

09:30:54

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

09:30:54

ORAL VIDEOTAPED DEPOSITION

WILLIAM J. REA, M.D.

May 21, 2010

09:30:54

09:30:54

ORAL VIDEOTAPED DEPOSITION OF WILLIAM J. REA,  
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  
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.

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BOARD STAFF  
EXHIBIT NO. 1

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10:11:53 1 understand, please indicate that and ask for a  
2 clarification okay?  
3 A. Yes.  
4 Q. I am not a medical doctor, we are going to  
10:11:59 5 have some medical terms today. I certainly may  
6 mangle the pronunciations. Feel free to correct me.  
7 I have no problem with that. But we want a good,  
8 clean record and an understandable exchange of terms,  
9 okay?  
10:12:14 10 A. Yes, that's fine.  
11 Q. If you need a break at some point, if you  
12 would let me know, I believe the courtesy ought to be  
13 extended, I don't have a problem. I may need to get  
14 to a breaking point, but I certainly will respect  
10:12:25 15 that request if need be, okay?  
16 A. Surely.  
17 Q. And with that in mind, Doctor, I would like  
18 to go ahead and ask you, you are a Texas medical  
19 licensed doctor, is that correct?  
10:12:36 20 A. Yes, that's correct.  
21 MR. SIMON: Scott, before -- I'm sorry  
22 to interrupt.  
23 MR. FRESHOUR: Sure.  
24 MR. SIMON: Who's keeping time? Who's  
10:12:44 25 keeping time?

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10:12:46 1 THE COURT REPORTER: I do.  
2 MR. SIMON: Okay. Because we have six  
3 hours.  
4 MR. FRESHOUR: Right. And if I may  
10:12:47 5 pause for a moment, just so we have it on the record,  
6 Jacques, we're doing this by the Texas Rules.  
7 MR. SIMON: Yeah.  
8 MR. FRESHOUR: So six hours?  
9 MR. SIMON: Six hours.  
10:12:55 10 MR. FRESHOUR: Okay. And objections  
11 by Texas Rules?  
12 MR. SIMON: Yes.  
13 MR. FRESHOUR: Okay.  
14 Q. That's just clarifying a few procedural  
10:13:01 15 things between Mr. Simon and myself, Dr. Rea.  
16 Again, you are licensed in Texas as a  
17 medical doctor?  
18 A. That's correct.  
19 Q. When was your license issued or how long  
10:13:11 20 have you been practicing in Texas, sir,  
21 approximately?  
22 A. Well, I think it was issued in 1962, so  
23 I've been -- almost 40 years.  
24 Q. Okay. And the other point I'd like to  
10:13:21 25 make, Doctor, is, I don't want this to be a memory

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10:13:24 1 contest. So if I ask you something and you can't  
2 remember exactly, if you'll indicate "I don't recall  
3 exactly" -- or I may ask for approximations, okay?  
4 A. Yes, that's okay.  
10:13:34 5 Q. And have you been licensed in any other  
6 states other than Texas in your career?  
7 A. Yes.  
8 Q. And what states would those be, Dr. Rea?  
9 A. Ohio, Illinois and Arkansas.  
10:13:44 10 Q. Okay. And whatever word you want, what is  
11 the status of those licenses other than your Texas  
12 medical license?  
13 A. They're all active.  
14 Q. Now, have you, besides this -- well, let me  
10:14:03 15 ask it this way: Are you privileged or credentialed  
16 at any hospital facilities currently, sir?  
17 A. No, I'm not.  
18 Q. Okay. Any particular reason that you don't  
19 have credentials, sir?  
10:14:16 20 A. Yes, there is.  
21 Q. And what would those reasons be, generally?  
22 A. Well, I -- when I was 65, I quit doing my  
23 surgeries and the like. And so there was really no  
24 need to be in a hospital.  
10:14:30 25 Q. And you quit doing surgeries at 65. What's

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10:14:37 1 your approximate age right now, Doctor?  
2 A. 75.  
3 Q. So it's been about ten years?  
4 A. Yeah, that's right.  
10:14:43 5 Q. Okay. In those ten years since 1965, has  
6 it just been the private practice and I believe in  
7 Environmental Health Center of Dallas; is that  
8 correct?  
9 A. Yes, that's correct.  
10:14:55 10 Q. Okay. In that ten years since you quit  
11 doing surgery, that's the only medical office or  
12 business you've had; is that correct?  
13 A. Yes.  
14 Q. And that's the address you gave us earlier  
10:15:08 15 today, that is the Environmental Health Center of  
16 Dallas?  
17 A. Yes, that's correct.  
18 Q. Now, prior to you giving up your hospital  
19 privileges and that kind of thing, just because you  
10:15:22 20 weren't working, had you ever been subject to any  
21 peer review or loss of privileges at a hospital  
22 facility where you had been credentialed?  
23 A. I think there was one time. It was  
24 temporary, they had made a mistake.  
10:15:35 25 Q. Okay. Just generally approximately when

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10:15:36 1 was that and what was the nature of it, Dr. Rea?  
 2 A. I don't even remember, it's been so long  
 3 ago. 30 years ago or something like that.  
 4 Q. Okay. And you said it was just temporary.  
 10:15:46 5 So it wasn't a long-term --  
 6 A. Oh, no, just temporary.  
 7 Q. Okay. In the other states where you're  
 8 currently licensed and hold licenses, have you ever  
 9 been subject to -- or have you ever held any hospital  
 10:16:01 10 privileges or credentials in those states?  
 11 A. No, other than licensure.  
 12 Q. Okay. And I know this is going back a  
 13 ways, but as a medical student and then a resident  
 14 and maybe you did an internship or a fellowship, were  
 10:16:17 15 you subject to any kind of disciplinary action in  
 16 your medical academic career?  
 17 A. Absolutely not.  
 18 Q. Now, other than the -- and you are aware,  
 19 obviously, we're here today because there's been an  
 10:16:29 20 investigation by the Texas Medical Board, correct?  
 21 A. I'm quite aware of that, yes.  
 22 Q. Right. Now --  
 23 MR. SIMON: A complaint has been filed  
 24 by the Texas Medical Board, it's not an  
 10:16:40 25 investigation, it's beyond the investigation.

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10:16:42 1 MR. FRESHOUR: Right. And thank you,  
 2 Mr. Simon. Let me correct that.  
 3 Q. You are aware you are subject of a  
 4 complaint at the State Office of Administrative  
 10:16:50 5 Hearings that has been filed by the staff of the  
 6 Texas Medical Board at this time, correct?  
 7 A. Yes, I am.  
 8 Q. And that's what this deposition is about  
 9 today, you're aware of that?  
 10:16:58 10 A. Yes.  
 11 Q. Now, prior -- and I want to take what we've  
 12 got on board today, the patients that are involved  
 13 and how we got here. I don't want to talk about  
 14 those particularly. Have you been subject to any  
 10:17:09 15 other investigation by the Texas Medical Board that  
 16 you're aware of?  
 17 A. Not that I'm aware of, no.  
 18 Q. Okay. Not currently pending, but has there  
 19 been any previously that you're aware of?  
 10:17:21 20 A. Not that I'm aware of.  
 21 MR. SIMON: The investigations that  
 22 you and I participated in, Scott?  
 23 MR. FRESHOUR: No.  
 24 MR. SIMON: Is that what you mean?  
 10:17:30 25 MR. FRESHOUR: No.

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10:17:31 1 Q. Other than what we've got on board at  
 2 this --  
 3 A. Recently.  
 4 Q. Right.  
 10:17:34 5 Say within the past five years, other  
 6 than this one, have you been subject to an  
 7 investigation?  
 8 A. No, not to my knowledge.  
 9 Q. Within the past ten years?  
 10:17:41 10 A. Not to my knowledge.  
 11 Q. Okay. Now, you've had a long career,  
 12 Doctor, so what I'm going to do in these next series  
 13 of questions is, I'm going to limit it to, say, the  
 14 past ten years, okay, for the frame of reference.  
 10:18:01 15 A. Surely.  
 16 Q. In the past ten years, have you been  
 17 subject to any medical malpractice claims arising out  
 18 of your medical practice that you're aware of?  
 19 A. Not that I'm aware of.  
 10:18:10 20 Q. Okay. Have you been the subject of any  
 21 settlements, or has your insurer or yourself settled  
 22 any claims with patients before they were filed as  
 23 medical malpractice claims?  
 24 A. In the last ten years?  
 10:18:23 25 Q. Yes, sir.

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10:18:23 1 A. Not that I'm aware of.  
 2 Q. Okay. Have you been the subject of any  
 3 civil lawsuits arising out of your medical practice  
 4 or conduct of your medical practice within the last  
 10:18:32 5 ten years?  
 6 A. No.  
 7 Q. Now, Doctor, I want to just go ahead and  
 8 expand that just a little bit, now. I want to ask  
 9 that same series of questions, if you can remember  
 10:18:44 10 back. I'm going to stop it at 20 years. In the last  
 11 20 years, have you been subject to any med mal claims  
 12 that you're aware of?  
 13 A. Oh, yes, I was a thoracic cardiovascular  
 14 surgeon.  
 10:18:55 15 Q. And we're going to get to that. But  
 16 generally will you go ahead and, if you can remember  
 17 approximately, about how many med mals, say, in the  
 18 last --  
 19 A. Probably three or four.  
 10:19:07 20 Q. Okay. And were any -- did you ever have  
 21 any payouts that you can recall?  
 22 A. Yes, I think there were some.  
 23 Q. Okay. Do you generally remember what any  
 24 of the claims were about?  
 10:19:20 25 A. Well, you know, cardiovascular surgery is a

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10:19:26 1 very risky deal, and particularly at that time. So  
2 it would be whatever was perceived to be the case. I  
3 can't remember any --  
4 MR. SIMON: Dr. Rea, the question was  
10:19:44 5 if you remember.  
6 A. I don't remember, no.  
7 Q. Okay. Now -- and, Doctor, let me tell you,  
8 I have a tendency to jump around. It's not to  
9 confuse you, it's just the way the mind works.  
10:19:54 10 A. Okay.  
11 Q. You've hit upon being a cardiothoracic  
12 surgeon, correct?  
13 A. Yes, that's correct.  
14 Q. Now, you were trained in that specialty, or  
10:20:03 15 that's what you began your medical career doing,  
16 correct?  
17 A. Yes, that's correct.  
18 Q. Now, how long did you continue to practice  
19 in that field? I know you said you stopped with  
10:20:10 20 hospital privilege about ten years ago. When did you  
21 stop doing thoracic surgeries?  
22 A. Well, sometime around then. I don't recall  
23 exactly. But sometime around 12 years ago, 10, 12.  
24 Q. Now, you're well aware that part of this  
10:20:33 25 suit relates to some of your, what I'm going to call

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10:20:35 1 the nature of your current practice, that being what  
2 is termed environmental medicine; is that correct?  
3 A. Yes.  
4 Q. Okay. Now, I know you were a thoracic  
10:20:44 5 surgeon. About when would you say you -- well, let  
6 me ask it this way: About when did you begin  
7 generally practicing any kind of environmental  
8 medicine?  
9 A. Well, I would say it was probably in the  
10:21:00 10 late '60s, because part of thoracic surgery at that  
11 time was environmental medicine.  
12 Q. And how do you mean, Dr. Rea?  
13 A. Well, for example, we would see cases of  
14 asbestosis, cases of coccidioidomycosis, fungus-type  
10:21:17 15 phenomena of the lungs and of the cardiovascular  
16 system, and pneumoconiosis, coal miner's disease. Of  
17 course, you wouldn't have it around here, but we have  
18 seen that. People who were exposed to dust, high  
19 levels of dust and things like that. So always from  
10:21:35 20 the beginning of the program I did that kind of  
21 stuff, and it was environmental.  
22 Q. Okay. Let me -- what percentage of your  
23 practice today -- or is the percentage of your  
24 practice today as environmental medicine 100 percent  
10:21:55 25 of your practice?

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10:21:57 1 A. I would say almost so, maybe 95, you know.  
2 Q. Okay. And if you can, generally when did  
3 you really transition out of thoracic surgery being  
4 kind of primary and moving into what I'm going to  
10:22:14 5 term primarily the environmental medicine in the  
6 fashion that you're practicing today generally?  
7 A. Well, I would say that in the '80s, I had a  
8 ward over at one of the hospitals, and I had 40 -- I  
9 would have 20 thoracic surgery patients and 20  
10:22:35 10 environmental patients in the hospital, as what you  
11 would call environmental now. And that went on until  
12 the late '90s, and then there would be more  
13 environmental medicine than surgery, I would say.  
14 Q. Now, the facility you talked about where  
10:22:53 15 you had kind of a thoracic, slash, environmental  
16 practice, was that Brookhaven?  
17 A. Yes, it was.  
18 Q. Okay. Now, at Brookhaven, did you ever  
19 have any kind of, any kind of peer review action or  
10:23:11 20 any action taken against your privileges at that  
21 facility?  
22 A. No.  
23 Q. Is that facility still operating today?  
24 A. Yes.  
10:23:20 25 Q. Okay. When did you quit, I guess for lack

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10:23:23 1 of a better term, going to that facility or having  
2 patients at that facility?  
3 A. I don't recall when that was. It may have  
4 been in the mid '90s, could be, something like that.  
10:23:38 5 MR. SIMON: Didn't it change names?  
6 THE WITNESS: Yes, it changed names.  
7 Q. And what name did it change to, do you  
8 know?  
9 A. Well, it changed to Dedman Hospital. And  
10:23:46 10 when they decided that wasn't very good  
11 advertisement, it became RHD Hospital. And I don't  
12 know what it is now. It may be a different name now.  
13 Q. And what motivated or what precipitated  
14 your decision to leave Brookhaven when you made that  
10:24:09 15 decision, Doctor?  
16 A. Well, they came to me and said, look, we  
17 bought another hospital close, small hospital.  
18 Wouldn't you like to put your patients there because  
19 we could isolate them more and they would not get the  
10:24:29 20 exposure and we could do more things to them. Now, I  
21 didn't give up my privileges at Brookhaven at the  
22 time, because the two were interspersed, okay. And  
23 so we had that there for several years.  
24 Q. Now, when you were at Brookhaven Hospital,  
10:24:49 25 you -- were you in partnership or working with a

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10:24:53 1 Dr. Alfred Johnson at that point in time in your  
2 career?  
3 A. Yes, he was first a fellow, and then he  
4 came into practice.  
10:25:08 5 Q. And this is one of those jump-arounds,  
6 okay, Doctor? So bear with me.  
7 A. Okay.  
8 Q. We're going to talk a little bit about some  
9 protocols later today related to some antigen prep.  
10:25:21 10 Is that -- do you generally or -- I  
11 don't know if it's you or Dr. Johnson, but you  
12 generally followed the same protocols, each of you,  
13 in your antigen kind of preparation and formulation,  
14 do you know?  
10:25:35 15 A. I really can't speak for Dr. Johnson. It's  
16 been several years now since he left and got his own  
17 practice, so I don't know how he makes his antigens  
18 or what he does. I can't really tell you.  
19 Q. And when did you and he part company, so to  
10:25:52 20 speak?  
21 A. Gosh, I don't even recall. I think it's  
22 been about eight or ten years ago now.  
23 Q. Doctor, I want to kind of come back to you  
24 and some of your training and medical expertise. Are  
10:26:04 25 you board certified by any ABMS organization?

10:26:10 1 A. Yes, I am.  
2 Q. And what, what certification do you have,  
3 Doctor?  
4 A. Number one, general surgery; and number  
10:26:16 5 two, cardiovascular surgery.  
6 Q. All right. Now, how long -- let's go with  
7 the general surgery first. How long have you been  
8 board certified?  
9 A. I think it was probably around 1960 -- I  
10:26:29 10 think it was '67. I'm not quite sure when I finished  
11 my residency, but I took the exams right then.  
12 Q. And on that board certification, being  
13 ABMS, are you under what they call the grandfather  
14 where you -- or do you have a renewal period?  
10:26:43 15 A. I think I'm grandfathered now.  
16 Q. Okay. Now, on your thoracic surgery, you  
17 also said you were also board certified; is that  
18 correct?  
19 A. That's correct.  
10:26:50 20 Q. And, again, approximately when did you get  
21 that, sir?  
22 A. Well, about two years later.  
23 Q. And, again, are you under a grandfather  
24 type of certification there?  
10:26:57 25 A. I think so, yes.

10:26:58 1 Q. Okay. Now, other than those two ABMS  
2 certifications, do you claim any other kind of board  
3 certifications, Doctor?  
4 A. I do, but not through the AMBS.  
10:27:11 5 MR. SIMON: ABMS.  
6 A. ABMS.  
7 Q. Okay, Doctor. If you will, enumerate what  
8 those board certification are and the certifying  
9 organization for me. Could you, sir?  
10:27:21 10 A. Yes, it's the American Board of  
11 Environmental Medicine.  
12 Q. All right. And what, I mean -- okay, the  
13 American Board of Environmental Medicine, do they  
14 certify you in environmental medicine, or what is  
10:27:36 15 that certification?  
16 A. That is certified in environmental  
17 medicine, which involves several entities, of course.  
18 Q. Okay. And you say -- and I want to be  
19 clear on that. It "involves several entities." What  
10:27:49 20 do you mean by that, Doctor?  
21 A. Well, I'm talking about immunology,  
22 toxicology, nutrition.  
23 MR. SIMON: Disciplines.  
24 A. Disciplines. That would be a better word.  
10:27:58 25 Q. Right. And that's what I was going to say,

10:27:58 1 the certification is environmental medicine, but --  
2 and I guess this will lead right to my next question.  
3 Do you have to take some kind of test or show certain  
4 competencies?  
10:28:09 5 A. Yes.  
6 Q. And what are those, sir?  
7 A. Well, it was both a written and an oral  
8 exam, just like the other ABMSes.  
9 Q. Okay. And what generally did you have  
10:28:18 10 to -- or what areas did these exams focus in on for  
11 this ABEM certification?  
12 A. Same that we just talked about, the same  
13 disciplines we just talked about.  
14 Q. And those are, just for the record, Doctor?  
10:28:32 15 A. Those would be immunology, toxicology,  
16 nutrition and, of course, the environment.  
17 Q. All right. Now, do you have any other  
18 certifications from any other organizations?  
19 A. I may have. I'm not quite sure if it's  
10:28:54 20 current or not. But it's, I think it's -- well, I'm  
21 not sure.  
22 Q. Okay.  
23 A. I don't ever claim them, so I -- you know.  
24 Q. All right. You have been a member, I  
10:29:09 25 believe, of -- is it the, is it the American Academy

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10:29:13 1 of Environmental Medicine?  
 2 A. I am a member, yes. Now, that's different.  
 3 Q. Okay. What is that?  
 4 A. Well, it's a certified academy of  
 10:29:24 5 physicians of -- it's multi-specialty. And it's  
 6 actually -- 19 different specialties are involved in  
 7 that, both surgically and medically. And it's been  
 8 around about 50 years now, and it was founded by both  
 9 surgeons and physicians to study the effects of the  
 10:29:48 10 environment upon the individual.  
 11 Q. Now --  
 12 A. By the way, I did forget one thing on the  
 13 board.  
 14 Q. Oh, certainly, go ahead, Doctor.  
 10:29:59 15 A. The requirement for the board, one of the  
 16 requirements is that you have to already be certified  
 17 in an ABMS specialty.  
 18 Q. And is that -- that's for the American  
 19 Board of Environmental --  
 10:30:09 20 A. Yes.  
 21 Q. -- medicine?  
 22 A. Yes.  
 23 Q. So they require an ABMS certification  
 24 before you can sit for their examination?  
 10:30:14 25 A. That's right, exactly.

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10:30:15 1 Q. And it can be in the ABMS certified areas?  
 2 A. Yes.  
 3 Q. The American Academy of Environmental  
 4 Medicine, did that -- and I'm going -- for lack of a  
 10:30:27 5 better term, is that a -- did that morph out of the  
 6 clinical ecology or Clinical Ecology Society or  
 7 association at some point?  
 8 A. Yes, I think it did.  
 9 Q. All right. So is it fair to characterize  
 10:30:42 10 what is today the American Academy of Environmental  
 11 Medicine arose out of what was known, I guess it was  
 12 in the '60s and '70, as the clinical ecologists; is  
 13 that true?  
 14 A. The Clinical Ecology Society, I think that  
 10:30:58 15 was true, yeah. It was a little bit before my time.  
 16 Q. And that's what I was going to say. When  
 17 did you join the -- I'm going to just call it the  
 18 AAEM. When did you join that, Doctor?  
 19 A. I think it was around 1973 or something  
 10:31:09 20 like that.  
 21 Q. And have you held any positions with that  
 22 organization?  
 23 A. I have, yes.  
 24 Q. And what positions have you held, Doctor?  
 10:31:15 25 A. Well, I was the president at one time. I

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10:31:17 1 can't even remember when, it's been so long ago.  
 2 Maybe 20 years ago or something like that. Just for  
 3 a year.  
 4 Q. Any other positions?  
 10:31:27 5 A. I think I may have -- I've been on the  
 6 board of directors sometimes.  
 7 Q. What do those duties entail, being --  
 8 A. Board of directors?  
 9 Q. -- on the board of directors? Yes, sir.  
 10:31:37 10 A. Well, they entail several things. One,  
 11 they entail planning of the meetings for  
 12 accreditation, for state licensure, and accreditation  
 13 association so that you meet all the criteria for the  
 14 state boards for continuing education. And they also  
 10:32:03 15 involve trying to help educate physicians about the  
 16 effects of the environment upon the individual, which  
 17 of course, as you realize, there's a broad expansion  
 18 of the knowledge of the environment now and how it  
 19 affects individuals.  
 10:32:21 20 So it would also involve those, those  
 21 kind of educational things. Helping medical students  
 22 become educated on these kind of things. We've had a  
 23 program for 20, 30 years on medical students being  
 24 involved in the education process.  
 10:32:44 25 Q. And are you currently -- do you currently

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10:32:47 1 have any position with that organization, Doctor?  
 2 A. You know, I don't recall, but I think  
 3 either I just went off the board or I went on. I'm  
 4 not sure which one.  
 10:33:05 5 Q. And how do they notify you if you're off or  
 6 on, Doctor?  
 7 A. By letters and everything. But I just  
 8 don't recall, okay?  
 9 Q. Okay. All right. What about -- there's an  
 10:33:15 10 organization and I've seen it referenced in some of  
 11 the materials, and I think it's the -- is it the Pan  
 12 American Allergy Society?  
 13 A. Yes, uh-huh, that's correct.  
 14 Q. And what exactly is that organization?  
 10:33:26 15 A. Well, it's another accredited organization,  
 16 both nationally and in the state of Texas. And --  
 17 for continuing education, for licensure. And it's  
 18 more dedicated to teaching physicians the techniques  
 19 that we use like the serial dilution titration,  
 10:33:51 20 neutralization, intradermal desensitization  
 21 techniques. But it also is dedicated to educate  
 22 practicing physicians and residents and students the  
 23 other aspects of environmental medicine also.  
 24 Q. And not knowing exactly how that society is  
 10:34:11 25 organized, did you ever hold any officer or official

7 (Pages 22 to 25)

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10:34:16 1 positions with them, Doctor?  
 2 A. Yes, I did.  
 3 Q. And what were those?  
 4 A. One time I was president, and one time I  
 10:34:22 5 was on the board.  
 6 Q. All right. Are you currently, today?  
 7 A. I think I am on the board, yes.  
 8 Q. Okay. And, again, the duties of the board,  
 9 would that be the same or similar to what you  
 10:34:32 10 described for the AAEM?  
 11 A. Yes, it would be, uh-huh.  
 12 Q. And I think some of the members on there --  
 13 correct me if I'm wrong -- are Dr. Sheridan, David  
 14 Sheridan?  
 10:34:45 15 A. Yes, David is on there.  
 16 Q. You know Dr. Sheraton?  
 17 A. Of course I do.  
 18 Q. Do you know Dr. Steven Hotze?  
 19 A. Of course I do. He's one of my students.  
 10:34:55 20 Q. Do you know Andrew William Campbell?  
 21 A. Yeah, but I don't think he's -- I don't  
 22 think he belongs to that society.  
 23 Q. Alfred Johnson?  
 24 A. Of course. Alfred was my former associate.  
 10:35:07 25 Q. Okay. Alan Broughton?

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10:35:10 1 A. Yeah, Alan was the laboratory guy. You're  
 2 talking about Alan Broughton, the laboratory man?  
 3 Q. I'm not sure. I just know I've seen the  
 4 name somewhere associated, I think with that society.  
 10:35:22 5 I'm not trying to trip you up. I'm just --  
 6 A. Okay. I don't know whether he ever  
 7 belonged to that society, but he was -- he had a  
 8 laboratory that some people used, I think.  
 9 Q. What laboratory did he have, do you know?  
 10:35:31 10 A. I can't recall what it was. It was out in  
 11 California.  
 12 Q. It wasn't Immunosciences Labs, was it?  
 13 A. Yes.  
 14 Q. Do you know Aristo Vojdani?  
 10:35:40 15 A. I sure do.  
 16 Q. Do you know Kaye Kilburn?  
 17 A. Of course I do. He's the cosponsor of my  
 18 conference.  
 19 Q. And when you talk about your conference, is  
 10:35:47 20 that your international symposium on Man and His  
 21 Environment or -- I'm sorry, I know that's not quite  
 22 what it is.  
 23 A. Yes. No, it's Man and His Environment and  
 24 Health Disease. And we're having our 28th in two  
 10:36:00 25 weeks.

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10:36:00 1 Q. And that's here in Dallas?  
 2 A. Yes, the world conference.  
 3 Q. And that's sponsored by -- or partly  
 4 sponsored by the -- by you; is that correct, Doctor?  
 10:36:10 5 A. Yes, I have organized it. And my  
 6 foundation, American Environmental Health Foundation,  
 7 is the one that sponsors it, along with Professor  
 8 Kilburn, Professor Bill Meggs at East Carolina  
 9 Medical School.  
 10:36:29 10 Q. It's the same Bill Meggs that you've  
 11 designated as an expert in this case, isn't that  
 12 correct?  
 13 A. Yes, it is.  
 14 Q. Are there any other sponsors of -- I'm  
 10:36:42 15 going to call it the -- can we agree to call it "the  
 16 symposium"?  
 17 A. Yeah, that will be fine.  
 18 Q. Because I don't want to keep saying the  
 19 big, long name, okay? Or it will take us longer  
 10:36:51 20 today if I have to keep saying that.  
 21 A. Yeah.  
 22 Q. Are there other sponsors besides the  
 23 American Environmental Health Foundation that help  
 24 sponsor that?  
 10:37:00 25 A. Well, our clinic also.

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10:37:02 1 Q. Right, the Environmental Health Clinic of  
 2 Dallas.  
 3 A. Right.  
 4 Q. And can we agree to call that just "the  
 10:37:09 5 clinic" for today?  
 6 A. Sure, that will be fine.  
 7 Q. Great.  
 8 You said something -- and we were just  
 9 talking about the Pan American Society. I'm just  
 10:37:24 10 going to call them that for short. And we talked  
 11 about a Dr. Broughton, and you referenced a  
 12 laboratory. You are familiar with a laboratory  
 13 called Immunosciences Labs in California?  
 14 A. Yes, I am.  
 10:37:36 15 Q. Okay. And you use -- do you use that  
 16 laboratory currently?  
 17 A. I think he's back in business, but I don't  
 18 think we -- he does what we are interested in, okay?  
 19 Q. Okay. And when you say what "we" are  
 10:37:51 20 interested in, meaning the clinic?  
 21 A. Yes. When I say that, I mean the clinic  
 22 and my practice, okay?  
 23 Q. And what is he doing that is not of  
 24 interest to your clinic right now, Doctor?  
 10:38:03 25 A. Well, I can't really tell you, because I

8 (Pages 26 to 29)

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10:38:06 1 haven't -- when he went back into business, I -- he  
2 concentrated on certain things, and I think maybe  
3 part of it was genetics and part was endocrine or  
4 something. It wasn't something that we thought would  
10:38:21 5 help our patients, okay?  
6 Q. And you are aware that Immunosciences Labs,  
7 for lack of a better term, ran into a little trouble  
8 in the state of California on some of their  
9 certification and CLIA licensing? Were you aware of  
10:38:40 10 that?  
11 A. Yes, I was, uh-huh.  
12 Q. But prior to -- and, again -- well, let me  
13 ask it this way: When did you quit or stop sending  
14 materials to Immunosciences Labs, approximately?  
10:38:53 15 MR. SIMON: I'll object to that form.  
16 We already established during Dr. Holland's  
17 deposition and on your own expert's testimony that he  
18 did not do business with Immunosciences Labs after  
19 that license or whatever it was, certification was  
10:39:08 20 revoked. So I object to the form of the question in  
21 the sense that it implies that he did anything with  
22 that lab at the time when that lab was not  
23 credentialed. And that was established already.  
24 MR. FRESHOUR: Okay. I'm going to --  
10:39:21 25 if you would, Mr. Simon, it's "form" unless I ask you

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10:39:25 1 for the explanation. You're supposed to just say --  
2 MR. SIMON: I'll object to the form.  
3 MR. FRESHOUR: Right. But unless I  
4 ask for an explanation, you should not articulate  
10:39:33 5 anything.  
6 MR. SIMON: I was just reminding you.  
7 MR. FRESHOUR: I understand. And I  
8 understand your form objection.  
9 Q. Let me pause here for a moment, Dr. Rea.  
10:39:39 10 Mr. Simon, if he objects and says "form," unless he  
11 instructs you not to answer, and I'll leave that to  
12 him, you'll need to answer my question even if an  
13 objection has been registered, okay?  
14 A. Yes.  
10:39:52 15 Q. I'm going to repeat the question.  
16 A. Please.  
17 Q. Do you remember about when you stopped  
18 using Immunosciences Labs with your clinic?  
19 A. Well, that was when they shut down with --  
10:40:01 20 I don't know what the ruckus was. But whatever it  
21 was, they had shut down for a period of time. And  
22 that must have been, what, four, five, six, eight  
23 years ago, whenever it was.  
24 Q. And at the time prior to them shutting  
10:40:15 25 down --

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10:40:16 1 A. Yes.  
2 Q. -- were you using them for -- mainly for  
3 mold antibody testing, is that correct, or were you  
4 using them for other services as well?  
10:40:26 5 A. No, we were using them for some other  
6 services also.  
7 Q. Okay. Was it -- okay, and let me ask you  
8 this way: Was it primarily for the mold antibody  
9 testing, or were there other tests? And if so, what  
10:40:36 10 generally did you use them for, Doctor?  
11 A. Well, I think it was for more like some  
12 kinds of immune tests at some times. Not  
13 particularly mold. I never -- just a few occasions  
14 used it for mold, because -- we did use some for some  
10:40:52 15 patients, but we didn't use it a lot.  
16 Q. What laboratories do you generally use  
17 today with -- for the clinic for your testing? Are  
18 there any particular labs you like to use?  
19 A. Well --  
10:41:07 20 MR. SIMON: Is that -- object to the  
21 form and also to relevancy. Is that part of this  
22 case?  
23 You can answer the question.  
24 A. Of course we use Quest and LabCorp. And we  
10:41:21 25 have our own laboratory also. And there's a lot of

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10:41:24 1 things we do right there. And then we use [Lab  
2 name redacted] and Metamatrix. I think that's  
3 Atlanta.  
4 Q. Metamatrix?  
10:41:38 5 A. Metamatrix, yeah.  
6 Q. Thank you, Doctor.  
7 A. I think -- I can't remember any more. I  
8 don't think we have any more.  
9 Q. Okay. Well, and the [Lab name redacted] that's  
10:41:51 10 not known as XXX commonly in the medical community,  
11 the [Redacted]? Is that what you --  
12 A. I don't know what it's known as. We know  
13 it as [Redacted]  
14 Q. What about Accu -- is it Accu Lab  
10:42:03 15 or Accu-Chem --  
16 A. Accu-Chem Laboratory is not in existence  
17 anymore.  
18 Q. That was bought out by somebody recently,  
19 wasn't it?  
10:42:11 20 A. Yes, it was.  
21 Q. Do you know who bought them out?  
22 A. I think Metamatrix did.  
23 Q. I was going to ask you --  
24 A. Don't quote me on that, okay?  
10:42:17 25 Q. But I think we can agree, I think, for some

9 (Pages 30 to 33)

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10:42:19 1 reason, I've seen the literature on that.  
 2 A. Yeah.  
 3 Q. Now, the Accu-Chem Laboratory, that used to  
 4 be run by a John Laseter, correct?  
 10:42:28 5 A. Dr. John Laseter. He's a world class  
 6 environmental chemist, biochemist, yes. He was at  
 7 the University of New Orleans for years.  
 8 Q. And you -- before Accu-Chem, when they were  
 9 in existence, your clinic did use them as a  
 10:42:46 10 laboratory, as well, generally for testing?  
 11 A. Oh, yes, because they were the best  
 12 laboratory for chemical analysis.  
 13 Q. Okay. And do you have -- do you have any  
 14 kind of a business relationship with Dr. Laseter?  
 10:43:04 15 A. No.  
 16 Q. Did you ever have any kind of business  
 17 relationship with Dr. Laseter?  
 18 A. No. He asked me to be on their board one  
 19 time, and I think I, I was for a few months, but then  
 10:43:15 20 I resigned.  
 21 Q. And when you say on the "board," the board  
 22 of Accu-Chem Labs?  
 23 A. Yes.  
 24 Q. What was your role there as -- on the  
 10:43:22 25 board, even though it was short-term?

