or in your medical records?
A. Yeah, I think she did.
Q. Okay.
A. By the way, we did test her for natural gas.
Q. What was --
A. She reacted.
Q. I'm looking at her initial history and physical. And are you aware the only chemical she put down that she had exposure to was cigarette smoke and perhaps --
MR. SIMON: Do we need to look at that record, because we don't have the same record he has in front of him.
THE WITNESS: No, I think what he's got is --
A. This may well be true because until --
MR. SIMON: We're not looking at the same records he's looking at. Do we need to pull the record for you to answer that?

THE WITNESS: I don't think so. I don't think so.
Q. Why did you prescribe immunotherapy to her for algae and molds?
A. Because she reacted to them.
Q. Why did you test her for them if she didn't articulate them in exposure history?
A. Because she was so ill and had been ill for such a long period of time, we couldn't leave any stone unturned without testing her.
Q. So although she presented talking about pain exposure, you went ahead and ended up giving her antigen therapies, also for feathers. Why feathers?
A. She expressed that she was sensitive to feathers.
Q. And why propane?
A. Same.
Q. She is sensitive?
A. (Nods head)
Q. She expressed that?
A. Yeah.
Q. Did you put it in your medical record?
A. I think we did, yeah.
Q. Okay.
MR. SIMON: If you don't know what you put in --

Q. Why did you test her for Tide and Bounce?
A. Because she was sensitive to it.
Q. Well, you say she is sensitive to it. She was sensitive after you tested. But did she come in and articulate that to --
A. Look, I don't really recall because -- you have to remember, we have a dynamic relationship with our patients. This woman is a Ph.D. And once they get to finding things, it reminds them that something else may have triggered them that they tried to get out of their life and they couldn't. And then we let our testing be guided by that very thing.
Q. I'm going to represent to you that I went through her immunotherapy records.
A. Okay.
Q. And is it normal -- I'm going to represent to you, and if we need to look, we can, from 11-24 of '04 to 12-27 of '04 -- that's a approximately, what, 34-, 33-day period?
A. Yeah.
Q. She had antigen therapy prescribed to her at a cost of $11,000. Is that a normal kind of treatment range for a 30-day period for one of your patients?

A. No.
Q. Now, she kept repeatedly getting sauna treatments for a diagnosis of headaches. Is headaches really a specific diagnosis, Doctor?
A. Yes.
Q. Okay. And if she was being treated for headaches, what are you trying to sweat out of her for in the sauna that is causing headaches?
A. Well, as I stated before, this doctor was extremely ill, had been incapacitated, and that she had an imbalance of her autonomic nervous system, which most likely caused the headaches. The question is, what were the triggers? Were they sequestered in her, or were they from outside? And so we tried to do the heat therapy to sweat out any toxics that might be in there.
Q. What do you mean that the triggers were sequestered in her? If something is sequestered, how is it a trigger?
A. Well, number one, they're never 100 percent sequestered.
Q. Well, how do you determine if a trigger is sequestered in a patient?
A. I think we went over all of that.
Q. Well, I'm sorry, Doctor, I guess I -- I

16:08:48 really guess I'm not understanding how can a trigger be sequestered in a patient. So if it's already inside her, I mean --

A. If it's inside her and it's starting to be released slowly and she doesn't need very much of it to trigger her blood vessels and trigger her autonomic nerves to make the blood vessels spasm, it can happen.

Q. Okay. What were her triggers, then? Do you know?

A. Well, yeah, we had a whole list of them here. She was almost pan sensitive, if you want to look at it that way. Look here, there's three and a half, four pages of substances that triggered a lot of her symptoms.

Q. And out of those, all of those substances, on any of them, could you quantify or qualify the concentration or the duration of her exposure that caused her to become sensitive to them? Let's say natural gas. How long was she exposed and what concentration, do you know?

A. You can't say. You know I don't know that.

Q. Okay. How about chlorine?

A. Same.

Q. How about ethanol?

A. Same.

Q. Formaldehyde?

A. Same.

Q. Ladies' cologne?

A. Same.

Q. Men's cologne?

A. Same.

Q. Orris root?

A. Same.

Q. Did she have a fireplace?

A. You know, I don't recall.

Q. Okay. Because you tested her for fireplace smoke. Are you aware of that?

A. She probably complained of it, that it bothered her.

MR. SIMON: Do you know if she did?

THE WITNESS: I don't know. That's what I said.

Q. You never went to her home, you don't know what it looked like, did you?

A. No. She lived in Manhattan.

Q. Did she live in a townhouse in Manhattan?

MR. SIMON: Brooklyn, I think it was.

A. Apartment. I don't know how you define "townhouse."

Q. Apartment?

A. It was an apartment, multi-person place.

Q. Do you know how old an apartment?

A. I don't.

Q. Do you know the location in Brooklyn? Was it Brooklyn?

A. No, no, she wasn't from Brooklyn. She was from Manhattan. All of these patients were in Manhattan, by the same insurance company, and one who's noted to turn people in.

Q. Why did you test her for stainless steel? She wasn't getting an implant, was she?

A. She probably complained of -- that it bothered her.

Q. How about tin?

MR. SIMON: Did you test her for tin?

A. Tin?

MR. SIMON: Did you test her for tin?

THE WITNESS: Did I test her? Did I see that?

MR. SIMON: I don't know. Don't take his word for it.

Q. I'm going to represent to you -- let me do it this way, make it very easy. I want to represent to you I'm reading an antigen intradermal testing

sheet in the medical records provided to me from you. How is that, Dr. Rea, okay?

A. That's a lot better.

Q. How is that? It will make it a whole lot easier. I'm reading right off the intradermal skin testing summary sheet.

A. Okay.

Q. You're familiar with those, aren't you?

A. I made them.

Q. Yeah, that's what I meant. You're familiar with those.

A. Look, if we tested her for tin, most likely she had tin in her hair, sometimes with tin, because they use that in hair things.

Q. Okay. Why did you test her for silver?

A. Probably amalgam, silver amalgam.

Q. Same thing for porcelain?

A. Yeah.

Q. Platinum?

A. Yes.

Q. Palladium?

A. Yeah.

Q. What about nickel sulfate?

A. She may have complained of that, of being sensitive to that.

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16:12:24 Q. What is nickel sulfate?
A. It's a metal that's -- can be used for nickel earrings, nickel bracelets and so on.
Q. Mercury?
16:12:37 A. Definitely.
Q. Lead?
A. Yes.
Q. Gold?
A. Yes.
16:12:42 Q. What about news material? Are you talking about the print, the paper? What is news material?
A. Combination of all of that.
Q. What is ALF?
A. Autogenous lymphocytic factor.
16:13:24 Q. What does that mean?
A. It's an immune booster made out of their own blood.
Q. How do you do that, Doctor?
A. Well, you draw blood, you put it in a
16:13:32 culture medium and cells divide every 24 to 36 hours, the weak ones die, the strong ones multiply again. After about 30 generations, you have very strong T cells and then they're processed in a special way, and then she gets injections of them every four days.
16:13:58 Q. Does she self-inject?

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16:14:00 A. Yeah.
Q. Intramuscular?
A. Subcu.
Q. Subcu. What does that mean?
16:14:05 A. Subcutaneously, right underneath the skin.
Q. And then, what, it's absorbed back into the body or into the bloodstream?
A. Yes.
Q. Okay. Now, if you give it subcu -- and
16:14:18 these are blood cells or T cells? What are they exactly?
A. They're -- actually they have all been destroyed, they're the lysates of them.
Q. And so when you do that subcu, do they
16:14:32 absorb into the bloodstream and that's how they fortify, or do they go through some other route in the body before they get --
A. Well, they may go through the lymphatics. A lot of this goes through the lymphatics.
16:14:48 Q. Is that some kind of a -- is that FDA approved therapy or --
A. No. You don't have to have approval for it.
Q. That was going to be my next question. You
16:14:56 don't have to?

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16:14:57 A. Yeah.
Q. You've got some kind of -- is it a patented process or anything to you, Doctor?
A. No.
16:15:06 Q. Now, when you send it to them for the subcutaneous, do you send them -- is it already broken into doses? Do they draw it up? Do they inject --
A. They just draw it up. I mean, if they take
16:15:21 the substances, you know, like the food shots or mold shots, they're already taught to do that. So they are taught to draw it up and take it.
Q. Okay. And I take it, then, it's sent to them wherever they may be at that point in time?
16:15:40 A. That's correct, yes.
Q. And does it have to be --
A. Frozen.
Q. -- refrigerated, frozen, something?
A. Frozen.
16:15:49 Q. Frozen, okay.
Then they have to defrost it or thaw it under certain conditions, though, right?
A. Right.
Q. And they're all prescribed how to do that?
16:15:57 A. Yes.

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16:15:59 Q. Do you know -- because that's a therapy, do they require any kind of a prescription from you for the, I guess the injections or the needles or syringes to do that?
16:16:09 A. Yeah.
Q. Okay. And you provide those with a kit?
A. No, they can buy the syringes anyplace they want. But we give the ALF.
Q. Okay.
16:16:21 A. That's what we provide.
Q. And -- so is that just a one-time series that you send them, or do you keep a reserve and build more for them? Or how does that work?
A. Well, it depends on how fast their T cells
16:16:34 and their other systems respond. We've had about 27 now that respond on the first shot. The majority of them takes about three months, six months to respond very well.
Q. And when you say they respond, what do you
16:16:46 mean by that?
A. More energy, more brain function, less infections. Usually it will wipe out infections on them.
Q. And since they are, I guess, remote by the
16:16:58 time they start that, do you observe that, or is this

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just anecdotal information they send you?
A. I don't know that that's anecdotal, but it's information they send me.
Q. You don't observe that, necessarily?
A. No -- well, some around here I do, those that live around here. Those that live far away, of course, I just have to take their word for it, or their physician's word. See, most of these patients have been sent by physicians.
Q. All right. I want to talk to you a little bit about patient R.B.
A. Who?
Q. R.B.
A. Ruth Burt, okay.
Q. Yes, Ruth Burt, exactly. Let me get to her, try to find it here, Doctor.
A. Okay.
Q. You're quicker than I am getting there, Doctor.
This one, Ms., Ms. R.B., she's the one -- I'm going to represent to you, she's the one who got the chelation that we had talked about in somewhat vague terms in an earlier part of the deposition. She had some -- she got chelation.
A. Yes, I think we talked about that.

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Q. We did generally. And my question is --
MR. SIMON: Do you have that?
THE WITNESS: I've got it right here.
Q. And you do recall that now, right?
A. Yeah, sure I do.
Q. Okay. And --
A. She was the one that had to have the pubic hair.
MR. SIMON: Let him finish his question.
Q. But she is the, she is the individual that we talked about where we had the concern over the provoked versus the unprovoked comparison, do you recall that?
A. Yes, yes.
Q. Okay. Now, this is the lady who claimed that she had -- somebody had attempted to arsenic poison her in the year or two before, right?
A. Yeah. You see, unfortunately, something about her family money was being stolen by the mafia and it got rather mysterious and complicated. And she didn't know it all because she was -- ran her own business and she was a professor at the college there and maybe somewhat naive a little bit. I didn't get into it, because I didn't want to do anything like

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that.
Q. Well, let me ask you, her chief complaints which she presented to you are swollen ankles or edema?
A. Yes.
Q. Looks like some water retention, which is edema, as well, right?
A. That's correct, yes.
Q. Okay. Spots, red blotches?
A. Yes.
Q. Failing eyesight, looks like stiff arm and neck, itching.
A. Yes.
Q. Fingernails open?
A. Yeah.
Q. Constant urination?
A. Right.
Q. And arsenic poisoning.
A. Well, plus a bunch more that you missed.
Q. Well, but that's her initial presenting chief complaints that are recorded in your medical records?
A. Yes, okay. We got more as time went on.
Q. Right. And you say you got more as time went on. Was this during the initial interview or as

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she was longer --
A. No. As we saw her each day. I would see them each day, every day.
(Mr. Cook leaves the room)
Q. Okay. So her initial -- let me make sure I've got the right date, Doctor.
So her initial patient questionnaire is filled out on -- looks like in September of '03, and it looks like, looks like on September 2 of '03, and it looks like before the end of that month she's in for, she gets a heavy metal urine testing. And by October, she's had a provoked chelation test. Why was that, Doctor?
A. I think we went over that. We wanted to decrease her total body burden to see if there was anything in there.
Q. Isn't it true that most -- almost all of us anymore, if we are tested, have -- and, I mean, as the general population, have some DDT or DDE that we would test positive for?
A. Well, I've never measured the general population, so I can't really tell you that. I can tell you about the chemically sensitive population.
Q. They have it.
A. And they -- almost all of them have DDE.

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Not DDT much anymore, as a matter of fact, but DDE.
Q. Now, this patient also had a history of arthritis and thyroid, correct?
A. Yes.
Q. Family history of diabetes?
A. Yes.
Q. And in fact she admitted to being a sugar addict, didn't she?
A. Yes, she did.
Q. Or worse than, I think was her words, right?
A. I think you're right.
Q. So we've talked earlier today, conditions such as thyroid, diabetes -- although I don't think she was a confirmed diabetic, being a sugar addict. All of those can manifest with some of the same symptoms that you attributed to chemical sensitivity, correct?
A. Well, I guess you would have to say which ones you're referring to.
Q. Well, I think we talked a little bit earlier today, things like fatigue and tiredness could be diabetes, could be thyroid?
A. Yeah, we've already talked about it.
Q. Right. So that's what I'm talking about.

That same constellation of general symptoms, correct?
A. Yes, sure. Of course she didn't have diabetes.
Q. Did you test her?
A. Yes.
Q. Okay. But she did admit to a chemical -- I'm sorry, to being worse than a sugar addict correct?
A. I believe you're right, yeah.
Q. So even though she may not have tested over into the diabetic range, that certainly high intake of sugar with a family history could be a complicating factor in her diagnosis and treatment, wouldn't you agree, Doctor?
MR. SIMON: Object to the form.
You can answer the question.
A. I don't know what you're talking about. Could be a complicating factor in what?
Q. In her treatment.
A. The fact that she was not diabetic?
MR. SIMON: Objection, form.
Q. Well, just generally if you're treating her, and when it goes to a differential diagnosis, you would have to rule things like that out and --
A. I did.

Q. You did? Okay.
And how did you rule out her diabetes?
A. Doing blood sugars.
Q. Okay. And on this patient, Doctor, did you -- why did you test her for lake algae?
A. Because she lived near a river.
Q. Did she complain about having sensitivities to anything from the river or algae?
A. I think she may have, yeah.
Q. Okay. I'm going to represent to you that you also tested her for natural gas, didn't you?
A. Yes.
Q. What kind -- how long was she exposed to natural gas and at what concentrations?
A. Now, you know I don't know what concentrations.
Q. How long was she exposed?
A. I don't know how long, because she fleeted back and forth between houses in Manhattan and houses across the -- what is it? Across the lake on the Hudson River there. But she wasn't sensitive, so...
Q. Okay. You tested her also for cigarette smoke, correct?
A. Yes.
Q. Okay. And, again -- let me do it this way.

I'll make it real easy, Doctor. I'm going to represent to you on your intradermal skin testing sheet, you tested her for all the chemicals you list, right?
A. The ones I list.
Q. The ones you list that are on your standard form.
A. Yeah, I think I did.
Q. You know what I mean, Doctor.
A. Yeah.
Q. Okay. Is it fair to say that under each and every one of those chemicals that you tested her for, you don't know when she was exposed, the duration of the exposure, or the concentration?
A. I think it's fair to say I don't at this time. I probably did before, but I don't now.
Q. And would you have listed that, if you knew it, in your medical records?
A. Not necessarily.
Q. Why not?
A. Because it gets rather burdensome to list these things over and over again when you're trying to develop a treatment program for somebody who's got a very complicated problem.
Q. And if you did an exposure history on

those, since you tested her for those, would you list those in your exposure history?
A. Yeah, if I could.
Q. Well, let me ask you, Doctor, why couldn't you or why wouldn't you?
A. Time factor, as I told you.
Q. But if you were trying to -- and I'm trying to understand that, a time factor. If it relates to her exposure history and you're treating her because of her exposures, why wouldn't you take the time to list that to be able to support the basis for your --
A. Well, I did, because I tested her. I listed it in the testing.
Q. I know you list it in the testing.
A. That's all I need. Why do I need to list it someplace else?
Q. Well, if you're going through an exposure history and she doesn't list all of those, then why would you test her for those? Those could be unnecessary tests if it doesn't --
A. Oh, I see. You're driving at unnecessary testing. We don't ever do unnecessary testing because we don't have time for it. We try to do the pertinent things. And as I said before, as we see patients every day, they realize, hey, I was exposed

to this, could I be sensitive, et cetera, and we just go ahead and do it.
Q. Do you realize -- do they realize or do you say, hey, don't you think you might have been exposed to -- do you know how your people are posing that, the question?
A. They'll come in and they'll say, they say, it dawned on me that maybe that was a problem.
Q. Well, I'm going to represent to you the only exposure she checked for chemicals on her initial sheet for you-all was cigarette smoke. So why would you test beyond that?
A. I just told you why.
MR. SIMON: Is this the one with the cigarette smoke?
MR. FRESHOUR: It's R.B., yeah, yeah.
MR. SIMON: R.B.
MR. FRESHOUR: Yeah.
Q. Let's go on and talk a little bit about E.F. You're familiar with E.F., aren't you, Doctor?
A. I certainly am, yes.
Q. Bear with me. I think I'm to the right one.
E.F. was -- got some trichothecene testing by Dr. Croft. Do you remember that?

A. Yes.
Q. Her initial presenting complaints were dizziness, headache, nausea, ringing in the ears, palpitations and labored breathing. Do you remember that?
A. I remember that, plus about 15, 20 more.
Q. Well, I'm just talking about --
A. She had 39 total.
Q. Well, Doctor, I'm just talking about her initial history and physical.
A. Okay. But as I explained to you, we never get the full history on the initial one. They can't remember it all.
Q. Right. And so -- and let me ask you, that's really interesting. They can't remember. These people, a lot of them, if they're suffering from chemical sensitivity, they have decreased mental sharpness and brain fog, how can their history giving be reliable and credible, in your opinion?
A. Well, they -- I mean, you talk to somebody and you know whether they're reliable. But you also know if they've got brain fog, that they're not remembering all the things that they might if their memory was tweaked.
Q. And how do you tweak their memory?