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10:43:24 1 A. Physician input.  
 2 Q. Did you ever have any kind of ownership  
 3 interest in Accu-Chem, Doctor?  
 4 A. I'm not sure that we did. I think our  
 10:43:36 5 foundation did. I'm not sure. They may have  
 6 stopped, but I don't really recall.  
 7 MR. SIMON: Did you yourself have  
 8 any --  
 9 THE WITNESS: I don't recall.  
 10:43:43 10 MR. SIMON: Okay.  
 11 Q. And that's the breakdown. I think  
 12 Mr. Simon has kind of helped me on that one.  
 13 A. Yeah.  
 14 Q. I'm asking, did you personally own any  
 10:43:53 15 interest in Accu-Chem that you're aware of?  
 16 A. Not that I'm aware of.  
 17 Q. Okay. Now, you also -- we've talked about,  
 18 and we're going to talk about some more here in a  
 19 minute, the -- I'm drawing a blank, your foundation.  
 10:44:07 20 A. Yes.  
 21 Q. What is it, again, one more time?  
 22 A. American Environmental Health Foundation.  
 23 Q. Okay. Can we agree, for the purposes of  
 24 today, to call that the foundation?  
 10:44:16 25 A. Yes, I think we did.

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10:44:18 1 Q. Okay. So we've got the symposium, the  
 2 clinic and the foundation?  
 3 A. Yeah.  
 4 Q. I'm going to try to keep those straight,  
 10:44:22 5 okay, Doctor?  
 6 A. Okay.  
 7 Q. If I don't, you'll straighten me out?  
 8 A. Yes.  
 9 Q. Do you know, did the foundation own any  
 10:44:28 10 interest in Accu-Chem Lab?  
 11 A. Not to my knowledge.  
 12 Q. And when you were using Accu-Chem Lab  
 13 before they were sold, was there any kind of  
 14 financial arrangement between the lab and the clinic  
 10:44:57 15 that you got any kind of favorable prices or reduced  
 16 rates on your testing costs?  
 17 A. No.  
 18 Q. Now, I want to go a little bit into -- just  
 19 generally -- I want to be sure, you don't have any  
 10:45:25 20 specialty training in neurology, do you, Doctor?  
 21 A. Only that I used to do neurosurgery at  
 22 Parkland Hospital.  
 23 Q. You did some neurosurgery?  
 24 A. Sure did.  
 10:45:35 25 Q. Okay. When did you do the neurosurgery?

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10:45:37 1 A. Oh, it's in the '60s, late '60s, mid '60s.  
 2 Q. Now, you were trained as a thoracic, so how  
 3 did you come to do the neurosurgery? I just need a  
 4 little clarification.  
 10:45:49 5 A. Well, Parkland Hospital, I don't know  
 6 whether you're aware, but, it's probably the greatest  
 7 trauma hospital in the world. And when you're a  
 8 surgeon at Parkland Hospital, you're trained to go  
 9 through all the specialties, and that's when I did  
 10:46:03 10 it.  
 11 Q. Okay. And I think that's -- perhaps I'm  
 12 being a little bit unclear on my question.  
 13 Was that during, say, your internship,  
 14 your fellowship, or were you actually a licensed  
 10:46:13 15 physician and working at Parkland?  
 16 A. Well, it was during my training, but I was  
 17 a licensed physician.  
 18 Q. Right. That's what I'm trying to  
 19 distinguish, though, it was your training, you  
 10:46:21 20 weren't there after -- it was like during an  
 21 internship or a fellowship, right, that you did that?  
 22 A. A residency, yes.  
 23 Q. Residency, okay.  
 24 A. I did six years there of residency after  
 10:46:34 25 internship.

10 (Pages 34 to 37)

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10:46:35 1 Q. Okay. Did you have any specialty -- do you  
2 have any specialty training in neurology?  
3 A. I just said, yes, I rotated through several  
4 times, yeah.  
10:46:44 5 Q. That was neurosurgery, neurology.  
6 A. Oh, well, I mean, the two are intertwined,  
7 yeah.  
8 Q. Okay. What about psychiatry?  
9 A. No.  
10:46:54 10 Q. Radiology?  
11 A. Only -- all of these things you ask, those  
12 are all interpretation of our specialty when you have  
13 so many long years of training that I have. I have  
14 rotated through there and I've worked with the  
10:47:06 15 radiologists. I don't have any special certificate  
16 of training from that, if that's what you're asking.  
17 Q. Right.  
18 A. And if you ask all of those, that will  
19 probably be the same.  
10:47:16 20 Q. Okay. And that's what I'm getting to, you  
21 have -- it's fair to say from our discussion today  
22 that you feel you have experience in all of those,  
23 but you didn't necessarily have specialized training  
24 or certifications?  
10:47:29 25 A. I had specialized training, but not

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10:47:32 1 certification.  
2 Q. Not certifications?  
3 A. Yes.  
4 Q. So just for the record -- bear with me on  
10:47:35 5 this, Doctor?  
6 A. Okay.  
7 Q. So you do not have certification in  
8 neurology?  
9 A. Same answer, right.  
10:47:40 10 Q. You don't have certification in psychiatry?  
11 A. Absolutely not.  
12 Q. You don't have certification in radiology?  
13 A. Okay, true.  
14 Q. And you don't have certification in  
10:47:49 15 allergy?  
16 A. No.  
17 Q. Okay.  
18 A. Although I'm a fellow.  
19 Q. Okay. A fellow of?  
10:47:55 20 A. American College of Allergy, or have been.  
21 THE COURT REPORTER: I'm sorry?  
22 THE WITNESS: A fellow is where you  
23 have a --  
24 MR. SIMON: No, fellow of what? She  
10:48:09 25 couldn't pick up --

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10:48:09 1 MR. FRESHOUR: The organization,  
2 Doctor.  
3 THE WITNESS: American College of  
4 Allergy. They keep changing the name, whatever it is  
10:48:12 5 now.  
6 Q. Immunology, you don't have --  
7 A. Same.  
8 Q. Toxicology?  
9 A. Same.  
10:48:18 10 Q. And genetics?  
11 A. Same.  
12 MR. SIMON: And we're talking about  
13 formal certifications, vis-a-vis training and  
14 experience, correct, Mr. Freshour?  
10:48:30 15 MR. FRESHOUR: Certifications, that's  
16 what I asked, yes, sir.  
17 MR. SIMON: Okay.  
18 Q. In your practice, your current practice at  
19 the clinic, Doctor -- I guess, why don't we do it  
10:48:48 20 this way: In your clinic, how many days a week are  
21 you there yourself, Doctor?  
22 A. At least five.  
23 Q. Okay. How many patients do you see a day,  
24 a week, a month, yourself, personally?  
10:49:03 25 A. I personally probably see 10 to 15 patients

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10:49:08 1 a day.  
2 Q. 10 to 15 a day?  
3 A. Yes.  
4 Q. Okay. Now, at the clinic, you're not the  
10:49:14 5 only physician; is that correct?  
6 A. That is correct.  
7 Q. Generally describe how, how the clinic is  
8 structured. And what I mean by that is, how many  
9 doctors do you have? If you have any -- what I'm  
10:49:27 10 going to call mid-level caregivers, such as PAs,  
11 ANPs, nurses. Can you just generally describe that.  
12 A. Yes. I'll say this, we've shrunk since the  
13 economic depression has gone down, as everybody has.  
14 But we have about four physicians that are not all  
10:49:53 15 full time.  
16 Q. They're not all full time?  
17 A. That's right.  
18 Q. Okay.  
19 A. And then we have our medical assistants who  
10:50:02 20 are unlicensed physicians who are waiting to either  
21 take their examinations or have decided not to. And  
22 I have some of those in charge, like, of my antigens  
23 and different areas of practice. So that makes for a  
24 very high caliber type of employee. And most of them  
10:50:26 25 have been with me for several years.

11 (Pages 38 to 41)

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10:50:28 1 Then I have some part-time, like  
2 massage therapists or -- of different categories,  
3 there. And, then we have, I guess they call them  
4 medical assistants. These are people who had two to  
10:50:49 5 three years of college that assist us with getting  
6 the patients in, weighing them, things like that.  
7 And then we have some testers for the antigens, and  
8 one physician and several technicians. And then we  
9 have several business people, I guess, front desk  
10:51:16 10 people who greet the patients and get their red tape  
11 going for their insurance or whatever, get them  
12 scheduled or that. And then I have a secretary  
13 and -- that's about it.  
14 Q. And you said you saw about 15 patients a  
10:51:38 15 day, you work about five days a week. Do you work a  
16 full eight-hour day, Doctor?  
17 A. A lot worse.  
18 Q. Generally, Doctor, generally how --  
19 A. Eight to ten hours, sometimes twelve.  
10:51:51 20 Q. Okay. And so you more or less have, say,  
21 50 to 75 patients a week you see; is that fair,  
22 Doctor?  
23 A. Yeah, that's fair.  
24 Q. So besides you, you've got some other  
10:52:04 25 physicians, maybe not full time. About how many

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10:52:06 1 patients, do you know, do they see on average as an  
2 aggregate? Do you know?  
3 A. I can't give you a number, but I'm sure  
4 it's not as many as I do.  
10:52:15 5 Q. And in that structure of your -- and I'm  
6 going to call it your organization, your clinic.  
7 A. Okay.  
8 Q. In the structure of your organization, do  
9 you monitor or double-check the work of the other  
10:52:27 10 physicians that are present or have any kind of  
11 oversight on them, formal or very informal?  
12 A. Informal, of course, because, you know,  
13 sometimes they trade patients. Sometimes I never see  
14 their practice patients, you know.  
10:52:43 15 Q. Okay. Now --  
16 A. We get a lot of second opinions.  
17 Q. Okay. You give a lot -- you get a lot or  
18 you give a lot?  
19 A. Well, both.  
10:52:52 20 Q. Okay.  
21 A. But I mean between them, between our  
22 physicians, we get second opinions.  
23 Q. So you confer with each other about  
24 patients?  
10:53:01 25 A. Yeah, that's correct.

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10:53:02 1 Q. Okay.  
2 A. That's a good way to put it, confer.  
3 Q. And what I'm trying to get at is there's an  
4 informal second kind of opinion in consulting amongst  
10:53:10 5 you as physicians at the clinic, correct?  
6 A. That's correct, yes.  
7 Q. But you also do formal consultations for  
8 second opinions for physicians that are outside of  
9 the clinic?  
10:53:20 10 A. Oh, yeah, sure.  
11 Q. Okay. So that's what you were trying to  
12 distinguish?  
13 A. That's correct.  
14 Q. Okay. When you were describing your -- the  
10:53:35 15 structure of the clinic, you said something about you  
16 have some front desk people kind of on the business  
17 side of it. Do you accept insurance, or is the  
18 clinic all kind of a cash business? How is that  
19 structured?  
10:53:46 20 A. It's cash, usually, the majority.  
21 Q. You don't take any Medicare, Medicaid,  
22 anything like that?  
23 A. No. But we treat Medicare patients, but we  
24 don't take it.  
10:53:55 25 Q. So how does that work for your clinic,

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10:53:58 1 Doctor?  
2 A. Very complicated. But my business people  
3 take care of it, but I think we have to file -- the  
4 law says we have to file on certain things, and we do  
10:54:10 5 that.  
6 Q. Okay.  
7 A. That's all -- but we don't accept payment  
8 or anything.  
9 Q. What percentage would you say, Doctor, of  
10:54:18 10 your medical practice there at the clinic is cash  
11 only, non-Medicaid -- Medicare, Medicaid patients?  
12 A. Oh, I'd say 95 percent.  
13 Q. And is there any kind of -- in all your  
14 years of doing this, is there any particular  
10:54:47 15 demographic population that seems to predominate your  
16 patient population?  
17 A. Well, it's very, very -- for example, we  
18 have Gulf War veterans, we have the people who got --  
19 survived the airplane crash in New York City. We  
10:55:06 20 have people who work in factories, who have gotten  
21 damaged from the fumes coming from the factories.  
22 We've had pesticide sprayers, we've had housewives,  
23 almost any profession, really.  
24 Q. Okay. And I guess that was a poorly asked  
10:55:32 25 question. Demographically, do you have -- or

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10:55:35 1 gender-wise, do you have a predominant population  
2 that is more female versus male or any kind of  
3 breakdown you can give me on that?  
4 A. Oh, I think there are few more female than  
10:55:47 5 male.  
6 Q. Okay. Now --  
7 A. We have a lot of professional people.  
8 Q. On the patients you see, just generically,  
9 and I don't want to talk about the specific patients  
10:56:04 10 in the case. We're going to get to those a little  
11 bit later today.  
12 A. Okay.  
13 Q. Generally when a patient comes to see you,  
14 do you have any kind of a set fee? Do you have an  
10:56:12 15 hourly rate? How do you price your services for a  
16 patient, say, on an initial visit?  
17 A. I'm embarrassed to tell you, I don't recall  
18 anymore, but I think it's \$150 for consultation to  
19 see them primarily.  
10:56:31 20 Q. And then that consultation, Doctor, is that  
21 for a set period of time? Or what is an initial  
22 consultation for that \$150? What is that?  
23 A. That's history and physical exam.  
24 Q. And that's you doing it yourself, eyeball  
10:56:45 25 to eyeball with the patient?

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10:57:54 1 diagnostic testing. Those are all charged  
2 separately, as well?  
3 A. Yes.  
4 Q. Okay. And do you know how -- what's  
10:58:02 5 charged, or is that all on the business end?  
6 A. It's all on the business end.  
7 Q. So you really don't know -- without putting  
8 words in your mouth, Doctor, is it fair to say you  
9 don't really know what your patients are charged,  
10:58:13 10 other than for your services?  
11 MR. SIMON: I direct him not to  
12 answer. I need a break.  
13 MR. FRESHOUR: On what basis are you  
14 instructing him?  
10:58:19 15 MR. SIMON: This is not subject of the  
16 complaint here. Looks to me like you're conducting a  
17 separate investigation from what the complaint is.  
18 And you know the procedure for separate  
19 investigation, and we've got to follow that.  
10:58:30 20 The complaint does not take aim at his  
21 general practice. It takes aim at particularly five  
22 patients. If you want to conduct a separate  
23 investigation, you've got to give me notice, you've  
24 got to tell me what the issues are and you've got to  
10:58:43 25 give me an opportunity to go through the informal

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10:56:47 1 A. That's right, exactly.  
2 Q. And they've come in and they carry in the  
3 paper and say, you know, one of your techs perhaps  
4 weighed them, measured them, did a BP --  
10:56:56 5 A. That's correct. And they usually come in  
6 with a stack of medical records, about this high  
7 (indicating).  
8 MR. SIMON: Mr. Freshour, when it's a  
9 logical point for you to break, I'd like a moment off  
10:57:05 10 the record.  
11 MR. FRESHOUR: Okay.  
12 MR. SIMON: Let me know.  
13 Q. Then we were talking about your initial  
14 consultation. The -- so you charge, say, 150 for  
10:57:31 15 your initial consultation.  
16 A. Well --  
17 Q. I'm sorry, go ahead.  
18 A. I mean, as I said, I really didn't  
19 remember, because I know there are some people that  
10:57:39 20 want just one thing and we may charge a lot less for  
21 that.  
22 Q. Okay. But they see you. And then if  
23 there's anything further that needs to be done, they  
24 need to see other individuals in your facility?  
10:57:51 25 Perhaps you subject them to some testing or

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10:58:48 1 settlement conference. Other than that, what are we  
2 doing here?  
3 MR. FRESHOUR: Are you instructing him  
4 not to answer?  
10:58:54 5 MR. SIMON: Right now, based on that,  
6 yeah. And I would like to talk to you about that,  
7 because this is a separate procedure than what it is  
8 that's before us all right now.  
9 MR. FRESHOUR: Certify that question,  
10:59:02 10 if you would, please, Court Reporter.  
11 For the purpose of the record, no,  
12 it's not, I'm just trying to get a feel for his  
13 general operation of his medical --  
14 MR. SIMON: Today? Today?  
10:59:14 15 MR. FRESHOUR: Give me a chance,  
16 Mr. Simon.  
17 MR. SIMON: Yes, sir.  
18 MR. FRESHOUR: I am trying to get a  
19 feel for how his medical practice is operated. It is  
10:59:22 20 clearly relevant to the complaint because we're  
21 talking about his medical practice with these five  
22 patients. That's the scope of this inquiry.  
23 Now, I've got your objection, you've  
24 instructed him not to answer. Certify it. I'm not  
10:59:36 25 yet at a break point, but as soon as we get there,

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10:59:38 1 I'll be glad to talk with you.  
 2 MR. SIMON: Of course.  
 3 MR. FRESHOUR: Or if you need to talk  
 4 to your client.  
 10:59:45 5 Q. When it comes to billing patients  
 6 generally, Doctor -- and we've just gone through, you  
 7 know more or less what you charge, you're not sure of  
 8 the rest of the business end -- do you know how the  
 9 billing is handled for patients? Generally do they  
 10 pay up front when they're there, or do you send them  
 11 a bill? How is that done?  
 12 THE WITNESS: Am I allowed to answer  
 13 that or not?  
 14 Q. Unless he tells you not to, you are.  
 11:00:09 15 A. Okay.  
 16 MR. SIMON: If you know what the  
 17 procedure is.  
 18 A. I know what the procedure is. They do give  
 19 them the bill after they've been seen.  
 11:00:15 20 Q. Okay. And then they either pay there or  
 21 you work out a payment plan? Do you know how that  
 22 works, Doctor?  
 23 A. I can't really tell you, no.  
 24 Q. Okay. Now, in some of the patients -- in  
 11:00:27 25 some of the patients that we're going to talk about

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11:00:30 1 in specific today, they get what is termed -- and  
 2 we'll get into this in a lot more detail, but I'm  
 3 looking just more or less at how you operate. They  
 4 get what's called immunotherapy. Do you recall that?  
 11:00:40 5 A. Yes.  
 6 Q. And they are billed or pay for these  
 7 immunotherapies that they're provided, correct?  
 8 A. That's correct.  
 9 Q. Okay. Now, I've seen some of those are  
 11:00:52 10 mailed to the individuals, is that correct? Some of  
 11 the immunotherapies can be sent to them?  
 12 A. Yes.  
 13 Q. And when they're billed for that, do you  
 14 know, do they pay beforehand, after they receive  
 11:01:03 15 them? Do you know how that is handled?  
 16 A. No, I don't.  
 17 Q. Do you know who in your clinic determines  
 18 the pricing or the charges to be made for  
 19 immunotherapies?  
 11:01:18 20 A. Well, I mean, we all usually do, we sit  
 21 down and we have an overhead that we have to make.  
 22 And so we go from that angle. But I don't recall all  
 23 the details of it. Because there's always --  
 24 Q. I'm not asking you for the formulation --  
 11:01:33 25 A. Yeah.

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11:01:33 1 Q. -- out, just wondering how the charges for  
 2 an immunotherapy are determined.  
 3 A. Well, my costs and then with a modest  
 4 profit in there.  
 11:01:45 5 Q. And that, and that cost, you can determine  
 6 because, if I -- and correct me if I'm wrong, the --  
 7 a large number, if not all the immunotherapies, are  
 8 being prepared in your own laboratory; is that  
 9 correct?  
 11:02:00 10 A. Yes, that is correct.  
 11 Q. Okay.  
 12 MR. FRESHOUR: I think this would be a  
 13 good breaking point. We're about two or three  
 14 minutes from the end of the first tape anyway. So  
 11:02:08 15 we're good.  
 16 THE VIDEOGRAPHER: The time is 11:02  
 17 a.m. This is the end of tape number one. We are  
 18 going off the record.  
 19 (Recess from 11:02 to 11:10)  
 11:10:41 20 THE VIDEOGRAPHER: The time is 11:10  
 21 a.m. We are on the record. This is the start of  
 22 tape number two.  
 23 Q. All right, Dr. Rea, just before we went on  
 24 break, we've been talking a little bit about costs  
 11:10:55 25 for antigens. You indicated that most, if not all of

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11:11:00 1 them were prepared in your own laboratory; is that  
 2 correct?  
 3 A. Yes.  
 4 Q. Let me ask it this way: Are there any  
 11:11:10 5 antigens that you use routinely that are not prepared  
 6 in your own laboratory, that you --  
 7 A. Well, you mean sources?  
 8 Q. Let me ask it this way, Doctor: The -- in  
 9 your laboratory at the clinic, you prepare a majority  
 11:11:34 10 of the antigens you use for your patients, including  
 11 the five that we've got in this complaint, correct?  
 12 A. Yes.  
 13 Q. Okay. Now, do you -- there's commercially  
 14 prepared antigens by all kinds of companies, correct?  
 11:11:47 15 A. Yes.  
 16 Q. So I don't want to talk about the antigens  
 17 that you prepare yourself, because I would assume you  
 18 have to have source materials to prepare those,  
 19 correct?  
 11:11:57 20 A. Yes.  
 21 Q. And you may get those at some kind of an  
 22 outside source?  
 23 A. Yes.  
 24 Q. You don't have those available in your  
 11:12:04 25 laboratory, necessarily, yourself?

14 (Pages 50 to 53)

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11:12:06 1 A. That's correct.  
 2 Q. Okay. I want to talk about a commercially  
 3 prepared antigen. You can probably think of a good  
 4 example for me, probably --  
 11:12:16 5 A. Pollens.  
 6 Q. Pollens or cedar?  
 7 A. Molds, yes.  
 8 Q. Do you use -- the majority of stuff that  
 9 you use for antigens, the majority of antigens you  
 11:12:28 10 prepare yourself in your laboratory, correct?  
 11 A. Yes, that's correct.  
 12 Q. Now, do you have any particular commercial  
 13 prepared antigens that you use for your patients  
 14 generally?  
 11:12:36 15 A. Yes.  
 16 Q. Okay. What are those generally, Doctor?  
 17 A. Well, those could be pollen, dust, mold,  
 18 and...  
 19 Q. And is there a particular -- and I really  
 11:12:52 20 don't know. Is there a particular company or source  
 21 you use for those, Dr. Rea?  
 22 A. It used to be called Antigen Laboratory,  
 23 but I don't know -- I think they sold out and  
 24 changed.  
 11:13:07 25 Q. Antigen -- and it may be changed. Are they

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11:13:10 1 located in Dallas, or do you know where they're  
 2 located, sir?  
 3 A. I think Kansas City.  
 4 Q. Kansas City -- Kansas City, Kansas or  
 11:13:19 5 Kansas City, Missouri?  
 6 A. I don't have any idea.  
 7 Q. Okay, I'll -- that's fine.  
 8 The Metamatrix Laboratory that we  
 9 talked about a little bit earlier, what services do  
 11:13:47 10 you generally use from them or ask them -- what  
 11 services do they provide to your clinic, Doctor?  
 12 A. Well, the chemical solvent profiles and the  
 13 pesticides and the nutritional amino acids, fatty  
 14 acids.  
 11:14:08 15 Q. Now -- and this kind of goes back to some  
 16 of, some of your, your training and education,  
 17 Doctor. Is there something in particular that  
 18 sparked your interest in environmental medicine  
 19 besides just seeing some -- I think you described  
 11:14:24 20 earlier this morning, you know, seeing some fungal  
 21 infections and I think asbestosis. Was there  
 22 something else in particular that triggered it?  
 23 A. Yes.  
 24 Q. And what was that, sir?  
 11:14:34 25 A. I had a son who almost died from asthma and

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11:14:38 1 they couldn't help him, and I had to go find  
 2 treatment for him.  
 3 Q. Now, are you aware that I have deposed  
 4 Dr. Meggs in this particular case?  
 11:15:02 5 A. No.  
 6 Q. Okay. Are you aware that I have deposed a  
 7 Dr. Gerald Ross in this case?  
 8 A. Yes.  
 9 Q. Okay. Dr. Ross, I think did an internship  
 11:15:16 10 with your clinic some years back, didn't he?  
 11 A. Yes. The --  
 12 MR. SIMON: Either yes or no.  
 13 A. Yes. It wasn't an internship, though.  
 14 That's what I was going to say.  
 11:15:27 15 Q. What capacity was he --  
 16 A. It was a fellowship --  
 17 Q. Generally describe, you know, who funded  
 18 it, that kind of thing.  
 19 A. The Province of Nova Scotia.  
 11:15:45 20 Q. And he had told me in there -- and I'm not  
 21 going to ask you for any specific details. He was a  
 22 patient of yours prior to that, wasn't he, before he  
 23 came to the internship?  
 24 A. Yes, he was. He was.  
 11:15:54 25 Q. Okay. And so you're not aware that Dr. --

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11:15:59 1 I think it's William Meggs from East Carolina State  
 2 is an expert for you in this case? Were you aware of  
 3 that?  
 4 A. Yes.  
 11:16:06 5 Q. Okay.  
 6 A. I just wasn't aware you had the deposition.  
 7 Q. Okay.  
 8 MR. SIMON: You asked him if he knew  
 9 you deposed him.  
 11:16:11 10 MR. FRESHOUR: Okay.  
 11 Q. Well, I'm going to indicate to you I did  
 12 depose him, all right?  
 13 A. Okay, fine.  
 14 Q. And he stated that you had been a victim of  
 11:16:20 15 multiple chemical sensitivity. Is that true?  
 16 MR. SIMON: Object. Direct him not to  
 17 answer, because his health is not at issue here.  
 18 MR. FRESHOUR: Certify the question.  
 19 MR. SIMON: And it is privileged.  
 11:16:32 20 MR. FRESHOUR: Certify the question,  
 21 please.  
 22 Q. Well, Doctor, you told me that you work  
 23 five days a week, a lot of hours, anywhere from eight  
 24 to twelve a day. Do you have any kind of, any kind  
 11:17:11 25 of physical impairment that limits your ability to

15 (Pages 54 to 57)

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11:17:14 1 practice as a physician, currently?  
 2 A. No.  
 3 MR. SIMON: Object --  
 4 THE WITNESS: Sorry.  
 11:17:19 5 MR. SIMON: All right. It's on the  
 6 record.  
 7 Give me some time to talk.  
 8 THE WITNESS: All right.  
 9 Q. We talked a little bit about your  
 11:17:44 10 foundation, Doctor, do you recall that, earlier  
 11 today?  
 12 A. Yes.  
 13 Q. What exactly -- well, first let me ask you  
 14 this: When did you form or did the foundation come  
 11:17:57 15 into being, approximately, do you recall?  
 16 A. I think -- I can't tell you the exact date.  
 17 I think in the late '70s.  
 18 Q. Okay. And what was the, the purpose for  
 19 you to begin this foundation, generally, Doctor?  
 11:18:11 20 A. Well, this is a c.1503 nonprofit foundation  
 21 designated for three main purposes. One is to  
 22 educate physicians and the public about the  
 23 environmental aspects of health and disease. Two is  
 24 to do research whenever possible and raise funds for,  
 11:18:36 25 for doing research. And three is to supply some

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11:18:41 1 products that patients may have difficulty finding to  
 2 change their homes or change their lifestyle.  
 3 Q. All right. Now, you said it's set up as a  
 4 nonprofit corporation, correct -- or nonprofit  
 11:19:12 5 foundation, I should say.  
 6 A. Foundation.  
 7 Q. Foundation, yes, sir.  
 8 And does the foundation have any, any  
 9 officers, board of directors, that type of thing?  
 11:19:21 10 A. Yes.  
 11 Q. And exactly -- that was a wide open  
 12 question. Does it have a board of directors, sir?  
 13 A. Yes.  
 14 Q. Okay. And who is on that board of  
 11:19:33 15 directors?  
 16 A. Unfortunately, we just lost a couple of  
 17 them due to deaths, Louise Henderson and Professor  
 18 Joel Butler. And I think Louise's husband was on  
 19 there for a while.  
 11:19:50 20 Q. And are you --  
 21 A. Yes, I'm on there also. Of course.  
 22 Q. All right. That's the board of directors.  
 23 Does it have any -- besides the board,  
 24 does it have any kind of officers, secretaries,  
 11:20:09 25 vice-presidents, executive officers, anything like

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11:20:11 1 that?  
 2 A. Well, yes, I guess it does.  
 3 Q. Okay. And who are those individuals,  
 4 including yourself, Doctor?  
 11:20:19 5 MR. SIMON: If you know.  
 6 A. Yeah, I'm the president.  
 7 Q. You're the president? Okay.  
 8 A. Yeah. And...  
 9 Q. And are you paid or compensated in any  
 11:20:38 10 manner by the foundation, Doctor?  
 11 A. No.  
 12 Q. Are any of the board of directors?  
 13 A. No.  
 14 Q. And I take it, obviously, as a foundation,  
 11:21:03 15 it would be -- the foundation is required to file tax  
 16 returns, correct?  
 17 A. Absolutely.  
 18 Q. All right. And you said one of the  
 19 purposes was to do research and raise funds for that  
 11:21:27 20 research. Is there any particular fundraising source  
 21 you use for the research as it relates to  
 22 environmental medicine?  
 23 A. No. We rely on donors.  
 24 Q. And those donors can be across the  
 11:21:40 25 spectrum, I take it. Could be yourself personally

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11:21:43 1 contributing or any patients or just people in  
 2 general?  
 3 A. That's right. That's correct.  
 4 Q. And the foundation is -- also sponsors the  
 11:21:56 5 symposium, correct?  
 6 A. 28 world conferences now.  
 7 Q. Now, I'm going to indicate to you that --  
 8 and I know you haven't read this. But Dr. Meggs and  
 9 I think Dr. Ross both talked about an article on  
 11:22:17 10 pupilligraphy written by Dr. Ishikawa. Do you  
 11 recall -- are you familiar with that article?  
 12 A. Yes.  
 13 Q. And you were part of the contributors to  
 14 that article, correct?  
 11:22:29 15 A. That's correct, yes.  
 16 Q. And part of the research for the  
 17 pupilligraphy article by Ishikawa that you also  
 18 participated in was the foundation, correct?  
 19 A. Part of it. The other part was the  
 11:22:42 20 Kitasato University and Medical School in Japan,  
 21 Tokyo.  
 22 THE COURT REPORTER: I'm sorry, what  
 23 university?  
 24 THE WITNESS: Kitasato, just like it  
 11:22:52 25 sounds. Everything is phonetic in Japanese.