A. Well, they just do that around the clinic, and their brain gets sharper as they live in a controlled environment. They start remembering things.
Q. And those things they remember, at least in these two or three patients, appear to be, remembered further exposure, which allows you to do further testing and treatment, correct?
A. Yeah, that's right.
Q. Not bad for business, is it, Doctor?
MR. SIMON: I'll object to the form. You don't have to answer that.
THE WITNESS: I'm not going to. It's an insult.
Q. Well, let me ask you this, Doctor: She was also a smoker, correct?
A. Yes, she was -- had been, uh-huh.
Q. And did she cease smoking when she got to your clinic?
A. Yeah, she did.
Q. Okay.
A. She knew I would throw her out.
Q. And I take it that is across the board they cease smoking.
A. Yeah.

16:30:40 Q. Do you know, did she resume after she left your care?
A. No, I don't think so.
Q. You don't know, though, for sure?
16:30:46 A. No, I know because I followed her very closely over the years.
Q. Okay. Now, the one question I have on this is, I'm going to represent to you -- and I'm not going to go way far into it -- is the Immunosciences Lab test.
16:31:00 A. Yes.
Q. Here, all of this Stachybotrys IG testing came back within normal limits and so did the trichothecenes. Are you aware of that?
16:31:13 A. Yeah.
Q. Then why did you send her for trichothecene testing to Dr. Croft?
A. Because Dr. Johanning, Eckardt Johanning, a professor at the University of Albany, had already
16:31:28 worked her up for a lot of mold antibodies and found it. And I think he worked her up for a hypersensitive lung disease, found positive in that. And that she had a history of severe exposure to mold. So I thought it would be a good idea to have
16:31:46 that.

16:31:47 Q. Are you aware that Dr. Johanning, just as recently as about two years ago, has had all of his -- had his theories on mold causation struck and not been allowed to testify in courts? Are you aware
16:32:00 of that?
A. No, I was not.
Q. Are you aware of a case in Austin, Texas commonly known as the Ballard case versus State Farm Insurance?
16:32:07 A. Oh, yeah, yeah.
Q. Are you aware he got struck in that case on all of the causation as it related to the mold-related illnesses?
A. No. But what's that got to do with this?
16:32:17 Q. I was just asking you, Doctor.
MR. FRESHOUR: We're good here for a pause.
THE VIDEOGRAPHER: The time is 4:32 p.m. This is the end of tape number six. We are off
16:32:30 the record.
(Recess from 4:32 to 4:36)
THE VIDEOGRAPHER: The time is 4:36 p.m., this is the start of tape number seven. We are on the record.
16:37:00 Q. Dr. Rea, in the years that you've been

16:37:05 practicing, you've testified in a number of court cases; is that correct, sir?
A. Yes, I have.
Q. And along with Dr. Johnson, he's testified
16:37:17 in a number of court cases. You're aware of that, correct?
A. Yes, uh-huh.
Q. Being Alfred Johnson, for clarity.
A. Yes.
16:37:25 Q. Dr. Gerald Ross has also testified. You're aware of that, correct?
A. Yes.
Q. Okay. And I think we talked about a Dr. Alan Broughton today. Do you know Dr. Broughton?
16:37:34 A. I don't know if he's testified or not.
Q. But you do know him?
A. I do.
Q. He practices in the area of environmental medicine, correct?
16:37:41 A. No, he's a laboratory doctor.
Q. Okay. You said you knew Dr. Kaye Kilburn, correct?
A. Yes.
Q. And a Dr. Janet Sherman, do you know Janet
16:37:51 Sherman -- or Jeanette Sherman?

16:37:54 A. Yeah, I know who she is. I don't really know her very well. I've met her a few times.
Q. Okay. Well, Dr. Rea, let me ask you, isn't it true that in the case of Brown -- Bradley V. Brown
16:38:05 in Indiana in 1994 the two federal courts excluded the testimony of you and Dr. Alfred Johnson because they found your methodology anecdotal and speculative?
A. When was this?
16:38:20 Q. 1994, Brown V. Bradley.
A. I don't recall.
Q. Okay. Are you aware in that case they said as to the general concept of MCS, the court held that the etiology of it had not progressed from hypothesis
16:38:38 to knowledge capable of assisting the jury?
A. No, I don't remember.
Q. Dr. Rea, isn't it true that in 1990 in the northern district of Texas in Brandon versus First RepublicBank Group Medical Plan, Federal Judge Mary
16:38:55 Lou Robinson ruled that the clinical -- the services of the clinical ecologists William Rea and Alfred Johnson weren't medically necessary and weren't coverable under an employee benefit play? Are you aware of that?
16:39:08 A. No.

Q. Did you testify in that case?
A. I don't have any idea. It's been 20 years ago.
Q. Okay. Dr. Rea, do you recall in Breen and Carrasco versus Carlsbad Municipal Schools in New Mexico in 1999, that the court excluded evidence from you because your treatment was neither reasonable nor necessary? Do you recall that?
A. No.
Q. Do you recall that the court ruled that in fact your treatment had proven to be counterproductive and deleterious for the treatment of workers' conditions?
A. No.
Q. Do you know a Dr. Thomas LaCava?
A. LaCava?
Q. LaCava.
A. Yeah.
Q. Okay.
A. Massachusetts.
Q. All right. Are you aware that in 2000 the Massachusetts supreme court ruled that there was no evidence that Dr. LaCava's methodology was reliable, and he failed to rule out other considerations when he claimed a patient suffered from multiple chemical

sensitivity and organic brain syndrome as a result of exposure to formaldehyde and cleaning solutions?
A. No.
Q. Are you aware in 1990, and then upheld by the fourth circuit court in January of 1995, that the federal court in North Carolina ruled that the lymphocyte and autoantibody testing of Alan Broughton lacked the proper factual basis, including no proper controls and no alternative causes excluded?
MR. SIMON: Counsel, what's that case?
MR. FRESHOUR: It is Carroll versus Litton, L-i-t-t-o-n -- t-o-n Systems.
A. The answer is no.
Q. Do you recall in the case of Coffey versus the County of Hennepin in Minnesota in 1998, the federal court excluded your testimony about multiple chemical sensitivity, holding that federal courts did not consider MCS a scientifically valid diagnosis?
A. No.
Q. You don't recall that?
A. I don't recall.
Q. Have you recalled any of the cases that you've been cited in and I've recited so far?
A. No. I think most of them we won, so you only got the negative ones.

Q. My question --
MR. FRESHOUR: And I'm going to object and ask to strike that.
Q. My question was, do you recall the cases that I am citing to you now?
MR. SIMON: That was asked and answered. He said --
MR. FRESHOUR: No, he didn't answer, Mr. Simon.
A. I said no.
Q. You only remember the ones you won, not the ones you lost, is that it?
A. I don't remember any of them, but I've won most of them.
Q. Oh, okay. And how do you know that if you don't remember them?
A. I don't know.
Q. Okay. Are you aware in 1997 in Frank versus the State of New York, the federal court excluded the testimony of six experts on MCS, holding that it failed to meet the Daubert test of standards of testability, peer review and general acceptance?
A. How does that have to do with me?
Q. No. I'm just saying, were you aware --
A. How do would I know that? I don't know.

Q. Are you aware that in 1998 in a case in Minnesota that Dr. Kaye Kilburn's testimony was excluded related to the claims that chemical exposure and polyneuropathy were caused by pesticide exposure? Were you aware of anything like that?
A. No.
Q. Do you recall the case of Gressel versus Ahern, A-h-e-r-n, in Arizona in 1997 that under the Frye standard, the court excluded the testimony of yourself and Dr. Simon in the use of provocation testing?
A. No.
Q. SPECT scans?
A. No.
Q. Balance tests?
A. No.
Q. Controversial diagnosis of toxic brain syndrome lacked sufficient controls to be generally accepted in the scientific community. Are you aware of that?
A. No.
MR. SIMON: What's the cite of the case again?
MR. FRESHOUR: It's Gressel versus Ahern.

MR. SIMON: What court?
MR. FRESHOUR: It is in Arizona superior court. December '97.
Q. Are you aware that that same court also excluded the neuropsychological testimony of Nancy Didricksen as lacking validation?
A. No.
Q. Are you aware in that case that the judge ruled and stated in his opinion that Dr. Rea -- he was talking about clinical ecology and then moving on to clinical sensitivity and said, Dr. Rea has changed labels but not methods, he has abandoned the label of clinical ecologist, he has also attempted to avoid the use of clinical ecology's most discredited theories. However, he continues to espouse the same baseless theory under new names in search of credibility. Were you aware of that?
A. No.
Q. Were you aware of the case in 1999, Guimond versus Fiberglas Canada, that Dr. Gerald Ross of Dallas -- it was a Canadian court -- held the theories of MCS had not been adequately tested, and excluded it?
A. No.
Q. Were you aware that in 1999 in Hannan

versus Pest Control Services, Incorporated in Indiana, the court excluded the testimony of Dr. Alfred Johnson, Michael Kelly and Doris Rapp regarding pesticide application, and that MCS was caused by that application?
A. No.
Q. Were you aware that the court held the experts failed to file generally accepted methodology of, one, identifying the substance at issue; two, determining the duration and level of exposure; three, determining the dose; four, analyzing the relevant literature; and five, ruling out other causes? Were you aware of that?
A. No.
Q. Were you aware that the Workers' Compensation Division in North Carolina in August 2003 rejected the testimony of William Meggs regarding multiple chemical sensitivity RADS as not being scientifically valid? Were you aware of that?
A. No. Professor Meggs, I doubt that.
Q. Were you aware that the court found that these diseases are not recognized by technical and medical community, therefore, aren't generally recognized?
A. No, it's simply not true. They may have

found that.
Q. So -- and are you aware that in 1996 in the case of Hundley versus Norfolk and Western Railroad, that the federal court excluded yours and Dr. Johnson's testimony concerning an exposure to herbicide as a cause of MCS?
A. Yeah, I believe I do remember that.
Q. Were you aware that in Koch versus Shell Oil in Kansas in 1999 -- well, let me first ask you this. Do you know Dr. Gunnar Heuser?
A. Yes.
Q. Okay. Are you aware in 1999 that the court excluded the testimony of Dr. Gunnar Heuser and Aristo Vojdani under a Daubert standard when they claimed that a larvicide had caused immunodysfunction?
A. I certainly wasn't.
Q. Do you recall that in -- do you know an Alan Lieberman?
A. Sure.
Q. Were you aware that in 1997 in Maxwell versus Sears, Roebuck in Florida, Dr. Lieber's (sic) testimony -- do you know Alan Roberts, D.O.?
A. Yeah.
Q. Do you know Susan Franks, Ph.D.?

A. Yes.
Q. Did you know that their testimony --
MR. SIMON: What about Lieberman?
MR. FRESHOUR: All three of them.
Q. You know them. Do you know that their testimony was excluded based, that the -- they were unable to bring forward proof of the basis for the opinions of the chemical sensitivity outside Lieberman, Roberts and Franks testifying to each other's testimony?
A. No.
Q. And they further found that multiple chemical sensitivity is theoretical and lacking scientific proof? Were you aware of that?
A. I wasn't. I don't see what that's got to do with me, but that's fine.
MR. SIMON: He's just asking you if you're aware of these things.
Q. Are you aware -- in 1993 in a case called Mullenax versus McRae, are you aware that the Mississippi Workers' Comp Division denied a multiple sensitivity -- multiple chemical sensitivity claim based on workplace exposure to solvents, and that you were the physician who was appearing on behalf of the claimant?

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A. Yes, I knew that one.
Q. Okay. And the commission found that your unorthodox methodology failed to establish any causal connection. And they even went further to say, even if you were to accept his theory that the exposure to one chemical can cause this, there were other legitimate explanations that weren't excluded. Were you aware of that?
A. No.
Q. Were you aware in 1995 the Texas court of appeals in North Dallas Diagnostic Center versus Dewberry, the appeals court ruled that Dr. Ross' testimony -- and that's Dr. Gerald Ross of the Environmental Health Center in Dallas, Texas -- holding there was no evidence that intradermal skin testing could reliably detect sensitivity to a contrast dye? Were you aware of that?
A. No.
Q. In Oppenheimer versus United Charities of New York, the superior court of New York in 1998, the court --
MR. SIMON: Supreme court.
MR. FRESHOUR: Supreme court. What did I say?
MR. SIMON: Superior court.

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Q. Oh, supreme court, I'm sorry.
The court excluded your testimony as untested and not generally accepted in the medical community? Were you aware of that?
A. No.
Q. In the case of Phillips versus Velsicol Chemical Corporation in 1995, were you aware that the court excluded your testimony and that from Accu-Chem Laboratories?
A. No.
(Mr. Cook enters the room)
Q. For -- they excluded your testing, your double-blind testing, which purportedly confirmed a chlordane exposure? Were you aware of that?
A. No.
Q. Were you also aware that the court excluded the back calculations of exposure by Dr. Robert Simon in that case, as unscientific?
A. No.
Q. Do you know a Dr. Michael -- is it DeWitt or LeWitt?
A. No.
Q. You don't?
A. No.
Q. Okay. Do you know a Dr. Elaine Panitz, P-a-i-t-z (sic)?
A. No.
Q. Do you recall in the case of Summers versus MoPac -- Missouri Pacific Railroad, eastern district of Oklahoma 1995, that the court excluded Dr. Johnson's testimony to distinguish chemical sensitivity from MCS and clinical ecology as unpersuasive, and they also rejected the use of Dr. Simon's SPECT testing? Were you aware of that?
A. No.
Q. Were you aware of the case of McNeel versus Union Pacific Railroad in Missouri in 2006 that -- there was a motion to limit your testimony, that of Dr. Simon and that of Nancy Didricksen? Do you recall that case?
A. No.
Q. Okay. Do you recall in that case that Nancy Didricksen also testified that Dr. Rea does not refer patients to her unless he already believes that they have toxic encephalopathy?
MR. SIMON: We went through that before.
THE WITNESS: Yeah, we went through that before.
MR. FRESHOUR: Did we?

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MR. SIMON: Yeah.
MR. FRESHOUR: On the McNeel one?
THE WITNESS: Yeah.
Q. Were you aware in there -- and do you know, does Dr. Didricksen still prescribe to the tenets of field therapy that postulates by tapping certain parts of the body that correspond to meridians that can rid one of anger and post-traumatic stress syndrome disorder?
A. I don't know what you're talking about.
Q. Okay.
MR. SIMON: Say that twice fast.
MR. FRESHOUR: Exactly.
Q. Doctor, in that very same case one of the questions that was asked was, how can you arrive at the conclusion that it was the odor that caused all of these problems simply because it occurred during that event? Dr. Rea responded, it seems to me that's the most logical thing, isn't it? Do you recall that testimony?
A. No.
Q. All right. Doctor, we have covered a lot of information and territory today. Would you agree?
A. Yes, I would.
Q. Okay. And, Doctor, you understand that

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800.829.6936 * 512.472.0880

this is -- matter is scheduled to go to hearing in August of this year, correct?

A. Yes.

Q. Now, I know you can't say for sure, but if I were to ask you generally the same type of questions in the same form today, I could anticipate more or less you would answer in the same fashion; is that fair?

MR. SIMON: What?

A. Well, I don't know.

MR. SIMON: Object to the form.

Q. Okay. Doctor, let me ask you this: The questions I've asked you today, have you understood them?

A. I think --

Q. For the most part?

A. For the most part, I have, yeah.

Q. And on those that you did not, Doctor, did you ask me for clarification?

A. I tried to, yes.

Q. And did I attempt at my best to rephrase or describe what I was trying to get from you as best I could?

A. I think you did.

Q. And did I allow you to give full and

complete answers and not interrupt you or cut you off?

A. Yes.

Q. All right. And on those questions where you did ask for explanation and we did kind of go back and forth, you answered them to the best of your ability, as I tried to clarify, correct?

A. Yes, of course I did.

MR. FRESHOUR: I think I'll pass the witness at this time.

MR. SIMON: No questions at this time.

THE VIDEOGRAPHER: The time is 4:57 p.m. This is the end of tape number seven. Going off the record.

(Proceedings concluded at 4:57 p.m.)

CHANGES AND SIGNATURE

PAGE	LINE	CHANGE	REASON

I, WILLIAM J. REA, M.D., have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

_____

WILLIAM J. REA, M.D.

THE STATE OF _____)

COUNTY OF _____)

Before me, _____, on this day personally appeared WILLIAM J. REA, M.D., known to me or proved to me on the oath of _____ or through _____ (description of identity card or other document) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he/she executed the same for the purpose and consideration therein expressed.

Given under my hand and seal of office on this _____ day of _____, _____.

_____

NOTARY PUBLIC IN AND FOR

THE STATE OF _____

My Commission Expires: _____

SOAH DOCKET NO. 503-07-4032
LICENSE NO. D-2294

IN THE MATTER OF THE)
COMPLAINT AGAINST) BEFORE THE
WILLIAM REA, M.D.) TEXAS MEDICAL BOARD

REPORTER'S CERTIFICATE
ORAL VIDEOTAPED DEPOSITION OF WILLIAM J. REA, M.D.
May 21, 2010

I, Cheryl Duncan, Certified Shorthand Reporter in and for the State of Texas, hereby certify to the following:

That the witness, WILLIAM J. REA, M.D., was duly sworn and that the transcript of the deposition is a true record of the testimony given by the witness;

That the deposition transcript was duly submitted on _____ to the witness or to the attorney for the witness for examination, signature, and return to me by _____.