16 (Pages 58 to 61)

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11:22:58 1 Q. The -- you've written a number of books on  
2 chemical sensitivity, correct? Four or five volumes?  
3 A. Yes, that's right.  
4 Q. That was underwritten or funded by the  
11:23:09 5 foundation, as well, was it not?  
6 A. Yes, it was.  
7 Q. In total?  
8 A. Well, I don't know whether it was in total.  
9 Q. And it -- did that funding include any  
11:23:21 10 compensation to you for being the author?  
11 A. No.  
12 Q. Now, the other thing you talked about with  
13 the foundation is, it supplies products to change  
14 homes and lifestyles. What did you mean by that,  
11:23:36 15 Doctor?  
16 A. Well, for example, a long time ago it was  
17 very difficult to get silk, like silk underwear, silk  
18 shirts, stuff like that. So they would acquire that.  
19 Sometimes there are certain bedding that's nontoxic  
11:23:54 20 that they acquire, paint, nontoxic paint, things like  
21 that.  
22 Q. Now, the foundation acquires that, and I  
23 assume -- well, tell me, are the products of the  
24 foundation available to the public at large or only  
11:24:13 25 to your patient population if they want to use them?

11:24:17 1 A. The public at large. Anybody can stop in  
2 and buy whatever they want, yes.  
3 Q. And now, I would assume, and perhaps even  
4 with the five patients that we're going to be looking  
11:24:29 5 at later today, they have, they have been given  
6 recommendations to live a less toxic lifestyle,  
7 correct, generally?  
8 A. Yes. That's part of the avoidance.  
9 Q. And when they -- and if they want to buy or  
11:24:46 10 are directed to buy certain products carried by the  
11 foundation, does that happen?  
12 A. Not necessarily. I mean, we give them  
13 generic what they might, might be able to use. They  
14 can get it anywhere they want.  
11:25:02 15 Q. And do you tell them that if they decide to  
16 get a product from the foundation, do you disclose  
17 that there is -- at least you have some involvement  
18 in that?  
19 A. Well, they know that. Everybody knows  
11:25:20 20 that. We set it up to help people, so I guess, yeah.  
21 Q. But my question is really specific --  
22 A. It's not a self-dealing thing, if that's  
23 what you're asking.  
24 Q. I'm just asking you if --  
11:25:30 25 MR. SIMON: That's what he's asking.

11:25:32 1 THE WITNESS: I know.  
2 Q. What I'm asking you, Doctor, is, do you  
3 tell them, hey, I've got an interest in, or I am part  
4 of the foundation, when they go over there  
11:25:42 5 potentially to get products?  
6 A. No, I don't tell everybody, no. But we do  
7 give them information on the American Environmental  
8 Health Foundation, and they would get it in that.  
9 Q. Now, there's also -- as a part of the  
11:26:17 10 foundation, and you talk about some of the products  
11 now -- changes to the home. What do you mean by  
12 that? What are you talking about when you say  
13 changes to the homes and products to change the  
14 homes?  
11:26:29 15 A. Well, for example, one lady from Brooklyn,  
16 I guess we're going to discuss. They found gas in  
17 her house, gas leaks, and she was made ill by that.  
18 And we recommended that they get it fixed. And that  
19 was -- somebody in Brooklyn did it.  
11:26:49 20 Q. Right. And I guess so my question is,  
21 something like that is not necessarily -- you're not  
22 selling them the gas pipeline to stop the leak, are  
23 you?  
24 A. No, I sure am not.  
11:27:01 25 Q. Okay.

11:27:02 1 A. And particularly in Brooklyn.  
2 Q. We're not going to touch that.  
3 I'm just trying to understand, because  
4 the products, you described. But then you said  
11:27:13 5 changes to the home, so I'm trying --  
6 A. Well, yeah, you asked that. That's of  
7 course one of our big ones, gas leaks in the home.  
8 Q. Okay. But you supply products that they  
9 can't get otherwise to help change the home. What  
11:27:25 10 kind of product is my question, Doctor?  
11 MR. SIMON: When you say "you," you  
12 mean the foundation, correct?  
13 MR. FRESHOUR: Right, the foundation.  
14 MR. SIMON: Because otherwise I object  
11:27:34 15 to the form.  
16 A. I want to qualify that, because some of  
17 society has caught up with us now. And our  
18 getting -- many stores are getting these things in  
19 there. So it's more of a convenience now for  
11:27:50 20 patients. Whereas, before, it was a necessity, you  
21 see. Although we keep trying to stay on the cutting  
22 edge of what's new and innovative and get them there  
23 first so people can -- hopefully society will --  
24 MR. SIMON: So he's asking you what  
11:28:04 25 type of products.

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11:28:05 1 THE WITNESS: And that's what I'm  
2 saying.  
3 A. We have nontoxic paints, we have nontoxic  
4 pillows, we have nontoxic blankets.  
11:28:12 5 MR. SIMON: Now you have them all  
6 over.  
7 THE WITNESS: Yeah.  
8 Q. Now, what is the William J. Rea defense  
9 fund?  
11:28:38 10 A. Oh, that's a fund set up to help fight you  
11 guys.  
12 Q. Okay. And that's paying for your experts,  
13 is that correct, do you know?  
14 A. No, it's not.  
11:28:50 15 Q. Okay. The foundation is paying some of  
16 your costs, though, for the defense in this lawsuit,  
17 is that correct, or this contested case proceeding?  
18 A. No, that's incorrect.  
19 Q. Okay. And so if it's not being used to  
11:29:20 20 defer or defray some of the costs of this, this  
21 action between the medical board and yourself, what  
22 was it started for, Doctor?  
23 A. Well, you said -- as I understood your  
24 question was that the foundation was paying, it was  
11:29:38 25 part of the foundation. It's not part of the

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11:29:40 1 foundation.  
2 Q. Okay.  
3 MR. SIMON: The defense fund has  
4 nothing to do with the foundation. that's what he's  
11:29:45 5 trying to explain.  
6 A. That's what I'm trying to say.  
7 Q. Okay. The defense fund has nothing to do  
8 with the foundation?  
9 A. That's right.  
11:29:52 10 Q. But there is a William J. Rea defense fund,  
11 correct?  
12 A. Yes.  
13 Q. And the William J. Rea defense fund -- and  
14 we'll call it "the defense fund," if we can agree.  
11:30:00 15 How is that?  
16 A. That would be fine.  
17 Q. So the defense fund was set up to help  
18 defray the costs in this action, correct?  
19 A. That's correct, yes.  
11:30:09 20 Q. And the defense fund is paying for the cost  
21 of the experts that you're using in this case; is  
22 that true?  
23 A. I don't recall. I think I paid out of my  
24 own pocket.  
11:30:25 25 Q. Is the defense fund, is the -- are you

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11:30:34 1 getting any kind of compensation or payment for being  
2 here today from the defense fund?  
3 A. No, I'm sure not.  
4 Q. So -- and is, is it true that at least some  
11:30:47 5 of the contributions are coming from your patients  
6 into the defense fund?  
7 A. Yes. We have a lot of grateful patients.  
8 Q. And are you in -- have any position in the  
9 defense fund? And what I mean by that, are you the  
11:31:12 10 administrator? Do you oversee the contributions, the  
11 expenditures?  
12 A. No.  
13 Q. Is anyone associated with the clinic in  
14 charge of that?  
11:31:23 15 A. Yes.  
16 Q. Is anyone associated with the foundation --  
17 A. No.  
18 Q. -- involved?  
19 THE WITNESS: Chris.  
11:31:43 20 Q. And the individual involved with the  
21 defense fund at your clinic, it is not you; is that  
22 correct?  
23 A. That's what I said.  
24 Q. Okay. So if patients are contributing to  
11:32:09 25 that, is it fair to say that your patients are not

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11:32:12 1 only paying for your medical services, but they're  
2 also paying some of you legal costs?  
3 MR. SIMON: Object to all of this.  
4 I'm going to direct you to stop  
11:32:18 5 answering this because that's, again, on the grounds  
6 that I am protecting your due process rights to a  
7 procedural investigation by the board into anything  
8 else.  
9 MR. FRESHOUR: Certify that question.  
11:33:10 10 Q. Doctor, I want to ask you some general  
11 questions. You would agree that by issuance of a  
12 medical license, to you or any other physician in the  
13 state of Texas, that that's, that's a privilege  
14 granted by the state, correct?  
11:33:29 15 MR. SIMON: Object to the form. Calls  
16 for a legal conclusion.  
17 Q. You can answer, Doctor.  
18 A. Well, it's -- yes, okay, I would say it  
19 was, probably.  
11:33:39 20 Q. And would you also generally agree that by  
21 accepting or being issued a license, there's an  
22 agreement that you're going to comply with the rules  
23 and statutes regulating the practice of medicine in  
24 the state of Texas?  
11:33:53 25 MR. SIMON: Object to the form. It

18 (Pages 66 to 69)

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11:33:54 1 calls for a legal conclusion.  
 2 Q. You can answer, Doctor.  
 3 A. Yes.  
 4 Q. And as a general proposition, Doctor, would  
 11:34:14 5 you agree that if there are a number of different  
 6 causes that have been identified that are known to  
 7 cause a disease, that would be considered multiple  
 8 causal agents versus a single causal agent, correct?  
 9 MR. SIMON: Object to the form.  
 11:34:36 10 You can answer if you understand.  
 11 A. Yes.  
 12 MR. FRESHOUR: Mr. Simon, on what  
 13 basis do you object to the form of the question?  
 14 MR. SIMON: I just didn't understand  
 11:34:44 15 what it is that you're asking. It's a compound  
 16 question.  
 17 Q. You understood it, didn't you, Doctor?  
 18 A. I thought I did.  
 19 Q. Okay.  
 11:34:54 20 MR. SIMON: If he understood it, of  
 21 course.  
 22 Q. And there's clearly a difference between  
 23 having a singular causal agent and multiple agents,  
 24 correct?  
 11:35:09 25 A. Yes.

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11:35:09 1 Q. Okay. And "multiple" means more than one,  
 2 correct?  
 3 A. Yes, it does.  
 4 Q. Okay. How do you define "chemical  
 11:35:20 5 sensitivity," Doctor?  
 6 A. The adverse reaction to the ambient dose  
 7 of -- or toxic dose of ambient chemicals, in air,  
 8 food and water.  
 9 Q. So it can be either the ambient dose or a  
 11:35:43 10 toxic dose of whatever the chemical agent is?  
 11 A. Agent or agents.  
 12 Q. Right. And, Doctor, I'm not going to play  
 13 semantics with you, but isn't it fair to say that in  
 14 most of your patients in general and in these five  
 11:36:08 15 fairly particularly, that we haven't discussed with  
 16 any detail yet, is that they were sensitive to  
 17 multiple chemicals as far as your opinion?  
 18 A. Yes, that is correct. That's why they came  
 19 here.  
 11:36:20 20 Q. Right. Now, it is accurate, then, to say  
 21 that they have sensitivity to multiple chemicals,  
 22 correct?  
 23 A. Yes.  
 24 MR. SIMON: Objection, form.  
 11:36:33 25 A. But I would have to go through each

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11:36:35 1 chart to --  
 2 MR. SIMON: Semantics.  
 3 A. Semantics, yeah.  
 4 Q. Well, how do you define "multiple chemical  
 11:36:43 5 sensitivity," Doctor?  
 6 A. I don't.  
 7 Q. Why not?  
 8 A. Because it was an erroneous definition by  
 9 the guy from Yale in which he said there were no  
 11:36:54 10 physical signs and no laboratory. Totally wrong. So  
 11 I never use the term, if I can help it, of multiple  
 12 chemical sensitivity.  
 13 Q. And the guy at Yale, that was Cullen,  
 14 wasn't it?  
 11:37:06 15 A. Cullen, yeah.  
 16 MR. SIMON: Cullen.  
 17 Q. So you don't agree with the term "multiple  
 18 chemical sensitivity"?  
 19 A. I do not.  
 11:37:14 20 Q. But your patients suffer from chemical  
 21 sensitivity from multiple chemicals; is that fair?  
 22 A. Well, generally. I mean, there are some  
 23 that's just one. But generally that's true. That is  
 24 a difference.  
 11:37:26 25 Q. Okay. What are the symptoms of -- well,

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11:37:32 1 withdraw that question.  
 2 Doctor, are you aware that the AA --  
 3 the American Academy of Environmental Medicine  
 4 website uses the term "multiple chemical  
 11:37:55 5 sensitivity"?  
 6 A. Was not aware of it.  
 7 Q. What is clinical ecology? Define that for  
 8 me generally in your own words, Doctor.  
 9 A. I can't, because it doesn't exist anymore.  
 11:38:16 10 Q. I'm sorry?  
 11 A. I said I can't. It doesn't exist anymore.  
 12 Q. Anymore?  
 13 A. Yeah.  
 14 Q. It did exist at one time, did it not?  
 11:38:22 15 A. Yes, it did. I've never used the term, so  
 16 I...  
 17 Q. You never used the term?  
 18 A. No.  
 19 Q. What did you understand it to mean?  
 11:38:33 20 A. Study of the effects of the environment  
 21 upon the individual.  
 22 Q. Why didn't you use the term, Doctor?  
 23 A. Just wasn't any need to.  
 24 Q. Why not?  
 11:38:44 25 A. I don't know.

19 (Pages 70 to 73)

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11:38:53 1 Q. Did you know -- are you familiar with an  
2 individual, I believe it's Theron Randolph?  
3 A. Yes, he's one of my teachers.  
4 Q. Didn't he coin the term "clinical ecology"?  
11:39:02 5 A. Yes, he did.  
6 Q. And before there was -- and in fact, I  
7 think we talked about it earlier, the American  
8 Academy of Environmental Medicine was the Clinical  
9 Ecology Society before it became the AAEM, right?  
11:39:23 10 A. That's correct.  
11 Q. Okay. Were you ever a member of the  
12 Clinical Ecology Society?  
13 A. Well, I think -- if the name changed before  
14 '74, then I -- as I said, I think I joined that  
11:39:35 15 academy in '73, so I don't recall whether it was  
16 called that or not at the time.  
17 Q. Have you ever heard the term "idiopathic  
18 environmental intolerance"?  
19 A. Rarely, yes, I have heard it.  
11:40:06 20 Q. Do you know what that means in your --  
21 A. No, I don't know what it means.  
22 Q. Well, what does "intolerance" generally  
23 mean to you, Doctor, from a medical standpoint?  
24 A. It means you can't tolerate something.  
11:40:39 25 Q. Okay. And isn't it fair to say that your

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11:40:42 1 patients, at least that you've seen, we're going to  
2 talk about in this case, have some problem with  
3 tolerance of chemicals, in your opinion?  
4 A. Yes, not idiopathic.  
11:40:53 5 Q. Okay. Well, what is idiopathic?  
6 A. It means you don't know.  
7 Q. And you know -- so you're saying you don't  
8 use that because you know why they're intolerant?  
9 A. We're dedicated to find out why people  
11:41:06 10 can't tolerate different substances, that's right.  
11 Q. You're dedicated to that?  
12 A. Yes.  
13 Q. And "you" being your clinic?  
14 A. Our clinic --  
11:41:13 15 Q. Your foundation?  
16 A. -- foundation, many other doctors around  
17 the world.  
18 Q. Okay. Do you yet have a specific answer in  
19 your dedicated research to what some of your patients  
11:41:50 20 are intolerant to, Doctor?  
21 A. Yes, we certainly do.  
22 Q. Is that the environment in general, Doctor,  
23 or is there something more specific?  
24 A. Well, I think there's something more  
11:42:03 25 specific.

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11:42:15 1 Q. Anything in particular, as far as  
2 specificity, or is it different for each patient?  
3 A. It's all totally individual, yes.  
4 Q. How do you distinguish chemical sensitivity  
11:42:34 5 from multiple chemical sensitivity?  
6 A. I just said.  
7 Q. Say it again, please, sir. I guess I  
8 missed it.  
9 A. That according to Cullen, multiple chemical  
11:42:43 10 sensitivity has no physical findings and no  
11 laboratory data. Chemical sensitivity has physical  
12 findings and laboratory data.  
13 Q. And so the physical findings you're talking  
14 about, is it fair to say that they can be a wide and  
11:43:06 15 varied and somewhat vague constellation of symptoms  
16 in a lot of the patients?  
17 A. Not vague, no. But sometimes it can be  
18 widespread. But there are symptoms involved usually.  
19 Q. Symptoms, symptoms?  
11:43:21 20 A. Well, I don't -- the symptoms aren't vague.  
21 Q. And when you say "the symptoms aren't  
22 vague," just generally describe, because I'm not a  
23 doctor, what do you mean they're not vague?  
24 MR. SIMON: Is that patient specific?  
11:43:57 25 Object to the form.

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11:43:58 1 A. I was going to say we can take these  
2 patients here.  
3 Q. Well, I'm not asking you about these  
4 patients, though, right now, Doctor. I'm just asking  
11:44:05 5 you generally.  
6 A. Well, if you've got runny eyes, you've got  
7 runny eyes. If you've got heart irregularity, you've  
8 heart irregularities. If you've got bloating, you  
9 can see it. If you've got diarrhea or constipation,  
11:44:22 10 you can see that. If you've got spontaneous bruises  
11 all over you, you can see that.  
12 Q. Okay. So they're not vague because they're  
13 observable or you can see them?  
14 A. That's correct, yes, uh-huh.  
11:44:41 15 Q. Okay. And although you can identify those  
16 symptoms, isn't it also fair to say that the exact  
17 causal agent of those could be varied, as well,  
18 Doctor?  
19 A. Absolutely.  
11:45:18 20 Q. Could you distinguish for me how the  
21 practice of clinical ecology and the underlying  
22 theories -- you're familiar with the underlying  
23 theories of clinical ecology, are you not, Doctor?  
24 A. I don't know what you're referring to.  
11:45:33 25 Q. Are there some theories that underlie the

20 (Pages 74 to 77)

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11:45:36 1 practice of clinical ecology that you're aware of  
2 from Dr. Theron Randolph?  
3 A. Well, I don't do clinical ecology, so I  
4 don't know what theories you're talking about.  
11:45:47 5 Q. Well, although you don't do clinical  
6 ecology, you did, you were a student of Dr. Theron  
7 Randolph, correct?  
8 A. Yes, that's correct.  
9 Q. And he coined the term "clinical ecology,"  
11:46:03 10 correct?  
11 A. Yes, I think he did.  
12 Q. And there were some theories or -- there  
13 were some theories or underlying medical beliefs that  
14 he held about what caused these symptoms that were  
11:46:25 15 known as clinical ecology, correct?  
16 (Mr. Cook enters the room)  
17 A. So you're asking me to tell what  
18 Dr. Randolph's theories were, are you?  
19 Q. I'm saying are you familiar with them?  
11:46:36 20 A. Well, I don't know what you're talking  
21 about. I, I could do it if you could put it in the  
22 form of modern medicine. I'll be glad to do it. But  
23 you're asking me, a man that I studied from at least  
24 40 years ago.  
11:46:50 25 Q. Right.

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11:46:51 1 A. And it's hard to, hard to say what theories  
2 you're talking about.  
3 Q. The theories underlying the terming or the  
4 usage of the term "clinical ecology."  
11:47:02 5 A. Well, I can just say this.  
6 MR. SIMON: That was asked and  
7 answered. He told you he can't answer the question.  
8 THE WITNESS: Do you want me to or  
9 not?  
11:47:12 10 MR. FRESHOUR: Under Texas Rules,  
11 Mr. Simon, objection, form, otherwise it's coaching.  
12 I'd ask you to refrain unless I ask you the basis.  
13 MR. SIMON: Yes, sir. I object to the  
14 form.  
11:47:22 15 Q. So let me ask it this way: You do not know  
16 what the underlying theories of clinical ecology are;  
17 is that correct, Doctor?  
18 A. I don't know what you're talking about.  
19 Q. What, number one is the theories or the  
11:47:33 20 clinical ecology, Doctor?  
21 A. The clinical ecology. I do know this, and  
22 I will say this, that Dr. Randolph felt that there  
23 were many things in the environment that affected the  
24 individual. So it was an environmental problem and  
11:47:47 25 it was an individual problem. Now, what you're

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11:47:49 1 talking about theories and everything, I don't know.  
2 Q. Well, then let me ask you this: You do  
3 have an opinion and you have developed some thoughts  
4 and theories on what causes chemical sensitivity in  
11:48:07 5 your practice, correct?  
6 A. Yes, that's correct.  
7 Q. Okay. And could you distinguish for me how  
8 your theories for chemical sensitivities differ from  
9 that of multiple chemical sensitivity other than in  
11:48:28 10 name itself?  
11 A. I believe I answered that twice now.  
12 MR. SIMON: Answer it again.  
13 A. That people with chemical sensitivity have  
14 objective physical findings and objective laboratory  
11:48:41 15 tests. People with multiple, according to Cullen,  
16 don't have.  
17 Q. I'm not asking according to Cullen. I'm  
18 asking you, as you understand multiple chemical  
19 sensitivity and you've used the term versus your  
11:48:53 20 theories of chemical sensitivity, how they differ  
21 other than in name alone as far as manifestation of  
22 symptoms and causal agents.  
23 MR. SIMON: Objection, form.  
24 A. Well, I believe I just said, physical  
11:49:05 25 findings. You've got a runny nose, according to the

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11:49:09 1 definition of multiple, you don't have a runny nose.  
2 It's all in your head. You've got a heart  
3 irregularity, okay, according to us, you can record  
4 that with a cardiogram. And you can record it on  
11:49:24 5 x-ray sometimes, angiograms. You can record it on  
6 all kind of technology. According to a multiple  
7 definition, you can't find that. There's no  
8 symptoms, no signs. So that -- I still hold to that,  
9 okay? And always have. Otherwise you make it into  
11:49:48 10 the psychiatric realm or some voodoo realm, which I  
11 don't do.  
12 Q. Well, you believe that psychiatry is a bona  
13 fide field and area of practice of medicine, don't  
14 you?  
11:50:03 15 A. Yes, I do.  
16 Q. Have you ever used the term "allergic  
17 depression," Doctor?  
18 A. I don't recall, but we do see patients that  
19 are depressed, put it that way.  
11:50:31 20 Q. In general, when your patients come into  
21 you, Doctor, do you do any kind of psychiatric  
22 testing or screening on your patients generally?  
23 A. Well, we do screening. I don't do  
24 psychiatric testing. I either send them to the  
11:50:48 25 psychiatrist or the psychologist.

21 (Pages 78 to 81)

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11:50:54 1 Q. Do you think if a patient articulates  
2 suicidal ideation, that they require psychiatric  
3 treatment?  
4 A. Well, they require treatment. You know, if  
11:51:07 5 I had a busted neck and was paralyzed down on my --  
6 from my neck down. I might have a suicidal  
7 depression. But I would say you found the cause, and  
8 I don't care what kind of psychiatric care you got,  
9 it wouldn't help you.  
11:51:22 10 Q. Okay.  
11 MR. FRESHOUR: Objection.  
12 nonresponsive.  
13 Q. Let me be sure that I was clear on that  
14 question, Doctor.  
11:51:30 15 A. Okay.  
16 Q. If someone comes into your clinic and  
17 expresses suicidal ideation, do you think they should  
18 be looked at from a psychiatric standpoint?  
19 A. Sometimes, yes. Sometimes, no.  
11:51:46 20 Q. And how do you make that differentiation?  
21 A. Clinical, human.  
22 Q. So you can tell if somebody's suicidal  
23 ideation doesn't require psychiatric treatment by  
24 talking to them?  
11:51:59 25 A. Generally you can, yes.

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11:52:16 1 Q. Have you ever looked at your patient  
2 population just even in an informal capacity and  
3 tried to correlate the frequency or presence of  
4 psychiatric comorbidities on your particular chemical  
11:52:33 5 sensitivity patients?  
6 A. Well, I had Professor Butler at the  
7 University of North Texas who worked with me for 15  
8 years on patients like that, yes. And what we found  
9 was that most of them didn't have psychiatric  
11:52:47 10 problems. Although there was a small group that did.  
11 Q. And I take it that you're also familiar  
12 with the literature that says the opposite by a  
13 Dr. Stottlemeyer, who I believe is a Ph.D. Are you  
14 familiar with that?  
11:53:03 15 A. Yeah, I'm familiar with it.  
16 Q. I take it you don't agree with that, do  
17 you, Doctor?  
18 A. No, I sure don't.  
19 Q. Well, Doctor -- and I don't mean to  
11:53:19 20 characterize or trivialize. But is it fair to say  
21 you don't agree with anybody who doesn't believe that  
22 chemical sensitivity is a disease in the manner and  
23 method that you describe as a practitioner and in  
24 your books?  
11:53:40 25 A. I'm sorry, that's a little too complicated

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11:53:43 1 for me. I wonder if you could rephrase that a little  
2 bit.  
3 Q. I'll just withdraw that question, Doctor.  
4 We'll proceed on.  
11:53:54 5 I want to kind of change gears a  
6 little bit, Doctor. These are more -- this is just  
7 kind of general, going back to some of the medical  
8 practice in general, okay?  
9 A. All right, sure.  
11:54:06 10 Q. You would agree that you or any physician,  
11 regardless of the area of practice, are required to  
12 keep medical records, correct?  
13 A. That what?  
14 Q. Are required to keep medical records?  
11:54:18 15 A. Yes. We keep voluminous ones.  
16 Q. And the records, they need to be true and  
17 accurate, correct?  
18 A. Correct.  
19 Q. And we could also agree that the records  
11:54:31 20 should contain pertinent, relevant or salient  
21 findings that you make as a physician, regarding the  
22 patient, correct?  
23 A. Yes, that's correct.  
24 Q. And we can also agree that the records  
11:54:42 25 themselves cannot be a verbatim of the entire

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11:54:47 1 discussion?  
2 A. That's correct, yes.  
3 Q. Not like they're doing to you and I today,  
4 Doctor, your medical record wouldn't look like that.  
11:54:54 5 A. That's correct.  
6 Q. You know, patient Smith said, good morning.  
7 Dr. Rea said, now it's afternoon.  
8 A. Yeah.  
9 Q. But you put in the salient and the  
11:55:03 10 pertinent facts?  
11 A. We try to, yes.  
12 Q. Okay. And also you would agree that -- and  
13 I think you hit on this earlier -- part of an  
14 adequate medical record includes a history and  
11:55:26 15 physical?  
16 A. Yes.  
17 Q. Particularly upon initial visit and  
18 presentation, correct?  
19 A. Yes, right.  
11:55:34 20 Q. History should include things like prior  
21 surgeries?  
22 A. Correct.  
23 Q. I think you're going to agree with a lot of  
24 this, Doctor, but please say "yes" or "correct" and  
11:55:45 25 don't nod your head.

22 (Pages 82 to 85)

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11:55:46 1 A. I did say "correct."  
2 Q. I know, but I noticed you started to nod  
3 and then said "correct" for the court reporter.  
4 Any description of allergies known to  
11:55:55 5 any kind of medications or medicines?  
6 A. True.  
7 Q. Whether they're a smoker, a drinker?  
8 A. That's correct.  
9 Q. Illicit drug use?  
11:56:05 10 A. (Nods head)  
11 MR. SIMON: Yes?  
12 A. Yes.  
13 Q. Other comorbidities like diabetes, thyroid  
14 disease?  
11:56:14 15 A. Yes.  
16 Q. You would also agree that one of the  
17 purposes of the medical records is to allow for  
18 continuity of care; is that fair, Doctor?  
19 A. Yes.  
11:56:33 20 Q. And what we mean, I think, by that, and  
21 correct me if I'm wrong, that means it would allow a  
22 subsequent health care provider, normally thinking of  
23 another doctor, but even, say, if it was a mid-level,  
24 they could at least pick up the medical record, read  
11:56:50 25 it and have an idea of what had been done to the

11:56:53 1 patient and what the treatment rational was, what  
2 their current perhaps regimen of care and treatment  
3 was, correct?  
4 A. To a point, yes, that's correct.  
11:57:03 5 Q. And, again, they can't necessarily know all  
6 of the discussion, but it should give them a pretty  
7 good idea, correct?  
8 A. Yes, that's correct.  
9 Q. And, again, this is just in general,  
11:57:31 10 particularly I think with your patient population.  
11 Do you believe that it's important to have an  
12 exposure history?  
13 A. Oh, yes, of course.  
14 Q. And in your particular area of practice,  
11:57:49 15 would it be fair to say that if there wasn't an  
16 exposure history, that might be an inadequate record,  
17 given the patient population you're dealing with?  
18 A. That might be true, yeah.  
19 Q. Now, if you take an exposure history  
11:58:06 20 generally, Doctor -- and I assume you take them with  
21 most, if not all your patients, correct?  
22 A. Correct. And we take it daily, because  
23 they recall different things different days.  
24 Q. And is there -- how do you go about  
11:58:24 25 verifying some of the exposures that are claimed, or

11:58:28 1 can you?  
2 A. Well, some of them, you can verify; some of  
3 them, you can't. Sometimes you can -- like, for  
4 example, somebody comes in, they say they've been  
11:58:34 5 exposed to mold, you can sometimes send out mold  
6 plates to their house and see if you can culture the  
7 molds. If they've been in an industrial exposure,  
8 where they work in a job that let's say puts out  
9 paint, that they're painting, constantly painting,  
11:58:54 10 you can usually verify that. Sometimes if they work  
11 at refineries, which a lot of people from Houston do,  
12 you can verify -- like, for example, I've had people  
13 come in that worked in the xylene unit. Well, you  
14 know they got exposed to xylene if they worked on the  
11:59:11 15 xylene unit. And so on down the line, you know.  
16 Q. And let me ask you just with a little bit  
17 of specificity -- I know we talked earlier. Mold  
18 exposure, we're getting exposed right now, aren't we,  
19 Doctor?  
11:59:27 20 A. I don't know, because I haven't measured  
21 this place.  
22 Q. Well, isn't there mold in the ambient air,  
23 Doctor?  
24 A. Yes. But sometimes indoors, there are  
11:59:38 25 areas indoors that there are not.