That pursuant to information given to the deposition officer at the time said testimony was taken, the following includes all parties of record and the amount of time used by each party at the time of the deposition:

Mr. Scott M. Freshour (5 hours, 34 minutes)
Attorney for Texas Medical Board
Mr. Jacques G. Simon (00 minutes)
Attorney for Witness

That a copy of this certificate was served on all parties shown herein on _____ and filed with the Clerk.

I further certify that I am neither counsel for, related to, nor employed by any of the parties in the action in which this proceeding was taken, and further that I am not financially or otherwise interested in the outcome of this action.

Further certification requirements pursuant to Rule 203 of the Texas Code of Civil Procedure will be complied with after they have occurred.

Certified to by me on this _____ day of June, 2010.

_____
Cheryl Duncan, CSR
Texas CSR 3371
Expiration: 12/31/10
KEN OWEN & ASSOCIATES, L.P
Firm # 115
801 West Avenue
Austin, Texas 78701
512.472.0880
512.472.6030 fax
800.829.6936

FURTHER CERTIFICATION UNDER TRCP RULE 203

The original deposition was/was not returned to the deposition officer on _____.

If returned, the attached Changes and Signature page(s) contain(s) any changes and the reasons therefor.

If returned, the original deposition was delivered to Mr. Scott M. Freshour, Custodial Attorney.

$_____ is the deposition officer's charges to the Texas Medical Board for preparing the original deposition and any copies of exhibits;

The deposition was delivered in accordance with Rule 203.3, and a copy of this certificate, served on all parties shown herein, was filed with the Clerk.

Certified to by me on this _____ day of _____, _____.

_____
Cheryl Duncan, CSR
Texas CSR 3371
Expiration: 12/31/10
KEN OWEN & ASSOCIATES, L.P
Firm # 115
801 West Avenue
Austin, Texas 78701
512.472.0880
512.472.6030 fax

F

H

I

SOAH DOCKET NO. 503-07-4032

LICENSE NO. D-1294

IN THE MATTER OF	BEFORE THE
THE COMPLAINT AGAINST	
WILLIAM REA, M.D.	TEXAS MEDICAL BOARD

NOTICE OF INTENTION TO TAKE THE ORAL VIDEOTAPED DEPOSITION OF WILLIAM J. REA, M.D. AND SUBPOENA DUCES TECUM

TO: WILLIAM REA, M.D., Respondent, by and through his attorney of record, Jacques G. Simon, 2174 Hewlett Ave., Ste 201, Merrick, NY 11566

PLEASE TAKE NOTICE that at **10:00 a.m. (Central Standard Time), on Friday, May 21, 2010**, and continuing from day-to-day until complete, the undersigned attorney or his designee, will take the oral videotaped deposition of **William J. Rea, M.D.** (hereinafter referred to as "Deponent"), at the Law Offices of Steve Coke, 13155 Noel Rd, Ste. 800, Dallas, TX 75240, where Deponent shall appear for the purpose of giving an oral and videotape deposition in the above styled and numbered case pending before the Board, pursuant to 22 T.A.C. §187.8(b), the Administrative Procedure Act, TEX. GOV'T CODE ANN. §2000.001 *et. seq.*, and TRCP 199.

The deposition will be reported by a duly certified court reporter.

The deposition shall continue from day to day until the deposition is begun and completed, or as mutually agreed by the parties, or as otherwise ordered by law. Furthermore, the deposition may be used as testimony at the trial of the above-entitled and number cause. Deponent is directed to bring to the deposition those documents and items listed in the "Subpoena Duces Tecum" attached hereto as Attachment A.

Respectfully submitted,

By: _____

Scott M. Freshour
State Bar No. 00789299
Texas Medical Board
333 Guadalupe, Tower 3, Suite 610
Austin, Texas 78701
Telephone: 512-305-7096
Fax: 512-305-7007

CERTIFICATE OF SERVICE

I hereby certify that on this the 13th day of May, 2010, a true and correct copy of the foregoing Notice of Intention to Take the Oral Videotaped Deposition of William J. Rea, M.D. and Subpoena Duces Tecum has been served on the following individuals at the locations and in the manner indicated below:

VIA FACSIMILE: 516-378-2700
Jacques G. Simon
2174 Hewlett Ave., Ste 201
Merrick, NY 11566

VIA FACSIMILE: (512) 288-1645
Laurie York
6633 Oasis Dr.
Austin, Texas 78749
Attorney for Respondent

BY HAND DELIVERY
Sonja Aurelius
Hearings Department
Texas Medical Board
333 Guadalupe, Tower 3, Suite 610
Austin, Texas 78701

_____
Scott M. Freshour

ATTACHMENT "A"

SUBPOENA DUCES TECUM

The term "you" or "your" as utilized in this subpoena duces tecum refers to, William J. Rea, M.D.

The term "Consulting Expert' means any person with whom you have consulted, either in person or in writing or otherwise, in forming your opinions regarding the care and treatment provided by you in SOAH Docket No. 503-07-4032.

The term "Respondent" means William James Rea, M.D.

As authorized by the Texas Rules of Civil Procedure, Texas Medical Board Statutes and Rules, and Texas Administrative Procedure Act, a subpoena duces tecum is issued requiring the Deponent, William J. Rea, M.D. to produce at the deposition the following documents:

REQUESTED DOCUMENTS

1. All medical records, billing records, laboratory reports and data, diagnostic test results, imaging, including but not limited to x-rays, CT scans, and MRIs, clinic records, nurse reports, and all other similar record or document concerning your patients identified in SOAH Docket No. 503-07-4032 that you as an expert saw, utilized, reviewed or relied upon in formulating/forming your opinions in this matter.

2. Complete copies of all documents and tangible items that have been provided to you by any attorney, consulting expert, testifying expert in this matter.

3. Complete copies of all documents and tangible items that have been made or prepared by any consulting expert you relied upon reviewed in formulating any of your opinions.

4. A copy of any journal, article, learned treatise, textbook, other reference material, or other professional material utilized by you or any consulting expert in forming your opinions regarding the care provided to and treatment of your patients identified in SOAH Docket No. 503-07-4032.

5. All documents, reports, notes, electronic communication of any form, data compilation, writings, or correspondence that have been sent, mailed, delivered, received, exchanged, or otherwise communicated between you and any other individual regarding your patients identified in SOAH Docket No. 503-07-4032, and any reports, drafts of reports, diagrams, models, charts, tests, records, graphs and notes made, used, reviewed or otherwise utilized by you in any way in forming your opinions concerning the care provided to and treatment of your patients identified in SOAH Docket No. 503-07-4032.

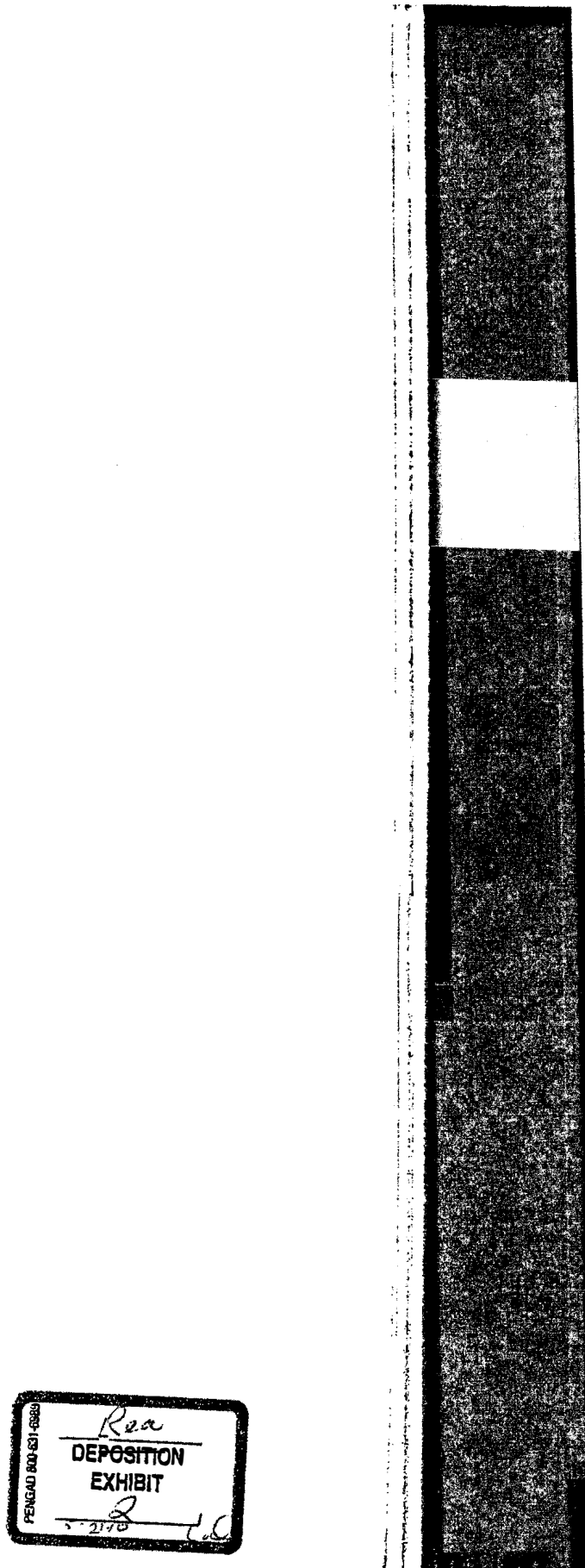
6. All tangible reports, compilations of data, or any other materials prepared by you in anticipation of deposition or trial testimony. This should include copies of all draft reports, notes or other communication, writings and any other materials you received or reviewed in preparing your opinions. This demand is inclusive and encompasses documents which were reviewed by the expert in preparation of the report but which were not cited in his report.

7. A copy of any journal, article, learned treatise, textbook, other reference material, or other professional material you intend to assert as authoritative with regard to your testimony and/or opinions in this matter.

8. All documents, records, or other media that evidence, demonstrate, or contain communications between you and any other testifying or consulting expert retained by or for you regarding the evaluation, opinion or analysis of your patients, and medical practice identified in SOAH Docket No. 503-07-4032.

9. All data, documents, records, protocols, descriptions, or other media that evidence, demonstrate, or contain description of the process(es), procedures, formulation, collection procedure(s), or any and all other methodology(s) used in preparing the antigens or intradermal skin testing incitants provided for clinical use, clinical testing, prescribed, ordered, administered to, or otherwise provided to your patients identified in SOAH Docket No. 503-07-4032.

10. Provide all data, documents, records, laboratory analysis (quantitative and qualitative); test results, findings, or any and all other materials related to the testing of, composition of, components found in, ingredients that comprise the antigen therapies or intradermal skin testing incitants used on, prescribed for, administered to, or otherwise provided to your patients identified in SOAH Docket No. 503-07-4032, this includes but is not limited diesel fuel fume extracts, jet fuel fume extracts, natural gas fume extracts, propane gas, fireplace smoke, lake algae, mercury, arsenic, titanium, porcelain, stainless steel, lead, and fusaric acid.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Rea
DEPOSITION
EXHIBIT
2

Protocol for Car Exhaust
January 1995

1. 300 cc of coca's solution (NaCl = amounts of NaC03).
2. 50% of each (unleaded gas exhaust and diesel exhaust).
3. Set air collecting machine one foot from the car exhaust pipe (gasoline or diesel) pulling the exhaust into a 450 cc of coca's solution for 15 minutes.
4. Dilute with 300 cc of coca's solution.
5. Run through a ceramic Millipore filter (smallest size) for sterility.
6. Dilute with saline ½ - this is the concentrate. Dilute 1/5, 1/25, 1/625, etc. as needed.
7. Analysis shows no toxic substances; however, the electromagnetic imprints still persist as evidenced by skin reactions until the #20 dilutions in some patients. This obviously is in the homeopathic frequencies.

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7. **Analysis shows no toxic substances; however, the electromagnetic imprints still persist as evidenced by skin reactions until the #20 dilutions in some patients. This obviously is in the homeopathic frequencies.**

ZEPHIRAN CHLORIDE PREPARATION

Benzalkonium Chloride can be purchased from ALDRICH-Sigma Chemicals
ALDRICH phone 1-800-558-9160
Customer #907281
Benzalkonium Chloride catalog #23,442-7
Available sizes: 5grams, 100grams, 1kilogram

PREPARATION OF ZIPHIRAN CONCENTRATE is as follows:

250grams of Benzalkonium Chloride
20ml of Ethyl Alcohol
960ml of Distilled Water

PREPARATION OF ZEPHIRAN SOLUTION (1:750) is as follows:

1oz (29.6ml) of Zephiran concentrate
127oz (3.8L or 1 gallon) of Distilled Water

Coca's Solution

Ingredients needed to prepare Coca's Solution:

1) medical/ionized water from the analytical laboratory
2) Sodium Chloride (NaCl)
3) Sodium Bicarbonate

In a large sterile beaker, collect 1000cc of medical/ionized water.

Using the calibrated scale, measure: 5.0 grams of Sodium Chloride
2.5 grams of Sodium Bicarbonate

Add both dry ingredients to the 1000cc of water.

Mechanically stir until completely dissolved and solution is clear.

Remove the mechanical stirrer with 2 wooden tongue depressors.

Write the date each batch of Coca's solution is made on a label on the beaker and cover tightly with foil.

There is no need to refrigerate the Coca's solution.

Notes:

Updated: 2008 (By Barbara Pond)

Steps for Making Antigen Concentrates

1) Use poly-shield to cover work area.
2) Calibrate scale with weights. (Use gauze pads to bring scale up to zero)
3) Log scale measurements into scale maintenance log for the day.
4) Add small, plastic weighing tray to the scale and hit 'Tare' button to zero out the scale.
5) Measure amount of material in the weighing tray on the scale. Consult the **List of Antigen Material** to decide whether material is food, liquid or solid (powder). Gases and exhausts are handled differently.
6) When weighing antigen material it is best to round up or down in order for the material amount to fall within the guideline ratios set forth in the **Measurements and Ratios Guide.** It is important to include a portion of any capsule or gel-cap with the substance for the measurement since these will be included within the concentrate.
7) Once the substance to be made into a concentrate has been measured, calculate the amount of Coca's solution needed for mixing. **Consult the Measurements and Ratios Guide for this calculation.**
8) Pour the calculated amount of Coca's solution into a sterile beaker. Next, add carefully the measured substance from the weighing tray into the measured Coca's solution. Tightly cover beaker with foil top.
9) Using a magnetic stirrer, stir the Coca's and the antigen material on the mechanical stirring machine for 30 minutes. Use 2 sterile wood tongue depressors to remove mechanical stirring device. **Exceptions to this stirring rule would be for making food antigens. Foods that are weighed

after cooking or that are to be made raw will be blended with the appropriate amount of Coca's solution in the blender until thoroughly mixed together. No extra stirring is needed.

10) Label beaker with appropriate labeling information such as whether antigen is for the **Clinic** or is a patient **Personal Antigen**. Check for examples and all pertinent information in the **Labeling of Antigens** section.

11) Store antigen concentrates in the refrigerator for the specified amount of 'sit time'. The sit-time for most antigens is 4 days with the exception of milk and eggs which are filtered sooner due to their spoilage nature. Consult the **List of Antigen Material** for specifics about milk and eggs.

12) After the appropriate amount of sit time, antigen concentrate will be mixed for 30 minutes with the mechanical stirrer before filtering.

13) Consult the **Filtering Guide and Recommendations** for specific filtering guidelines.

14) Sterility tests will be accomplished with each newly made antigen concentrate. Please consult the guidelines for **Sterility Procedures.**

15) Log the antigen concentrate into the concentrate log and mark the appropriate information about final production and sterility of each concentrate.

16) Vials of filtered and labeled concentrates will be stored in the refrigerator for an additional 48 hours until the sterility test has been successfully accomplished.

17) After sterility tests have been successfully completed and the antigen concentrates will be brought to the Antigen Lab for further processing.

18) If the antigen is a personal antigen, make sure the billing paperwork is filled out and accompanies the concentrate to the Antigen Lab. The pink copy of

this paperwork is to be delivered to the Front Desk mailbox for payment processing.

19) Please consult with management for proper antigen charges for personal antigens.

List of Antigen Material

Foods:

If a food is clearly in the liquid form, like Coke or Pepsi, then it is considered a liquid and should be measured out in the liquid ratio of 1:10.

If the food is clearly in the solid form like sugar, flour or spices then it should be considered a solid and measured in the solid/powder ratio of 1:30.

Most items in the food category are things such as vegetables, fruits and meats and should be prepared and measured in the food ratio of 1:20 (food: Coca's).
Vegetables (cooked and raw), fruit, meat (usually cooked by boiling in medical water or browned slowly in glass pan), grains (cooked by boiling in medical water), dairy such as butter or cheese, nuts, beans/legumes (cooked), chocolate.

Eggs have special processing. Eggs should be boiled in their shells for 3 minutes. Cool and peel. Weigh cooked egg in the food ratio of 1:20. Blend egg with Coca's solution and let mixture sit for 30 minutes before filtering. This mixture may require extensive filtering due to the high protein viscosity.

Cooking oils, syrups, honey and sauces are all considered liquids and should be prepared in the liquid ratio of 1:10 (liquid: Coca's)

Preservative powders (MSG, BHT, BHA) are considered powders/solids and should be weighed in the 1:30 ratio.

Milk (cow and goat) are considered liquids and have special processing. See liquids section for details.

Pepsi, Coke, Dr. Pepper, Perrier, etc. are considered liquids since they are already in liquid form.

Coffee and tea should be weighed as a powder/solid in their leaf or granular form and added as such to the Coca's solution in a 1:30 ratio.

Solids/Powders:

Medications (tablets, capsules, powder or granules)
Vitamin Supplements (tablets, capsules, powder or granules)
Hair = human, pets or farm animals
Feathers
Dental Materials (plastics, acrylics, metals, cements, composites)
Implant Materials (mesh, stints, contact and intraocular lens, metal joints, pace maker parts)
Clothing, fabrics, vinyl, leather, rubber
Surgical sutures
Building Materials (caulk, sheetrock, wood, tile)
Plant Material (weed, tree, grass pollen, flowers)
Terpene Powder
Baker's Yeast and Brewer's Yeast
Sugars and Flours
Spices and Preservative powders
Insects
Mold and Mildew (powder concentrates)
Dust/Mites (powder concentrates)
Dander (powder concentrates)
Metals
Plastics
New material (news paper and magazine papers combined)

Liquids/Gels:

Beverages such as Coke, Pepsi, Dr. Pepper, Perrier, bottle water
Liquids anesthetics
Body fluids (sweat, urine, tears, semen, abdominal fluid)
Silicon and Saline for implants
Safe coat sealers, stains and paints
Beauty products (shampoo, conditioner, liquid soap)
Liquid chemicals
Liquid medications
Liquid Supplements (vitamin E, A, CoQ10, fish oils, beta carotene)
Unleaded gasoline, diesel and jet fuel
Perfumes and colognes
Ethanol

Formaldehyde
Phenol

*Milk (goat and cow) are prepared specially due to the high protein content. Initially, milk should be measured in the standard liquid ratio of 1:10. If this still is too viscous, then the ratio can be further diluted down to 1:50 (milk: Coca's). The sit time for milk is only 4 – 8 hours and then immediate filtering due to the tendency of milk to curdle.

*Perfumes are measured in 10cc amounts of each individual perfume to be combined as a mix of all perfumes to be combined. The total cc amount will be 1:10 ratio. Example: 10cc perfume A, 10cc perfume B, 10cc perfume C would be 30 cc to be in a ratio with 300cc of Coca's. This is for a liquid mix concentrate.

*Some highly viscous liquids such as oils or gels may need to be diluted down to a 1:50 ratio of liquid: Coca's solution in order to be effectively filtered.

Gases, Air and Exhaust:

Home or workplace air sample
Car exhaust
Cigarette smoke
Fireplace smoke
Natural and propane gas fumes

Sterility Procedures

1) Once antigen concentrate is filtered and contained in its labeled, sterile vial, a sterility test must be accomplished.

2) The following items are needed to perform sterility testing: a burner and lighter, test tube with prepared culture media, small 1cc syringe, Zephiran, white tape or small label for labeling culture tube.

3) Light burner flame with lighter. CAUTION: keep flame away from Zephiran.

4) Sterilize rubber top of antigen concentrate vial with Zephiran.

5) Draw .2cc of concentrate in a small .5cc syringe.

6) Uncap sterility culture tube and rotate the uncapped, glass neck of the tube through the flame for several seconds or until tube is fogged around the neck.

7) Remove tube from flame and empty the .2cc contents of the concentrate into the culture media within the sterility tube.

8) Cap the sterility tube and label on the tube with tape and a Sharpie marker the name of the antigen concentrate. (regular ink pens may bleed in the incubator)

9) Place the labeled sterility tube in the incubator for 48 hours.

After 48 hours, check the tube for cloudiness or the presence of heavy particulates floating in the media. If culture has remained clear, the sterility test is **Negative** and the concentrate can go the Antigen Lab or further processing. Log the negative result in the antigen concentration log.

10) If the culture is cloudy or there is material floating or growing in the tube then repeat all the filtering procedures and repeat the sterility test using a fresh culture tube.

NOTES:

Filtering: A Guide and Recommendations

Mechanical Filtering:

First make sure of the following:
*Antigen concentrate has sat in the refrigerator for the required 4 days.
*Antigen concentrate has been mechanically stirred for 30 minutes prior to filtering.

1) The hose from the mechanical filter is attached by wetting the tube's tip with sterile water and fitting over the end of a sterile flask.

2) A sterile ceramic funnel is fitted tightly into the mouth of the flask. Different grades of round filter paper are available to fit in the ceramic funnel.

3) Place the filter paper in funnel and turn on the mechanical pump. This should start a vacuum seal.

4) Pour the antigen concentrate solution into the funnel. Most of any material that was in suspension of the concentrate will be captured by the filter paper. It is best to run the liquid captured in the flask back through the funnel with a new filter paper to further filter out any material still in suspension.

5) Transfer filtered solution to a sterile beaker for further hand filtering.

6) It is important to note that some concentrates are so dilute, such as Vitamin C in Coca's that mechanical filtering can be skipped and the concentrate can be directly hand filtered.

Notes:

Hand Filtering:

Hand filtering is the more refined filtering. The concentrate at this stage will either have been mechanically filtered or is so dilute it is thin enough for finer filtering.

*Generally a 50 cc sterile vial is used for concentrates; however, a smaller 20 cc vial may be used for personal antigen concentrates

1) Prepare the concentrate vial by wiping the top with Zephiran and passing through an open flame just enough for the glass neck of the vial to fog. Insert 2 sterile needle tips into the rubber top of the vial.

2) Under the dust hood, draw up a full 10cc needle-less syringe of concentrate material. Affix a Millipore syringe (disk) filter by screwing onto the end of the syringe. Push contents of concentrate through the disk filter and into one of the needle tips into the sterile vial. *If it is too forceful to push liquid through the disk filter, consider mechanically filtering to further thin the concentrate or replace a fresh disk filter on the end of the syringe and continue filtering.

3) After all of the concentrate has been filtered through disk filters. Label all of the vials that with proper labeling and follow **Sterility Procedures** before storing the filtered concentrate in the refrigerator while awaiting the sterility test results.

- Often times a concentrate is too viscous to pass through any or all filtering methods. In this case the concentrate should be diluted out to a ratio of 1:50 and filtered. In some cases, a material may be too slippery or oily, such as a medication, and the decision must be made on a case by case basis whether an antigen can successfully be made of that specific substance.
- Be careful not to overfill a vial in that is may crack upon thawing and freezing during storage. Fill only up to the bend in the vial's neck.

Notes:

Measurements and Ratios for Concentrates

There are 4 classes of materials considered for making antigen concentrates:

1) Food
2) Solid/Powder
3) Liquids/Gel
4) Gas/Air/Exhaust

Foods:

All foods are mixed with Coca's solution in a 1:20 ratio.

20 grams food = 400 cc Coca's
10 grams food = 200 cc Coca's
5 grams food = 100 cc Coca's

Foods are to be prepared in the manner in which they are most often eaten. Most fruits will be weighed as raw food. Most meats will be cooked. Certain foods will be eaten both raw and cooked such as carrots. In this case, half of the amount weighed should contain the food in its cooked form and the other half should be in the raw form.

All foods whether raw or cooked will be blended with the measured amount of Coca's solution in the blender before refrigerated for the 4 day sit time.

Foods such as beverages will be treated as liquids if they are already in liquid form, such as bottled waters, sodas, fruit juices. However, coffee and tea for example will be treated as a food in that the tea leaves or coffee granules will be weighed in the 1:20 ratio before being combined with the measured amount of Coca's solution.

Notes:

Solids and Powders:

All solids and powders are mixed with Coca's solution in a 1:30 ratio.

0.5 grams = 15 cc Coca's
1.0 gram = 30 cc Coca's
5.0 grams = 150 cc Coca's
10.0 grams = 300 cc Coca's
15.0 grams = 450 cc Coca's

Consult the **List of Antigen Material** to determine if a substance is considered to be a solid or powder.

In the case of medications or vitamin supplements, capsules should be broken open and the actual substance or ingredient should be measured; however, a piece of the capsule material must be included in the weight total so that all materials of the desired substance can be included in the antigen.

Important Note: if a substance is too small to register as a measurable weight on the scale, such as small pieces of dental material or a single dose pill, use the smallest ration of material to Coca's by mixing the immeasurable substance with 15cc of Coca's solution.

Notes:

Liquids and Gels:

Liquids and gels are mixed with Coca's solution in a 1:10 ratio.

10 cc = 100 cc Coca's
20 cc = 200 cc Coca's
30 cc = 300 cc Coca's
40 cc = 400 cc Coca's

Measure the amount of Coca's solution into a sterile beaker.

Collect the liquid/gel into a small plastic disposable weighing tray. Using a sterile 10cc (without the needle attached) draw liquid/gel into syringe for measuring. Add each metered syringe amount to the measured Coca's solution until the desired amount of liquid/gel has been added to the Coca's.

To extract substances such as medications or vitamins from gel capsules, use a disposable blade to pierce capsules. With sterile gloved hands, squeeze contents into collection tray for drawing up into sterile syringe for metered measurement.

Notes:

Gas, Air and Exhaust:

Labeling of Antigens

Every antigen concentrate must be labeled clearly with the antigen substance name, whether it is a clinic or personal antigen, an assigned inventory number, number of vials to be made and completion date.

1) First step is to look for the material in the inventory list of all catalogued antigen materials. Each material used for the clinic has an assigned inventory number. Each new substance that is not already in the inventory must be assigned an inventory number. New numbers are used for new items for the clinic as well as for personal antigen concentrates.
2) If the substance to be made is already catalogued in the inventory list, then the inventory number is reassigned to the concentrate.
3) If the substance is new to the clinic or is for a specific patient, then a new inventory number is assigned from a running list of concurrently assigned numbers for new antigen concentrates. These numbers are all found in the antigen concentrate log.
4) Once an inventory number has been assigned or reassigned to a concentrate, a label must be affixed to the beaker in which the concentrate is being made. Later, this label will be reaffixed to the vial once the antigen concentrate is filtered and sterility checked.
5) The label must clearly state the antigen material such as: *Carrots, Grass Terpene or Personal: Tippy's Cat Hair.* The label must also clearly state either Clinic or the patient's name if it is for a personal antigen. The inventory control number and number of vial to be made will be printed on

the label with space for the completion date to be added to the label after all filtering and sterility is accomplished.

Label Examples:

Goat Milk
Clinic
10118- 02-10-10-08

T-3 Thyroid Medication
Jane Doe – personal antigen
30,509-01-10-10-08

Label Format:

Name of Material
Either Clinic or Name of Patient

Inventory number – number of vials to be made – date sterility test is completed

Log all labeling information into Antigen Concentration Log including whether the concentrate passed the sterility test and on what date.

GENERAL PROTOCOL FOR PREPARATION OF PRESERVATIVE FREE

INCITANT CONCENTRATES

A. Extraction

1. Coca's Solution

Check your Coca's solution first before you start making any extract.s.
Prepare coca's solution by mixing:
1 gallon of sterile water
9 gm of sodium bicarbonate
19 gm of sodium chloride

Mix them all together with the help of stirrer machine and the stirrer.

2. Food Extract Measurement

Food extracts are made from organic food only (either cooked or raw, depending upon how the food is usually eaten), and if eaten both ways, make antigen for each). Weigh out 11 gm.food and place into 220 cc coca's solution. Blend in the blender as fine a consistency as possible. Pour into flask and let stand for four days in the refrigerator. Everything stands for four days except Terpenes.They stand for seven days. Blend 5 gm powdered extracts into 150 cc coca's solution. Shake flask four times each day to mix solution.

3. Weighing of antigen

Food 1/20 = 11 gm food - 220 cc coca's

Powder 1/30 = 5 gm powder -150 cc coca's
10 gm powder-300 cc coca's
15 gm powder-450 cc coca's

Liquid 1/10 =20 cc liquid -200 cc coca's
30 cc liquid -300 cc coca's
40 cc liquid -400 cc coca's

Trees, Weed, terpene = 1 gm – 30 cc coca's

B. Filtration

1. First Filter

(a) Place sterile funnel into sterile flask with the rubber stopper so it fits very tightly.
(b) Place a C.80U filter into sterile Buckner funnel.
(c) Attach the rubber tubing pipe one end to the flask container and the other end attaches to the Nalgene hand-operated vacuum pump.

(d) Remove antigen in coca's solution from refrigerator.

(e) Begin pouring through funnel. Filter may have to be changed frequently depending upon the thickness of the antigen.
(f) Start vacuum pump.
(g) If it doesn't look completely clear, repeat filtering with filter G.65U. Follow the same pocedure. The next filter is G.45U. Stop the pump. Cover antigen with foil.

2. Second Filter

This procedure has to be done under dust free filter hood. We need
(a) Zephiran to clean rubber tops of vials.
(b) 10 ml or 50 ml sterile empty vials.
(c) 10 ml syringes.
(d) Bunson burner.
(e) 0.22 micro Millipore Millex GV filter.
(f) 20 ga needle.

Second step in this filtration is as follows
(a) Draw the antigen into the 10 ml syringe without the needle.
(b) Screw the millex filter on the 10 ml syringe then screw 20 ga needle on and secure them tight-this has to be quick and sterile technique to prevent any contamination.
(c) Wipe the rubber cap of the sterile 10cc vial with Zephiran solution and then flame with Bunson burner.
(d) Insert the needle into the vial and use another 1 cc syringe w/o plunger for an air vent.
(e) Push the entire antigen inside the sterile empty vial.

Third step
Take out .5 cc of antigen from the vial that has been filtered and insert it in a culture media tube over the Bunsen burner, close the cap,keep the tube inside incubation chamber for 72 hours. Keep antigen in the refrigerator.

After 72 hours if there's no change in culture media and looks clear then the antigen is ready to use, but if it is hazy or cloudy re-filter the antigen and inoculate for 72 hours again. Keep record of all culture.

GENERAL PROTOCOL FOR PREPARATION OF PRESERVATIVE FREE

INCITANT CONCENTRATES

A. Extraction

1.Coca's Solution

You should have enough Coca's Solution before you start making extract.
1 gallon of sterile water
9 gm of sodium bicarbonate
19 gm of sodium chloride

Mix them all together with the help of stirrer machine and the stirrer.

2.Food Extract Measurement

Food extract are made from organic food only (cooked or raw, depending upon how the food is usually eaten), and if eaten both ways, make antigen for each). Weigh out 11 gm.food and place into 220 cc coca's solution. Blend in the blender as fine a consistency as possible. Pour into flask and let stand for four days in the refrigerator. Everything stands for four days except Terpenes.They stand for seven days. Blend 5 gm powdered extract into 150 cc coca's solution. Shake flask four times each day to mix solution.

3. Weighing Of antigen

Food 1/20 = 11 gm food - 220 cc coca's

Powder 1/30 = 5 gm powder -150 cc coca's
10 gm powder-300 cc coca's
15 gm powder-450 cc coca's

Liquid 1/10 =20 cc liquid -200 cc cocas
30 cc liquid -300 cc cocas
40 cc liquid -400 cc cocas

Trees, Weed, terpene = 1 gm – 30 cc coca's

B.Filtration

1. First Filter

(a) Place sterile funnel into sterile flask with the rubber stopper so it fits very tightly.
(b) Place a 4x4 gauze sponge into sterile funnel.
(c) Attach the rubber tubing pipe one end to the flask and the other end attaches to the Nalgene hand-operated vacuum pump.
(d) Remove antigen in coca's solution from refrigerator.

(e) Begin pouring through funnel. Filter may have to be changed frequently depending upon the thickness of the antigen. 4x4 for thicker extract and 1x1 for finest extract.

(f) Start vacuum pump. If it doesn't look completely clear, repeat filtering with smaller pores-until it looks clear. Stop the pump. Cover antigen with foil .

2. Second Filter

This procedure has to be done under dust free filter hood. We need
(a) zephiran to clean rubber tops of vials .
(b) 10 ml or 50 ml vials.
(c) 10 ml syringes.
(d) Bunsen burner.
(e) 0.22 micro Millipore Millex GV filter.
(f) 20 gaze needle.

Second step in this filtration is as follows
(a) Pull antigen into a 10 ml syringe without the needle.
(b) Screw the millex filter on the 10 ml syringe then screw 20 gaze needle on it secure them tight-this has to be quick and sterile technique, make sure the needle and filter doesn't get contaminated.
(c) Clean rubber top of 10 ml or 50 ml glass vial with zephiran.
(d) Stick the needle into the vial and use another 1 cc syringe to stick into the same vial on the side, and take the 1 cc syringe's plunger out to let the air out from the vial.
(e) Push the entire antigen inside the vial.

Third step
Take out .5 cc of antigen from the vial that has been filtered and insert it in a culture media tube over the Bunsen burner, close the cap keep the tube inside incubation chamber for 72 hours. Keep antigen in the refrigerator.

After 72 hours if there's no change in culture media and looks clear then the antigen is ready to use, but if it is hazy or cloudy re filter the antigen and inoculate for 72 hours again. Keep record of all culture.

Zephiran Preparation

Preparation of Zephiran concentrate:

20 grams of Benzalkonium Chloride
2 ml of Ethyl Alcohol
96 ml of medical water

Mix all ingredients in a large sterile beaker. Mechanically stir until all contents are thoroughly mixed.

Preparation of Zephiran solution (1:750 ratio):

1 oz. (29.6 ml) of Zephiran concentrate
1 gallon (3.8 liter) medical water

*no stirring required for making the Zephiran solution

Benzalkonium Chloride can be purchased from ALDRICH Chemicals
Phone: 1-800-558-9160
Available sizes: 5 grams, 100 grams, 1 kilogram

Quality Control Procedures for Zephiran

For each batch of Benzalkonium Chloride that is produced, Quality Control must be carried out on the batch.

1) For Quality Control, inoculate 1 Thioglycolate tube, 1 TSA Blood Agar plate and 1 Sabouraud Agar plate with Staphylococcus bacteria obtained from the analytical lab.
2) Then, inoculate half of the Staphylococcus inoculated media with a sample of diluted (1:750) Benzalkonium Chloride.
3) Expected results will be no growth in the Staph infected zones in which the antiseptic was applied.
4) Observe the cultures for 14 days and record results in the maintenance log sheet.

Suppliers for Antigen Concentrate Materials

American Biologicals
P.O. Box 70
Piedmont, Oklahoma 73078
1-800-345-5719
no available website
Powder Concentrates: pollens, molds, dust/mites, foods, animal hair, dander, insects.