11:59:40 1 Q. By and large for the most part, isn't it  
2 fair to say that if you go to just about anybody's  
3 home, and absolutely if you walk outside, you're  
4 going to be exposed to mold today, are we not?  
11:59:51 5 A. Is that a two-part question?  
6 Q. Yes, it is.  
7 A. Okay.  
8 Q. At the house --  
9 A. Outside, definitely, because that's the way  
11:59:55 10 nature disintegrates. Inside, not necessarily.  
11 We've measured thousands of houses now, and we have  
12 many that have no molds in them and then we have  
13 others that have high levels of molds in them.  
14 Q. What does it mean -- and you said a little  
12:00:15 15 bit earlier, and I think just for the record, what do  
16 you mean when you say -- you used the term "ambient."  
17 What do you mean when you say -- I think it was in  
18 connection to an ambient level of chemicals.  
19 A. "Ambient" means your surrounding.  
12:00:33 20 Q. Okay. Is ambient the same thing as a  
21 background level, or is that different?  
22 A. No, it's probably a little different. And  
23 the background could be just in that particular area;  
24 whereas, ambient is surrounding you.  
12:01:11 25 Q. Back -- and, again, that was -- just kind

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12:01:13 1 of veered off there on the molds for a minute. I  
2 just wanted to verify that.  
3 Is there a difference between having a  
4 mold exposure and an infection from a mold?  
12:01:24 5 A. Yes.  
6 Q. They're really quite different medically,  
7 aren't they, Doctor?  
8 A. Sometimes, yes.  
9 Q. Well, is it -- and I would need you to just  
12:01:37 10 make that distinction for me, because I really don't  
11 understand, Doctor. You said sometimes an exposure  
12 is different than an infection. Can an infection and  
13 exposure be the same thing?  
14 A. Yes.  
12:01:47 15 Q. Help me, because I really don't understand  
16 what you mean, Doctor.  
17 A. All right, look, you've got mold here,  
18 you've got infection -- and the person is healthy,  
19 okay, but you've not infection over here, and this  
12:01:58 20 patient got too much mold so they have a mold ball in  
21 their lungs or they have it in their bronchial tubes  
22 or they have it in their sinus or so on. They can  
23 have an allergic reaction to it, a hypersensitivity  
24 reaction to it, or they can have a flat infection  
12:02:14 25 where the temperature goes to 105 and, you know, they

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12:02:17 1 can die from it.  
2 So, so that's what I'm trying to  
3 distinguish for you. Everybody who lives gets  
4 exposed to mold. But mold doesn't always hurt  
12:02:29 5 everybody.  
6 Q. Now, in the example you just gave, there  
7 would be someone who has a mold ball or -- is it  
8 hypersensitive pneumonitis, is that what you're  
9 talking about?  
12:02:43 10 A. Well, that's one thing. No, I wasn't  
11 talking about that, but that certainly occurs with  
12 different molds, yes.  
13 Q. Right. But those are the existing fungal  
14 infections that have been caused by a mold, but it's  
12:02:54 15 different than just simply being exposed, they now  
16 have an identifiable infection, correct?  
17 A. That's correct, yes.  
18 Q. Generally if you and I were tested today,  
19 Mr. Simon and Mr. Cook, I see he's joined us, if any  
12:03:06 20 of us were tested today for probably an IgE antibody  
21 for molds, we would probably test positive because of  
22 living in the world, correct?  
23 A. Wrong.  
24 Q. Wrong?  
12:03:20 25 A. Right.

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12:03:20 1 Q. Okay. So not everybody would have an IgE  
2 positive test?  
3 A. That's correct.  
4 Q. If I represented to you that Kaye Kilburn  
12:03:38 5 in a different case has testified that he doesn't  
6 believe in using IgE testing because everybody tests  
7 positive, you would disagree with Dr. Kilburn, then?  
8 A. Yes, I would.  
9 Q. Do you use IgE testing for your mold  
12:03:55 10 patients, Doctor?  
11 A. Yes.  
12 Q. What laboratory do you use now for that, do  
13 you know?  
14 A. I think it's Quest.  
12:04:07 15 Q. Okay. And we covered this, but before they  
16 got in trouble, you used Immunosciences Labs for that  
17 kind of testing, correct?  
18 A. No.  
19 Q. You did not?  
12:04:17 20 A. No.  
21 Q. You didn't use them at all for mold  
22 testing?  
23 A. No, I didn't say that. I said I used them  
24 for some mold testing.  
12:04:24 25 Q. Some mold testing?

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12:04:26 1 A. Yeah.  
2 Q. You're also aware that some of what they  
3 got in trouble in California for, was mold, their  
4 mold testing parameters? Were you aware of that?  
12:04:34 5 A. I'm not aware of the intricacies of that  
6 problem.  
7 Q. Okay. So you really didn't know anything  
8 about --  
9 A. No.  
12:04:42 10 Q. -- the problem at all? Okay.  
11 A. Well, I knew they had a problem.  
12 Q. Would you agree that just because you've  
13 had a positive IgE test for a mold antibody, it is  
14 not necessarily medically -- it is not medically  
12:05:04 15 necessary to treat that person for the mold exposure  
16 alone, is it?  
17 A. If they had a -- are you talking about a  
18 low level IgE?  
19 Q. Well, just a positive -- just generally,  
12:05:17 20 generically a positive IgE, meaning it showed that  
21 there were some antibodies.  
22 A. Well, not without symptoms, of course.  
23 Q. So it takes more than just the test, there  
24 has to be clinical correlation --  
12:05:28 25 A. You've got to be a doctor, yes.

24 (Pages 90 to 93)

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12:05:32 1 MR. FRESHOUR: I think this is  
2 probably a good break point.  
3 THE VIDEOGRAPHER: The time is 12:05  
4 p.m. This is the end of tape number two. We are  
12:05:39 5 going off the record.  
6 (Recess from 12:05 to 12:15)  
7 (Mr. Cook did not come back)  
8 THE VIDEOGRAPHER: The time is 12:15  
9 p.m. This is the start of tape number three. We are  
12:15:45 10 on the record.  
11 Q. All right, Dr. Rea, we're back, we've taken  
12 a break. We had just talked a little bit with a  
13 little specificity, not a great deal, a little  
14 specificity about molds. You recall where we ended,  
12:16:00 15 correct?  
16 A. Yes.  
17 Q. As a general proposition, Doctor -- and  
18 again, this is general, so please keep that in mind  
19 when I phrase this question. Would you agree that we  
12:16:12 20 as people here today in this office or in the city of  
21 Dallas are exposed to many different things, molds,  
22 possibly chemicals, pollutants of all sorts,  
23 generally? Is that fair?  
24 A. Yes.  
12:16:28 25 Q. And is it also fair to say that just

12:16:31 1 because we are exposed -- again, on a general term --  
2 doesn't mean that a sickness or any kind of disease  
3 is necessarily going to result from that exposure,  
4 correct?  
12:16:46 5 A. Yes, that's correct.  
6 Q. Okay. I just want to explore some of the  
7 information that we hit on with molds just a little  
8 bit more, okay, Doctor?  
9 A. Yes.  
12:17:01 10 Q. I don't even know. There's probably, what,  
11 hundreds of thousands of different molds in the  
12 world?  
13 A. Yes, I think there are.  
14 Q. And all kinds of -- they would be genus and  
12:17:13 15 species of all different kinds, correct?  
16 A. Yes, that's correct.  
17 Q. And molds -- we hear the term sometimes,  
18 and we've heard it a lot recently in recent years,  
19 black mold. Are you familiar with that?  
12:17:35 20 A. Yes, I am.  
21 Q. And technically -- and correct me if I'm  
22 wrong -- black mold really is somewhat of a misnomer  
23 because there's a number of molds that are black;  
24 isn't that also correct?  
12:17:47 25 A. Yes.

12:17:48 1 Q. Okay. The one that most people think about  
2 or the one that's got to the headlines is  
3 Stachybotrys, correct?  
4 A. Yes, that's correct.  
12:17:57 5 Q. And -- now, what is a mycotoxin?  
6 A. It's a -- it's the mold's defense that it  
7 puts out to stop or kill other molds or bacteria or  
8 virus. Penicillin is a great example of mycotoxin.  
9 So we've learned to harvest some of the mycotoxins to  
12:18:20 10 help us.  
11 Q. Okay. Do you know, do all molds produce a  
12 mycotoxin?  
13 A. I think the majority of them do. I think  
14 this is nature's way of defending. Some of them are  
12:18:33 15 rather benign, others are rather virulent.  
16 Q. Right. And -- so just the generic term  
17 "mycotoxin" really doesn't carry a lot of  
18 specificity? Could we agree to that?  
19 A. Yes, that's correct.  
12:18:48 20 Q. So if somebody says they've been exposed to  
21 mycotoxins, it might mean something and it might not,  
22 correct?  
23 A. Yes.  
24 Q. And that would go back to what was the mold  
12:19:02 25 species that generated the mycotoxin and a number of

12:19:06 1 steps in the inquiry to make any kind of  
2 determination if there was medical significance with  
3 that mycotoxin, correct?  
4 A. Yes, that's correct.  
12:19:31 5 (Brief interruption)  
6 Q. Now, you can visualize molds if there's a  
7 fairly large -- I guess they call them colonies, is  
8 that correct, Doctor?  
9 A. Yes, that's correct.  
12:19:44 10 Q. That's where, you know, you look, it can be  
11 green, it can be black, it can be red, you just see  
12 it, correct?  
13 A. Yes, that's correct.  
14 Q. We had a little bit of a discussion. If  
12:19:55 15 there were some mold right now airborne in this room,  
16 we wouldn't be able to see the mold airborne unless  
17 it was just a huge concentration; is that true?  
18 A. Yes.  
19 Q. And wouldn't it also be true, unless it was  
12:20:08 20 just a huge, huge amount, it would be very difficult  
21 to see out in the ambient air of the outside? You  
22 wouldn't necessarily really see the mold, would you?  
23 A. Well, you can see it usually on buildings  
24 or grass or pavement where there's a lot. Like, for  
12:20:24 25 example, buildings would get colored, you might see

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12:20:28 1 some black mold growing on that or green mold or so  
2 on. But if you look out here, just look out the  
3 window, you could not see it.  
4 Q. Right. Just generally to the naked eye,  
12:20:38 5 you couldn't look and say, well, gee there's a bunch  
6 of mold blowing between, you know, my house and  
7 Mr. Simon's house, if we were neighbors? We wouldn't  
8 necessarily be able to do that?  
9 A. That's correct.  
12:21:08 10 Q. And as far as it relates to the  
11 identification of -- in like serum blood testing,  
12 like an IgE, IgG -- I think it's IgM is another one.  
13 Am I correct on that, Doctor?  
14 A. Yes, that's correct.  
12:21:43 15 Q. When you run those tests, let's say for a  
16 mold in general -- let's use an example,  
17 Stachybotrys, since everyone, I think, has probably  
18 heard of that one.  
19 A. Okay.  
12:21:57 20 Q. The positive test, a blood serum positive  
21 IgE test for Stachybotrys, doesn't necessarily -- is  
22 not able to let you quantify or exactly pinpoint the  
23 time of the exposure or the extent of it. Is that  
24 true?  
12:22:20 25 A. Yes.

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12:22:20 1 Q. I mean, you can say you've been exposed --  
2 A. That's all you can say.  
3 Q. And I think, isn't it -- the IgE shows a  
4 more recent, and an IgM usually is a longer exposure?  
12:22:33 5 Or am I wrong on that?  
6 A. The IgE is the hypersensitivity response to  
7 exposure. The IgM is the initial exposure. The IgG  
8 is the secondary exposure.  
9 Q. Okay. Thanks for that, Doctor.  
12:22:50 10 And we've been talking a lot, Doctor,  
11 and what does it mean -- and I think we need to pin  
12 these terms down. What does it mean when you say  
13 "exposure," what is your definition of "exposure"?  
14 A. Came in contact with.  
12:23:13 15 Q. What is generally from a -- what does  
16 "duration" mean when you're talking about exposures?  
17 A. Time of exposure.  
18 Q. Length of time?  
19 A. Yes, length of time.  
12:23:27 20 Q. Okay. And we've already talked about  
21 ambient. What does "concentration" mean when you're  
22 talking about chemicals? And I think you said a  
23 little bit earlier, we were talking about ambient and  
24 everything, that deals with the concept of  
12:23:55 25 concentration, correct?

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12:23:57 1 A. Yes.  
2 Q. And what is "concentration," Doctor?  
3 A. Well, "concentration" is the amount that  
4 you -- you're talking about exposure?  
12:24:03 5 Q. Right.  
6 A. The amount that you might be exposed with.  
7 For example, on, say, benzene you might get one part  
8 in one person. You might get a 1,000 parts per  
9 million in another person. That would be a change of  
12:24:19 10 concentration.  
11 Q. And also when we talk about concentration  
12 as it relates to chemicals, you're talking about the  
13 amount that the person may have been exposed to in  
14 a -- potentially a discrete event, correct?  
12:24:33 15 A. Well, either discrete event or long-term.  
16 You could have either.  
17 Q. Right. But right now I'm saying  
18 concentration can be defined as the amount that was  
19 present at a discrete event?  
12:24:46 20 A. Yes, you could say that.  
21 Q. And there's certainly, again -- and I'm  
22 not -- there is also a concentration, potentially  
23 long-term, depending on the source of the exposure,  
24 where you are and a number of factors, right?  
12:25:05 25 A. That's correct.

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12:25:06 1 Q. And the thing is, with all of this chemical  
2 exposure, there are multiple factors that go in that  
3 have to be looked at in making those kind of  
4 determinations?  
12:25:19 5 A. Which kind --  
6 Q. Chemical exposures, there's all kinds of  
7 factors, concentration, dose, duration. All of those  
8 go into it, correct?  
9 A. No.  
12:25:27 10 Q. Okay.  
11 A. If, if you've got exposure, you've got  
12 exposure. I mean, then if you want to quantitate it,  
13 then the concentration and all of these other things  
14 come into it. But let's say you've got an odor --  
12:25:41 15 you know, perfume, you've got exposure, it doesn't  
16 matter the concentration. You can perceive it, okay?  
17 Q. Okay. So there is the exposure.  
18 A. Yes.  
19 Q. Because you could perceive it. Let's use  
12:25:59 20 your perfume example.  
21 A. Right.  
22 Q. But that alone, because I could smell it --  
23 say, in your area of practice, that alone is not  
24 enough to make a medical determination of whether or  
12:26:11 25 not I have chemical sensitivity, is it?

26 (Pages 98 to 101)

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12:26:14 1 A. No.  
2 Q. And you couldn't make a determination that  
3 I perhaps had some kind of -- other than smelling it,  
4 that I had any kind of adverse reaction to perfume  
12:26:24 5 with just saying I smelled it, correct?  
6 A. That's right.  
7 Q. And to, to be able to make a further  
8 determination, you as a physician, would want to know  
9 if you can determine it, the duration of the  
12:26:37 10 exposure, correct?  
11 A. Yes.  
12 Q. And you would like to know, if you can, the  
13 concentration of the exposure coupled with the  
14 duration, correct?  
12:26:45 15 A. If you can. But frequently you can't.  
16 Q. Exactly.  
17 And there is a relationship between  
18 the concentration of the agent, that being -- and the  
19 length and duration of the exposure, as far as --  
12:26:57 20 well, there is a relationship between concentration  
21 and duration as it relates to making some  
22 determinations medically, possibly?  
23 A. Well, it's possible. It doesn't have to  
24 be. Yes.  
12:27:11 25 Q. What is a dose response curve?

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12:27:14 1 A. Well, dose response curve is one of the  
2 basic premises of the old toxicology in which, for  
3 example, you take a drug or you take a chemical, and  
4 the stronger the dose, the more problems you have  
12:27:34 5 until it exceeds the threshold and then you get ill  
6 or toxicity occurs. But there are other dose  
7 response curves now that have been shown, and these  
8 are the J curves and U curves or the hormetic effect  
9 which occurs in about 50 percent of the chemicals.  
12:27:52 10 And so you have to take that into consideration also.  
11 Q. Do you know generally, is there a -- is it  
12 true that there's no proven dose, no proven dose  
13 exposure relationship in your chemical sensitive  
14 patients?  
12:28:11 15 A. I guess that's -- I'm unclear what you mean  
16 by that.  
17 Q. Okay. Well, let me try to be clear,  
18 Doctor.  
19 A. Okay.  
12:28:20 20 Q. Isn't it true that there -- well, let me  
21 ask it this way: Isn't it true that in the -- in  
22 most or a lot of your chemical sensitive patients  
23 that you see, that you cannot pinpoint the duration  
24 or the concentration of the exposure that they were  
12:28:42 25 subjected to?

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12:28:43 1 A. Well, you can usually pinpoint the  
2 exposure. But you can't pinpoint the concentration  
3 other than grossly. For example, somebody says, I've  
4 got a -- somebody just put on a lot of perfume and  
12:29:03 5 they got sensitive to it, okay. Well, you know it  
6 was a high concentration for that patient. But you  
7 can't always do that. You can just always say  
8 they've been exposed, okay.  
9 Q. So you can try, you can try or attempt to  
12:29:30 10 pinpoint the exposure, but it's much harder and it's  
11 hard to pinpoint the concentration, correct?  
12 A. Yeah, that's correct.  
13 Q. And is it also hard to pinpoint the  
14 duration of the exposure in most of your patients?  
12:29:46 15 A. Well, no, a lot of people can tell you,  
16 hey, in five minutes, if I'm exposed to formaldehyde,  
17 I always get a runny nose and I always get a  
18 headache. Other people tell you that they don't know  
19 and it may go on for an hour before they have  
12:30:01 20 problems. A lot of the patients I see have already  
21 been problems -- at treatment for years, and a lot of  
22 them really know the time of exposure that can occur  
23 before they get sick.  
24 Q. Well, and isn't it true that at least in  
12:30:20 25 some of these patients we're going to look at, the

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12:30:23 1 exposure can range anywhere from minutes to years?  
2 A. I don't -- now, are you talking about the  
3 cause of the chemical sensitivity or the triggering?  
4 It's two different things, okay?  
12:30:38 5 Q. Okay. I will represent to you that when I  
6 talked to Dr. Ross in deposition and Dr. Meggs, they  
7 say that the exposure that can result in these people  
8 becoming chemical sensitivity can be anywhere from a  
9 couple of minutes to years in length.  
12:30:57 10 A. Causing the chemical sensitivity?  
11 Q. Right.  
12 A. Yes, that's correct. That's why I was  
13 asking you the cause of the triggering agent.  
14 Q. Right.  
12:31:03 15 A. Triggering symptoms.  
16 Q. Right. And what about the exposure time  
17 for triggering symptoms?  
18 A. Well, usually it's acute to within 24 to 48  
19 hours.  
12:31:27 20 Q. And is it also true in these patients that  
21 the concentration that they're being exposed to can  
22 be a high concentration or a low?  
23 A. Depending on the individual. That's the  
24 biochemical individuality response.  
12:31:42 25 Q. And is it fair to say that in at least

27 (Pages 102 to 105)

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12:31:45 1 these five patients that we're going to look at  
2 today, that your determination is it was a long-term  
3 low-dose exposure that led to their chemical  
4 sensitivity, generally?  
12:32:05 5 A. Well, with the exception of J.S. She had  
6 five distinct exposures that were rather acute,  
7 although they were cumulative, I think. So -- and if  
8 you want to look at it that way, your premise would  
9 be right, okay?  
12:32:25 10 Q. And we hit on this a little bit earlier.  
11 But the exposure is to a multitude of agents with  
12 these patients?  
13 A. Yes.  
14 Q. Chemical agents?  
12:32:35 15 A. Yes, we've seen them. And physical, too.  
16 Q. And I think it's correct to say that in all  
17 five of these patients, the records are devoid of any  
18 articulation of a specific concentration of any  
19 particular chemical. Is that true?  
12:33:02 20 A. I, I don't recall whether that's the case  
21 or not. I'd have to go back and see.  
22 Q. And I'm going to go through the patients  
23 with a little bit of detail on that, Doctor. But if  
24 I represent to you generally that as -- going through  
12:33:15 25 the records there was no concentration really

12:33:18 1 specified for any of the patients from a historical  
2 perspective, does that sound right?  
3 MR. SIMON: Object. That was asked  
4 and answered.  
12:33:27 5 A. Yeah, I can't say any more than that, okay?  
6 Q. And do you recall that in these five  
7 patients that the records don't specify the length of  
8 any particular exposure or -- let me rephrase it.  
9 The duration to any particular exposure that led to  
12:34:03 10 the chemical sensitivity.  
11 A. Yes, there were some.  
12 Q. There were?  
13 A. For example, J.S., she was exposed for  
14 about a year in a basement that had a gas leak. She  
12:34:12 15 was exposed to the 9-11, she lived right there. So  
16 that exposure lasted, what, two months or so, as I  
17 understand it. It was acute and then it, the ambient  
18 air was contaminated at that time. And there may  
19 be -- for example, Liz Qudell (phonetic) had a  
12:34:36 20 problem where she lived in a house with -- the house  
21 next to it was moldy and she could smell that mold  
22 coming in for a year. So there were some timelines  
23 in there that did make them either worse or brought  
24 them down. I'd say the majority, probably they  
12:34:58 25 weren't.

12:35:09 1 Q. And isn't it also correct that in -- in all  
2 of these patients, there is, there is not one  
3 chemical that you can specify in your records that  
4 actually caused these problems or triggered these  
12:35:23 5 problems?  
6 A. No, that's not true.  
7 Q. There's a specific trigger or causing  
8 chemical identified in your records?  
9 A. Yeah.  
12:35:30 10 Q. We can go in -- and I'm just asking you,  
11 Doctor -- go in and say, for example, on A.R. -- and  
12 I'm going to use initials.  
13 A. Yes.  
14 MR. FRESHOUR: And for purposes of the  
12:35:40 15 record, Jacques, if we use names, can we agree to  
16 just edit them to initials?  
17 MR. SIMON: Please.  
18 Q. A.R., you could go in and say, there it is,  
19 she was exposed to -- now I'm going to have to grab a  
12:35:52 20 chemical out of here -- xylene on or about this day  
21 that caused all the symptoms?  
22 A. Well, we can't say it caused all the  
23 symptoms. We can say it caused symptoms. And that's  
24 true of some of these patients. Yes, I can tell you  
12:36:07 25 those in the charts do show that.

12:36:10 1 Q. Okay. Doctor, I've marked what's Exhibit  
2 Number 1, Doctor, and I think Mr. Simon has probably  
3 shown this to you, and I imagine at some point you  
4 probably discussed this. This is the notice to take  
12:36:35 5 deposition. And attached to that was a request for  
6 some records. Are you familiar with that, Dr. Rea?  
7 A. Yes.  
8 Q. Okay. And for purposes of the record, too,  
9 Mr. Simon and I have had a discussion, and we agreed  
12:36:48 10 that I didn't need you to bring up your books. I'll  
11 represent to you, Dr. Meggs had brought them in at a  
12 deposition. I think Dr. Ross may have brought them  
13 in. I think Dr. Holland had -- or one of the doctors  
14 I think had some of them that were my experts. Same  
12:37:08 15 thing with medical records, and I think we'll go  
16 through those today.  
17 A. I did bring them. They're in my car. But,  
18 as you know, there's a mass of records.  
19 Q. And I'm not asking for that.  
20 The records I want to focus in on is,  
21 did you bring any records today related to any  
22 standard protocols, procedures for antigen  
23 preparation?  
24 A. Yes, I did.  
12:37:30 25 Q. All right. And Mr. Simon is handing me a



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12:37:33 1 notebook, and I assume these are the responsive  
2 records?  
3 A. That's correct, yes.  
4 Q. Okay. And just looking through these, the  
12:37:58 5 other thing I asked for -- and you can perhaps tell  
6 me without going through all of these. I also asked  
7 for -- if you had had any independent laboratory  
8 tests where you sent out any of your preps for -- or  
9 your preparations for your antigens to be looked at  
12:38:22 10 and broken down by their actual components and  
11 concentration. Did you have anything responsive to  
12 that, Doctor?  
13 A. I don't think I did. You have to remember  
14 some of this has been so long ago that we started  
12:38:33 15 this, that we may have, but I don't have the records  
16 of it if we do, okay?  
17 Q. And, Doctor, one of the things -- and  
18 again, I'm looking through this -- is before  
19 Mr. Simon came on the case, I'll make this very  
12:38:51 20 clear, I think -- and before I came on the case, I  
21 think some of this has been asked for before, perhaps  
22 not in -- and it wasn't responded to. So that was  
23 one of the reasons I was looking for --  
24 A. Oh, no, I responded to everything that was  
12:39:05 25 asked for. If we overlooked it, nobody ever asked

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12:39:09 1 us, because we certainly have it, you know.  
2 Q. Now, my question is, looking at these, and  
3 it shows protocol for 1995, these have been in  
4 existence since '95 in this very form, or is this in  
12:39:23 5 a changed form or --  
6 A. No, in this form. We have -- you know --  
7 MR. SIMON: Do you want to mark this?  
8 A. We followed this very rigidly, okay?  
9 Q. And this is in -- and you say "we," we're  
12:39:38 10 talking about the clinic and your lab that you --  
11 A. That's correct, yes.  
12 Q. Now, your in-house lab doesn't have any  
13 kind of a CLIA certification, does it, Doctor?  
14 A. We've got some kind of certification. I  
12:39:59 15 can't remember which it is, okay. I could call and  
16 find out. But I don't -- if it's really important.  
17 MR. FRESHOUR: Well, if we can agree,  
18 Mr. Simon, will you just verify what the --  
19 MR. SIMON: I'll verify what the  
12:40:14 20 certification is.  
21 MR. FRESHOUR: -- certification is and  
22 notify me. I don't need anything more than you to  
23 say it's whatever --  
24 A. It's certified by somebody.  
12:40:19 25 Q. Right. Maybe the Texas Department of

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12:40:20 1 Health or something like that?  
2 MR. SIMON: It may be CLIA, as well.  
3 A. I think it might be CLIA, too. We'll check  
4 and see.  
12:40:29 5 MR. SIMON: Of course.  
6 THE WITNESS: I know we jump through a  
7 lot of hoops for some people.  
8 Q. Now, I think other than that, Doctor, the  
9 documents I asked for, I think we've all -- they've  
12:40:43 10 all been exchanged.  
11 A. Good.  
12 Q. The question is, this singular notebook, is  
13 this the only copy?  
14 A. No.  
12:40:50 15 MR. SIMON: We have one at the office.  
16 I can make an extra copy.  
17 MR. FRESHOUR: I think for purposes of  
18 the record, what I may do is get this marked and then  
19 I can just, when it comes back to me with the  
12:41:00 20 deposition, I'll have it there.  
21 MR. SIMON: That's fine.  
22 MR. FRESHOUR: We'll deal with that in  
23 a few moments.  
24 Q. Now, Dr. Rea, one of the other experts that  
12:41:13 25 has been retained in this case is a Dr. Abadonia

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12:41:15 1 (phonetic). You're familiar with Dr. Abadonia,  
2 aren't you?  
3 A. Oh, yes, yes, yeah.  
4 Q. And one of the preparations -- and I'm  
12:41:26 5 going to call the preparations antigens -- well, let  
6 me ask you this, Doctor: For clarity of the record,  
7 what is an antigen? Just generally how would you  
8 define that?  
9 A. Well, it's a minute substance -- a part of  
12:41:45 10 whatever you're trying to get, a pollen or a food or  
11 a chemical -- that will stimulate a response in the  
12 body.  
13 Q. Now, generally, Doctor, one of the issues  
14 that we have in this case is there's been some  
12:42:08 15 concern. And let me ask it this way: You're aware  
16 of the board's complaint generally, I'm sure?  
17 A. I sure am.  
18 Q. Okay. One of the things is, there's  
19 concern over a use of an antigen of jet fuel. Are  
12:42:22 20 you familiar with that?  
21 A. I certainly am.  
22 Q. Okay. Now, other than yourself, are there  
23 other physicians that you know that are making this  
24 kind of preparation and administering it to patients?  
12:42:34 25 A. Yes, I think there are.

29 (Pages 110 to 113)

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12:42:35 1 Q. I'm sorry?  
 2 A. I think there are, yes.  
 3 Q. Okay. Do you know any in particular that  
 4 are using jet -- I'm going to call it jet fuel  
 12:42:43 5 antigen, okay? Are you familiar with any?  
 6 A. Well, I think Dr. Johnson does, probably.  
 7 Probably Dr. Ross does. Probably Dr. Fox does.  
 8 And --  
 9 Q. Is that Randolph Fox up in Canada?  
 12:42:57 10 A. Yeah, uh-huh.  
 11 Q. Okay. How about --  
 12 A. And I can't -- I really don't know past  
 13 that because it's been taught in our courses, so, you  
 14 know, you don't really know who does and who don't.  
 12:43:11 15 Q. And I'm going to represent to you that I  
 16 asked Dr. Abadonia, I said -- when I deposed him, I  
 17 asked him, if you're deriving an antigen based on jet  
 18 fuel --  
 19 A. Yes.  
 12:43:25 20 Q. -- this is rather crude, I said, well, even  
 21 if you call it an antigen, isn't it still jet fuel?  
 22 And he said, absolutely. Do you agree with that or  
 23 not?  
 24 A. No, I disagree.  
 12:43:35 25 Q. Okay. Now, I want to be sure of your point

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12:43:38 1 of disagreement. Now, because you are not using jet  
 2 fuel or because you're using the exhaust fumes from  
 3 jet fuel is that where you're drawing the  
 4 distinction?  
 12:43:47 5 A. Well, we're using the exhaust fumes from  
 6 it, and that is not jet fuel.  
 7 Q. Okay. The components of jet fuel exhaust,  
 8 do you know what all is in the, what it is composed  
 9 of, jet fuel exhaust?  
 12:44:01 10 A. No, I don't. You would have to look that  
 11 up from a chemist. But it's just enough to -- people  
 12 work around it at the airport all the time, so it  
 13 must be safe.  
 14 Q. Jet fuel exhaust must be safe?  
 12:44:16 15 A. Well, it's generally accepted as safe at  
 16 the doses that we do our extracts from.  
 17 Q. And who generally accepts them as safe at  
 18 the doses that your extracts happen?  
 19 A. American Airlines, Southwest Airlines, the  
 12:44:30 20 state of Texas, the city of Dallas. Apparently most  
 21 insurance companies. I guess I could go on and on.  
 22 The medical profession.  
 23 Q. And what do you mean they accept it?  
 24 They've tested it and said the level you're using is  
 12:44:44 25 an acceptable level?

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12:44:46 1 A. No. People working around it. They don't  
 2 put any restrictions on it.  
 3 Q. But you said they accepted yours. And --  
 4 A. You didn't ask me that. So I misunderstood  
 12:44:54 5 you.  
 6 Q. I think we had a misunderstanding.  
 7 A. I'm sorry about that.  
 8 Q. That's okay. That's why we do this.  
 9 The -- okay, you said something that,  
 12:45:07 10 you know, American Airlines accepts it and -- now,  
 11 you're talking about a certain level of jet fuel  
 12 exhaust that's set by the government or something; is  
 13 that correct?  
 14 A. Well, I guess it is, yeah. I mean, it's  
 12:45:21 15 generally accepted in society, put it that way, okay.  
 16 Q. And that's an airborne, that's an ambient  
 17 air standard for jet fuel exhaust, correct?  
 18 A. That's correct. And that's where we get  
 19 our extract, so it has to be much less than that.  
 12:45:37 20 Q. I understand. But my question was, what  
 21 you're talking about is the ambient air standard for  
 22 jet fuel exhaust?  
 23 A. Correct.  
 24 Q. Okay. Now, there's a different between an  
 12:45:55 25 ambient air standard and what would be a -- the

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12:45:58 1 concentration that may be directly put into the human  
 2 body by some delivery mechanism such as saline?  
 3 Wouldn't those be two different things, Doctor?  
 4 A. Well, if you don't consider breathing and  
 12:46:12 5 absorbing through the skin, so, yes. But, you know,  
 6 if you breathe the substance, that's going to be the,  
 7 that's going to be mixed with saline as you go down  
 8 the bronchial tubes into the lung.  
 9 Q. Okay. But I'm saying, the ambient air  
 12:46:30 10 standard that you're talking about that is acceptable  
 11 by whatever authorities is different than  
 12 administering it to someone under their skin through  
 13 a saline solution, correct?  
 14 A. No, I don't see how it is.  
 12:46:42 15 Q. Okay. That's my question. You think  
 16 they're the same?  
 17 A. Yeah.  
 18 Q. Breathing it is the same as -- let me ask  
 19 it this way, one more step further. You believe that  
 12:46:52 20 breathing jet fuel is the same as you giving an  
 21 intradermal injection of your jet fuel antigen?  
 22 A. Yes -- well, no, because our jet fuel  
 23 antigen has much less concentration than that.  
 24 Q. Now, let's talk a little bit about that.  
 12:47:11 25 A. All right.

30 (Pages 114 to 117)

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12:47:13 1 Q. Is there an exact description in here? And  
2 rather than looking through, you can tell me, is  
3 there an exact description here of how you get your  
4 jet fuel antigen and prepare it?  
12:47:27 5 A. Yes, I think there is.  
6 MR. SIMON: He can help you find it.  
7 Q. Yeah. If you would --  
8 A. Or there's certainly one of car --  
9 MR. SIMON: Can we mark it so he can  
12:47:38 10 reference it as an exhibit?  
11 MR. FRESHOUR: Yeah, we can mark it  
12 and --  
13 A. Well, here's one for car exhaust, and that  
14 would be --  
12:47:42 15 MR. SIMON: Let's mark this so the  
16 record is clear.  
17 MR. FRESHOUR: Mark this as Exhibit 2,  
18 if you would, just the whole thing, please.  
19 (Exhibit 2 marked)  
12:47:56 20 MR. SIMON: And also, the pages aren't  
21 numbered so we should describe the page that he's  
22 reading from with particularity.  
23 Q. And this is -- what you've directed me to,  
24 Doctor, is the protocol for car exhaust?  
12:48:09 25 A. That's correct, yes.

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12:48:09 1 Q. And it says January 1995?  
2 A. Yes, that's right.  
3 Q. All right. Now, before we get into it, I'm  
4 taking it that this has been in place since 1995 with  
12:48:19 5 your laboratory?  
6 A. Yes. And probably longer, because we were  
7 experimenting with it before.  
8 Q. Okay. Now, my question is, this protocol,  
9 although it's directed for car exhaust and you're  
12:48:34 10 representing for purposes of the record and your  
11 testimony that this is the protocol that you used to  
12 get your jet fuel antigen, correct?  
13 A. Well, the difference would be we don't, we  
14 don't do jet fuel right near the airplane as we would  
12:48:54 15 the car. Because jet fuel would be -- like if you  
16 were at the airport where the jets were revving up or  
17 getting ready to go, you know, as they were just  
18 going around. So that would be a much, much longer  
19 distance.  
12:49:06 20 Q. So you would be a further distance away  
21 from the source?  
22 A. That's correct, yes.  
23 Q. Okay. Bear with me, I need to make some  
24 notes, because I can't mark on this page.  
12:49:18 25 A. Oh, all right.

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12:49:21 1 MR. SIMON: Have to get close to the  
2 place where it happens.  
3 Q. So -- and again, this is just to be clear,  
4 this protocol you use for jet fuel antigen, even  
12:50:00 5 though it says protocol for car exhaust --  
6 A. Yeah.  
7 Q. -- it's exactly the same, correct?  
8 A. And with the exception of collection  
9 distance.  
12:50:07 10 Q. Of the?  
11 A. Collection distance.  
12 Q. Collection distance, okay. Which is what  
13 we just talked about?  
14 A. Yeah, it's just what we just talked about.  
12:50:13 15 Q. Further from the source?  
16 A. That's right.  
17 Q. Okay. And before I go into this protocol,  
18 I want to be sure, are you -- do you have any idea  
19 what the general chemical components are of the jet  
12:50:59 20 fuel exhaust that you're collecting?  
21 A. I could get you a list for it, if you like.  
22 But I can't, right offhand, tell you all the things,  
23 you know.  
24 Q. I take it -- could we agree it's probably  
12:51:11 25 published in some literature?

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12:51:12 1 A. It is, that's what I say, yeah.  
2 Q. By the EPA, or --  
3 A. Yeah.  
4 Q. -- what is it, the agency for toxic  
12:51:18 5 substance and hazard registration?  
6 MR. SIMON: Disease registry.  
7 A. I mean, you never know, but one of them has  
8 published it, okay.  
9 MR. SIMON: I believe the EPA does.  
12:51:28 10 A. EPA may, yeah.  
11 Q. And before we go any further, Doctor, we've  
12 covered a lot of areas, and I apologize, I think I  
13 may have missed this. Is there a difference between  
14 an allergic reaction and an irritant reaction?  
12:51:43 15 A. Yes, some people say there is. The  
16 allergists say that there is. And there's a lot of  
17 semantics that are problems in there, because, you  
18 know, you can have a hypersensitivity reaction and it  
19 doesn't have to be an allergic reaction. For  
12:52:01 20 example, it could be nonimmune, and then an  
21 irritation is like if you start rubbing your hand or  
22 your wrist like that (indicating), and say you rub it  
23 with some substance, and it just gets locally  
24 inflamed. That's an irritant reaction.  
12:52:18 25 Q. Is it a -- say a contact dermatitis, say

31 (Pages 118 to 121)

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12:52:21 1 if I -- is a contact dermatitis, is that allergic, is  
2 that irritant or what is that, could --  
3 A. It could be either.  
4 Q. That's what I was going to say.  
12:52:29 5 A. Yeah. Or it can be nonallergic and be  
6 neurological, so there's three possibilities.  
7 Q. Okay. Now, when I say "source material"  
8 when it comes to antigens, do you understand what I,  
9 what I'm saying by that, or could you define -- let's  
12:53:00 10 do it this way: Will you define for me what source  
11 material is when it comes to antigens? What is  
12 source material?  
13 A. Well, source material would be whatever you  
14 extracted from the air. Like, for example, if you  
12:53:10 15 wanted formaldehyde or something like that or the jet  
16 fuel we're talking about here, or apple, if you  
17 wanted to make an extract of apple, it would be an  
18 apple or orange, okay. So on down the line. The  
19 molds, you do mold cultures and they extract -- they  
12:53:29 20 can extract the source from that.  
21 Q. And diesel fuel would be -- the diesel fuel  
22 would be the source?  
23 A. Well, it would be the exhaust.  
24 Q. Exhaust?  
12:53:38 25 A. It is probably a little bit of a misnomer,

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12:53:40 1 we should say -- jet fuel extract, we should really  
2 call it jet exhaust extract, I guess.  
3 Q. Okay. Because you're not -- and I think  
4 that's the other thing. For clarity, you're not  
12:53:52 5 taking the liquid gasoline --  
6 A. No way.  
7 Q. -- and diluting that?  
8 A. No way.  
9 Q. You are taking the exhaust or the  
12:54:02 10 combustion product?  
11 A. That's correct. See, it's what, what you  
12 would get exposed to like in the dang freeway out  
13 there, you know, or at the airport or whatever.  
14 Q. Okay.  
12:54:13 15 A. So that's a little bit of a misnomer, I  
16 would agree with you there.  
17 Q. Let's look a little bit now with your  
18 specificity here and your protocol.  
19 A. All right.  
12:54:38 20 Q. First off, do you know whether the  
21 composition of the jet fuel exhaust is a uniform  
22 product? And what I mean by that is that from each  
23 jet burning each batch of jet fuel, is it going to be  
24 the same or is it going to be slightly different, do  
12:55:03 25 you know?

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12:55:04 1 A. I don't really know. But I would suspect  
2 it would be slightly different.  
3 Q. Because I've at least heard, and I don't  
4 know anything about it, that each batch of jet fuel  
12:55:15 5 may be just a little bit different in its  
6 composition, the lead there, the octanes, perhaps  
7 some of the various other hundred chemicals that make  
8 it up.  
9 A. That would be my suspicion, yes.  
12:55:28 10 Q. Okay. And I know I asked you this, but in  
11 the materials here, we don't have a breakdown of all  
12 of the components that might be found in your jet  
13 fuel exhaust antigen, correct?  
14 A. No, we don't, certainly.  
12:55:48 15 Q. I'm going to go -- the first thing says  
16 you've got 300 ccs of coca solution.  
17 A. Yes.  
18 Q. And then it, in parentheses it says,  
19 NaCl equal amounts of NaCO3.  
12:56:05 20 A. NaHCO3. It should be.  
21 Q. Well, let me show you what's here, Doctor.  
22 A. Oh, that should be NaCHO -- bicarbonates is  
23 what it is.  
24 Q. Okay.  
12:56:15 25 A. Soda bicarbonates and soda chloride.

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12:56:16 1 MR. SIMON: That's still on the  
2 page -- for the record, that's still on the page of  
3 the car exhaust extract?  
4 MR. FRESHOUR: Yes, we still are.  
12:56:23 5 MR. SIMON: Okay.  
6 Q. Then it says the second step is 50 percent  
7 of each. And it says, unleaded gas exhaust and  
8 diesel exhaust. I assume obviously -- and correct me  
9 if I'm wrong -- it would be -- instead of 50 percent,  
12:56:39 10 it would be 100 percent of jet fuel exhaust there?  
11 A. Yes, that's correct. Well, you know, it is  
12 ambient air so you don't get too close to a jet  
13 burner, so there could be other things in there, too.  
14 But it seems to work and it seems to reproduce  
12:56:56 15 people's symptoms when you're diagnosing it, that  
16 they get when they get around an airplane.  
17 Q. The third step, it says, insert a gas rod  
18 into the car exhaust pipe, connect it to the air  
19 machine, pulling the exhaust into 400 cc of coca  
12:57:11 20 solution for 15 minutes. Now --  
21 A. Correct.  
22 Q. I want to stop there.  
23 Explain to me very clearly how you  
24 catch the jet fuel exhaust.  
12:57:26 25 A. Well, you just have to go out to Love Field

32 (Pages 122 to 125)

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12:57:28 1 there and stand behind the fence, and you will get  
2 jet fuel exhaust. You can smell it.  
3 Q. Okay. Explain to me, Doctor -- well, let  
4 me ask you. Do you do -- I take it you're not doing  
12:57:43 5 this yourself?  
6 A. No, but I have done it. So I would know  
7 what I'm doing, okay.  
8 Q. Very good.  
9 A. But I am not doing it, okay.  
12:57:50 10 MR. SIMON: So he wants you to explain  
11 the process.  
12 THE WITNESS: Okay.  
13 Q. So you're standing at the fence at Love  
14 Field?  
12:57:56 15 A. Okay, we've got a collector, okay.  
16 Q. What is the collector?  
17 A. Say this is a collector -- well, it's a, a,  
18 you know, a petro-type chemical -- you've seen the  
19 chemical flask, and things like that.  
12:58:11 20 Q. Like a beaker?  
21 A. Yeah, like a beaker with a lid on it.  
22 Q. Okay.  
23 A. And the lid has a hose attached to them,  
24 one for in and one for out, okay? And you have a rod  
12:58:24 25 that goes down so it bubbles through, you're sure it

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12:58:28 1 bubbles through the coca solution. You put your air  
2 collector there. And it's a motor, there's a motor  
3 on it that will suction -- there's a very mild  
4 suction, okay? And the reason those things are not  
12:58:43 5 totally detailed, because that's just standard for  
6 what you do for most antigens, okay.  
7 Q. Okay.  
8 A. And then you put it there for 15 minutes,  
9 and, and go ahead and then you sterilize it with cold  
12:59:02 10 sterilization.  
11 Q. I'm--  
12 A. Cold sterilization. That's Millipore  
13 filters.  
14 Q. Then it run -- well, so that's the actual  
12:59:13 15 collection you just described --  
16 A. Yes, right.  
17 Q. I know you know it better than me. Let me  
18 finish my question, Doctor.  
19 A. All right.  
12:59:21 20 Q. We've been doing fair. I think the court  
21 reporter will only say fair.  
22 So the little motor runs bubbles  
23 through, after 15 minutes you shut the motor off, I  
24 take it you, you cap off the tubes or remove them and  
12:59:34 25 put a new cap in?

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12:59:36 1 A. Yes, that's correct.  
2 Q. And then you go and you, then it says  
3 dilute with 300 cc's of coca solution. I assume  
4 you're now back at the laboratory, you pull the top  
12:59:47 5 off, you put the solution in?  
6 A. That's correct. So that makes it much  
7 less.  
8 Q. Okay. Then you run it through the ceramic  
9 Millipore filter?  
12:59:57 10 A. Yes. These are specific filters that I  
11 have engaged to exclude bacteria and viruses. In  
12 other words, you either -- you know, when you  
13 sterilize something, you either have to do it by heat  
14 or what you can do here, it's got to be cold  
13:00:12 15 sterilized.  
16 Q. Okay. Then you dilute with saline,  
17 one-half, this is the concentration. What does that  
18 mean, Doctor?  
19 A. Well, then you dilute it with -- where does  
13:00:24 20 it say one-half?  
21 Q. I'm sorry -- we're at number six, I'm  
22 sorry.  
23 A. Oh, okay, that would be again one-half the  
24 volume, you dilute again. So now you're down to  
13:00:42 25 very, very small molecules of -- very few molecules

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13:00:47 1 of the substance, because you've diluted it twice,  
2 plus you diluted it when you collected it. So you  
3 may have diluted it a million times by then, okay?  
4 And then -- go ahead, you get this and I can tell you  
13:01:02 5 the rest, okay.  
6 Q. Please do, sir, go ahead.  
7 A. So you've got this vial here that is the  
8 concentrate -- we talked about concentrations, so I  
9 guess I don't have to go over that again. But that's  
13:01:14 10 the amount that you've got after you collect it and  
11 it's been diluted, okay? Then for patient care after  
12 you're sure it's sterilized is you dilute it with  
13 four c -- what you call a 1-to-5 dilution, that's  
14 four cc's of saline and one cc of the concentrate.  
13:01:31 15 And you just keep doing that. That's number one,  
16 number two and number three, that would be number 1  
17 to 25, 1 to 125, 1 to 625, and then into the  
18 thousands, okay. And that is extremely diluted.  
19 Q. And -- okay. And I'm going to jump for a  
13:01:52 20 moment, Doctor.  
21 A. Okay, fine.  
22 Q. So then you take these. And as I  
23 understand from reading some of your materials, you  
24 would go and you would start with the -- some of the  
13:02:07 25 weaker solutions and do then skin testing with this

33 (Pages 126 to 129)

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13:02:11 1 going up towards stronger solutions, not the other  
2 way? You don't start with a strong and go to weak.  
3 You start with a weak solution until you get a  
4 reaction?

13:02:18 5 A. Yeah. Well, we might go weak or stronger,  
6 depending on what the skin response is or the  
7 patient's response. For example, usually we'll start  
8 at number three, that's the 1 to 625, I believe it  
9 is.

13:02:30 10 Q. Yes, sir.  
11 A. And let's say that the patient got a  
12 swelling, called a wheal, and the wheal grew, then  
13 you would dilute it until you got the right dose.  
14 But that's provoking. Let's say the patient had no  
13:02:46 15 symptoms and the patient had no wheal, then you would  
16 go stronger to find the concentration. That's for  
17 treatment only, though. That has nothing to do with  
18 the diagnosis.

19 Q. Right. And we're going to get to the  
13:03:02 20 diagnostic aspect here in a bit, okay?

21 A. Okay.

22 Q. Bear with me.  
23 Number seven, explain that to me.  
24 And, again, if you need to look at it, Doctor, it  
13:03:09 25 says, analysis shows no toxic substance. However,

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13:03:14 1 the electromagnetic imprint still persists as  
2 evidenced by skin reactions until number 20 dilutions  
3 in some patients.

4 A. Yes.

13:03:28 5 Q. What does that mean? And there's another  
6 sentence, I just didn't get to that. What does that  
7 mean? Or explain that to me.

8 A. Well, number one is that apparently, as you  
9 well know, other people have analyzed it, not ours,  
13:03:46 10 but other people have analyzed this technique. And  
11 also I think that Professor Fenavitz (phonetic), who  
12 is in our group from the University of Texas, who is  
13 a physicist, has checked this out that long ago, and  
14 felt there was no active chemical in it. And that --  
13:04:09 15 but there is electromagnetic imprints still there.  
16 And that's why they react.

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

13:04:43 20 A. Well, when you give a chemical, chemical  
21 exposure of any kind, there's both a chemical  
22 response and a physical, or a physics response, okay.  
23 Now, the physics response is in frequencies  
24 apparently. So like you might have 10 hertz, 500  
13:05:09 25 hertz, 300 hertz, or so on, okay. That still appears

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13:05:13 1 to be there; whereas, the chemical content is gone.  
2 And that's why we explain why some people have  
3 reactions on their skin.

4 MR. SIMON: Mr. Freshour, really

13:05:27 5 quick, to clarify the record because you said the  
6 attorneys before us did not provide this. It's also  
7 the attorney -- from what I recall now looking at the  
8 interrogatories and the document demands, the reason  
9 why this wasn't provided I remember there was an  
13:05:41 10 objection, it was not asked for properly the way you  
11 asked for it here. So I did provide it for you.

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

14 MR. SIMON: My recollection.

13:05:51 15 MR. FRESHOUR: I'm sorry.  
16 For purposes of the record, I agree  
17 with that representation by Mr. Simon, just for  
18 clarity. And that was also part of the reason that I  
19 just a little bit ago asked Dr. Rea to clarify that.

13:06:07 20 So no implication that there was noncooperation  
21 between us. It was just an issue that we've resolved  
22 and this does it.

23 MR. SIMON: Okay, good.

24 Q. Now, let me ask you, Doctor, on the -- this  
13:06:36 25 is for car exhaust. This applies to your diesel fume

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13:06:42 1 exhaust antigen, right, as well?

2 A. Yes, that's correct.

3 Q. And I just want to be clear, because  
4 several -- it might have been Dr. Meggs. Pardon me  
13:06:53 5 if I'm wrong. I don't want to misquote the good  
6 doctor. He had a little trouble reconciling unleaded  
7 diesel fuel in the way it's labeled because there's  
8 unleaded gas and there's diesel fuel. But as I  
9 understood it, he had a little bit of concern that I  
13:07:17 10 think some of the labeling might have said unleaded  
11 diesel. Are you familiar with that in your records?

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

14 Q. Which is fine. I just want to be sure.  
13:07:32 15 And I'll represent to you, I think if we look today  
16 some places in antigen -- or it might be in the  
17 immunotherapy, it says unleaded diesel. But we're  
18 talking about diesel exhaust antigen when we see  
19 that.

13:07:46 20 A. That's correct.

21 Q. Okay.

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

24 Q. Okay. That will help.

13:07:55 25 A. Yeah.

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13:07:55 1 Q. I want to talk now -- okay, and I think we  
2 can finish this up and it will work well. I want to  
3 talk about the same procedure for your diesel fume  
4 exhaust. It comes under this car protocol exhaust we  
13:08:08 5 just explored.  
6 A. Yes.  
7 Q. And my question would be, to collect the  
8 diesel fuel, do you have an engine or a vehicle  
9 that's set up at your office? Or what is the  
13:08:26 10 combustion source, I guess is the question for --  
11 A. Well, it would be a diesel, diesel car.  
12 Q. Okay. Now, my question to you is, is that  
13 any diesel car? Do you have a specific diesel car  
14 where you actually put this glass pipe in, or how is  
13:08:40 15 it collected, Doctor, for diesel exhaust?  
16 A. For diesel exhaust, it's -- this may have  
17 been a glass rod originally, but now we just do it  
18 several feet away, a foot or two away and collect it  
19 just like the jet fuel exhaust.  
13:08:58 20 Q. Okay. So -- and this sounds really crude.  
21 and I'm not --  
22 A. Yeah.  
23 Q. Please don't take it that way. I mean, are  
24 you at the store parking lot, are you in your medical  
13:09:09 25 office parking lot? Where are you getting --

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13:09:12 1 A. Medical office parking lot, okay.  
2 Q. Okay. So you go out and --  
3 A. That's right.  
4 Q. -- find somebody who has got a diesel  
13:09:20 5 vehicle?  
6 A. Yeah.  
7 Q. Okay. And I take it, then, do you do the  
8 same thing for the car exhaust, out into the parking  
9 lot?  
13:09:33 10 A. Yes.  
11 Q. And, again, it goes -- same question I  
12 asked before, you are aware that there's all kinds  
13 of -- there's all different types of diesel fuels?  
14 A. I am aware of that, yes, I am.  
13:09:48 15 Q. There's what they call red diesel, which  
16 is -- I think there's a dye poured in it so it can be  
17 used off road and not taxed. Some diesels are a  
18 higher sulfur content than others?  
19 A. Yes, that's true.  
13:10:02 20 Q. So there's a wide chemical composition of  
21 diesel fuels that are used in a variety of different  
22 vehicles, correct?  
23 A. Correct.  
24 Q. And, again, we can, I guess, from a rather  
13:10:15 25 crude scientific standpoint assume that the exhaust,

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13:10:19 1 depending on the source of the diesel fuel, may be  
2 slightly different at each collection if it's a  
3 different vehicle at a different time?  
4 A. That's correct.  
13:10:28 5 Q. Okay. And other than those variations,  
6 this protocol is exactly what you do for your diesel  
7 collection?  
8 A. Yes, that is correct.  
9 Q. Okay.  
13:10:39 10 MR. FRESHOUR: I think we're at a very  
11 good breaking point here.  
12 THE VIDEOGRAPHER: The time is 1:10  
13 p.m. This is the end of tape number three. We are  
14 going off the record.  
13:10:47 15 (Recess from 1:10 to 1:38)  
16 THE VIDEOGRAPHER: The time is 1:38  
17 p.m. This is the beginning of tape number four. We  
18 are on the record.  
19 Q. Doctor, when we had taken a short break, we  
13:38:14 20 had just gone through some of the -- what has been an  
21 exhibit to some of the protocols related to diesel  
22 exhaust fume antigens, as well as the jet fuel  
23 exhaust antigens. Do you recall that, sir?  
24 A. Yes, I do.  
13:38:31 25 Q. And going through these procedures during

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13:38:42 1 our break, I've flagged a couple of pages and I'm  
2 going to just ask you questions.  
3 MR. FRESHOUR: For purposes of the  
4 record, I'm going to remove the flags. It's just to  
13:38:53 5 identify them for questioning, Mr. Simon.  
6 Q. Near the back, it says it's EHC-D, which is  
7 Environmental Health Center of Dallas, that's the  
8 clinic, correct?  
9 A. That's correct.  
13:39:08 10 Q. Chemical listing numerical. Let me show  
11 you that. Do you know exactly what that's supposed  
12 to be telling us generally, Dr. Rea?  
13 A. I think it's probably tailored antigens for  
14 an individual.  
13:39:33 15 Q. Okay. As best you can tell from looking at  
16 it?  
17 A. As best I can tell, yeah.  
18 Q. And I want to ask you a couple of  
19 questions. Although we're not sure who the patient  
13:39:44 20 may or may not be or the tailoring, I don't think  
21 it's necessary for purposes of these questions, okay?  
22 A. Okay.  
23 Q. In there, one of the things -- and I'll be  
24 glad to show them all to you. It says north wind,  
13:39:59 25 and then there's a number out there, 0823. Do you

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13:40:05 1 know what north wind means?  
 2 A. Yes.  
 3 Q. Okay. What does that mean, sir?  
 4 A. Well, there's some people who get ill when  
 13:40:12 5 the north wind blows in, and so we made an extract of  
 6 it.  
 7 Q. And I will represent to you I've looked  
 8 through this and I didn't see a collection procedure  
 9 for the north wind. But generally how do you do  
 13:40:29 10 that?  
 11 A. Well, it would be generally the same,  
 12 except you just collect -- when the north wind blows  
 13 real hard, you just collect it from there.  
 14 Q. Okay. And, again, I would take it that,  
 13:40:39 15 for lack of a better term, the collection point would  
 16 be right there around your clinic?  
 17 A. Correct.  
 18 Q. I'm going to do the same thing. There's a  
 19 couple of them that I -- one says air, it says air  
 13:41:06 20 Dallas. It's just collecting an --  
 21 A. Probably ambient air of Dallas, I would  
 22 expect, yes.  
 23 Q. Okay. And other one says air office. Is  
 24 that --  
 13:41:16 25 A. It would be for our office, yeah, or

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13:41:18 1 somebody else's, you know, I can't be sure.  
 2 Q. What about south wind Richardson?  
 3 A. Well, that would be similar to the north,  
 4 north wind. This would be the south wind coming from  
 13:41:44 5 the south, probably somebody who lives in Richardson  
 6 had problems.  
 7 Q. What about -- this says coconut, Austin  
 8 air.  
 9 A. I would suspect that would be coconut  
 13:42:06 10 charcoal that was used for Austin air.  
 11 Q. What is -- it says zeolite, z-e-o --  
 12 A. Zeolite.  
 13 Q. Yeah.  
 14 A. It's some -- I don't know what it is, it's  
 13:42:20 15 some benign substance that people reacted to. Again,  
 16 probably a tailored antigen, you know.  
 17 Q. It says anthracite coal, Austin air.  
 18 A. Oh, I guess I made a mistake on that other  
 19 one.  
 13:42:35 20 Q. I'm sorry. It was zeolite --  
 21 A. No, I understand. But the one before, it  
 22 said Austin -- it said coconut, and this one said  
 23 anthracite. There are two different charcoals that  
 24 are used through the Austin air machine, which is a  
 13:42:49 25 filtration device. In some of the air filtration

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13:42:49 1 devices, some of the patients are sensitive to  
 2 different sources of charcoal. So, for example, if  
 3 you're sensitive to the coconut charcoal and you do  
 4 an antigen and it doesn't work, go ahead and use the  
 13:43:06 5 anthracite coal one, and see if it works.  
 6 Q. Okay. So the Austin air is not Austin,  
 7 Texas, it's the machine?  
 8 A. Yeah, I'm sorry, I made a mistake on that  
 9 one.  
 13:43:17 10 Q. Okay. One of them says -- and I'm going to  
 11 have to spell this. You may know what it is, Doctor.  
 12 A. Okay.  
 13 Q. It says porcelain, Cerabein ZR luster. Let  
 14 me spell it for you, Doctor -- and you can look at  
 13:43:34 15 it, too. C-e-r-a-b-e-i-n. Then a capital Z, capital  
 16 R, and the word "luster"?  
 17 A. I would suspect that that's porcelain used  
 18 for fillings or teeth.  
 19 Q. Okay. And then there's a number of other  
 13:43:53 20 porcelains, Omega --  
 21 A. Yeah.  
 22 Q. -- Impress?  
 23 A. That's what those are.  
 24 Q. So that porcelain is for like dental  
 13:44:01 25 fillings?

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13:44:02 1 A. Yes, that's correct.  
 2 Q. What is -- is it fusaric acid, what is  
 3 that?  
 4 A. Oh, that's a mycotoxin.  
 13:44:11 5 Q. Is that from the -- it's from the mold?  
 6 A. It's one of the molds, yeah.  
 7 Q. Okay.  
 8 A. Fusaric mold, I think.  
 9 Q. Okay. Thank you.  
 13:44:21 10 What is -- is it vanadium?  
 11 A. Vanadium?  
 12 Q. Vanadium.  
 13 A. That's an element like, you know, lithium  
 14 or calcium or magnesium.  
 13:44:33 15 Q. Now, also it shows down here, men's and  
 16 women's cologne.  
 17 A. Yes.  
 18 Q. And it shows the source, the mall. What  
 19 exactly is that, Doctor? What do you mean by that?  
 13:44:50 20 A. Oh, we have perfumes extracts and -- men's  
 21 cologne sometimes seems to be worse sometimes than  
 22 women's cologne for some people.  
 23 Q. Let me ask you this: Could the  
 24 compositions of -- how do you know what cologne to  
 13:45:07 25 choose? I mean, that sounds funny, but I'm serious.