Exotic Meats.com
www.exoticmeats.com
1003 NE Loop 410
San Antonio, TX 78209
1-800-680-4375
1-210-828-6328

Meat: alligator, antelope, bear, buffalo, caribou, crocodile, elk, frog legs, kangaroo, lion, llama, rattlesnake, turtle, wild boar, yak

Whole Foods Market
11700 Preston Road #714
Dallas, Texas 75230
214-265-3100
www.wholefoodsmarket.com
organic fruits, vegetables, meats, spices, dairy, beverages

Central Market
5750 E. Lover's Lane
Dallas, Texas 75206
214-234-7000
www.centralmarket.com
organic fruits, vegetables, meats, spices, dairy, beverages

Roy's Natural Market
6025 Royal Lane, Suite 130
Dallas, Texas 75230
214-987-0213
www.roysnaturalmarket.com
limited organic fruits, vegetables, cooking oils, grains, supplements, cosmetics

Sprouts Natural Market
11722 Marsh Lane #317
Dallas, Texas 75229
214-353-0574
www.sprouts.com
organic fruits, vegetables, limited meats, cosmetics, hygiene items, some groceries

TJ's Fresh Seafood Market
11661 Preston Road # 149
Dallas, Texas 75230
214-691-2369
http://www.tjsseafood.com

fish, shellfish, can order unusual fish

Notes:

Instructions for Using the Air Sampling Machine

1. Open the case, remove the packing material and the three glass bottles containing the Cocas solution provided by EHCD.

2. Open one of the bottles of solution and pour it into the Flask marked "A". The solution is pre-measured and ready to use. Replace the cap on the bottle, as you will use it to put your sample into when the sampling is completed and we do not want any contamination to enter the bottle during that time. Flask "B" is an overflow tube and does not need to be dealt with at all during this procedure.

3. Replace the stopper for flask "A" firmly leaving the masking tape on the tube edging in place. The tape is there to avoid any cuts as the flask edges are jagged from previous breakage.

4. Grasp the two free hose ends which are labeled "To Outside" and place them through the holes in the case itself (this may already be done). It makes no difference which one goes in each hole although length may be a determining factor.

5. Place the case in the room in which you wish to sample. If a particular appliance is suspected in causing your reactions, ensure that it is operating during this test.

6. Grasp the electrical cord and plug it in to your wall socket. The pump should hum and the solution in flask "A" should bubble. If no bubbling occurs, check the stopper to make sure it is firmly inserted into the flask. There is also a gold air control value, which can be adjusted if needed, to obtain proper bubble activity. The amount of bubbling should be moderate but not so much that the water spills over into tube B.

7. Allow the machine to run for 8 hours. It is all right to run it a little bit over or under.

8. After the 8-hour sampling, unplug the machine, remove the stopper from flask "A" and pour the solution in flask "A" back into the bottle that it originally came in. Use one of the labels provided to mark the sample appropriately.

9. If another sample is to be conducted, rinse flask "A" and the outside of the tube extending from the bottom of the stopper with tap water (or distilled if available) for a few seconds.

10. Repeat the above procedure for the next sample using a new Cocas solution. If any solution spills into flask "B", just ignore it until you are ready to ship the machine back to EHCD and pour it out prior to shipping. Any solution in flask "B" will not be used for antigen production.

11. When all sampling is completed, ensure that the solution bottles are tightly capped and labeled appropriately, making sure that all of the information blocks on the label have been completed. Then repack the case as it was upon receipt and return it to EHCD.

12. The antigen will be made upon receipt of the samples and will be ready after three days (the time required for Quality Control of the antigen). After that time, testing can be conducted of the antigen.

Three solution bottles are enclosed for three samples to be made. The machine needs to be returned to EHCD as soon as you are finished with your air sampling. If you require the machine for more than 10 days, please notify me so that I will be aware of it.

Please feel free to call me if you have any questions. To reach my voice mail, call 1-214-368-4132 then hit #, 273, # after the recorded message for EHCD begins.

PROCEDURE FOR WASHING AND MAKING CULTURE MEDIA FOR INNOCULATION TUBES

Washing the tubes: -

1. Open the tube caps and place them in the steel pot.
2. Transfer the tubes into the blue steel rack and cover the tubes with another blue steel rack so it holds the tubes tight.
3. Pour the liquid culture media turning the rack up-side down-make sure the racks are held tight and all the tube are not coming out of the racks.
4. Wash the sink with tap water and close the drain, fill the sink with water.
5. Pour very small amount of liquid soap in the sink.
6. Now hold the tubes with the other blue rack tight and drown it in the soap filled water sink and let the water get inside the tubes fully.
7. Shakes the tubes to run the soap water inside the tubes so it washes away all the liquids from inside, make sure to hold the both the racks in right place and hold them tight too.
8. Pour soap water out and repeat no# 6 & no# 7. Repeat it for 4-5 times.
9. Check for stains inside tubes; use brush to wash away the stains from the tubes.
10. Fill sink with clean tap water only, now drown the tubes to wash away soap from the tubes, pour out water from tubes repeat this for 4-5 times until the soap is completely washed away.
11. Let all the tubes dry turning them upside down holding both the racks tight and tubes in right place. Please be careful while doing this part.

Making culture media for the tubes: -

1. Fill beaker with 1800 ml of sterile water.
2. Weigh 1.8 gm of **yeast extract**-pour it in the sterile water container.
3. Weigh 1.8 gm of **bacteriological peptone**-pour it in the sterile water container.
4. Plug in the magnetic stirrer machine put the sterile water beaker on the machine drop a stirrer in the beaker and turn on the stirring power on slowly and stand it for 30 minutes or until the **yeast extract** and **bacteriological peptone** is dissolved completely in sterile water.
5. Now using the measured pipette string in 3ml of the culture media (the dissolved solution) inside the pipette and push back the pipette to fill the dried tubes with culture media repeat this to fill every single tubes.
6. Cap the tube loosely so it doesn't break on pressure in the autoclave machine.
7. Open the autoclave tray out to keep all the tube racks inside-push back the tray.
8. Check water level inside the machine for water storage –fill it to the tip with sterile water.
9. Check temperature for 260 degree.
10. Turn the power knob to fill the autoclave with water till the plate fills and turn the knob to sterile.
11. Put an **OK** slip on the top of the tube rack.
12. Close the door turning the handle. Turn the timer to 25 minutes.
13. After 1 hour turn the knob to vent and after 10-15 minutes open the door pushing the knob and handle together, let the steam come out and cool down for 5 min. Take out the rack and tight the caps-transfer them in the box and they are ready to use for culturing.

March, 2008

EHC-D MEDICATION LISTING
NUMERICAL

Biaxin 250mg	*1806	
Candistat		
Chloramphenicol 250mg; Chloromycetin		
Doxycycline	*1807	
EyePhrine 2.5% - see **Phenylephrine**		
Effexor XR 75mg	4000E	
Erythromycin 250mg	*1805	
Floxin 300mg	*1840	
Glucotrol 5mg		
Glucotrol 10mg		
Prednizone	*09005	
Pyridostigmine Bromide – see Regonol		
Somatropin 5 IU		
Sulfamethoxazole	*1805	
Suprax 400mg	*1807	
Translite		
Versed – see Midazolam HCL		
Wydase – see Hyaluronidaze		
Nystatin	0814	
Nisoral 200mg	0821	
Tylenol ES 500mg	0824	
Caprystatin(Candistat)	0834	
Amphotericin B	0853	
Vicodin (Hydrocodone and Acetaminophen)	0875	
Melatone	0881	
Inderol 10mg	0903	
Progesterone AQ Cream 100mg/2ml	0907	

Estrone AQ Cream 0.625mg/ml	0908	
Tri-Est Powder	0908TE	
T-3 - SR	0910	
Cortisone Acetate 5mg	0930	
Diazepam 10mg/2ml	0933	
Avapro 75mg	0935	
Diprovan 1% (Propofol)	0936	
Zofran 2mg/ml	0941	
Lutein 5% (beads)	0942	
Naltrexone HCl 1gm (The Compounder)	0945	
Proparacaine HCl 0.5% (Ophthalmic Solution)	0946	
Cyclopentolate HCl 1% (Ophthalmic Solution)	0947	
Tobramycin 0.3% (Bosch & Lomb)	0947	
Ful-Glo 1mg (Fluorescein Sodium	0948	
Prilosec OTC 20mg	0961	
Nexium 40mg	0962	
Benadryl Allergy	1800BA	
Lanoxin 0.125mg	1800L	
Levaquin 250mg	1800LQ	
Methronidozole 50mg	1800MD	
Norvasc 10mg	1800N	
Penicillin VK 500mg	1800P	
Xanax	1801X	
Ativan (Lorazepan)	1802	
Biaxin 500mg; Clarithromycin	01802	
Clonazepam 2mg	1804	
Lutalyse-dinoprost tromethamine 5mg/ml	1804	
Cefaclor 500mg	1808	
Duricef 500mg	1808	
Cephalexin; Keflex	1810	
Cipro500mg	1811	
Biaxin 500mg	1812	

Estradiol Powder	1812	
Cipro 250mg	1813	
Alprazolam 1mg	1814	
Ampicillin 500mg	1815	
Hismanal; Astemizole 10mg	1817	
Amoxicillin 500mg	1818	
Butalbital 50mg	1819	
Tritec; Ranitidine Bismuth Citrate 400mg	1820	
Ibuprofan 100mg	1821	
Acetaminophen 500mg	1822	
Cimetidine-Pure	1823	
Neurontin 300mg	1824	
Clindamycin HCl-Pure	1825	
Hydrocodone w/Acetaminophen 5/500mg	1826	
Clotrimazole-Pure	1827	
DMSA-Pure	1828	
Pingxiao Pian (Cancer Remedy)	1829	
Diltiazem XR 120mg	1832	
Niaspan 500mg	1833	
Augmentin 500mg	1834AC	
Lozol 2.5mg	1835	
Tenex 1mg	1835	
Zithromax 250mg	1836ZC	
Catapres 0.1mg	1837	
Lasix 20mg (Furosemide) **BP**	1837	
Tequin 400mg	1837	
Avelox 400mg; Moxifloxacin	1838	
Cardura 8mg	1838	
Cardura 50mg	1839	
Cefzil 250mg	1839	
Cozaar 50mg **BP**	1839	
Norpace 100mg	1840	

Primaxin 250mg	1841	
Tamoxifen 10mg	1841	
Bio-Statin 10 mg (Abr) Powder	1842	
Neo-Synephrine Hydrochloride	1842	
Proparacaine 0.5%	1843	
Sodium Bromide 200mg	1843	
Econopred Plus 1%	1844	
Albuterol 5mg	1845	
Neosporin Ointment	1845	
Hyaluronidase (Wydase) 150U/ml	1846	
Armour Thyroid	1847	
Profenal (Suprofen) 1%	1847	
Cytomel (Thyroid)	1848	
Mydriacil (Tropicamide) 1%	1848	
Ciloxan (Ciprofloxacin HCl) 0.3%	1849	
Levoxyl 0.1mg	1849	
Fosamax	1850	
Thyrolar	1851	
Hydrocortisone (Abr.powder)	1852	
Thyroid-P (Abrams)	1855	
Coumadin 5mg	1857	
Bacitracin	1858	
Neomycin	1859	
Xalantan 0.005% - Eye drops	1874	
Timolol 0.5% (Timoptic XE - eye drops)	1875	
Regonol 5mg (Pyridostigmine Bromide)	1876	
Atacand 32mg (Candesartan Cilexetil)	1877	
Altace 5mg (Ramipril) **BP**	1878	
Dexamethasone Sodium Phosphate 4mg	1879	
Betaine HCl - Pure Powder (Abrams Royal)	1880	
Boniva 150mg	1881	
Ketek 400mg	1882	

Ocuflox 0.3% (eye drops) (Allercan)	1883	
Voltaren 0.1% - Eye drops	1884	
Alcaine 0.5% (Proparacaine HCl - eye drops)	1885	
Cyclogyl 1% (Cyclopentolate HCl - eye drops)	1886	
Phenylephrine 2.5% (EyePhrine – eye drops)	1887	
Midazolam HCl 2mg/ml (Versed)	1888	
Vigamox 0.5% (Eye drops-antibiotic)	1889	
Lithium Carbonate 50mg/ml	1890	
Carbamazepin 200mg	1891	
Midodrin	1891	
Aerobid Aerosol (3M Pharmaceutical0	1893	
Flovent FA 110mcg	1894	
Klonopin 2mg	1895	
Celestone Soluspan	1896	
Nitroglycerin	1897	
Synthroid 50mcg	1898	
Immodium	1899	
Lotrel 10mg **BP**	1900	
Allopurinol	1904	
Trimethoprim	1905	
Cromolyn	1908	
Heparin Sodium 100Units/ml	1908	
Healon 10mg (Sodium Hyaluronate)	1910	
Methotrexate 2.5mg	4000M	
Indomethacin 25mg	04001	
Sporanox	04022	
Keflex 250mg	04040	
Clonazepam 0.5mg	04045	
Darvon 6.5 mg	04053	
Motrin 800mg	04100	
Rocephin 1g	04102	
Captopril 25mg **BP**	05003CC	

Vancocin 125mg	05007VP	
Depo-Medrol 40mg	05008DM	
Vistaril 50mg	05009	
Aspirin-Pure	1830 or 04021	
DHEA	07000	
L-Tryptophan (Abrams)	7000LT	
Tetracycline 250mg	7000TC	
Diflucan	07135	
Theophylline Solution 5.3mg/ml	07225	
Atrovent	07226	
DHEA 25mg - KAL	07229	
Evoxac	07233	
Cosamin DS	07234	
Fludrocortizone (Florinef)	8000Fl	
Prozac 20mg	8000PZ	
Bactrim DS	1801or 07171	
Lincocin 300mg	09004	
Ambien 10mg	09018	
Narcan (Naloxone Hydrochloride)	09022	
Marinol 2.5mg	09028	
Benicar 40mg **BP**	10322	
Tambocor 50mg **BP**	10323	
Cardizem LA 240mg **BP**	10324	
Maxzide 25mg **BP**	10325	
Dyazide 37.5/25 **BP**	10326	
Diovan 80mg **BP**	10327	
Phenytoin 50mg	30009	
Papaverine HCl 30mg	30012	
Cefdinir 300mg	30015	
Ceftin 250mg	30016	
Noroxin 400mg	30017	
Tazicef 1gm (Ceftazidime)	30018	

Zyvox 600mg	30019	

Protocol for Car Exhaust
January 1995

1. **300 cc of coca's solution (NaCl = amounts of NaC03).**
2. **50% of each (unleaded gas exhaust and diesel exhaust).**
3. **Insert a glass rod into car exhaust pipe (gasoline or diesel) connected to air machine pulling the exhaust into a 450 cc of coca's solution for 15 minutes.**
4. **Dilute with 300 cc of coca's solution.**
5. **Run through a ceramic Millipore filter (smallest size) for sterility.**
6. **Dilute with saline ½ - this is the concentrate. Dilute 1/5, 1/25, 1/625, etc. as needed.**
7. **Analysis shows no toxic substances; however, the electromagnetic imprints still persist as evidenced by skin reactions until the #20 dilutions in some patients. This obviously is in the homeopathic frequencies.**

March, 2008

EHC-D CHEMICALS LISTING
NUMERICAL

Angiofluor 10%		
All Bond-2 Etch		
Bounce		
Charcoal, Church		
Creatine Monohydrate		
Ethilon – see Suture, Black Nylon		
Formaldehyde **37%!!!**		
Fuji II – see Glass Ionomer		
Glycerin		
Office Filter		
Phenol		
Potassium Oxylate (made by Dr.Griffiths)		
Rug Padding		
Suture, Dexon		
Suture, Maxon		
Talcum Orthodox, perfumed		
Tetrahydrofuran		
Trichothecene Verrucarin A 5mg		
Cologne,Men's	0842/0848	
MIM (Mycotic Immune Modificator) made by Dr.Griffiths	11-02-07	
Silicone Dioxide FCC	0800SD	
Stearic Acid	0800SA	
Vicryl Braided (Polygloctin)	800VP910	
Wool, Lamb's	0801	
Nylon	0802	
Newsprint, blank, inkless paper	0803	
Silk	0805	

Cigarette Smoke	0806	
Cotton	0807	
Orris Root	0808	
Kleenex	0809	
Gum Arabic	0810	
Unleaded Gas Exhaust Fumes	0811	
Diesel Exhaust Fumes	0812	
Natural Gas Exhaust Fumes	0813	
Mosquito (insect)	0815	
Stinging Insect Mix	0816	
Red Ants	0817	
Fire Ants	0818	
Polyester Fabric FZ-3Box1-2,Box6-1	0819	
Jet Fuel, Liquid	0820	
Xylene – SL(OK for skin test. per Trep)	0822	
North Wind	0823	
Chalk	0826	
Household Insect Mix	0827	
Jute	0828	
Mesquite Smoke	0829	
Musk Oil & Cologne	0830	
NCR Carbonless Paper	0831	
Rayon 09025 or	0832	
Iodine	0835	
Kerosene	0836	
Pipe & Cigar Smoke	0837	
Pyrethrum	0839	
Fire Place Smoke	0840	
Carbon (Black carbon paper)	0841	
Kapok	0843	
Nickel Sulfate, 1%	0844	
Propane Gas	0846	

Linen 100%, Flax Fiber & Seeds	0847	
Air,Dallas	0850	
Air,Office	0851	
Office Air	0851	
News Material	0852	
Charcoal,Coconut Shell,Office Charcoal	0854	
Titanium, Surgical Steel	0856	
Aluminum	0857	
Tin	0858	
Copper	0859	
Lead	0860	
Silver, Dental FZ-2Box1-1,FZ-3Box1-1	0861	
Gold	0862	
Cadmium	0863	
Palladium	0864	
Lanolin	0865	
Cement, Bone	0866	
Latex	0867	
Lava Rock, Sauna	0869	
TCE(1,1,1 Trichloroethane) -SL	0870	
Fireplace Ashes,Canadian	0871	
Melatonin, Nutricology Inc.	0872	
Silicone, Breast Implant	0873	
CSW-508,Anti-Corrosion Material	0874	
Marlex Mesh, Garland Com.Hospital	0876	
Saline Breast Implant	0878	
Mercury	0879	
Polytef, Vocal Cork Infection Paste	0880	
Melatone, Cardiovascular Research Ltd.	0881	
Diaminopentane 1,597%	0882	
Black Fly,Biopol Lab	0883	
Formaldepure	0884	

Lignite (Carbone)	0885	
Hydestop, Potassium Permanganate	0886	
Bituminous	0887	
Stainless Steel	0888	
Herculite, Kerr Co.	0889	
Celay Blank w/o color,Vident Co.	0890	
Tylok Plus, Cement, L.D.Caulk Co.	0891	
LIV Cinera Cement, G.C. Americal Co.	0892	
Lavender Oil NF	0893	
Lavender Oil, Artificial	0894	
Rose Oil, Artificial	0895	
Peppermint Oil, Artificial	0896	
Lemon Oil NF, Natural	0897	
Lime Oil	0898	
Collagen, Hydrolysate Powder	0899	
South Wind - Richardson	0929	
Warts	0931	
Temp-Bond (Kerr)	0934	
Rely X (3M ESPE - w/acrylate)	0937	
Luxatemp – Dental Material (DMG)	0938	
Carbon Zeolite (anthracite)	0943	
Coconut Zeolite	0944	
Silica	0944	
Tungsten	0949	
Boron Citrate (Abrams)	0950	
Cobalt Gluconate (Abrams)	0951	
Nickel	0952	
Coconut – Austin Air	0954	
Super Blend – Austin Air	0955	
Zeolite – Austin Air	0956	
Anthracite Coal – Austin Air	0957	
Trimethylbenzene (1,2,4 TMB) (made by Dr.Griffiths)	0958	

Bounce –2 (made by Dr.Griffiths for EHC-C)	0959	
Downy – Fabric softener (made by Dr.Griffiths for EHC-C)	0960	
Pro-Cad Block – Dental Material	0963	
Vita Block- Dental Material (Crown)	0964	
Paradigm Block 3M – Dental Material (Crown) = Bell glass	0965	
Multi Link – Dental Cement	0966	
Basswood (Sauna)	0967	
Sitka Spruce	0968	
Hemlock (Sauna)	0969	
Hemlock Fir (Sauna)	0970	
Vinyl Acetate	0971	
Acetic Acid	0972	
Porcelain-Cerabein ZR Luster	0973	
Bell Glass (Dental material)	0974	
Excite –Dental adhesive (Bonding agent)	0977	
Panavia-Dental Cement	0978	
Aria-Dental Composite (Flowable composite/fillings)	0979	
Lucite glass-Dental	0980	
SE Bond- Dental	0981	
Simile – Dental Composite	0982	
Concrete Mix (Cement)	0983	
Celestone Phosphate–Betamethasone Sod.Phosph	1803	
Kenalog 40	1809	
Indole-3-Carbinol (Indolemethanol)	1854	
Cellophan	2000-013	
Tygon Tubing	2000-002	
Polyvinyl	4000V	
Zinc Phosphate	4000ZNP	
Hydrogen Peroxide	04001	
VMK-68 Porcelain	04002	
Porcelain, Fuji	04003	
Zinc-Oxy-Phas Cement	04004	

Ketac-Cement	04005	
Z-100 Filling Material	04006	
Saturn Filling Material	04007	
Heliomolar Filling Material	04008	
Porcelain, Omega	04009	
Porcelain, Du-Cerum	04010	
Porcelain, Impress	04011	
Occlusin Filling Material	04012	
Porcelain, DiCor	04013	
Durelon Cement	04014	
Caulk,Filling	04015	
Dura Lay Cement	04016	
Porcelain, LIV Carbo	04017	
Flexite,TMJ Appliance	04018	
Conquest Resin-Dental	04019	
Methyl Methacrylate	04020	
Wood Charcoal, Mask,Foundation	04023	
Lens, Acrylic (Acrosoft from"Alcon")	04024	
Porcelain-Dental	04025	
ISO VUE 370, Squibb Diag.	04026	
Dacron Craft	04027	
Urethane, Breast Implant	04028	
Gas Additive,Texas	04029	
Suture, Prolene	04030	
Polyvoidene 2/0, Green Braided Polyester Coated	04031	
Tantalum, Hedrocel Porous Material	04032	
Proplast, TMJ Material	04033	
HEPA, Air Filter Material	04034	
Mercury Chloride	04035	
Barium,Liq.Polibar Susp.	04036	
Methyl Alcohol w/Saline	04037	
Platinum	04038	

Latex Medical Exam Gloves,Powder-Free	04039	
Senicare (Non-Latex Med.Gloves)	04039	
Sauna Air Sample	04043	
Barium Sulfate	04046	
TMP/SMX	04047	
Ursodeoxycholic Acid	04048	
Vanco	04049	
Methyl Mercaptan (Sodium Thiomethoxide)!!!!!	04050	
Nitrofuran	04051	
2-amino-5-diethylaminopentane-SL	04054	
Jojoba Oil	04054	
Lactated Ringer's Injection USP	04055	
Polyethylene	04056	
PVC (Polyvinylchloride)	04057	
Toluene - SL	04058	
Sodium Fluoride –2%Sol	04059	
Titanium & Iodine	04060	
Jellyfish Tentacles	04061	
Polyurethane	04062	
Hypaque Meglumine-Diatrizoate Meglumine	04063	
Fluorine(Difluoroethane)	04065	
EDTA (Edetate Disodium) 150mg/ml	04066	
Diisobutylamine-SL	04067	
Methyl Paraben	04068	
Sulfur-Pure	04069	
Diamine-Trypan Blue-SL	04070	
Isopropyl Alcohol-70%	04071	
Zirconium - Pure	04072	
Furan-Pure-SL	04074	
Dimethyl Phthalate-Pure-SL	04075	
Vanadium - Pure	04076	
Acrylic-Pure	04077	

Ultra Cryl Acrylic Powder - Dental	04078	
1,2-Propanediol-Pure;Propylene Glycol	04079	
Benzophenone- Pure	04080	
Molybdenum-Pure	04081	
Magnesium Stearate-Pure	04082	
Poly(dimethylsiloxane),200	04083	
Tide Liquid Detergant	04084	
Hexane, n-Hexane 95%	04085	
Smoke from Mexico	04086	
Benzene	04087	
Pentane	04088	
Gold Alloy(Degudent)	04089	
JCBD-Dental Alloy	04090	
JWG Dental Alloy	04091	
Aloe Vera - Pure	04092	
Targis/Vectris-Crowns & Bridges	04093	
Procera Crown	04094	
Diamond Crown	04095	
Empress 2 Crowns and Bridges	04096	
Empress Crown	04097	
Tannic Acid	04098	
Flexite Partial Denture(Pink)	04099	
Flexite Partial Denture (Clear)	04100	
Photo Bond (Dental Material)	04101	
Photo Core (Dental Material)	04102	
Sculp-it	04103	
Xanthan Gum Powder	04103	
Guar Gum Powder	04104	
Karaya Gum	04104	
Mineral Oil	04105	
Variolink – Dental Material (Cement)	04106	
Titanium Dioxide	04107	

Starflow – Dental Composite (Flowable composite)	04108	
Suture, Black Monofilament Nylon = **Ethilon**	04500BMN	
Suture, Chromic Gut Surgical	04500CG	
Suture, Silk Black Braided Surgical	04500BB	
Super Clean	4999	
Naptha	05002	
2-Butanone	05005BC	
Castor Oil	6000	
Depakote	07103	
Key Phos.425	07190	
Ultra Care/kids	07191	
Bismuth Subcarbonate	07194	
Super Malic	07198	
Chamomile Oil	07199	
Astragalus Root	07220	
Siberian Ginseng Herbal Extract	07221	
St.John's Wort (Nature's Way)	07222	
Chondroiton Sulfate	07223	
Tanalbit – Herbal Tannates	07228	
UltraInflam X	07238	
Zinc Oxide	07240	
Lens, PMMA (Bausch & Lomb)	08994	
Lens, Collamer (Staar Labs)	08995	
Lens, Hydroview	08996	
Titanium Alloy	08997	
Cobalt Chromium Alloy	08998	
Beryllium	09019	
Tetrachlorethylene (Perchlorethylene)	09020	
Ethylene Glycol	09023	
Gutta Percha	09024	
Cologne,Ladies'	09026	
West Wind - Richardson	09027	

Glass Ionomer-Fuji II	09030	
SE Primer - Dental Bonding Material	10377	
Multi Link A&B – Dental Bonding material	10378	
Ultra Etch – Dental Material	10381	
Fuji I – Dental Cement	30000	
Prelude Prime –Dental material	30002	
Prelude Adhesive – Dental material	30003	
Photo Bond w/Porcelain Activator – Dental material	30004	
Heliomolar Flowable Composite	30010	
Prodigy Composite – filling material	30011	
Sun Rays	30013	
Ribbon – Splinting Dental material	300001	
Zone – Temporary Dental Cement	300006	
S-Bond – Dental material	300007	
Thermoplastic Resin – Dental Retainer	300008	
Invisalign – Dental braces	05010	
Lava – Dental Crown	05011	
P2Z –Dental Crown	05012	
Polypropylene 2/0, Blue Monofilament - Suture 04030 or	05013	
Integrity – Dental Temporary Crown and Bridge material	05014	
Dynablast	05015	
Ladies' Cologne	05016	
men's Cologne	05017	

March, 2008

EHC-D SUPPLEMENTS LISTING
NUMERICAL

5-HTP	Ortho Molecular Products		
D-Mannose	Bio-Tech	*09005	
***Ambrotose N/A	MannaTech	04052	
Butyrate Mix	T.E.Neesby	08991BM	
Betaine HCl	Freeda	08999 or 07239	
***Milk Thistle N/A	Natrol	09000	
Molybdenum	Bio Tech	09002	
Salmon Oil	Carlson	09003	
***Glioxidase N/A	Thorne	09006	
Glutathione Power	DFHI	09007	
Free Aminos	ARG	09008	
Potent C Guard 1000mg	Perque	09009	
***Egsentials N/A	Bio Tech	09010	
Biotin-8 8.000mcg	Thorne	09011	
Super D-3	ARG	09012	
SynovoDerma	ARG	09013	
Vital-10	Klaire	09014	
Gugul Extract	Vital Nutrients	09016	
Q-Gel Forte (Co-Q10)	Jordet's	09021	
Strontium Citrate	Vital Nutrients	0940	
Vitamin K-1 1000	Biotech	0953	
***Thyroid N/A	BioTech	1803	
Lyprinol 100mg	Tyler	1844	
Adrenal 200mg	Bio Tech	1853	
Lithate 5mg	Bio Tech	1860	
Mag-Oro	Bio Tech	1861	
Magnesium Ascorbate	Bio Tech	1862	

Malic B-6	Bio Tech	1863	
Mn 50 (Manganese)	Bio Tech	1864	
Vanadium	Bio Tech	1865	
L-Threonine	AEHF	1866	
L-Threonine	Freeda	1867	
L-Lysine	AEHF	1868	
Vital Dophilus Plus	Klaire	1869	
Formula SF 722 (Castor Bean Oil)	Thorne	1870	
L-Aspartic Acid	Carlson	1871	
Vessel Health Guard	Pergue	1872	
L-Phenylalanine	Twin Lab	1873	
Gentle Iron	Solgar	1901	
Cysteine Pep	ARG	1902	
Pregnenolone 50	ARG	1903	
Sialex	Ecological Formula	1906	
Refluxin	Cardiovascular Research	1907	
L-Arginine	ARG	7000ALA	
L-Carnitine	ARG	7000ALC	
L-Glutamine	ARG	7000ALG	
L-Lysine	ARG	7000ALL	
L-Tyrosine	ARG	7000ALT	
***L-Cysteine (Cystech) N/A	Bio Tech	7000BLC	
***B-Complex 50mg N/A	Vitaline	07002	
B Complex 100mg	Vitaline	07003	
Calcium-Magnesium Aspartate	Vitaline	07007	
Total Formula	Vitaline	07008	
Calcium Complex	Klaire	07012	
Iron Caps BFZ-2B3-4	Twin Lab	07014	
Alpha Ketoglutaric Acid	Klaire	07016	
Taurine special order	Twin Lab	07018	
DuoZyme	Karuna	07020 or 07235	
Anti-Ox	ARG	07023	

Multi Vitamin-Mineral	ARG	07024	
Super B Complex	ARG	07025	
Allergy Multi Caps	Twin Lab	07028	
Calcium Citrate+Mag.= Ca Citr. Caps	Twin Lab	07030	
Magnesium Caps (Oxide)	Twin lab	07031	
Multi Vitamin Complex	Klaire	07032	
Multi Mineral Complex	Klaire	07033	
P5P, Vitamin B6 Metabolite FZ-4#50-1	Klaire	07034	
Amino Complex IV=AminoAcidComplete	Klaire FZ-3B4-1	07035	
Ultra Clear	Metagenics	07036	
L-Glutamine	Klaire	07055	
Buffered Vit C - Corn	ARG	07056	
Ultra Clear Sustain	Metagenics	07057	
***Mycopryl 680 Ca/MagCaprylate N/A		07058	
Magnesium Complex (Mag.Glycinate)	Klaire	07059	
Total Formula 2	Vitaline	07063	
Multi Minerals	ARG	07064	
B-50	Twin Lab	07067	
Micel-A	Klaire	07069	
P5P Plus	Klaire	07070	
Pure E	Klaire	07072	
Zinc Caps	Twin Lab	07073	
Chromium Picolinate Plus	Klaire	07074	
***Mycelized Children's Multi-Vit. N/A	Metagenics	07075	
Vitamin C Ascorbic Acid Powder (Corn)	Klaire	07076	
Ascorbic Acid Powder,Vit.C-Corn	ARG	07077	
Reduced L-Glutathione	Klaire	07080 or 07303	
Evening Primrose Oil	AEHF	07081	
Pancrease Pork	ARG	07082	
Pancrease Beef	ARG	07083	
Pancrease Lamb FZ-3Box10-1	ARG	07084	
B-6	Twin Lab	07086	

***Multi Vitamin-Min.-Copper free N/A	ARG	07145	
Co Q10 25mg	Vitaline	07149	
Co Q10 60mg	Vitaline	07150	
***Ester C N/A	Bionutritional F	07151	
Calcium Citrate	ARG	07157	
Magnesium Citrate	ARG	07158	
***Gastro Cort N/A	ARG	07159	
Manganese (Mag.Gluconate – Potato)	Twin Lab	07161	
Calcium Apatite	Metagenics	07162	
Probiotic Complex w/FOS	Klaire	07164	
Grape Pips (Grape Seed Extract)	ARG	07165	
Ultra Clear Plus	Metagenics	07167	
***Zinc Picolinate N/A	Metagenics	07168	
Magnesium Gluconate 500mg	Freeda	07170	
Magnesium Glycinate	Metagenics	07172	
Allerdophilus	Twin Lab	07173	
Total Formula 3 w/o Iron	Vitaline	07174 or 07306	
Fibro-XL Fiber Laxative	Key Company	07175	
Biotin 600mcg	Twin lab	07177	
Multi Mineral Complex w/o Iron	Klaire	07182	
Choline & Inositol	Twin Lab	07184	
Zinc Lozenges	Twin Lab	07185	
***Calcium Gluconate 500mg N/A	Freeda	07186	
***Mexican Yams N/A	Twin Lab	07193	
Co Q10 60mg	AEHF	07202	
Melatonin	AEHF	07203	
Bromelain = Bromase 400mcg	AEHF/Biotech	07204	
***Zinc Gluconate N/A	AEHF	07205	
Bi-Salt Powder	AEHF	07209	
Potassium Bicarbonate	AEHF	07210	
Sodium Bicarbonate	AEHF	07211	
Calcium Carbonate	AEHF	07212	

Tri-Salt Powder	AEHF	07213	
Psyllium	AEHF	07214	
***Mineral Salt Powder N/A	AEHF(Biotech)	07216	
L-Leucine	AEHF	07220	
L-Isoleucine	AEHF	07221	
L-Valine	AEHF	07222	
L-Phenylalanine	AEHF	07223	
Zinc Picolinate	Cardiov.Res./Ecol.Formula	07225	
Zinc Picolinate	ARG	07227	
Buffered Vit.C - Cassava	ARG	07230	
Citricidin (Grapefruit Seed Extract)	Thorne	07232	
***Progreens N/A	ARG	07232	
Sago Palm Vit.C (Allergy C Buff)	Twin Lab	07233 or 07027	
Curcumin	Bio Tech	07234	
SAMe 200mg	DFHI	07236	
Black Cohosh	Vital Nutrients	07237	
Vital Immune Biotic	Klaire	07237	
Milk Thistle 250mg	Vital Nutrients	07238	
Berbercap	Thorne	07240	
Sacro-B	Thorne	07241	
Melatonin 20mg	Bio Tech	07242	
Multi-Flora Spectrum	Kirkman	07244	
Magnesium Glycinate	Profes.Formula	07245	
Calcium Glycinate	Carlson	07246	
Acidophilus Plus	GNLD	07247 or 07305	
Carotenoid Complex	GNLD	07248	
Tre-en-en	GNLD	07249	
Borage Oil	Vital Nutrients	07250	
Cortitrol	Pharmanex	07251	
Lipoic Acid	Bio Tech	07252	
Glycine 500mg	Thorne	07253	
Intra MAX	Drucker Labs	07254	