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<p>13:45:11 1 A. How do we know? I mean, of course, number 2 one, the patient usually knows, but sometimes they 3 don't. But what we try to do is get every different 4 type of perfume or cologne and put it in there. You 13:45:23 5 have to constantly update it because, you know, there 6 are always these new things coming on the market. 7 Q. And that -- I guess a cologne in a sense 8 is, is it the same as diesel fuel? And what I mean 9 by that is, are there various chemical components 13:45:44 10 that make up a cologne, do you know, Doctor? 11 A. I think that there are, because, you know, 12 it used to be all flower fumes. But now there seems 13 to be a lot of synthetics that are involved in these 14 things. That's why I say it's really hard to keep 13:46:01 15 updating it. 16 Q. And I guess my question is, because you 17 said -- do you just get like one kind of cologne, or 18 do you mix a bunch together? I mean, how do you 19 determine it? 13:46:14 20 A. We mix a bunch together. 21 Q. And let me ask you, Doctor -- this may 22 sound silly, but let me do it this way: You mix Old 23 Spice, some Christian Dior scent, a Ralph Lauren 24 scent, and then you get some knock-off brand that you 13:46:40 25 would get at the Dollar Store and put them all</p>	<p>13:47:48 1 don't really care if it is one specific one. In 2 other words, you're trying to help the patient work 3 or help the patient survive, okay? 4 Q. And I guess my question is, something that 13:48:06 5 has multiple components to it, let's say, for 6 example -- I'm going to jump back. Let's go to 7 sulphur, the jet fumes, it's probably got -- I don't 8 know all the components. Probably it's got toluene 9 component, it's probably got multiple benzene 13:48:24 10 components, it's got some aliphatic hydrocarbons -- 11 A. Sure. 12 Q. -- probably got some hexane, maybe some 13 heptane. You make that solution, that antigen and 14 you give it to them and the individual reacts. How 13:48:42 15 do you discern, as a physician, if the reaction is to 16 only one specific component? Say, how do you know 17 it's the toluene versus the benzene versus the 18 heptane? 19 A. We don't care. I mean, all we care is if 13:48:58 20 the -- let's say it's the airline stewardess, okay, 21 and she can't work because she's -- every time she 22 goes to the airport she gets zapped, okay. Well, you 23 get a neutralizing treatment dose and it works for 24 her. So she's like the other personnel. Then it 13:49:15 25 doesn't matter.</p>
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<p>13:46:42 1 together? 2 A. Yes, yes, we do. Although we will tailor 3 them. Some people know exactly what brought it, some 4 people blanket, almost every odor bothers them, and 13:46:50 5 so you mix those. You have a composite. But then we 6 might tailor for -- if an individual, say, works 7 for -- knows that this Dior perfume bothers them, we 8 might make that particular one. Because sometimes 9 at, you know, they're working in a cubicle next to 13:47:09 10 somebody that insists on being doused with perfume 11 all the time, and they can't work. So you can 12 neutralize them for that. 13 Q. Let me ask you and kind of go back to where 14 you don't have an identifiable discrete perfume or 13:47:24 15 cologne. But if you mix, say, those four together, 16 just hypothetically. 17 A. Yeah. 18 Q. Let's do that. Hypothetically you mix 19 those together, if the individual reacts, my question 13:47:31 20 is, how do you know what they're reacting to? Is it 21 all of it, what components? I mean, how do you 22 discern that to make a treatment decision, Doctor? 23 A. Well, you go ahead and do the neutralizing 24 dose with the neutralizing technique. And if it 13:47:45 25 shuts off the reaction, that's all you care. You</p>	<p>13:49:19 1 Q. And you said a couple of times, and I want 2 to talk to you a little bit about this. You keep 3 talking about a treatment dose. 4 A. Yes. 13:49:27 5 Q. What do you mean when you say "treatment 6 dose," Doctor? 7 A. Treatment dose is the dose that shuts off 8 the provoked reaction. It's the dilution that shuts 9 off the provoke reaction. You know, we said 1 to 5, 13:49:43 10 1 to 25, 1 to 125, 1 to 625. Let's say that the 1 to 11 5 gave you provocation of all your symptoms, okay, 12 then the 1 to -- say the 1 to 125 turned off all your 13 symptoms, just they eliminated after you took that 14 shot, that's all you care. 13:50:02 15 Q. Well, and I guess my question is, if the 1 16 to 5 provokes and then the 1 to 25 doesn't provoke, 17 that's still -- so you're saying it doesn't matter 18 what component as long as whatever the diluted -- 19 because all the components are diluted 1 to 25, so it 13:50:28 20 doesn't matter? 21 A. Yes. 22 Q. Let me ask you this. I'm trying to 23 understand from an immunological standpoint. 24 A. Well, this may not be immunological, now. 13:50:41 25 Q. Okay. Well, let me understand it from a</p>

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13:50:43 1 layperson's standpoint.  
 2 A. That would be better.  
 3 Q. It would be easier -- probably better for  
 4 me.  
 13:50:47 5 A. Yeah.  
 6 Q. It does not provoke a response, but how --  
 7 is provocation different than neutralization?  
 8 A. Yes, that's right.  
 9 Q. Okay. So just because it does not provoke  
 13:51:09 10 does not necessarily equate to neutralization, does  
 11 it?  
 12 A. Generally you're not sensitive, then, if it  
 13 doesn't provoke.  
 14 Q. Then how does it neutralize?  
 13:51:21 15 A. Well, it has to provoke. You see what I'm  
 16 saying? I mean, if you've got a perfume and it makes  
 17 you sick and you reproduce your system with the 1 to  
 18 5, and then your symptoms keep going and you get a 1  
 19 to 25 and it turns it off, stops the reaction right  
 13:51:41 20 there cold. Say your nose was running, your eyes  
 21 were running, and it stops it right there, then  
 22 that's your treatment dose.  
 23 Q. Okay. So clarify for me, you've got a  
 24 treatment -- you're doing these, so -- you're doing  
 13:51:57 25 the testing at these certain levels to find out at

13:52:02 1 what level it no longer provokes. So that's the --  
 2 is that the diagnostic phase of it?  
 3 A. No, no.  
 4 Q. Okay.  
 13:52:08 5 A. The diagnostic part is you provoke it.  
 6 Provoke symptoms, okay.  
 7 Q. So at 1 to 5, I provoke?  
 8 A. Yeah.  
 9 Q. So that's diagnostic?  
 13:52:18 10 A. That's right.  
 11 Q. You drop down now to 1 to 25, it does not  
 12 provoke?  
 13 A. And the symptoms turned off.  
 14 Q. What do you mean "the symptoms turned off"?  
 13:52:28 15 A. Your eyes were watering, your nose was  
 16 running, it stopped it.  
 17 Q. Did it stop because of the dose or because  
 18 it was so diluted it just didn't trigger a reaction?  
 19 A. No, no, no. If you got the wrong dose, it  
 13:52:41 20 will continue to be provoked. That just happened to  
 21 be the nature of the physiology of it.  
 22 Q. So, so the minute -- okay, so you give me a  
 23 shot that's 1 to 5, my eyes water.  
 24 A. Yeah.  
 13:52:55 25 Q. That's the example you keep using. You

13:52:57 1 give me -- I assume you wait a while, you give me --  
 2 A. Ten minutes, ten minutes, usually.  
 3 Q. You give me 1 to 25. So now let me stop.  
 4 In that ten-minute interval, you've given it to me  
 13:53:10 5 and seven or eight minutes in, my eyes stop watering,  
 6 I stop having my symptoms, right?  
 7 A. Yes.  
 8 Q. Then you give the 1 to 25, correct?  
 9 A. Right.  
 13:53:19 10 Q. Nothing happens?  
 11 A. That's right.  
 12 Q. Okay. So you now have deduced, because my  
 13 eyes didn't water, that that is now the treatment  
 14 dose?  
 13:53:28 15 A. That's correct.  
 16 Q. Now that you've determined the treatment  
 17 dose, I have to do -- do I have to keep giving myself  
 18 these 1 to 25 shots?  
 19 A. For a period of time until you're okay,  
 13:53:46 20 until you get desensitized.  
 21 Q. And how do you determine the  
 22 desensitization, Doctor?  
 23 A. Well, when you get hit by that perfume  
 24 mess, you don't have any symptoms.  
 13:54:13 25 Q. And, Doctor, I want to go to this antigen

13:54:17 1 formulation again. What is orris root?  
 2 A. It's a root that they used to use in  
 3 cosmetics.  
 4 Q. One of the things you collect to test them  
 13:54:49 5 for is fireplace smoke.  
 6 A. Well, it's only if they have problems  
 7 around a fireplace.  
 8 Q. And how do you collect that?  
 9 A. Really similar to what we've done on the  
 13:55:00 10 other. You put a collector in front of a fireplace  
 11 wood and you, you know, it's either pine wood or hard  
 12 wood, soft wood or hard wood, so you try to collect  
 13 them, whichever one they have problems with.  
 14 Q. And when they say they are, you know,  
 13:55:22 15 allergic to fireplace smoke, do you, before you go in  
 16 and test, do you have them check and be sure they've  
 17 got all of the positive air flows and ventilations  
 18 that are required and they didn't just have the  
 19 damper shut on the fireplace when they reacted?  
 13:55:41 20 A. Well, of course.  
 21 Q. How do you make an antigen of stainless  
 22 steel, Doctor?  
 23 A. You soak it in that solution for 24 hours.  
 24 Q. In the coca solution?  
 13:55:50 25 A. Yes.

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13:55:53 1 Q. Okay. So you -- so --  
 2 A. Any of the metals are that way.  
 3 Q. Okay. Let's take stainless steel just as  
 4 an example, all right, Doctor?  
 13:56:03 5 A. Okay.  
 6 Q. And walk me through the process. You put  
 7 it into your coca solution, and it's the same coca  
 8 solution that's used for the car exhaust?  
 9 A. That's correct.  
 13:56:15 10 Q. So you've got your coca solution in a  
 11 beaker, tub, whatever?  
 12 A. Yeah.  
 13 Q. And you put in stainless steel into it.  
 14 Now is it, is it sheet metal, is it a metal rod?  
 13:56:28 15 What's the source material of the stainless steel?  
 16 A. We usually have metal rods because it's  
 17 something that somebody puts in the prosthesis. So  
 18 we've gotten the different rods from the companies.  
 19 And you soak the prosthesis in there, the rod from  
 13:56:45 20 the prosthesis. You can get small ones, you know,  
 21 for like plates.  
 22 Q. You just get the plate itself, not the  
 23 entire prosthesis, obviously?  
 24 A. Yeah. Well, there would be no reason to.  
 13:56:59 25 Q. Now, if somebody doesn't have, say, an

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13:57:02 1 artificial knee, an artificial hip, something like  
 2 that, why do you test them for stainless steel  
 3 sensitivity?  
 4 A. I don't unless they're working around it.  
 13:57:13 5 You have to remember, you've got a lot of antigens  
 6 there. We don't test the same antigens on everybody.  
 7 I mean, we just have groups of what their clinical  
 8 demands -- we have a whole segment of people in our  
 9 practice who have implants, a growing number, and  
 13:57:29 10 that's because I'm a cardiac surgeon, and I know  
 11 about implants, I've put plenty of them in. And so  
 12 we've developed that, and that's why Ms. E.L. came  
 13 down, because she's going to have a knee transplant  
 14 -- or a knee implant. She wanted to be sure that she  
 13:57:45 15 wasn't going to be sensitive to it.  
 16 Q. So you're testing them for anticipated --  
 17 you tested her for an anticipated --  
 18 A. Anticipated. But, of course, we do a lot  
 19 of people who have them in because they complain that  
 13:58:00 20 they've got excruciating pain.  
 21 MR. SIMON: But her particularly.  
 22 A. But her particularly. That's why we did  
 23 it. It worked successfully. She had her implant in  
 24 and she didn't have any pain and didn't get allergic  
 13:58:16 25 to it.

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13:58:17 1 Q. What about titanium alloy?  
 2 A. Same. See, the difference between -- I  
 3 guess you're seeing titanium and then titanium alloy.  
 4 Q. Right.  
 13:58:24 5 A. And one is pure titanium, okay. But if you  
 6 test them, say, for pure titanium and they don't  
 7 react, but they put a titanium alloy in there, that's  
 8 got copper, cobalt, nickel, malignum and several  
 9 different ones in there, and I've seen where just a  
 13:58:39 10 small percentage of them is what they reacted to.  
 11 Q. Okay. Well, take me back to the stainless  
 12 steel -- and I think I got a little ahead of myself,  
 13 Doctor.  
 14 A. All right.  
 13:58:53 15 Q. So you drop it in the coca solution. What  
 16 do you do to get the antigen? Walk me through the  
 17 process.  
 18 A. You'll have to get the process out, but  
 19 it's the same one.  
 13:59:04 20 Q. Soak it for --  
 21 A. 24 hours.  
 22 Q. Okay, 24 hours, then you -- you --  
 23 A. Dilute it down, remove it, dilute it down,  
 24 sterilize it first, see, you know, through the cold  
 13:59:15 25 filtration so that there's no bacteria or virus in

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13:59:20 1 there. And then you dilute it down. And then you  
 2 take that concentrate solution, dilute it 1 to 5, 1  
 3 to 25, just like the others.  
 4 Q. Well, let me ask you -- and this is a small  
 13:59:31 5 step in it, but if you've put that piece of metal in  
 6 there, do you just pour the solution out? Or how do  
 7 you extract the metal or extract the solution one way  
 8 or the other without some kind of contact that could  
 9 introduce a contaminant?  
 13:59:47 10 A. Well, they're sterile. The solution -- or  
 11 the metal is sterile when we do it.  
 12 Q. Now -- okay, I need to -- I'm trying to  
 13 understand, Doctor.  
 14 You put the piece in -- now, in that  
 13:59:59 15 24 hours, is the entire piece of metal dissolved?  
 16 A. Yeah -- it doesn't dissolve, no, it just  
 17 soaks in there. And whatever electrons or protons or  
 18 whatever elements come off, come off into the fluid,  
 19 okay.  
 14:00:12 20 Q. Right. Okay, stop right there. This is my  
 21 next question, Doctor. I guess I'm not saying it  
 22 very clearly.  
 23 So you've got a solution, let's say  
 24 for example it would look like the cup here of the  
 14:00:23 25 court reporter's (indicating).

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14:00:23 1 A. Yeah, okay.  
2 Q. There's a piece of metal in there and  
3 there's a solution, how do you get either the metal  
4 out or the solution out without touching it? I need  
14:00:31 5 to know that process.  
6 A. Pour it out.  
7 Q. Just pour it out?  
8 A. Yeah. Pour it in another flask or test  
9 tube.  
14:00:39 10 Q. The gold you test for, is that because of  
11 dental fillings?  
12 A. Yes.  
13 Q. How about the copper?  
14 A. Well, I think titanium alloy has copper  
14:00:56 15 cobalt in it, or chrome cobalt. Maybe the copper is  
16 separate, but it's in there. Some of the other  
17 different substances have copper. People are  
18 supplemented with copper as a nutrient.  
19 Q. What about the platinum?  
14:01:17 20 A. Same. Teeth, generally teeth, generally  
21 fillings.  
22 Q. How about palladium?  
23 A. Same.  
24 Q. Dental fillings?  
14:01:26 25 A. Yeah.

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14:01:27 1 Q. What is a trichothecene?  
2 A. That's a -- the mycotoxin that's put out by  
3 Stachybotrys and Ethлотoxin and the Aspergillus.  
4 Q. And so if you are making trichothecene into  
14:01:55 5 an antigen, I didn't see it in there -- and I may  
6 have missed it, Doctor. How do you do that?  
7 A. Well, same way. If you put in the  
8 mycotoxin and trichothecene, there's only -- you can  
9 only get commercially three mycotoxins. You know,  
14:02:14 10 you just, those are your -- and then you take them.  
11 Micro food are like a mold.  
12 Q. And all of these we've gone through -- and  
13 I just want to be clear because I may not have asked  
14 it. All of these antigens that we've just gone  
14:02:34 15 through, you've not sent them out to independent  
16 laboratories to break down the concentration or  
17 the -- all of the elemental compositions of them,  
18 correct?  
19 A. No, I have not.  
14:03:32 20 Q. Now, on a couple of your patients, you --  
21 and I want to talk -- just because we hit on the  
22 mycotoxin testing. There's a couple patients that  
23 you ran some --  
24 A. Urine.  
14:03:52 25 Q. -- urine, urine mycotoxin testing on,

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14:03:56 1 correct?  
2 A. Yes, that's correct.  
3 Q. And that urine mycotoxin testing was  
4 through a Dr. William A. Croft, correct?  
14:04:05 5 A. That's correct.  
6 Q. Now, one of the things is -- and I'll  
7 represent to you and I'll certainly be glad to show  
8 it -- I've got the results from June of '04 for  
9 patient E.F.  
14:04:18 10 A. Yeah, okay.  
11 Q. And Dr. Croft lists, and he tells the  
12 sample was processed, and then he says, no bacterial  
13 growth to total 100 mill -- MLS of urine was  
14 submitted, and then protein observed within the urine  
14:04:39 15 sample, and he goes 2, 2, 2, and he comes to a total  
16 of 4. It says, score of 8 was -- I'm sorry, a score  
17 of 8 was given to this urine sample out of a possible  
18 18. Are you familiar with those kind of reports from  
19 him?  
14:04:52 20 A. Yeah.  
21 MR. SIMON: We're not asking about  
22 that particular report, just in general?  
23 MR. FRESHOUR: In general. But I'm  
24 using this as an example.  
14:04:58 25 MR. SIMON: Yeah, because I'd say

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14:05:00 1 maybe you would want to see the document.  
2 THE WITNESS: Yeah, of course.  
3 Q. And I'll get to that.  
4 What is the unit? What does that 8  
14:05:07 5 mean? What unit is that, Doctor? And I'll be glad  
6 to show it to you.  
7 A. I was going to say I don't recall.  
8 (Mr. Freshour shows the  
9 document to witness)  
14:05:21 10 Q. And my question is just simply, do you know  
11 what kind of -- what that unit means, what that 8  
12 means?  
13 A. No, I can't really tell you right now.  
14 Q. Okay.  
14:05:32 15 A. I did at the time that we used him.  
16 Q. Do you use him anymore?  
17 A. No.  
18 Q. When did you quit using Dr. Croft?  
19 A. Oh, it's been probably three years ago.  
14:05:44 20 four years ago.  
21 Q. Okay. Are you using anybody for urine  
22 mycotoxin testing right now?  
23 A. Oh, yes. Yeah.  
24 Q. Who?  
14:05:57 25 A. Hooper.

40 (Pages 154 to 157)

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14:05:58 1 Q. Dennis Hooper?  
 2 A. Yeah.  
 3 Q. Out of California?  
 4 A. Well, he's in Richardson, Texas.  
 14:06:02 5 Q. He's in Richardson?  
 6 A. Yeah.  
 7 Q. Does he have a laboratory here?  
 8 A. Yes, he does, realtime laboratory.  
 9 Q. Okay. Is he an M.D., do you know?  
 14:06:27 10 A. Yes.  
 11 Q. And at the time that you were using  
 12 Dr. Croft, you were aware, obviously, that he was a  
 13 veterinary doctor and not a medical doctor, correct?  
 14 A. Oh, yes, yes, I was. At that time it was  
 14:07:00 15 the only people that knew much about molds.  
 16 Q. Are you aware that in March of 2005 that  
 17 the CDC came out with a data sheet on trichothecene  
 18 mycotoxins? Were you aware of that at all?  
 19 A. I believe I saw that.  
 14:07:25 20 Q. Yes. And were you aware that in one of  
 21 those things, one of the entries, it talks about  
 22 laboratory criteria for diagnosis for trichothecene  
 23 mycotoxins?  
 24 A. I don't recall.  
 14:07:38 25 Q. Okay. And I'm going to represent to you it

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14:07:40 1 said that, selected laboratories are offering  
 2 immunoassays to identify trichothecenes or  
 3 trichothecenes specific antibodies in human blood and  
 4 urine. Then they give a citation at the side, giving  
 14:07:56 5 a footnote 2 and 3, and then they follow with,  
 6 however, these procedures have not been analytically  
 7 validated and are not recommended. Were you aware of  
 8 that position from CDC?  
 9 A. No.  
 14:08:08 10 Q. I'm going to represent to you -- were you  
 11 aware that under footnote number 2, it's like  
 12 specifically to Dr. Croft and his clinic confirmation  
 13 of trichothecene mycotoxicosis in patient urine?  
 14 A. No.  
 14:08:21 15 MR. SIMON: Mr. Freshour, for the  
 16 record, was that physician that you are reading about  
 17 from the CDC, was that before or after these patients  
 18 were treated and after Dr. Croft's labs were  
 19 rendered?  
 14:08:37 20 MR. FRESHOUR: I'm going to let you  
 21 make that determination, Mr. Simon.  
 22 MR. SIMON: Okay. Because I was just  
 23 wondering about that.  
 24 MR. FRESHOUR: Well, and as I told  
 14:08:44 25 you, that came out -- the date on that was March of

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14:08:47 1 '05. I think I specified that. But if not, that's  
 2 what it is.  
 3 Q. Is the trichothecene antigen that you  
 4 talked about in your antigen prep, is that -- you  
 14:09:39 5 obtained that commercially? Is that one of the ones  
 6 you obtained commercially, Dr. Rea?  
 7 A. Yes.  
 8 Q. Now, Doctor, one of the things that you  
 9 believe or that you advocate is that continued  
 14:10:44 10 exposure over time, even to low level of chemicals,  
 11 can lead to the patient's sensitivity at some point,  
 12 correct?  
 13 A. Well, yes, that's a known fact.  
 14 Q. And then the -- and that, that goes to what  
 14:10:58 15 I think has been described, and I think I've read it  
 16 in some of your literature, is the -- kind of the  
 17 total load theory; is that correct?  
 18 A. It sure could be part of it, yes.  
 19 Q. Yes. And I think you've at various times  
 14:11:11 20 described it as it's like a rain barrel that fills up  
 21 and then all of a sudden, whatever that last little  
 22 bit of rain makes everything pour over, correct?  
 23 A. That's correct, yes.  
 24 Q. Okay. And I guess my question is on that,  
 14:11:25 25 is, under that theory, is it basically that at some

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14:11:31 1 unknown level or just at some point people can just  
 2 no longer handle chemicals, is that in a very crude  
 3 way what you're saying?  
 4 A. Yes. It's like somebody who had a lot of  
 14:11:42 5 bacteria, and they cut their skin. And let's say  
 6 that one time you washed it off real good and the  
 7 other time you didn't wash it off so good. It's the  
 8 same principle, you've got too many bacteria and the  
 9 patient got an infection the second time.  
 14:12:01 10 Q. In those patients, once whatever the event  
 11 is that sends them kind of over, if you will, into  
 12 the sensitivity, is it true that any further addition  
 13 of any chemical loading would cause them to worsen,  
 14 in your opinion?  
 14:12:23 15 A. Well, in some people, it does, yeah.  
 16 Others, it doesn't. They recover.  
 17 Q. So some -- one day somebody triggers, they  
 18 feel real bad, then for whatever reason, it passes.  
 19 I mean, do you see cases like that?  
 14:12:38 20 A. Yes, we do.  
 21 Q. Okay. And you see the other cases where  
 22 the people go over the edge and then they're --  
 23 A. Keep going on.  
 24 Q. -- allergic to everything?  
 14:12:46 25 A. Yeah.

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14:12:49 1 Q. In a person like that, where it seems to  
2 keep getting worse, is it, is it true or do you  
3 believe that those people, you shouldn't add anything  
4 to their chemical load at all because it's only going  
14:13:01 5 to get worse? Or how does that work?  
6 A. Well, you don't want to add anything to the  
7 chemical load that's of significance because you want  
8 to lighten it. On the other hand, there may be  
9 therapeutic things that you have to do to help buck  
14:13:17 10 up their detox systems or buck up their nutrient  
11 systems, and that could add to their load a little  
12 bit.  
13 Q. So you add to their load to lessen their  
14 load?  
14:13:30 15 A. I said occasionally.  
16 Q. Okay. And so on these patients that we're  
17 talking about today where you first gave them, let's  
18 say you give them a 1 to 5, they provoke, you give  
19 them a 1 to 25, they provoke, it's true that in those  
14:13:47 20 situations you have actually added to that person's  
21 chemical load, correct?  
22 A. Not if you've been able to neutralize it.  
23 Q. I didn't say you've been able to neutralize  
24 it, I said they provoked. So you've added to the  
14:13:59 25 load, haven't you?

14:14:01 1 A. Okay, yes, I would say. That's why some  
2 people you can't test.  
3 Q. So how do you then diagnose they've got  
4 chemical sensitivity if you can't test them?  
14:14:12 5 A. Well, you have to go by history and  
6 physical. You have to be a doctor.  
7 Q. So -- well, how do you make the  
8 determination that they're not a testable individual,  
9 Doctor?  
14:14:37 10 A. I -- well, number one, from clinical  
11 experience, you can tell. A lot of them are so  
12 fragile that there's no way they're going to do it.  
13 The other thing is is that you may have to do a probe  
14 and test one or two things and see. And if they  
14:14:53 15 react and you can't turn off their reactions, you  
16 know these -- you can't test right away.  
17 Q. You keep saying turn off the reactions,  
18 what does that mean medically, to turn off the  
19 reactions?  
14:15:04 20 A. Stop the reaction.  
21 Q. Well, and this is -- and I'm going to go  
22 back to it. I'm trying to understand that -- are you  
23 stopping the reaction at a dilute level, or are you  
24 just giving them such a dilute level that you're not  
14:15:20 25 creating a reaction?

14:15:22 1 A. No.  
2 Q. And is there a difference?  
3 A. There is a difference.  
4 Q. Okay. Explain it to me.  
14:15:24 5 A. Well, I did. A runny nose, we provoked it.  
6 The nose ran. We gave the second dose and it stopped  
7 it. That's a turn-off.  
8 Q. Right. But in the scenario I gave you, I  
9 said you wait seven minutes, it would shut off before  
14:15:38 10 the provocation, you gave it again, it didn't  
11 provoke. How do you know that you shut it off or it  
12 was so dilute you didn't trigger a reaction?  
13 A. Well, that might have been. But what you  
14 do then is you give it to them every four days and  
14:15:50 15 see. And if it does stop the reactions or prevent  
16 the reactions from occurring, you know that was a  
17 turn-off dose.  
18 Q. Well, is it preventing the reaction, or is  
19 it just not creating it at that level?  
14:16:01 20 A. No. When you -- like, for example, the  
21 patient then breathes it someplace down the line, and  
22 if it stops that reaction, then you know you got the  
23 turn-off dose. You might not even, you might not  
24 even treat it with a second -- or the number two dose  
14:16:22 25 because of the fact that they stopped at eight

14:16:25 1 minutes.  
2 Q. Well, let's say they didn't stop at eight  
3 minutes. Let's say at ten minutes you gave it to  
4 them. How do you know it was the dose that shut them  
14:16:41 5 off or that the higher dose had finally worn off and  
6 the lower dose doesn't provoke? How do you  
7 distinguish that?  
8 A. I just told you. The way you distinguish  
9 it is you treat them on the number two dose and see  
14:16:52 10 if they -- as they go through a few, few days, you'll  
11 know whether it's, it can start preventing the  
12 reaction or turn off the reaction right away.  
13 Q. Well --  
14 A. By empirical seeing, observing, clinical  
14:17:09 15 experience.  
16 Q. Well, let's take -- let's explore that,  
17 because I want to be sure I understand really the  
18 theory that you're articulating there. So say at a 1  
19 to 25, you say that's the treatment dose, a person  
14:17:32 20 doesn't react. You also say you want to stop giving  
21 them the chemical load, so if you can't distinguish  
22 between whether it's just stopping or too dilute to  
23 trigger a reaction, if you give them four days of  
24 that treatment, you are in essence still contributing  
14:17:48 25 to their chemical load, correct?

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14:17:50 1 A. Very, very miniscule.  
 2 Q. But you are contributing to their chemical  
 3 load?  
 4 A. I would think so, yes.  
 14:17:57 5 Q. All right.  
 6 A. That scenario is not a very good scenario  
 7 because what you really do is -- most of these, they  
 8 are still reacting in the ten minutes. So when you  
 9 give that second dilution, it shuts it off.  
 14:18:11 10 Q. Again, do you know if it's shutting it off  
 11 or if you give it and wait another ten minutes has  
 12 the first dose just completely worn off and the  
 13 second not provoked?  
 14 A. No. You can turn it off almost  
 14:18:23 15 instantaneously.  
 16 Q. And that instantaneous turn-off, should  
 17 that be reflected in your medical records?  
 18 A. No, because that's the technique.  
 19 Q. So you shouldn't record in the records what  
 14:18:33 20 the reaction was?  
 21 A. No, because it's a given. You know. You  
 22 record the reaction, okay, but then, then you'll have  
 23 one that says, say, five over three, okay, bang,  
 24 that, that's the neutralizing dose because there's no  
 14:18:51 25 more reaction. That's just a given. Your tester

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14:18:54 1 does that, he knows that, no need to write it down.  
 2 Q. Okay. And the reactions you're talking  
 3 about in these patients, at certain doses -- and I  
 4 think we can probably use some of the patients, and  
 14:19:06 5 we'll get to them today -- you know, at two five,  
 6 they say it's a headache and they feel flush, then  
 7 you give it to them at five five and they say, my  
 8 left elbow hurts.  
 9 A. Uh-huh.  
 14:19:23 10 Q. Well, if it's, if it's a triggering or  
 11 provoking dose, why is the symptomatology completely  
 12 different and it provoked reaction at the changing  
 13 doses? Shouldn't it systemically or from a symptom  
 14 standpoint create more or less the same reaction?  
 14:19:41 15 A. Well, it does sometimes. But sometimes  
 16 it's called a switch phenomena because it's a  
 17 neurological reaction and they'll go to each --  
 18 another organ. Well, if that's the case, then you've  
 19 got to wait until that goes away also.  
 14:19:57 20 Q. Well, how do you know what organ it's going  
 21 to to trigger the reaction?  
 22 A. You don't.  
 23 Q. What's the half life of hexane?  
 24 A. I think it's about two hours.  
 14:20:08 25 Q. What's the half life of --

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14:20:10 1 A. Two to four hours.  
 2 Q. Okay. What's the half life of heptane?  
 3 A. I think much similar.  
 4 Q. And when you're giving these antigens, is  
 14:20:34 5 there a specific target organ that you're looking to  
 6 affect or what?  
 7 A. Yes, it's individual for an individual  
 8 patient. It can be any of the neurological -- or any  
 9 of the organs, major system, musculoskeletal,  
 14:20:54 10 neurological, cardiovascular, so on.  
 11 Q. So --  
 12 A. That's an individual thing.  
 13 Q. And given that the half life, say, of  
 14 heptane, for example, is about two hours, if you give  
 14:21:10 15 it in a 1 to 100,000 solution or dosage, how do you  
 16 know it even reaches the target organ and it just  
 17 isn't excreted by simply going straight through the  
 18 system?  
 19 A. Well, the patient is hypersensitive, you're  
 14:21:28 20 only doing these on people who are hypersensitive.  
 21 The half life, then, really doesn't have a lot to do  
 22 with it on these short half lives. I've seen  
 23 reactions for that same thing last -- if you didn't  
 24 neutralize it, last for a day or two. Well, that  
 14:21:42 25 doesn't have anything to do apparently with the half

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14:21:44 1 life. It has to do with what was triggered in the  
 2 body.  
 3 Q. Well, and could -- and a lot of the  
 4 reactions that are described by your patients --  
 14:21:59 5 A. Yes.  
 6 Q. -- when antigen tested, they're fairly  
 7 subjective, lots of times, right? They're like, my  
 8 elbow hurts, my head hurts, my eyes feel pressure.  
 9 Those are subjective, you can't measure those, can  
 14:22:12 10 you, Doctor?  
 11 A. No, but I can measure the other things.  
 12 What if they're short of breath? Can I measure that?  
 13 Not really, but I can observe it. Can I measure with  
 14 a blow meter and quantitate it? You bet I can. If  
 14:22:25 15 I've got some that's got -- they're hurting in the  
 16 hand and the hand turns blue or their finger turns  
 17 blue, I can see that there's vascular spasm there.  
 18 And I can also do a pulse oxygen and it will show it  
 19 going down in that area.  
 20 So, you know -- I mean, it's like  
 21 everything else that one does in medicine, there are  
 22 some things that you can objectify and you always  
 23 have to have the patient have credibility before you  
 24 take just symptom, symptom responses, okay?  
 14:22:57 25 Q. Okay.