Krill Oil Cap	DFHI	07255	
Vitamin A	GNLD	07256	
Magnesium Taurate	CVR/Ec..Form.	07257	
Vital-Zymes Forte	Klaire	07258	
Cod Liver Oil	GNLD	07259	
Taurine	ARG	07260	
Black Currant Seed Oil	Vital Nutrients	07261	
Pro -5	Klaire	07263	
Super Cranberry Extract	Kirkman	07264	
Garlic Powder	Vital Nutrients	07265	
Digesta Guard Forte (Potato)	Perque	07266	
Micropryl (Caprilic Acid)	TE Neesby	07267	
Niacin B-3	AEHF	07268	
DHEA 5mg	Thorne	07269	
Manganese 20mg(Manganese glycinate)	Carlson	07270	
Children's Multi Vit-Min	ARG	07271	
FA – 8 (Folic Acid)	Bio Tech	07272 or 07304	
Uva-Ursi	Ortho Molecular Products	07273	
Glucosamine Sulfate Plus Chrondroitin	Vitaline	07275	
Olive Leaf Extract	Thorne	07276	
Calcium Assimilate Plus	Klaire	07277	
Niacin 50mg	Abrams	07279	
5-HTP	ARG	07280	
Indole-3-Carbinol	Thorne	07281	
Nattokinase	ARG	07282	
Natural Beta Carotene	Vital Nutrients	07283	
Fish Oil	Pharmax	07284	
Thiamine B-1 100mg	AEHF	07285	
Neuromins	Pure Encapsulations	07286	
Pantothenic Acid 500mg (B-5)	ARG	07287	
B-6 100mg	Douglas Labs	07288	
Boron Plus 6mg	Douglas Labs	07289	

Co Q10 100mg	Klaire	07290	
Co Q10 150mg	Bio-Tech	07291	
Co Q10 300mg (Mito Guard)	Perque	07292	
Vitamin E Factor 400/400	Yasoo	07295	
Ultra Trienols Plus – Vit.E	DFHI	07296	
Soy Isoflavones 50mg	Vital Nutrients	07297	
Phosphatidyl Serine	DFHI	07298	
Zen 200mg	ARG	07298	
L-Histidine	Twin Lab	07299	
Pantothenic Acid	Vitaline	07299	
Calcium Gluconate 50mg	Freeda	07300	
Copper Sebacate	ARG	07300	
DHEA	Vital Nutrients	07301	
D3 – 5 Cholecalciferol	Biotech	07301	
Boron Picolinate	Thorne	07302	
Copper Cu-5	Biotech	07302	
Ultra Meal Rice	Metagenics	07303	
***Biopure Protein N/A	Metagenics	07304	
Ultra Meal Natural Vanilla	Metagenics	07305	
***Ultra Balance Protein N/A	Metagenics	07306	
L-Cysteine 500mg	Solgar	07307	
***ProGain N/A	Metagenics	07308	
Ultra Meal Whey	Metagenics	07309	
Phosphatidyl Choline 40%	DFHI	07310	
Seren Aid	Klaire	07311	
Wobenzym	Longevity Plus	07312	
Pantethine	Eco-Formula	07313	
***Manna Cleanse N/A	Manna Tech	07314	
Corvalen	Valen Labs	07315	
Ther-Biotic Complete	Klaire	07316	
L-Tryptophan	Lidtke	07317	
Ox-Bile	ARG	07318	

***L-Glutamine N/A	Pure Encapsulation	07319	
Suoer Z-Lite	Omica Health	07320	
Active Ionic	Omica Health	07321	
Artemisinin	ARG	07322	
Vitamin D-3 1000IU	Integrative Therapeutics	07323	
Immunoti X 3-6	Xymogen EP	07324	

ENVIRONMENTAL HEALTH CENTER-DALLAS
IMMUNOTHERAPY DEPARTMENT
ANTIGEN CONCENTRATES WORKSHEET

Antigen Concentrate	Source	Original #	Antigen Lot #	Set-up Date	Filtration and Inoculation Date	Quantity	72 hours		Tech
							Negative	Positive	
Ethibond* Excel Polyester Suture (plus braided)	Ethicon	X833	30,060	2·9·09	2·13·09	10 cc	N/G		[illegible]
Glyburide 1.25mg	Ambrams Royal	6040876	30,061	2·13·09	2·20·09	50cc	N/G		[illegible]
Glimepiride 1mg	Abrams Royal	6040814	30,062	2·13·09	2·20·09	50cc	N/G		[illegible]
~~Kat~~ Levothyroxine	Abrams	6044256	30,063	3·6·09	3·9·09	35cc	N/G		UB
MetaGuard 100 Plus ~~Pyrogen~~	Perrigo (DFH)	~~6044~~	30,064	3·9·09	3·16·09	35cc	N/G		UB
Cardiuve Tartrate Powder	Design Health		30,065.	3·9·09	3·16·09	2x35cc	N/G		UB
Beef	Clinic		1069	3·13·09	3·16·09	10x35cc	N/G		UB
Tuna	clinic		1071	3·13·09	3·16·09	10 x 35cc	N/G		UB
Cucumber	Clinic		1113	3·19·09	3·24·09	6 x 50cc	N/G		UB
Celery	clinic		1123	3·19·09	3·24·09	6 x 50cc	N/G		
Lettuce	clinic		1042	3·19·09	3·24·09	6 x 50cc	N/G		UB
Zucchini	Clinic		1077	3·19·09	3·24·09	6 x 50cc	N/G		UB

ENVIRONMENTAL HEALTH CENTER – DALLAS
IMMUNOTHERAPY DEPARTMENT
PERSONAL ANTIGEN CONCENTRATES WORKSHEET

Patient's name & Account number	Antigen Concentrate	Source	Original #	Antigen Lot #	Set-up Date	Filtration & Inoculation Date	Quantity	72 hours		Tec
								Negative	Positive	
Buckwheat		Whole Food		1107	4.3.09	4.6.09	5x35cc	N/G		UB
Blk. eyedpeas				1012	4.3.09	4.6.09	5x35cc	N/G		UB
Kidney Beans				1122	4.3.09	4.6.09	5x35cc	N/G		UB
Beets				1010	4.3.09	4.6.09	5x35cc	N/G		UB
Sesame Seeds				1062	4.3.09	4.6.09	4x35cc	N/G		UB
Maple Sugar				1126	4.9.09	4.10.09	3x35cc	N/G		UB
Chloramphenicol		Abrams.		30,067	4.10.09	4.13.09	3x35cc	N/G		UB
Butylated Hydroxy-Anisole (BHA)		Abrams.		~~30,066~~ 1307	4.10.09	4.13.09	2x35cc	N/G		U
Doxycycline		Abrams		1807	4.10.09	4.13.09	2x35cc	N/G		UB
Safflower Oil		Clinic		1135	4.10.09	4.13.09	3x35cc	N/G		UB
Lad. Colofac		Dep. Store		05016	4.10.09	4.10.09	3xsalt	N/G		I.C
Men's Colofac		Dep. Store		05017	4.10.09	4.10.09	3x salt	N/G		I.

ENVIRONMENTAL HEALTH CENTER – DALLAS
IMMUNOTHERAPY DEPARTMENT
PERSONAL ANTIGEN CONCENTRATES WORKSHEET

Patient's name & Account number	Antigen Concentrate	Source	Original #	Antigen Lot #	Set-up Date	Filtration & Inoculation Date	Quantity	72 hours		T
								Negative	Positive	
Canola Oil	E	Clinic		1144	4·10·09	4·13·09	2x35cc	N/G		L
Apple		Whole Foods		1003	4.13.09	4.16.09	5x50cc	n/s		Z
Cashew		"		1020	4.13.09	4.16.09	5x50cc	n/s		
Grapefruit		"		1036	4.13.09	4.16.09	3x50cc	n/s		
Orange		"		1046	4.13.09	4.16.09	5x50cc	n/s		
Citrus fruit seed		"		1273	4.13.09	4.16.09	2x50cc	n/s		
Molybdamspectinate		Thorne		30,068	4.20.09	4.24.09	3x5D	N/G		
Drops for Health Super liver 3D Folate		DFH		30,069	4.20.09	4.24.09	3x35cc	N/G		
Endocal, Filling mat. for vials 1 & 2		PH		30,070	5.16.09	5.21.09	1x10cc	N/G		U
B Dental mat. Pancreatin A+B		PH.		30,071	5.18.09	5.21.09	1x10cc	N/G		L
Norwegian Cod Liver Oil.		Carlson		30,072	5.18.09	5.22.09	1x35cc	N/G		L
Rx Vitamins Licorice		Rx Vitamin		30,073	5.18.09	5.21.09	3x35cc	N/G		L

ENVIRONMENTAL HEALTH CENTER – DALLAS
IMMUNOTHERAPY DEPARTMENT
PERSONAL ANTIGEN CONCENTRATES WORKSHEET

Patient's name & Account number	Antigen Concentrate	Source	Original #	Antigen Lot #	Set-up Date	Filtration & Inoculation Date	Quantity	72 hours		T
								Negative	Positive	
Flaxseed Oil		Vital Nutrients		30,074	5.18.09	5.22.09	1x35	NG		U
Acetyl L-Carnitine		Klaire		30,075	5.18.09	5.22.09	1x35	NG		U
Melatonin 5mg		Bio-tech		30,076	5.18.09	5.22.09	1x35	NG		U
Niacin		Freeda		30,077	5.18.09	5.22.09	1x35	NG		U
News material		Dallas Morning [illegible] Calendar/Arts magazine.		0852	5.29.09	6.01.09	4x35	NG		U
E-Phenal		V line		30,078	6.1.09	6.5.09	4x35	NG		U
Canada RNA		Bluebonnet		30,079	6.1.09	6.5.09	1x35	NG		U
Liposomal Mg ATP		Eco formula		30,081	6.5.09	6.8.09	1x35	NG		U
Clarinol CLA		PL		30,082	6.5.09	6.8.09	1x35	NG		U
ACES		Carlson		30,083	6.5.09	6-8-09	1x35	NG		U
Ambrotose		Mannatech		04052	6.6.09	6-12-09	1x35cc	NG		U
~~Ruta Biotyn~~										

ENVIRONMENTAL HEALTH CENTER – DALLAS
IMMUNOTHERAPY DEPARTMENT
PERSONAL ANTIGEN CONCENTRATES WORKSHEET

Patient's name & Account number	Antigen Concentrate	Source	Original #	Antigen Lot #	Set-up Date	Filtration & Inoculation Date	Quantity	72 hours		T
								Negative	Positive	
	Tramadol HCl	Adams Royal		30.084	6/12/09	6.15.09	1x35cc	NG		U
L-Glutamine powder DF		DFHI		30.085	6-12-09	6.15.09	1x35cc	NG		L
Agave Nectar		Madhava		30,086	6.15.09	6.19.09	2x35cc	NG		
Calcium Glycinate		Carlson		07246	7.10.09	7.13.09	2x35cc	NG		L
Mimosa flowers				0518	7.10.09	7.13.09	2x35	NG		L
Peach				1048	7.13.09	7.17.09	3x35	NG		U
Rye				1060	7.13.09	7.17.09	3x35	NG		U
Papaya				1047	7.13.09	7.17.09	3x35	NG		U
Coconut				1026	7.13.09	7.17.09	3x35	NG		U
Shady baby's					7.17.09	7.20.09	3x35	NG		U
Honey	Organic wild flower	365 Organic		1039	7.17.09	7.20.09	5x35	NG		U
Brewer's Yeast				1014	7.17.09	7.20.09	5x35	NG		U

ENVIRONMENTAL HEALTH CENTER – DALLAS
IMMUNOTHERAPY DEPARTMENT
PERSONAL ANTIGEN CONCENTRATES WORKSHEET

Patient's name & Account number	Antigen Concentrate	Source	Original #	Antigen Lot #	Set-up Date	Filtration & Inoculation Date	Quantity	72 hours		T
								Negative	Positive	
Pork				1055	7.24.09	7.27.09	3x35cc	NG		
Blueberries				1013	7.24.09	7.27.09	3x35cc	NG		
Carrots				1019	7.24.09	7.27.09	3x35cc	NG		
Cauliflower				1021	7.24.09	7.27.09	3x35cc	NG		
EHC-D	Liposomal Glutathione	Readisorb		30,087	8.3.09	8.6.09	3x30	NG		
EHC-D	Reduced L-Glutathione	Klaire		~~30,088~~ 07303	8.6.09	8.10.09	2x35	NG		
EHC-D	Glucosamine Sulf + Condroitin	Vital Line		30,089	8.14.09	8.17.09	3x30	NG		
EHC-D	Formula SF 722	Thorne		1870	8.14.09	8.17.09	3x30	NG		
EHC-D	Hemp 0.1	NUTIVO		30,090	8.14.09	8.17.09	3x30	NG		
EHC-D	Filtek ESPE	3M		30,091	8.21.09	8.24.09	1x10	NG		
EHC-D	Topiramate 25mgs	Abrams Royal		30,092	8.24.09	8.24.09	2x35	NG		
EHC-D	Treponemal 1,2,3			0524	9.04.09	09.07.09	2x30	NG		

ENVIRONMENTAL HEALTH CENTER – DALLAS
IMMUNOTHERAPY DEPARTMENT
PERSONAL ANTIGEN CONCENTRATES WORKSHEET

Patient's name & Account number	Antigen Concentrate	Source	Original #	Antigen Lot #	Set-up Date	Filtration & Inoculation Date	Quantity	72 hours		T.
								Negative	Positive	
EHC-D	Mm A	International Biological		0114	09-04-09	09-07-09	2x30	Neg		
EHC-D	mm 3	International Biologicals		0103	09-14-09	09-18-09	2x50	Neg		
EHC-D	B-12	Freeda		30,093	09-21-09	9-25-09	3x40	Neg		
EHC-D	Curvularia SPIC	International Biologicals		0136	09-21-09	09-25-09	2x40 1x30	Neg		
EHC-D	Limonene	Sigma		30,094	09-25-09	9-28-09	2x40 @1:10	Neg		
EHC-D	Periwinkle Tea	Patient Delonis Hamil		30,095	10-2-09	10-5-09	1x10	Neg.		
EHC-D	Garlic	Whole Food		1116	10/06/09	10/09/09	3x50	neg.		
EHC-D	Beet Sugar	Rays		1011	10/06/09	10/09/09	2x50	neg.		
EHC-D	Plantain Banana	WF		1240	10/06/09	10/09/09	2x50	neg.		
EHC-D	C. Grape	WF		1029	10/06/09	10/09/09	2x50	neg.		
EHC-D	Alligator	Nate's Restaurant		30096	10/09/09	10/12/09	4x50	neg.		
EHC-D	Crawfish	Nate's Restaurant		03052	10/09/09	10/12/09	5x50	neg.		

ENVIRONMENTAL HEALTH CENTER – DALLAS
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PERSONAL ANTIGEN CONCENTRATES WORKSHEET

Patient's name & Account number	Antigen Concentrate	Source	Original #	Antigen Lot #	Set-up Date	Filtration & Inoculation Date	Quantity	72 hours		T
								Negative	Positive	
EHC-D	D-3 Cholecalciferol	BioTech		07301	11/6/09	11/9/09	1x50	neg		G
EHC-D	Post-under crown Dental material	Dentist		30097	11/9/09	11/12/09	1x50	neg		G
~~EHC-D~~	~~Glycerine~~	~~Thorne~~		~~07253~~	~~11/13/09~~	~~11/16/09~~				
EHC-D	Glycine	Thorne		07253	11/13/09	11/16/09	2x50	Neg		G
EHC-D	Cod Liver Oil	GNLD		07259	11/19/09	11/23/09	3x50	neg		G
EHC-D	Tamiflu	Roche Laboratories	21899033	30098	11/19/09	11/23/09	1x50	Neg		G
Chem EHC-D	Tick	Pt: Dixie Peterson		30099	11/23/09	11/27/09	1x50	Neg		G
EHC-D	Dust	IBI		0108	12/9/09	12/14/09	3x50	Neg		G
Inh EHC-D	Douglas Fir	IBI		30100	12/9/09	12/14/09	5x50	Neg		G
EHC-D	Sheep's Cheese (manchego)	Whole Foods		30101	12/14/09	12/17/09	1x10	Neg		G
EHC-D	Cassava	Whole Foods		1209	12/14/09	12/17/09	1x50 1x10	Neg		G
EHC-D	Horse Raddish	Whole Foods		30102	12/14/09	12/17/09	1x10	Neg		G

ENVIRONMENTAL HEALTH CENTER – DALLAS
IMMUNOTHERAPY DEPARTMENT
PERSONAL ANTIGEN CONCENTRATES WORKSHEET

Patient's name & Account number	Antigen Concentrate	Source	Original #	Antigen Lot #	Set-up Date	Filtration & Inoculation Date	Quantity	72 hours		T
								Negative	Positive	
EHCD	Anchovies	Whole Foods	Crown Prince Northern	30103	12/14/09	12/17/09	1X10	Neg		(
EHC-D	Lithium Carbonate	Abrams		1890	1/5/10	1/8/10	1X2	Neg		(
EHC-D	Rely X	North Penn Dental Associates		0137	1/5/10	1/8/10	1X50	Neg		(
EHCD	Trichophyton mentagrophytes	IBI	F2031	0139	1/8/10	1/11/10	3X50	Neg		(
EHC-D	~~Aburnus~~ Thymus	Abrams		011410-10	1/24/10	2/1/10	3X50	Neg.		G
EHC-D	Aerobic H20	AEF		30104	2/4/10	2/4/10	2X50	Neg		(
EHCD	Red Palm Oil			30105	2/5/10	2/9/10	1X50	Neg		(
EHCD	Acqua Panna Water	AEF		30106	2/15/10	2/15/10	2X50	Neg		(
EHCD	Clinic Air	EHD		30107	2/19/10	2/19/10	1X50	Neg		G
EHC-D	Monilia Sitophila	IBI	18486		2/22/10	2/25/10	3X50	Neg.		,
EHC-D	AcrySof Natural	Alcon		30108	2/25/10	2.25.10	1X50	Neg.		B
EHC-D	AcrySof Foldable-Single	Alcon		30109	2/25/10	1	1X50	Neg		

ENVIRONMENTAL HEALTH CENTER – DALLAS
IMMUNOTHERAPY DEPARTMENT
PERSONAL ANTIGEN CONCENTRATES WORKSHEET

Patient's name & Account number	Antigen Concentrate	Source	Original #	Antigen Lot #	Set-up Date	Filtration & Inoculation Date	Quantity	72 hours		T
								Negative	Positive	
EHC-D	AcrySof Foldable-Multi	Alcon		30110	2/25/10	2.28.10	1x50	neg		
EHC-D	Fleas spores	Dr. Rea		30111	3.18.10	3.22.10	2x50	neg.		
EHC-D	Partridge	S. Haag			3.18.10	"	2x50	neg		
EHC-D	Cladosporium Herbarum	IBI	18852		3.18.10	"	6x50	neg.		
EHC-D	Almond	Whole Foods	*	1002	4.6.10	4.9.10	3x50	neg		
EHC-D	Bounce	Dr. Griffith		30112	4.6.10	"	2x50	neg.		
EHC-D	MM-2	IBI	F198 18411, 18287	0102	4.6.10	"	5x50	neg.		
EHC-D	Yerba Mate ~~Tea~~	Estella		30113	4.9.10	4.12.10	1x50	neg.		
EHC-D	Hormodendrum hordei	IBI	16564	0112	5.4.10	5-7-10	3x50	neg.		
EHC-D	Soy Beans	WF	1064		5.13.10	5/17/10	3x50			
EHC-D	Wheat	WF	1075		5.13.10	5/17/10	3x50			
EHC-D	Cinnamon	WF	1210		5.13.10	5/17/10	1x50			

ENVIRONMENTAL HEALTH CENTER – DALLAS
IMMUNOTHERAPY DEPARTMENT
PERSONAL ANTIGEN CONCENTRATES WORKSHEET

Patient's name & Account number	Antigen Concentrate	Source	Original #	Antigen Lot #	Set-up Date	Filtration & Inoculation Date	Quantity	72 hours		T
								Negative	Positive	
EHCD	Garbanzo bean	WF		1219	5.13.10	5/17/10	2x50			C

October, 2008

COMMON FOODS

Acorn Squash	1001	FZ-1Box11-2
Almond	1002	FZ-1Box11-2
Apple	1003	FZ-1Box15-1
Apricot	1004	FZ-1 Box2-3
Avocado	1005	FZ-1Box12-2
Baker's Yeast	1006	FZ-1Box2-5
Banana	1007	FZ-1Box3-2
Barley	1008	FZ-1Box11-2
Beef	1009	FZ-1Box4-1
Beet Sugar	1011	FZ-1Box4-1
Beets	1010	FZ-1Box6-2
Black Eyed Peas	1012	FZ-1Box14-1
Blueberries	1013	FZ-1Box2-4,Box11-2
Brewer's Yeast	1014	FZ-1Box13-2
Broccoli	1015	FZ-1Box4-2,Box9-8
Cabbage	1016	FZ-1Box8-1,Box18-5
Cane Sugar	1017	Fz-1Box13-8
Cantaloupe	1018	FZ-1Box13-2
Carrot	1019	FZ-1Box12-1
Cashew	1020	FZ-1Box6-1
Catfish	1021	FZ-1Box14-2
Cauliflower	1022	FZ-1Box8-1
Celery	1023	FZ-1Box12-1
Chicken	1024	FZ-1Box2-1,Box14-10,Box15-2
Chocolate (dark)	30033	
Chocolate (milk)	1025	FZ-1Box6-1
Coconut	1026	FZ-1Box9-1
Cod	1027	FZ-1Box1-2
Coffee,W/Caffeine	1028	FZ-1Box4-2
Concord Grape	1029	FZ-1Box8-1
Corn	1030	FZ-1Box9-17
Cow's Milk	1031	FZ-1Box14-8
Dates	1032	FZ-1Box1-2
Egg	1033	FZ-1Box2-4
Fig	1034	FZ-1Box6-1,Box10-1
Goat's Milk	1035	FZ-1Box6-2,Box16-1
Grapefruit	1036	FZ-1Box10-1
Green Beans	1037	FZ-1Box9-4
Green Grapes	1038	FZ-1Box10-4
Honey, Clover H&M Brand	1039	FZ-1Box1-1
Lamb	1040	FZ-1Box12-5

Lemon	1041	FZ-1Box3-1,Box10-1,Box11-1
Lettuce	1042	FZ-1Box4-1
Lima	1043	FZ-1Box13-5
Oats	1044	FZ-1Box12-7
Onion	1045	FZ-1Box3-5
Orange	1046	FZ-1Box10-1
Papaya	1047	FZ-1Box10-1
Peach	1048	FZ-1Box6-1
Peanut	1049	FZ-1Box2-3
Pear	1050	FZ-1Box8-1,Box10-2
Peas, Green	1051	FZ-1Box4-2
Pecan	1052	FZ-1Box15-3
Pineapple	1053	FZ-1Box3-2,Box10-1
Pinto	1054	FZ-1Box4-2
Pork	1055	FZ-1Box12-2
Potato	1056	FZ-1Box
Raisin	1057	FZ-1Box4-2
Red Snapper	1058	FZ-1Box4-2
Rice	1059	FZ-1Box3-4
Rye	1060	FZ-1Box3-1
Salmon	1061	FZ-1Box5-1,Box10-1
Sesame Seed	1062	FZ-1Box8-1
Shrimp	1063	FZ-1Box2-5
Soy Beans	1064	FZ-1Box13-2
Spinach	1065	FZ-1Box6-2,Box5-2
Strawberry	1066	FZ-1Box1-2
Sunflower Seeds	1067	FZ-1Box6-2,Box5-1
Sweet Potato	1068	FZ-1Box1-2
Tea, Caffeinated organic	30032	
Tea,Decaffein.Lipton	1069	
Tomato,cooked	1081	
Tomato,uncooked	1070	FZ-1Box16-5
Tuna	1071	FZ-1Box12-1
Turkey	1072	FZ-1Box17-7
Walnut	1073	FZ-1Box11-4
Watermelon	1074	FZ-1Box5-4
Wheat	1075	FZ-1Box15-2
Yellow Squash	1076	FZ-1Box5-4
Zucchini	1077	FZ-1Box

UNCOMMON FOODS

Alfalfa Sprouts	1101	FZ-1Box12-2
Amaranth	1142	FZ-1Box11-2
Artichoke,Jerusalem	1102	FZ-1Box11-2
Asparagus	1103	FZ-1Box11-2
Black Pepper	1104	FZ-1Box2-7
Brazil Nut	1105	FZ-1Box 1-2
Brussel Sprouts	1106	FZ-2Box17-2
Buckwheat	1107	FZ-1Box2-1
Butternut Squash	1108	FZ-1Box6-2,Box9-2
Canola Oil	1144	FZ-1Box14-1
Carob	1109	FZ-1Box1-2
Cherries	1110	FZ-1Box15-2
Coke	1111	FZ-1Box7-1
Crab	1112	FZ-1Box4-4
Cucumber	1113	FZ-1Box6-1
Filbert	1114	FZ-1Box15-5
Flounder	1115	FZ-1Box2-3,Box16-1
Garlic	1116	FZ-1Box7-1,Box11-1
Goat Meat	1117	FZ-1Box8-1,Box11-1
Green Pepper	1118	FZ-1Box8-2,Box11-2
Halibut	1119	FZ-1Box14-3,Box16-1
Honeydew	1120	FZ-1Box4-2,Box17-3
Hops	1121	
Kidney Beans	1122	FZ-1Box
Lentils	1123	FZ-1Box2-2
Macadamia	1124	FZ-1Box7-2,Box10-2,Box17-3
Malt	1125	FZ-1Box11-1,Box1-1
Maple Sugar	1126	FZ-1Box
Millet	1127	FZ-1Box13-2
Navy Beans	1128	FZ-1Box17-3
Okra	1129	FZ-1Box17-3
Perch,Ocean	1130	FZ-1Box7-1
Pistachio	1131	FZ-1Box10-2
Plum	1132	FZ-1Box15-2
Prune	1133	FZ-1Box5-2
Pumpkin Seeds	1134	FZ-1Box6-2
Quinoa	1141	FZ-1Box15-2
Safflower Oil	1135	FZ-1Box1-1
Scallops	1136	FZ-1Box1-1

Sole	1137	FZ-1Box12-2
Teff	1145	FZ-1Box7-2
Trout	1138	FZ-1Box4-2
Turnip	1139	FZ-1Box5-2
Venison	1140	FZ-1Box1-1

MISC. FOODS

Allspice		FZ-1Box7-2
Anasazi Beans	03065	FZ-1Box7-1,Box12-2
Antelope Meat		FZ-1Box4-2
Arrow Root	03031	FZ-1Box7-1
Asafoetida	1292	
Avian Water	30014	
Azuki Beans	1201	FZ-1Box12-2
Baking Powder	03064	FZ-1Box7-1
Baking Soda	1299	FZ-1Box8-1,Box10-1
Bamboo Sprouts,Japanese	03051	
Basil	1270	FZ-1Box7-1
Bass	1202	FZ-1Box6-2
Bay Leaves	1203	FZ-1Box4-1
Beans,North American	03034	
Bear Meat	1204	FZ-1Box17-2
Black Beans	1205	FZ-1Box13-2
Black Cohosh	03027	
Blackberry	1206	FZ-1Box2-4
Blue Cohosh	03026	
Blue Corn Meal	03061	
Boar Meat,Wild	1207	
Bok Choy Mix	03058	FZ-1Box16-2
Buffalo Meat	1208	FZ-1Box10-2
Camel Meat	03062	FZ-1Box10-3
Cardamon	1294	FZ-1Box8-1,Box10-1
Caribou	1284	FZ-1Box8-1
Cassava	1209	FZ-1Box5-1
Catfish,Lake	1225	
Cayenne Pepper	1258	FZ-1Box8-1,Box11-1
Chayote Squash	03070	
Cheese, Caciotta Del Lazio	03076	FZ-1Box15-1
Cheese, Greek Sheep Myzithra	03075	FZ-1Box15-1
Cheese, Mancheso	03073	FZ-1Box15-1
Cheese, Mozzarella Di bufala	03077	FZ-1Box15-1
Cheese, Pecorino	03074	FZ-1Box15-1
Chili Pepper,Hot	1276	FZ-1Box13-2
Chinese Yam	03079	FZ-1Box4-1
Chives	0626	FZ-1Box7-1
Cilantro	03055	FZ-1Box7-1

Cinnamon	1210	FZ-1Box17-2
Citrus Fruit Peel Mix	1273	FZ-1Box
Clams	03022	FZ1Box3-1
Cloves	1279	FZ-1Box7-2
Collard Greens	03033	FZ-1Box1-2
Cornish Hen	1262	FZ-1Box16-5
Cotton Seed	1278	FZ-1Box4-2
Cow's Cheese	1211	FZ-1Box6-2
Cranberry	1212	FZ-1Box10-2
Crawfish	03025	
Cumin Seeds	1274	FZ-1Box8-1,Box10-1
Dandelion Greens	03057	FZ-1Box7-1
Dhaniya;Coriander	1288	FZ-1Box3-2,Box10-1
Dill Weed	1275	FZ-1Box15-2
Dove	1266	FZ-1Box8-1,Box9-1
Dr.Pepper	1213	FZ-1Box17-2
Duck	1214	FZ-1Box3,Box9-1
Dulse	03023	FZ-1Box11-1
Eggplant	1215	FZ-1Box7-1
Elk meat		FZ-1Box14-2
Emu Fillet	03060	FZ-1Box12-2
Endive (Belgium)	03072	FZ-1Box15-1
Fennel Seeds	1267	FZ-1Box17-2
Fiddle Head,Canadian	03035	FZ-1Box3-1
Flaxseed	1216	FZ-1Box6-2
Frog Legs	1217	FZ-1Box7-2
Fructose	1218	FZ-1Box17-3
Garbanzo Beans	1219	FZ-1Box7-1
Ginger Root	1287	FZ-1Box8-1,Box9-1
Goat Cheese	1220	FZ-1Box3-2
Goose		FZ-1Box7-2
Grape Seed Oil,Mediterranean	03052	FZ-1 Box6-2
Green Tea	1082	FZ-1Box13-1
Grouper	1261	FZ-1Box1-2
Guanco Meat	1221	
Guinea Hen	03059	FZ-1Box1-2
Haddock	1222	FZ-1Box1-2
Jalapeno Pepper	1223	FZ-1Box14-2
Japanese Agar,Clear	03007	
Japanese Beefsteak Leaf	03011	
Japanese MA-1;Milk	03040	
Japanese Sardine	03047	
Japanese Unag Eel	03046	
Japanese White Meat Fish	03041	
Jeera;Cumin	1291	

Jellyfish	03053	FZ-1Box5-1
Kale	1295	FZ-1Box8-1,Box10-1
Kamut	03002	FZ-1Box1-1,Box11-1,Box16-1
Kangaroo meat		FZ-1Box14-2
Kelp	03030	FZ-1Box5-1
Kiwi	1224	FZ-1Box8-1,Box10-1
Kombu Seaweed	03072	FZ-1Box1-1
Leeks	03024	FZ-1Box5-1
Lettuce,Swiss Chard	1251	FZ-1Box18-5
Licorice Chews	03056	FZ-1Box3-1,Box11-1
Lime	1272	FZ-1Box4-2,Box11-1
Linseed Oil	1281	FZ-1BoxBox3-2
Llama Meat	1226	FZ-1Box15-1
Lobster	03020	FZ-1Box6-2
Lotus Flour	03045	FZ-1Box11-1
Mackerel	1227	FZ-1Box8-1
Mahi-Mahi Fish	1155	FZ-1Box15-1
Maize	1228	
Malanga Flour	03043	FZ-1Box5-1
Mango	1229	FZ-1Box8-1
Marjoram	1277	FZ-1Box4-2
Methi;Fenugreek	1290	FZ-1Box11-1
Milo Flour	03042	FZ-1Box7-1
Molasses	1230	FZ-1Box14-2
Moose	1283	FZ-1Box7-1
Mung Beans	1231	FZ-1Box3-1
Mushrooms	1269	FZ-1Box6-2
Mussels	03050	FZ-1Box8-1
Mustard	1232	FZ-1Box7-1
Mustard Seeds	1289	FZ-1Box5-1,Box9-1
Nectarine	1233	FZ-1Box16-8
Nopalitos Cactus	03069	FZ-1Box8-1
Nutmeg	1280	FZ-1Box11-1,Box16-1
Octopus	03049	FZ-1B8-1
Olive Oil	1234	FZ-1Box3-3
Orange Roughy	1263	FZ-1Box12-2
Oregano,Greek	1271	FZ-1Box7-1
Ostrich		FZ-1Box7-2
Oyster	1235	FZ-1Box3-2
Pablum	1268	
Paprika Hungarian	03054	FZ-1Box7-1
Parsley	1285	FZ-1Box5-1,Box11-1
Parsnips	1282	FZ-1Box8-1,Box11-1
Partridge	03003	
Pennyroyal	03028	FZ-1Box8-1

Peppermint	03071	FZ-1Box5-1
Pepsi	1236	FZ-1Box17-2
Perch,Freshwater	1237	
Perrier Mineral Water	03067	FZ-1
Persimmon	1238	FZ-1Box18-6
Pheasant	03005	FZ-1Box5-1
Picante Sauce,Mild	1260	FZ-1Box13-2
Pig Fascia		FZ-1Box4-1
Pine Nuts	1239	FZ-1Box17-3
Plantain Banana	1240	FZ-1
Polluck	03021	FZ-1
Pomegranate		FZ-1Box14-2
Pumpkin	1241	FZ-1Box5-2
Purple Hull Peas	1242	FZ-1Box5-1
Quail	1265	FZ-1Box3-2,Box8-1
Rabbit	1259	FZ-1Box5-1
Radish,Dicon	1243	FZ-1Box16-5
Radish,Red	1244	FZ-1Box4-1
Radish,White	1245	FZ-1
Raspberry	1246	FZ-1Box1-2,Box16-1
Red Bell Pepper		FZ-1Box4-2
Rhubarb	03032	FZ-1Box1-2
Rosemary		FZ-1Box14-1
Rutabaga	03004	FZ-1Box5-1
Sage		FZ-1Box7-2
Sardine	1078	FZ-1Box16-1
Semolina	1298	FZ-1Box5-2
Shark,Black Tip	1286	FZ-1Box12-2
Sorghum	1247	FZ-1Box17-1
Spelt,Wheat	1297	FZ-1Box5-1,Box16-1
Splenda	03070	FZ-1Box8-1
Spot Fish	1249	
Squab	1250	FZ-1Box5-1,Box8-1
Squash,Spaghetti	1248	FZ-1Box6-2
Squash,White	1257	FZ-1
Squid	03048	FZ-1Box8-1
Stevia	03078	FZ-1Box15-3
Swordfish	1264	FZ-1Box7-1
Taheebo Tea	1252	FZ-1Box1-1
Tamarida	1293	FZ-1Box5-1
Tangelo	1253	FZ-1Box5-2,Box8-1
Tangerine	1254	FZ-1Box17-2
Taro Root	03068	FZ-1Box12-2
Tarragon	03029	FZ-1Box7-2
Tilapia	1000T	FZ-1Box4-2

Tumeric Root	03055	FZ-1Box7-1,Box10-1
Turbot	1255	FZ-1Box12-2
Vanilla	1256	FZ-1Box5-1,Box8-1
Vinegar,Heinz White	1296	FZ-1Box5-1,Box8-1
Wakame Seaweed	03071	FZ-1
Water Chestnut Flour	03044	FZ-1Box7-1
Watercress	1154	10cc – side board
White Sweet Potato Flour	03066	FZ-1Box
Wild Rice	03001	FZ-1Box5-1
Yams	1082	FZ-1Box8-2,Box16-
Zebra Meat		FZ-4Box10-3

FOOD ADDITIVES

Aspartame; Nutrasweet	1308	FZ-1Box16-1
BHA	1307	FZ-1Box8-1
BHT	1301	FZ-1Box18-2
Carrageen	1302	FZ-1Box17-1
Citric Acid	1303	FZ-1Box17-3
MSG	1304	FZ-1Box8-2,Box10-3Box15-1
Sodium Bisulfite	1305	FZ-3Box8-1,FZ-1Box15-1
Vivonex	1306	FZ-1Box7-1