43 (Pages 166 to 169)

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14:22:58 1 MR. FRESHOUR: And I'm going to object  
2 as nonresponsive because my question was, wasn't  
3 things like pressure in the eyes and a pain in the  
4 left elbow subjective.

14:23:06 5 Q. That was my question.  
6 A. And I said yes.  
7 Q. Okay. Thank you.  
8 A. But then I elaborated so you would  
9 understand what I was talking about.

14:23:12 10 Q. I understand.  
11 So when you -- and this goes even to a  
12 lot of the exposure history. You're taking the  
13 patient's word for whatever they're describing as it  
14 relates to these subjective symptoms and  
15 manifestations, correct?  
16 A. Well, if they're subjective, I'm taking it.  
17 Why do people come and pay money to physicians to  
18 solve the problem, right? So are they going to lie  
19 to me? Well, I suppose one in a thousand will. But  
20 on the other hand, most people who take their time  
21 and money want to get well. That's the ones I like  
22 to treat.  
23 Q. Doctor, would you agree, generally, that  
24 we -- and when I say "we," just the public at  
14:24:07 25 large -- are still finding out more and more about

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14:24:10 1 the long-term consequences from use or exposure of  
2 chemicals?  
3 A. Yes, I would say that's true.  
4 Q. Okay. And so it's fair to say, although we  
14:24:25 5 don't know, even at your dilute solutions, it's  
6 possible that your antigens could be contributing to  
7 a long-term problem as far as the state of science  
8 right now, right?  
9 MR. SIMON: Object to the form.

14:24:36 10 Speculative.  
11 A. Wrong.  
12 Q. You couldn't be contributing? You're sure  
13 of that?  
14 A. I'm pretty sure, yes. I've been practicing  
14:24:44 15 long enough to know that.  
16 Q. Have you done long-term follow-up studies  
17 with your patients that you treated years ago to see  
18 if they've had further consequences or  
19 manifestations?  
20 A. Yes, I have, yes.  
21 Q. You are aware that some of the components  
22 in gasoline and diesel fuel are carcinogenic or  
23 teratogenic, correct?  
24 A. Yes.  
14:25:11 25 MR. SIMON: Object to the form in

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14:25:14 1 retrospect.  
2 Q. One of the things that you, I think tested  
3 perhaps one, maybe two of these patients -- and if  
4 I'm mistaken, correct me, Doctor -- is lake algae,  
14:25:39 5 correct?  
6 A. Yes.  
7 Q. Okay. How do you get your lake algae for  
8 making your antigen?  
9 A. We collect them from ponds. We have red  
14:25:49 10 algae, blue algae, green algae.  
11 Q. From ponds. I mean, do you own the ponds?  
12 Where are the ponds?  
13 A. Out in the country.  
14 Q. Any particular place in the country?  
14:26:00 15 A. Well, a place where there's not any  
16 pesticides or anything sprayed.  
17 Q. Where are your ponds, Doctor?  
18 A. East Texas.  
19 Q. Can you be a little more specific? Around  
14:26:11 20 Tyler? Marshall? Henderson? Mount Vernon? Sulphur  
21 Springs? Where?  
22 A. Lake Tawakoni, near Lake Tawakoni.  
23 Q. Lake Tawakoni.  
24 What's the -- so there's a separate  
14:26:29 25 pond for each kind of algae?

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14:26:32 1 A. There are separate types of algae. There's  
2 green algae, blue algae and red algae.  
3 Q. Are they in separate ponds, or are they all  
4 in one pond?  
14:26:42 5 A. I can't really tell you that. I suppose  
6 that at some certain times of the year they may be in  
7 the same pond. They may not be.  
8 MR. SIMON: He doesn't do the  
9 collection.  
14:27:00 10 Q. Depending on the waterway, would you agree  
11 that there may be different compounds found in the  
12 algae, depending on the waterways?  
13 A. Yes.  
14 Q. Okay. So I think generally, do you think  
14:27:17 15 that possibly -- I mean, algae as an organism is --  
16 structurally more or less looks the same, is that  
17 true? Or do they look structurally different, do you  
18 know?  
19 A. I really don't know. I can't --  
20 Q. Okay. So would you agree that probably a  
21 saltwater algae is different than freshwater algae?  
22 A. It's possible.  
23 Q. Okay. And you're treating your patients --  
24 when you do algae testing, it's the freshwater algae?  
14:27:45 25 A. Generally I would say yes, unless, unless

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14:27:47 1 they have lived by the ocean and they complained of  
2 that particular algae, then we might have them catch  
3 it and make a vaccine for them.  
4 Q. A vaccine or an antigen?  
14:27:59 5 A. Antigen, I'm sorry.  
6 Q. I just want to be sure, because I think  
7 there's a difference between those two, right?  
8 A. Well, I suppose, yes.  
9 Q. Well, if there isn't, Doctor, you can  
14:28:07 10 certainly explain it to me, because I really don't  
11 know.  
12 A. Well, no, I won't go any further than that.  
13 There is a difference.  
14 Q. Well, in exploring this algae thing just a  
14:28:20 15 little bit further, do you agree that algae from a  
16 lake in Texas probably in August would not be the  
17 same as an algae from a lake in -- high up in the  
18 Adirondacks in April?  
19 A. It's possible. I can't agree that it may  
14:28:38 20 not be the same. But it's possible, put it that way.  
21 Q. Well, and I guess, then, the -- one of the  
22 other things is, that these east Texas ponds that  
23 you're using, I mean, how do you know that the ponds  
24 aren't being subjected to runoff from, say, a coal  
14:29:05 25 plant or anything of that nature?

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14:29:07 1 A. I don't know any coal plants around there.  
2 Q. Okay. Well, if -- this is around Lake  
3 Tawakoni, right?  
4 A. Uh-huh.  
14:29:16 5 Q. Is it in a particular town?  
6 A. No.  
7 Q. It's just out there by Lake Tawakoni?  
8 A. Yeah.  
9 Q. Okay. Are there any farms around there?  
14:29:27 10 A. No, they're all ranches.  
11 Q. Ranches, okay. So cattle, horses?  
12 A. Yes.  
13 Q. Probably do some hay baling out there, have  
14 pastures?  
14:29:40 15 A. Yes.  
16 Q. How do you know they're not using  
17 pesticides?  
18 A. Because we don't use those.  
19 Q. I'm not asking -- it's your ranch?  
14:29:47 20 A. I have a ranch and then I have neighbors,  
21 and I know all the neighbors.  
22 Q. Okay. So let me ask you -- I guess I've  
23 got to be real specific, Doctor.  
24 The ponds that you get your algae from  
14:29:57 25 for algae testing your patients are on your ranch?

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14:30:01 1 A. Well, generally. Not always, but  
2 generally.  
3 Q. So what other places do you get algae from?  
4 A. I sometimes will do it from west Texas.  
14:30:16 5 Q. Where in west Texas?  
6 A. Well, out there where there's hardly  
7 anything, past Possum Kingdom.  
8 Q. Let me ask you, you get a patient from the  
9 northeast, who lives in New York City.  
14:30:31 10 A. Yeah.  
11 Q. Mostly saltwater around there, there's some  
12 freshwater?  
13 A. Yeah, there's both.  
14 Q. So how do you determine if they're -- why  
14:30:42 15 would you test them with an algae from east Texas,  
16 taken in August, if they were exposed to their  
17 claimed algae somewhere in New York and you don't  
18 know what the body of water was they were exposed to?  
19 How does that help you.  
14:30:55 20 MR. SIMON: Object to the form.  
21 That's assuming they are exposed to  
22 algae?  
23 MR. FRESHOUR: Yes.  
24 A. Well, how we would do it, number one, we  
14:31:02 25 would have to see whether they were exposed to algae,

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14:31:05 1 and number two, if they were, we might test them here  
2 and see if there was a cross reaction, because a lot  
3 of them do have cross reactivity, and third, if not,  
4 we would have them collect some and make a specific  
14:31:20 5 one for them.  
6 Q. So then the algae for the source of the  
7 antigen would come from them and you wouldn't know  
8 any way how it was handled, shape, form, nothing,  
9 correct?  
14:31:29 10 A. Well, we would tell them how to handle it.  
11 Then I wouldn't know for sure. But, again, these are  
12 people who want to get well.  
13 Q. When you do some antigen testing, is there  
14 any risk or concern that there may be some kind of a  
14:31:47 15 reaction such as an anaphylactic shock?  
16 A. Well, that's the nice thing about this  
17 technique we use, we have the largest series in the  
18 world of treating anaphylactic shock. And we've  
19 never had one from testing.  
14:32:03 20 Q. You have the largest series?  
21 A. Yes. Of people who go into anaphylactic  
22 shock with different things.  
23 Q. I'm sorry, I don't understand, Doctor.  
24 A. Well, you may not be aware of it, but there  
14:32:15 25 are people who have to carry adrenaline around all

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14:32:19 1 the time because they go into anaphylaxis with  
2 certain exposures, insects, things, or eating a food  
3 or smelling the odor of peanuts or some chemical or  
4 whatever, okay. That's dying episodes, okay. That's  
14:32:33 5 a good way to die real fast. And we have treated 150  
6 of those where they've been able to get around the  
7 substances by this neutralization technique.  
8 Q. Do you have the underlying data on those  
9 150?  
14:32:48 10 A. Of course I do. It's written up in my  
11 book,  
12 Q. Do you have the underlying data that  
13 supports what's written in your book?  
14 A. I don't know whether I do anymore. Why?  
14:32:55 15 Would you think I'm lying?  
16 Q. I'm just asking the question, Doctor.  
17 A. No, I'm asking you that.  
18 Q. I ask the questions here, Doctor. I'm not  
19 trying to be disrespectful. I'm asking you a  
14:33:02 20 question. Do you have the underlying data for the  
21 150 patients you just --  
22 MR. SIMON: That's asked and answered.  
23 He said he doesn't know if he has it down in --  
24 A. I probably do, but I don't know yet.  
14:33:10 25 Q. All right.

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14:33:11 1 MR. FRESHOUR: Probably a good  
2 breaking point here.  
3 THE VIDEOGRAPHER: The time is 2:33  
4 p.m. This is the end of tape number four. We are  
14:33:19 5 going off the record.  
6 (Recess from 2:33 to 2:38)  
7 (Mr. Cook is now present)  
8 THE VIDEOGRAPHER: The time is 2:38  
9 p.m. This is the start of tape number five. We are  
14:38:36 10 on the record.  
11 Q. Dr. Rea, we were just going through a line  
12 of questioning that dealt with some provocation and  
13 neutralization, then we were talking a little bit  
14 about lake algae, and we had a discussion over you  
14:38:52 15 testing some patients for lake algae and the source  
16 of the lake algae. And you indicated it was from a  
17 ranch in east Texas and it was your ranch, correct?  
18 For the most part, there may be a few other sources.  
19 A. Correct.  
14:39:08 20 Q. What is the collection and antigen  
21 formulation method you used for your lake algae  
22 antigen?  
23 A. Well, we would scoop up the algae and put  
24 it in a flask, and then put it in the coca solution  
14:39:25 25 and do just like we do for the other molds.

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14:39:29 1 Q. And I don't know how far your ranch is from  
2 Dallas, but there's a transport period. Is it just  
3 in the flask? Is it iced? What's the mechanism and  
4 chain of custody?  
14:39:41 5 A. Just in the flask, and it's about an hour.  
6 Q. Okay. It's about an hour drive?  
7 A. Yeah.  
8 Q. Okay. And then you put it through the coca  
9 solution, do you -- have you ever tested any of the  
14:39:54 10 algae that comes from your ponds, for lack of a  
11 better term, from your ponds for parasites, bacterias  
12 or heavy metals?  
13 A. No.  
14 Q. Now, those allergies that are out there,  
14:40:13 15 are those naturally occurring algae, or have you  
16 brought in some specimens to create the algae colony  
17 growths?  
18 A. No, they're naturally occurring.  
19 Q. Okay. Doctor, you would just agree as a  
14:40:52 20 general proposition that at least some of your  
21 medical views that we're discussing here today are at  
22 least controversial or disputed by another whole  
23 segment of the medical community, fair enough?  
24 A. I would say a small segment, yes, uh-huh,  
14:41:11 25 as is most things in medicine that progress.

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14:41:15 1 Q. Okay. And were you aware of an article in  
2 the -- let me make sure I cite the proper journal,  
3 Doctor. A Journal of Allergy and Clinical Immunology  
4 in December 6 (sic), did you ever read an article, it  
14:41:43 5 was about multiple chemical sensitivities, a  
6 systematic review of provocation studies. Are you  
7 familiar with that article?  
8 A. No.  
9 MR. SIMON: December 6 of what year?  
14:41:53 10 MR. FRESHOUR: I'm sorry, it's  
11 December of '06.  
12 A. Of '06?  
13 Q. Yes.  
14 A. I may have read it. I don't know. It's  
14:41:59 15 been a long time.  
16 Q. Okay. And they're talking generally about  
17 provocation studies, and they've done a review. It  
18 included a citation to your work in there. I don't  
19 know if you're aware of that.  
20 Are you aware that they concluded that  
21 persons with -- and I know you don't agree with this  
22 term so don't object to that, Doctor -- multiple  
23 chemical sensitivity do -- we conclude that persons  
24 with MCS do react to chemical challenges; however,  
14:42:27 25 these responses occur when they can discern the

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14:42:29 1 differences between active and sham substances,  
2 suggesting that the mechanism of action is not  
3 specific to the chemical itself and might be related  
4 to expectations and prior beliefs. Were you aware of  
14:42:40 5 that article or that finding?  
6 A. I think I was. It wasn't a finding. It  
7 was just their opinion.  
8 Q. But you are aware of that?  
9 A. Biased opinion, yes.  
14:42:49 10 MR. SIMON: You are aware of the  
11 article?  
12 THE WITNESS: Yes, I believe I was,  
13 yeah.  
14 Q. And you said it's a biased article?  
14:42:56 15 A. Obviously.  
16 Q. Okay. And it is obviously biased because  
17 it disagrees with you or --  
18 A. There's a lot of points in there that it  
19 showed people were uninformed.  
14:43:05 20 Q. Okay. I just wanted to be sure the basis  
21 that you --  
22 A. Yeah, I wanted you to be sure of that, too.  
23 Q. Okay. Well, I'm very clear on that.  
24 All right, Doctor, you run a number of  
14:43:20 25 different tests on your patients that you see for

14:43:26 1 chemical sensitivity, correct?  
2 A. Well, sometimes, yes.  
3 Q. Well, let me be sure. I think in most of  
4 these patients we're looking at today, and what I've  
14:43:37 5 seen, is you quite often use pupillography, correct?  
6 A. Yes, that's correct.  
7 Q. Heart rate variability?  
8 A. Yes.  
9 Q. SPECT scan?  
14:43:48 10 A. I don't use that on everybody, no.  
11 Q. But you do use it in your practice?  
12 A. I do, surely.  
13 Q. And I don't recall, do you recall right off  
14 the top of your head, did any of the five that we've  
14:43:58 15 got here have a SPECT scan?  
16 A. Yeah, I think one or two of them did.  
17 Q. Sometimes you do a chelation testing; is  
18 that true?  
19 A. No.  
14:44:09 20 Q. You don't? Do you use chelation at all?  
21 A. Very, very rare.  
22 Q. Do you recall that any of these patients  
23 had any chelation?  
24 A. Not to my knowledge.  
14:44:25 25 Q. Heat depuration?

14:44:27 1 A. Yes.  
2 Q. And that's a treatment, not a test,  
3 correct, Doctor?  
4 A. Yes.  
14:44:32 5 Q. Thermography?  
6 A. Yes.  
7 Q. And that's a test, correct?  
8 A. Yes.  
9 Q. All right. And this is in addition to the,  
14:44:42 10 some of the -- and you always -- not always, but you  
11 do a lot of blood and serum testing, correct, on  
12 these patients?  
13 A. Yes.  
14 Q. On a number of them, you did urine testing,  
14:44:51 15 correct?  
16 A. Yes, some, some.  
17 Q. For specific things?  
18 A. Yes.  
19 Q. But generally you did some urine testing?  
14:44:58 20 A. Yeah.  
21 Q. Did some hair analysis?  
22 A. Yes.  
23 Q. I think in most of them you did -- I guess  
24 I have to say it, all of your -- various antigen and  
14:45:10 25 testing, as well as food sensitivities, correct?

14:45:13 1 A. Yes.  
2 MR. SIMON: Mr. Freshour, when you  
3 refer to "them," we mean these five patients?  
4 MR. FRESHOUR: These five generally.  
14:45:19 5 MR. SIMON: The subject of the  
6 complaint?  
7 MR. FRESHOUR: Uh-huh. All right.  
8 Q. Now, Doctor, when we talked quite a while  
9 ago, we talked about medical records and you need to  
14:45:39 10 list things, and talk about things like thyroid, if  
11 there's thyroid condition, if there's diabetes,  
12 because those are important in helping you come to a  
13 diagnosis, right?  
14 A. Yes.  
14:45:51 15 Q. Because those conditions can certainly  
16 impact your decision as a physician, correct?  
17 A. Correct.  
18 Q. Now, before we get real deep into that,  
19 generally what is a differential diagnosis, Doctor?  
14:46:10 20 A. Differential diagnosis is a person has a  
21 set of symptoms, you want to see what, which  
22 diagnosis fits, is it something like lupus or  
23 something like arthritis or something like  
24 gastrointestinal upset, colitis, so on.  
14:46:31 25 Q. All right. And I think we hear -- as

14:46:34 1 laypeople, sometimes we hear the term "rule in" and  
2 "rule out" in medicine, right?  
3 A. Yeah, that's right.  
4 Q. What does that generally mean to you,  
14:46:43 5 Doctor?  
6 A. Well, generally it means that there's  
7 certain, a certain disease. Let's say you got -- you  
8 worry about meningitis and you want to rule out the  
9 cause, meningococcal or hemophilus or whatever, and  
14:47:01 10 so you can specifically diagnose something or you can  
11 say, no, they for sure don't have that.  
12 Q. Now, when you're doing some of the  
13 testing -- and I particularly want to talk a little  
14 bit about laboratory testing. Quite often, we'll  
14:47:16 15 see -- in laboratory testing, you'll see what's  
16 called a reference range in the results.  
17 A. Yes.  
18 Q. And my understanding is -- and correct me  
19 if I'm wrong -- a reference range is what has been  
14:47:28 20 determined looking at a number of individuals that  
21 are tested and this is what basically the average  
22 findings are for whatever the test may be?  
23 A. Yeah, that's correct, average.  
24 Q. And that's called -- normal population,  
14:47:39 25 usually, a reference range, an average population?

14:47:43 1 A. Average population, not a normal  
2 population.  
3 Q. Okay. Average.  
4 And then what you do is -- when a  
14:47:50 5 laboratory normally does a test, they do whatever the  
6 test is you've ordered on your patient and they send  
7 back the results, they list the specific findings,  
8 whatever the test is, of that patient. And that's  
9 normally compared to what we're calling this  
14:48:04 10 reference range or average --  
11 A. Average patient, yeah.  
12 Q. Okay. And that's because that gives you a  
13 frame of reference to know, this is what the average  
14 patient looks like and here's where -- that just  
14:48:17 15 helps you, correct?  
16 A. Yeah, sometimes it does. Sometimes it  
17 doesn't.  
18 Q. Okay. And what are you looking for in  
19 those kinds of ranges that do help you? And you say  
14:48:27 20 sometimes it doesn't. What are you kind of telling  
21 me generally?  
22 A. Well, I mean, sometimes, for example, take  
23 thyroid, some people will fall like in the lower  
24 limits of average range. And, in fact, for them,  
14:48:41 25 they might be hypothyroid and they might need some

14:48:46 1 thyroid supplementation.  
2 Q. What you're talking about there is what  
3 we're now seeing a lot of, is this subclinical  
4 hypothyroidism?  
14:48:54 5 A. That's correct, yes.  
6 Q. Where you look at a thyroid-stimulating  
7 hormone level and it's in the normal range, but it  
8 may be towards the low end, and it appears that  
9 they've got subclinical hypothyroidism?  
14:49:07 10 A. That's all I'm saying, yes.  
11 Q. Okay. Now -- so you're looking at these  
12 average ranges, and you test your patient, and you  
13 get the results -- and where I'm really going with  
14 this -- I'll go directly to the point. The chelation  
14:49:27 15 testing. I'll represent to you --  
16 A. Chelation testing.  
17 Q. Chelation.  
18 MR. SIMON: He said he doesn't do it.  
19 MR. FRESHOUR: Okay. Let me ask my  
14:49:35 20 question. If you've got an objection, Mr. Simon,  
21 I'll, you know, be glad to hear it.  
22 Q. I'm going to represent to you that in --  
23 and I don't remember the patient. I'll find it if we  
24 need to. But one of these patients had a 24-hour  
14:49:47 25 urine heavy metal test. Do you recall --

14:49:50 1 A. Yes.  
2 Q. Okay. And I will represent to you at the  
3 bottom of the sheet it was done by [Redacted].  
4 it said that --  
14:49:58 5 MR. SIMON.  
6 Q. [Lab name redacted]  
7 It said something to the effect that  
8 these reference are the normal population range that  
9 we've established.  
14:50:07 10 A. Okay.  
11 Q. That means that laboratory --  
12 A. Yes.  
13 Q. -- has established what they consider --  
14 A. Do they say normal or average?  
14:50:13 15 Q. I believe they said normal.  
16 A. All right.  
17 Q. And we'll double-check. If it's average, I  
18 will certainly correct it.  
19 Do it over 24 hours and get these  
14:50:23 20 heavy metal urine results. Then the patient is  
21 chelated. It shows what they call a provoke test, ...  
22 says at the bottom provoke, meaning they had a  
23 chelating agent, okay. Now, my understanding is a  
24 chelating agent is a material that is ingested by the  
14:50:44 25 individual with the thought being that it will grab

14:50:46 1 any heavy metals in the body and flush them out  
2 through the urine, correct?  
3 A. Yes.  
4 Q. Rather crude description, but generally  
14:50:54 5 that's what it is, right?  
6 A. That's correct.  
7 Q. Now -- and I want to understand, because in  
8 this particular patient, I think -- and I'm sorry,  
9 I'll find out who it is. One of the determinations  
14:51:09 10 you made was this person had heavy metal toxicity.  
11 MR. SIMON: Mr. Freshour, I think  
12 we've got to venture into the particulars of the  
13 medical record.  
14 MR. FRESHOUR: Let me withdraw the  
14:51:24 15 question and ask --  
16 MR. SIMON: Here's what the problem  
17 is, that the medical records are in the --  
18 MR. FRESHOUR: Mr. Simon, I withdrew  
19 the question. Let me go.  
14:51:30 20 MR. SIMON: Okay.  
21 Q. I'm going to represent to you that the  
22 patient had a chelation test and they found abnormal  
23 levels after the chelation test, after the provoke.  
24 But the comparison was for the chelated patient  
14:51:42 25 against the normal unchelated patients.

14:51:47 1 A. All right.  
2 Q. Okay. Now, I'm trying to understand how,  
3 if that person was first average without chelation,  
4 that being your patient, against this same normal  
14:51:57 5 range, then you chelate them with an expectation of  
6 having higher metal levels removed, how can you use  
7 that if it's compared to a reference range of a  
8 non-chelated average or normal group? What use is  
9 that? Because you would expect higher levels,  
14:52:13 10 wouldn't you?  
11 A. Well, you don't necessarily get higher  
12 levels. A lot of them, nothing comes out when you do  
13 that.  
14 Q. Well, let me ask you, if you're  
14:52:22 15 comparing -- if you're going to compare a chelated  
16 range against a -- the first test was non-chelated  
17 versus non-chelated, right?  
18 A. Yes, that's right.  
19 Q. So if you're comparing to see if what was  
14:52:35 20 drawn out of this person, by chelating, it would seem  
21 to me as a layperson, make more sense they should be  
22 against a normal chelated population to see if it's  
23 the same kind of results coming.  
24 A. Well, if that's what you're asking, you're  
14:52:51 25 right. But the point is, when it's only -- it's a

14:52:54 1 small part of the burden, and it wasn't within the  
2 patient's history, physical or complaints. If they  
3 had a little bit of, say, mercury or lead come out of  
4 them, that would only be what's part of the burden,  
14:53:08 5 then you might try to get it out just so you could  
6 lower the burden. It doesn't really matter whether  
7 it's compared to a normal or not, because what you're  
8 saying is, hey, these people have got mercury parked  
9 someplace in their body, we would like to get rid of  
14:53:26 10 that so we can start treating the other things and  
11 take care of it.  
12 Q. Well, and how do you know if it's a burden  
13 on them if you're not comparing them against the  
14 normal population? Because if you chelated them and  
14:53:37 15 they came out with the same results and they're not  
16 showing any, how do you know you're relieving a  
17 burden?  
18 A. Well, because, number one, you're not  
19 supposed to have mercury in you and you're not  
14:53:46 20 supposed to have lead in you, you're not supposed to  
21 have cadmium in you. So you know that that's part of  
22 a burden, always. Some may have symptoms, some may  
23 not, but it's still part of their body burden.  
24 Q. Okay. And what I'm trying to do is, as a  
14:54:01 25 layperson, understand that if you've got a

14:54:04 1 non-chelated to a non-chelated, that's kind of like  
2 an apple to an apple. It seems to me when you look  
3 at a chelated versus a non-chelated and say the  
4 levels are abnormal, that's an apple and an orange  
14:54:17 5 comparison.  
6 A. So?  
7 Q. So you don't see anything wrong  
8 with comparing --  
9 A. Not in that situation because of what I  
14:54:22 10 said. If you've got, if you've got mercury in you,  
11 you don't want it in you, I'm going to tell you that.  
12 And you don't want cadmium in you and you don't want  
13 lead in you, because it's very devastating over the  
14 long run. And in these patients -- I'm not sure  
14:54:38 15 which one you're talking about here, because I don't  
16 recall I chelated any of them -- is that we would do  
17 that just to decrease their burden, their total body  
18 burden, part of the barrel effect.  
19 Q. Right. But if you say to them, you're  
14:54:51 20 burdened with heavy metals because of that chelated  
21 result, isn't it true to say that if it's based on  
22 that ... test in the normal range, it's a  
23 self-fulfilling prophecy because you chelated them,  
24 you would expect the metals to come out if the  
14:55:06 25 chelation works, so, therefore, oh, look your levels

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14:55:09 1 are abnormal?  
 2 A. Only if the metal is there. If the metal  
 3 is not there, you're not going to have any.  
 4 MR. FRESHOUR: Mr. Simon, I wish you  
 14:55:18 5 would quit with the head and the arm gesture.  
 6 MR. SIMON: I'm sorry, I'm just, I  
 7 just want to maybe -- and I'm going to shut up after  
 8 this. I guess that the differential between the  
 9 schools of thought is one is an elective procedure,  
 14:55:31 10 one is not.  
 11 MR. FRESHOUR: Mr. Simon --  
 12 MR. SIMON: I'm just bringing it to  
 13 your attention.  
 14 MR. FRESHOUR: I don't need your  
 14:55:32 15 attention, I need an objection. Quit coaching your  
 16 witness.  
 17 MR. SIMON: I think he knows more --  
 18 MR. FRESHOUR: I didn't ask for an  
 19 explanation.  
 14:55:39 20 MR. SIMON: -- than me. I don't --  
 21 MR. FRESHOUR: There's no objection.  
 22 MR. SIMON: -- think I can coach him.  
 23 MR. FRESHOUR: But there's no  
 24 objection on board. Just if you would, please.  
 14:55:44 25 MR. SIMON: Sure.

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14:55:45 1 MR. FRESHOUR: Don't need to explain  
 2 to me how --  
 3 MR. SIMON: Let's move it along, no  
 4 problem.  
 14:55:48 5 MR. FRESHOUR: Okay.  
 6 Q. So you don't see any problem with that  
 7 comparison? That's what I'm getting down to.  
 8 A. In certain circumstances, as I've said  
 9 before.  
 14:56:05 10 Q. Now, one of the things you -- several of  
 11 these patients had was brain fog. You're familiar  
 12 with that term, aren't you?  
 13 A. Yes, I am.  
 14 Q. What is brain fog, Doctor?  
 14:56:16 15 A. Well, brain fog is like you're under a  
 16 little bit of anesthetic, you can't think right, you  
 17 feel tired, fatigued, things just aren't going with  
 18 enough energy, and so you're sort of fogged over.  
 19 It's a proper medical term.  
 14:56:38 20 Q. Okay. Now, well, let me, if it's a, it is  
 21 a -- if you say it's a proper medical term --  
 22 A. It's in my dictionary, yes.  
 23 Q. That's fine.  
 24 Isn't brain fog, though, completely  
 14:56:52 25 subjective? I mean, how do you objectively measure

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14:56:56 1 brain fog, Doctor?  
 2 A. Well, most of these people have short-term  
 3 memory loss when they have it. That's an objective  
 4 finding. Most of them drop their words. A lot of  
 14:57:07 5 times they can't remember words. Some of them, they  
 6 have trouble putting sentences together.  
 7 Q. And do you give them some kind of test to  
 8 determine brain fog?  
 9 A. No, other than the SPECT scan or  
 14:57:22 10 Dr. Didriksen's work, I don't. I mean, I can tell  
 11 that clinically. You can tell it clinically when  
 12 somebody is fogged over.  
 13 MR. SIMON: What does Dr. Hedrickson  
 14 (sic) do?  
 14:57:37 15 MR. FRESHOUR: I'll ask him about  
 16 Didriksen if I want.  
 17 Q. Well, what's the difference between brain  
 18 fog and decreased mental sharpness?  
 19 A. Probably much the same. Maybe a matter of  
 14:57:48 20 degree.  
 21 Q. How do you get a baseline on somebody to  
 22 determine whether they've got brain fog or decreased  
 23 mental sharpness?  
 24 A. How do you get a baseline?  
 14:57:56 25 Q. Yeah.

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14:57:56 1 A. Get them to when they're clear, when the  
 2 brain is clear.  
 3 Q. Well, they're coming to you, saying they've  
 4 got it. How do you establish a baseline to say  
 14:58:04 5 they've got brain fog, Doctor?  
 6 A. Well, I just told you some of the things.  
 7 And then I may send them to Dr. Didriksen, who is a  
 8 neuropsychologist, to find out what she feels. She  
 9 does objective tests on them.  
 14:58:18 10 Q. Is this the same Didriksen that works with  
 11 -- used to work with Joel Butler?  
 12 A. Yes, that's correct.  
 13 Q. Is this the same Didriksen that works  
 14 fairly closely with -- his name, is it Theodore  
 14:58:36 15 Simon?  
 16 A. Not that I know of, no.  
 17 Q. She doesn't work with Dr. Simon?  
 18 A. Not to my knowledge.  
 19 Q. Dr. Simon does a lot of spectrum brain  
 14:58:46 20 scans --  
 21 A. Yes, he does, uh-huh.  
 22 Q. What about lack of mental sharpness, isn't  
 23 that also fairly subjective? I mean, how do you  
 24 establish a baseline on that and distinguish it from  
 14:58:58 25 brain fog?

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14:58:59 1 A. I think I already answered the question.  
 2 Q. Degree, degrees?  
 3 A. (Nods head)  
 4 Q. Now we talked earlier today and you said  
 14:59:13 5 you knew a Dr. Stephen Hotze, correct?  
 6 A. Yes.  
 7 Q. Are you aware that he also diagnoses a lot  
 8 of his patients with brain fog?  
 9 A. No, but I would assume he had.  
 14:59:25 10 Q. Are you also aware that he attributes that  
 11 all to just hormone imbalance?  
 12 A. I don't think he does.  
 13 Q. Well, do you know if he does?  
 14 A. You asked me my opinion. I don't know for  
 14:59:38 15 sure. He sends up patients to me that's got brain  
 16 fog.  
 17 Q. How do you distinguish brain fog that you  
 18 see between brain fog that he attributes to hormone  
 19 imbalance? How do you distinguish different brain  
 14:59:54 20 fogs?  
 21 A. How do you distinguish somebody who's got a  
 22 sinus infection due to pseudomonas versus one that is  
 23 due to a virus? Same way, clinical things and  
 24 cultures. And the other way it would be, how you --  
 15:00:08 25 if you found what the triggering agents were.

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15:00:11 1 Q. Well, how do you -- your patients you find  
 2 for the most part the trigger mechanism is usually  
 3 chemical sensitivity, correct?  
 4 A. Well, could be foods that could do it. You  
 15:00:26 5 can't say it's just chemicals, no. Sometimes foods  
 6 do it, sometimes mold will do it. I've seen pollens  
 7 do it, I've seen bacteria do it, I've seen viruses do  
 8 it. So I think that your statement is not correct.  
 9 Q. Okay. Have you seen hormones do it?  
 15:00:41 10 A. Yeah, I sure have.  
 11 Q. Are there any other causes that you can  
 12 think of for a lack of mental sharpness, besides  
 13 bacterias, chemicals, hormone imbalance, the litany  
 14 you just ran through?  
 15:00:57 15 A. Well, yes, sometimes metabolic. For  
 16 example, a diabetic may get brain fog because they  
 17 don't have enough blood sugar.  
 18 Q. How about somebody who is on thyroid  
 19 medication or has a low thyroid function?  
 15:01:10 20 A. Yes, of course.  
 21 Q. Right. Because you said brain fog includes  
 22 things like tiredness and fatigue?  
 23 A. Yeah.  
 24 Q. Which could also be signs of  
 15:01:17 25 hypothyroidism?

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15:01:18 1 A. That's correct, yes.  
 2 Q. Could be signs of diabetes?  
 3 A. Right.  
 4 Q. Could be signs of another number of  
 15:01:23 5 other --  
 6 A. Oh, yeah. Differential diagnosis.  
 7 MR. SIMON: Let him finish the  
 8 question.  
 9 Q. Right. And that's exactly what we're  
 15:01:29 10 talking about in a differential diagnosis, correct?  
 11 A. (Nods head)  
 12 Q. You have to establish at least what you  
 13 think it most likely is, or hopefully you can say  
 14 what it isn't, making it easier to narrow your  
 15:01:42 15 universe, correct?  
 16 A. That's right.  
 17 Q. Now, at least one of these patients that  
 18 you had complaints of insomnia and kind of low moods,  
 19 malaise. And malaise is just generally not feeling  
 15:02:02 20 well, is that what malaise means?  
 21 A. I would say that's good enough.  
 22 Q. As far as -- and a couple of them, I think,  
 23 said they had some increased body size. Other than  
 24 the chemical sensitivities and those kinds of things  
 15:02:17 25 that you gave me, there's a number of other medical

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15:02:20 1 reasons that persons might have increased body size  
 2 and malaise, including things like we've already  
 3 talked about?  
 4 A. Yes.  
 15:02:27 5 Q. Diabetes, thyroid?  
 6 A. Yes.  
 7 Q. Sleep apnea, I guess, could cause fatigue,  
 8 couldn't it?  
 9 A. Oh, yes, certainly can.  
 15:02:36 10 Q. Obesity?  
 11 A. Yes.  
 12 Q. Perhaps even cigarette smoking, because  
 13 you're not getting enough oxygen, and if it's  
 14 damaging the body, correct?  
 15:02:44 15 A. Possible.  
 16 Q. Same thing goes with, you know, if a  
 17 patient complains of shortness of breath, you've got  
 18 to begin to look at all kinds of things, weight,  
 19 smoking, just a whole litany, correct?  
 15:02:57 20 A. Correct.  
 21 Q. If somebody is a smoker, what -- in your  
 22 general patient population, when you see someone come  
 23 in who's a smoker, without knowing the extent of it,  
 24 but it looks like it's a fairly long, chronic habit,  
 15:03:27 25 what kind of impact does that have, Doctor? What

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15:03:30 1 significance does that carry to you generally?  
 2 A. Well, usually that's an environmental  
 3 insult that damages one of their systems or multiple  
 4 systems.  
 15:03:40 5 Q. And we know what -- and when you say  
 6 insults systems, you're talking things like the lung  
 7 cancer and --  
 8 A. Lung cancers, emphysema, chronic  
 9 bronchitis, skin wrinkling, heart disease.  
 15:03:56 10 Q. Okay. Now, some of the -- and I'm going to  
 11 jump back, Doctor, and I apologize for this. When we  
 12 get back -- we're talking about the heavy metals.  
 13 There's some heavy metals that naturally occur in our  
 14 bodies, isn't that true? Like selenium, magnesium.  
 15:04:18 15 Don't they naturally occur to some level in the body?  
 16 A. Those aren't heavy metals.  
 17 Q. Okay. What are those, Doctor?  
 18 A. Well, they're just minerals.  
 19 Q. Minerals?  
 15:04:27 20 A. Yeah.  
 21 Q. Okay. Now, arsenic is a -- is arsenic a  
 22 heavy --  
 23 A. Well, it's in between. But it's considered  
 24 a very toxic metal, of course, because you can die of  
 15:04:38 25 arsenic poisoning.

15:04:40 1 Q. Right. And there is -- arsenic naturally  
 2 occurs in the earth's crust, right?  
 3 A. Yes, unfortunately.  
 4 Q. Right. And there's -- in all of our food  
 15:04:48 5 and water, there may be some traces of that that's  
 6 unavoidable, correct, particularly water, in arsenic?  
 7 A. Well, it's not unavoidable. But it can be  
 8 in water, yes. Certain wells are contaminated with  
 9 arsenic.  
 15:05:09 10 Q. Now, I just want to be sure, and I'm going  
 11 to go back to the chelation example once again. When  
 12 that patient -- and like I said, I'll find the  
 13 results before we leave today. When that patient  
 14 came back and had somewhat elevated levels -- you may  
 15:05:27 15 not remember right now, and we'll go specifically to  
 16 that patient here in a bit -- did you sit down and  
 17 explain to them the significance of that finding in  
 18 your opinion that they had some metals that chelated?  
 19 A. Yes.  
 15:05:40 20 Q. Now, in doing that, do you recall -- and  
 21 I'm going to represent to you that there's the  
 22 wording at the bottom of that chelation test that  
 23 they're compared against an unprovoked normal. Did  
 24 you explain to them what that meant or --  
 15:05:58 25 A. I probably did. I don't recall, but I

15:06:00 1 probably did.  
 2 Q. You don't remember, obviously. It was  
 3 many, many years ago, correct?  
 4 A. That's correct.  
 15:06:04 5 Q. Okay. But you --  
 6 A. I generally do, so...  
 7 Q. Right. Because you want to be honest,  
 8 forthright with your patients, make them have a full  
 9 understanding of what they're getting, what they're  
 15:06:14 10 not getting?  
 11 A. Yes.  
 12 Q. All of that kind of stuff?  
 13 A. That's correct.  
 14 Q. All right. One of the things I talked to  
 15:06:25 15 one of your other experts about -- and I think  
 16 several of your patients here had some hair testing.  
 17 Are you --  
 18 A. Yes, that's correct.  
 19 Q. And I think the hair testing, if I'm not  
 15:06:37 20 mistaken, was done through [Lab redacted] as well?  
 21 A. Yes.  
 22 Q. Do you, do you know exactly what the chain  
 23 of custody today is after you take the hair sample  
 24 from your patients and it goes to the [Lab named redacted] --  
 15:06:51 25 XXX for short?

15:06:52 1 A. Well, I know our chain of custody. I don't  
 2 know whether we have to have a chain of custody.  
 3 They're honorable labs. By from our lab where we cut  
 4 the hair, there's a special kit that you put it in,  
 15:07:03 5 and it goes directly to [Redacted]. Now, I can't  
 6 tell you what happens after [the lab] gets it.  
 7 Q. Okay. And I'm going to represent to you  
 8 that I talked a little bit -- I think it was to  
 9 Dr. Ross, about this.  
 15:07:16 10 A. Yes.  
 11 Q. When you give a -- get a hair sample from a  
 12 patient, you need to know, or it's important to know  
 13 whether the patient has recently bleached their hair,  
 14 dyed their hair, if they've had a shampoo, what kind  
 15:07:33 15 of shampoo it was, correct?  
 16 A. That's correct, yeah.  
 17 Q. Because all of those things can contaminate  
 18 and skew results for a hair test?  
 19 A. Yes, that's correct.  
 15:07:40 20 Q. And --  
 21 A. In fact, I think we had to use pubic hairs  
 22 for one of the girls.  
 23 Q. Right. And it also makes a difference  
 24 where the sample was taken from, whether it's near  
 15:07:50 25 the end of the follicle or close to the head because



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<p>15:07:53 1 of the way --  2 A. That's right.  3 Q. -- hair grows, correct?  4 A. Yes.  15:07:55 5 Q. Isn't it also true that when you get back  6 the testing results -- and I'm going to use, for  7 example, it says, hair has some arsenic on it, for  8 example -- or it doesn't say it had it on it, it said  9 it tested positive for arsenic, right? That's what  15:08:09 10 the results says.  11 A. Yes.  12 Q. Isn't it also correct that on those  13 results, you can't determine if that was arsenic that  14 was internal in the follicle or external? It doesn't  15:08:19 15 distinguish in the results, does it?  16 A. No.  17 Q. Okay. And there's also -- and I don't  18 know, there's certain -- and I don't know if it's  19 arsenic or not, but there's certain organic and  15:08:32 20 inorganic materials that are distinguished when you  21 get a hair result, right?  22 A. Correct.  23 Q. So it just says something is there, but  24 you're not sure exactly the source of it, just that  15:08:42 25 it's there?</p>	<p>15:10:09 1 Q. And that's been established by some  2 research?  3 A. Yes.  4 Q. Okay. Now, the -- those reference  15:10:16 5 ranges -- it's not a reference range you've  6 established, it's from some other source; is that  7 correct?  8 A. Yes, that's correct.  9 Q. All right. Now, when you see these heat  15:10:27 10 variations, it doesn't necessarily distinguish what  11 the cause of the heat variation is, it just manifests  12 there is a heat variation, correct?  13 A. That's correct.  14 Q. And you certainly -- I would assume that  15:10:40 15 you can't take it and put it on a point and say,  16 well, you know, because this point -- I don't even  17 know if it's a point, here on your left elbow has got  18 a three degree fluctuation, that means that you've  19 got a, a liver that's full of heavy metal?  15:10:56 20 A. They have certain patterns that they've  21 done. You've got to remember, there's 14,000  22 articles on thermography now. And they do have  23 patterns where there are points for like the liver  24 and the heart and the brain and different areas. I  15:11:10 25 personally don't know those because you have to have</p>
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<p>15:08:43 1 A. That's correct.  2 Q. What is thermography, Doctor?  3 A. What has been found is that there are nerve  4 points all over the body that reflect the internal  15:09:06 5 temperature of different organs and different areas  6 of organs, and this is a special technique that  7 measures these temperatures in 120 places around the  8 body. And it gives you an idea of what the  9 temperature is on that particular area.  15:09:24 10 Q. All right. And these are -- these 120  11 points, and they show it graphically by different  12 colors, is that correct? Is that how it's done?  13 A. Well, there's two types of thermography.  14 One is where you actually see a green or a red or a  15:09:39 15 yellow color, okay, that's -- and then the other one  16 that I'm talking about, you actually take the  17 temperatures with a probe on the different parts of  18 the body.  19 Q. Okay. And you use the one that goes to the  15:09:50 20 different probe points?  21 A. Yes, that's correct.  22 Q. Okay. And so it gives you -- and are  23 there -- is there a normal or average temperature  24 range you're looking for at those particular points?  15:10:09 25 A. Yes.</p>	<p>15:11:14 1 a regular thermographer read it. And -- but they do  2 interpret it a lot of times as whether the liver is  3 bad or the blood vessels are bad or the brain is not  4 functioning right or so on.  15:11:27 5 Q. Right. And even if they do that, Doctor,  6 even if they say there's something wrong --  7 A. Yeah.  8 Q. -- they can't tell the cause? They can  9 just tell there's something wrong because of the heat  15:11:36 10 fluctuation?  11 A. Exactly.  12 Q. Okay. So you couldn't put it on and say,  13 well, the left temple, there's a three degree  14 difference, that means he's got, you know, a, a left  15:11:46 15 side, you know, aneurysm that's growing or something?  16 It's not like that? It's just there's something  17 going on up there? And that's a very poor example,  18 but --  19 A. Yeah, like, for example, breast lesions, a  15:12:02 20 lot of times they can differentiate between benign  21 and malignant lesions.  22 Q. Right.  23 A. When they're real small, you know, before  24 you can pick them up on our mammogram.  15:12:08 25 Q. Right. But if you go to, say, internal</p>

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15:12:11 1 organs in particular, you -- say, well, that point  
2 correlates to the liver, but -- and it seems off, but  
3 you can't tell what the cause of it being off is?  
4 A. You can't tell the cause in any test  
15:12:21 5 hardly, except challenge tests.  
6 Q. Except challenge tests?  
7 A. Yes.  
8 Q. And what do you mean by "challenge tests,"  
9 Doctor?  
15:12:28 10 A. Well, either intradermal challenge, oral  
11 challenge, inhale challenge, where you breathe  
12 something.  
13 Q. And you do inhale challenges at your  
14 office, don't you, Doctor?  
15:12:38 15 A. Yeah, sure.  
16 Q. And when you do those inhalation challenges  
17 you put them in a. I guess like a sealed room or  
18 little chamber or something; is that correct?  
19 A. We have an environmentally controlled room,  
15:12:57 20 then an environmentally controlled chamber inside  
21 that.  
22 Q. Okay. And then you send in various, I  
23 guess, chemicals and odors and --  
24 A. Yeah.  
15:13:08 25 Q. -- that kind of thing --

15:13:09 1 A. That's correct.  
2 Q. -- to see the reaction?  
3 A. Yes.  
4 Q. Okay. And on those, do you ever -- do you  
15:13:16 5 use any masking agents?  
6 A. Well, no, we don't. We use placebos, but  
7 we don't use masking agents because then you're  
8 compounding the problem, you don't know what you're  
9 dealing with.  
15:13:30 10 Q. Okay. And when you give them a placebo,  
11 what is your placebo? Just air?  
12 A. Saline.  
13 Q. I mean --  
14 A. In a flask. We set everything in a flask  
15:13:40 15 and have it open. It's all standardized, okay?  
16 Q. Okay. And do you -- so if the flask goes  
17 in there, I mean, are all of the materials, are they  
18 all the same color? Are they different color? Are  
19 they clear liquids?  
15:13:55 20 A. All the same color.  
21 Q. Okay. What color?  
22 A. Well, it's an off-white.  
23 Q. Okay.  
24 A. Or I should say off clear.  
15:14:04 25 Q. Is there such a thing as an off clear,

15:14:06 1 Doctor?  
2 A. I don't know.  
3 Q. All right.  
4 Doctor, one of the tests you use is  
15:14:23 5 pupillography; is that correct?  
6 A. Yes.  
7 Q. And that's a -- and what you're measuring  
8 there, I believe, is the autonomic response to the,  
9 of the pupils. Is that what it is?  
15:14:33 10 A. Yeah, of the upper area of the head and  
11 eyes.  
12 Q. Okay. So what are you looking for when you  
13 do pupillography?  
14 A. Well, we -- you're looking for autonomic  
15:14:42 15 nervous system dysfunction, which most of these  
16 people have. And I think we talked about that a  
17 little bit this morning. But what -- this was one of  
18 the first tests that you could ever do to objectify  
19 autonomic dysfunction.  
15:14:58 20 Q. All right. That was the one -- the study  
21 that you and Dr. Ishikawa did?  
22 A. Yes, that's correct, uh-huh.  
23 THE COURT REPORTER: Dr. who?  
24 MR. FRESHOUR: Ishikawa.  
15:15:09 25 THE WITNESS: Again, phonetic,

15:15:09 1 I-s-h-i-k-a-w-a.  
2 Q. And besides chemical exposure or chemical  
3 sensitivity --  
4 A. Yes.  
15:15:27 5 Q. -- there's a number of other conditions  
6 or -- that can cause autonomic nervous responses in  
7 pupillography, correct?  
8 A. Yes, that's true.  
9 Q. And do those include things such as  
15:15:43 10 diabetes?  
11 A. Yes.  
12 Q. Just generally fatigue can cause --  
13 A. No.  
14 Q. -- a different, differentiating --  
15:15:51 15 A. That's up in the air, that's very dubious.  
16 Tumors could do it.  
17 Q. Okay. How about stress?  
18 A. How about what?  
19 Q. Stress, just putting someone under a great  
15:16:01 20 deal of stress and then measuring their pupil  
21 response.  
22 A. It all depends on how you define "stress."  
23 You can get a response from that, yes.  
24 Q. How about if somebody suffers from Behcet?  
15:16:13 25 A. Pardon?

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15:16:13 1 Q. Behcet disease. B-e-c-h-t (sic).  
 2 A. Behcet disease?  
 3 Q. You can pronounce it better than --  
 4 A. I'm sorry, I don't know what you're talking  
 15:16:22 5 about there. I just -- I don't know what you're  
 6 talking about.  
 7 Q. Okay. How about Horner's syndrome?  
 8 A. Well, Horner's syndrome says you've got a  
 9 droopy eye from the autonomic nervous system. That  
 15:16:32 10 doesn't tell you anything.  
 11 Q. How about Adie syndrome?  
 12 A. I don't know what that is.  
 13 Q. Okay. How about MS?  
 14 A. Yes, you can have autonomic dysfunction  
 15:16:49 15 from MS.  
 16 Q. How about psychotropic drugs?  
 17 A. Yes, a lot of drugs can do it.  
 18 Q. Whether they're legal or illegal?  
 19 A. Yeah, I would say so. You get the pinpoint  
 15:17:01 20 pupils from the illegals.  
 21 Q. Right. And, in fact, one of the articles  
 22 cited, I think dealt with a Dr. Fincher, was all  
 23 about Ecstasy, I believe, wasn't it, and the response  
 24 by the autonomic nervous system? Do you remember?  
 15:17:13 25 A. She may have written some section. I don't

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15:18:24 1 A. No, I don't own any. We work --  
 2 Q. Go ahead, Doctor.  
 3 A. No.  
 4 Q. You don't own any. Do you provide any or  
 15:18:31 5 do you have a working arrangement with a hotel, motel  
 6 or a facility here in town?  
 7 A. Yes, we have -- with the Marriott hotel, we  
 8 have one building that's environmentally controlled.  
 9 And a lot of patients live there.  
 15:18:44 10 Q. Okay. And did any of these five patients  
 11 live there, do you recall?  
 12 A. Yeah, I think maybe they did.  
 13 Q. What do you charge them for that, Doctor?  
 14 A. I think it's \$110 a night.  
 15:18:59 15 MR. SIMON: What does he charge?  
 16 A. I don't charge anything. But I mean...  
 17 Q. Well, indirectly, when you put them there,  
 18 they're assessed a charge, correct?  
 19 A. Yes, certainly.  
 15:19:08 20 Q. And that charge is about \$110?  
 21 A. I think so, yeah.  
 22 Q. So it's with the Marriott, and I assume  
 23 there's some kind of relationship between your clinic  
 24 and the Marriott to do this?  
 15:19:18 25 A. Yes, that's correct.

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15:17:16 1 think her whole article is that.  
 2 Q. Now, when you do pupillography tests, do  
 3 you just have the patients come in and sit them down,  
 4 or are they subject to any kind of stimuli or  
 15:17:27 5 anything before you test them?  
 6 A. Well, these patients are usually on a  
 7 controlled diet, safe water and safe air, and we have  
 8 a special room that is a faradic cage-type room so  
 9 you get less electromagnetic radiation. And then  
 15:17:47 10 they're placed in there, and just let them  
 11 equilibrate for 15 minutes to a half hour. Dr. Pan  
 12 does those studies.  
 13 Q. Dr.?  
 14 A. Pan.  
 15:17:57 15 Q. P-a-n?  
 16 A. Yes.  
 17 Q. He's one of the physicians at your clinic  
 18 that we were discussing in generic terms this  
 19 morning?  
 15:18:05 20 A. Yes, that's correct.  
 21 Q. Doctor, you said, you know, that you put  
 22 them in the controlled room and everything. Do you  
 23 own any -- or provide for your patients any off-site  
 24 facilities that are environmentally controlled while  
 15:18:23 25 they're being treated by you?

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15:19:19 1 Q. And I assume that your clinic gets some  
 2 kind of either monetary portion of that monies or  
 3 something from Marriott for whatever this agreement  
 4 is?  
 15:19:30 5 A. That's correct.  
 6 Q. Okay. And is there any average length of  
 7 stay that your patients have there, or is it all  
 8 dependent?  
 9 A. This is all dependent. But some people  
 15:19:42 10 just get so well, get so good there, I can't get them  
 11 out. Our problem is we line up patients that we want  
 12 to get in there -- or who want to get in. We don't  
 13 recommend -- or we don't force them in or anything.  
 14 They do that on their own. So we've had some there  
 15:19:58 15 up to two years. And others -- our average we like  
 16 is two to three years weeks, get them out.  
 17 Q. And in that two to three weeks, are they  
 18 coming back and forth to your clinic for treatments?  
 19 A. Yes, every day.  
 15:20:13 20 Q. Okay. Now, you said they're  
 21 environmentally controlled rooms. And I'm talking  
 22 about at the Marriott.  
 23 A. Yeah.  
 24 Q. What does that entail generally? What do  
 15:20:25 25 you mean when you say that, Doctor?

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15:20:26 1 A. Number one, no pesticide. Number two, no  
2 carpets. Number three, special nontoxic paints.  
3 Number four, electric, all electric. And number  
4 five, the beds and the mattresses are environmentally  
15:20:43 5 sound without any foam or the contamination. Same as  
6 with the furniture. And they're maintained with  
7 nontoxic soaps and so on.  
8 Q. Okay. Now, just so I understand about  
9 those, let's say a patient has been there, two weeks,  
15:21:04 10 three weeks on an average stay, patient leaves.  
11 A. Yeah.  
12 Q. How do you ensure the integrity of that  
13 room for the next patient? What steps do you go  
14 through to maintain its integrity?  
15:21:17 15 A. Well, we have specific protocols for  
16 cleaning them.  
17 Q. Such as?  
18 A. Well, as I said, nontoxic soaps. We use  
19 mostly elbow grease, no deodorants, anything like  
15:21:33 20 that, and obviously you change the sheets, you change  
21 the bedding and all that.  
22 Q. Well, let me ask you --  
23 A. No pesticides, no fragrances squirted in  
24 there, things like that.  
15:21:44 25 Q. And let me ask you, does the Marriott do it

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15:21:47 1 with their own hotel staff, or do you know who does  
2 it?  
3 A. No, no, we have to do it with our own,  
4 because we have to have control over them so they  
15:21:55 5 don't mess up, which is an easy thing to do.  
6 Q. Okay. One of the tests you use is heart  
7 rate variability, correct?  
8 A. Yes, right.  
9 Q. Okay. What is -- what do you mean by  
15:22:09 10 "heart rate variability," Doctor?  
11 A. The better the heart, the more it will vary  
12 in response. So, you know, if you get into some  
13 stimulus -- well, it can go real fast, it can beat in  
14 a different way that's normal, it can pump in a  
15:22:30 15 different way that's responsive to the stimulus. The  
16 person with a damaged heart, the more they got  
17 damaged, the more shrinking is the variability of the  
18 heart. And that's sort of now become a well  
19 established valuation of the autonomic nervous system  
15:22:52 20 going to the heart.  
21 Q. And are you familiar at all with the task  
22 force of European Society of Cardiologists and the  
23 North American Society of Pacing and  
24 Electrophysiology position on heart rate variability  
15:23:32 25 and its applications?

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15:23:33 1 A. No. What year was it?  
2 Q. It was in -- I'm talking about the 1996  
3 position paper. Are you familiar with that?  
4 A. No, that's a long time ago. I would expect  
15:23:43 5 it's outdated by now.  
6 Q. Well, I'm going to represent to you that  
7 Dr. Meggs actually cited to this during his  
8 deposition.  
9 A. Okay.  
15:23:50 10 Q. Are you aware that that publication at that  
11 time said there was only two clinical uses for HRV?  
12 A. No, I'm not.  
13 Q. Were you aware that they said it was  
14 only -- one use was to assess risks after an acute MI  
15:24:03 15 and to look at symptoms related to the development of  
16 diabetic neuropathy?  
17 A. No. But that's old literature, and I  
18 wouldn't --  
19 MR. SIMON: That's a position paper,  
15:24:17 20 Mr. Freshour, not a peer reviewed article?  
21 MR. FRESHOUR: That is -- as I said,  
22 it's an article from the European task force of  
23 European Society of Cardiology and the North American  
24 Society of --  
15:24:28 25 MR. SIMON: Position paper?

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15:24:29 1 MR. FRESHOUR: -- Pacing and  
2 Electrophysiology.  
3 MR. SIMON: That's a position paper.  
4 MR. FRESHOUR: It's what it looks like  
15:24:35 5 to me.  
6 A. Okay. And this was in '96?  
7 Q. Yes.  
8 A. Well, it's changed a lot since then.  
9 Q. Okay. I understand that. But do you  
15:24:42 10 understand my question that -- were you aware of  
11 that?  
12 A. I wasn't aware of it.  
13 Q. And you weren't aware either that this is a  
14 paper that Dr. Meggs cites specifically in his expert  
15:24:51 15 report?  
16 A. No, I wasn't.  
17 Q. Okay. Dr. Meggs is one of your experts,  
18 correct?  
19 A. Yes, he is. Excellent guy.  
15:24:59 20 Q. You trust his opinion, don't you?  
21 A. Pardon?  
22 Q. You trust his opinion, don't you?  
23 A. Well, I trust it to a point.  
24 Q. Well, there's certain things you don't  
15:25:19 25 trust him on?

56 (Pages 218 to 221)

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# Ken Owen & Associates, L.P.

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15:25:20 1 A. Well, you know, I don't know how you -- if  
2 you know how medicine works. But we take everybody's  
3 opinion and we synthesize it. If it fits the case,  
4 we use it. If it doesn't, we don't. So that's all  
15:25:34 5 I'm saying.  
6 Q. You talk about a SPECT scan a little bit  
7 earlier. Do you recall that, Doctor?  
8 A. Yes.  
9 Q. What is a SPECT scan?  
15:25:49 10 A. A SPECT scan is a specialized scan that can  
11 have one, two or three cameras. And what you -- we  
12 happen to have a three-dimensional one that Dr. Simon  
13 works with. And it reads 3-D. You give technetium,  
14 which is a radioactive substance, and you can measure  
15:26:12 15 different areas of the body like the brain, and the  
16 stomach and so on. And you can show function on it  
17 and -- in contrast to a CAT scan or MRI, which shows  
18 anatomy.  
19 Q. Okay. Now, isn't it also true that  
15:26:33 20 abnormalities that are shown up on a SPECT scan can  
21 be caused by or attributed to conditions such as  
22 depression?  
23 A. Yes. You can show a depression pattern.  
24 Q. OCD?  
15:26:45 25 A. Yeah.

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15:26:46 1 Q. Schizophrenia?  
2 A. I believe there is a pattern for that.  
3 Q. Alzheimer's?  
4 A. Yes.  
15:26:51 5 Q. And I believe that drugs cause like --  
6 drugs, methamphetamine, cocaine cause a particular  
7 pattern, as well, correct?  
8 A. Yeah, I think you're right.  
9 Q. And when you're looking at a SPECT scan,  
15:27:04 10 are you looking for a hypo or a hyperperfusion in  
11 your field of practice, Doctor?  
12 A. Both.  
13 Q. It can be either?  
14 A. Yeah, there can be areas that are hyper and  
15:27:15 15 areas that are hypo.  
16 Q. And have you ever seen Dr. Simon's normal  
17 views that he -- his baseline studies?  
18 A. Yes. We have them all over the clinic.  
19 Q. All right. Now, basically in the SPECT  
15:27:38 20 scan, as I understand it, it's a continuous image,  
21 isn't it, Doctor? It doesn't just -- it's just not a  
22 single shot in time?  
23 A. That's right, it's (indicating), like that.  
24 Cut after cut after cut.  
15:27:51 25 Q. And it goes for a number of minutes, as

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15:27:54 1 well, right, it's --  
2 A. Yes, it does. I don't know what the time  
3 is, I've forgotten.  
4 Q. So if, if you're looking in the medical  
15:28:02 5 records and you've got just a single shot in time,  
6 that's not representative of the entire SPECT scan,  
7 true?  
8 A. Well, I wouldn't say that wasn't true,  
9 because he picks out, he picks out the ones that are  
15:28:13 10 representative and sends them to us.  
11 Q. Now, when a patient gets a SPECT scan, I  
12 guess then my question would be, do you get the  
13 entire -- I don't know if you call it the film or the  
14 entire picture or just certain pictures from  
15:28:27 15 Dr. Simon?  
16 A. We just get the three-dimensional pictures.  
17 We don't get the whole run, because it wouldn't do us  
18 any good.  
19 Q. Why not?  
15:28:35 20 A. Well, number one, I'm not an expert on  
21 interpreting SPECT scans. And number two, it would  
22 take a long period of time to analyze it if I knew  
23 what I was doing.  
24 Q. Do you know if the use of a SPECT scan has  
15:29:02 25 ever been struck in a court in a chemical sensitivity

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15:29:06 1 case?  
2 A. Oh, I'm sure it has, because it's been used  
3 hundreds of times, and I think probably one or two  
4 times it has.  
15:29:19 5 Q. Are you aware of the position of the  
6 Council on Brain Imaging as to the use of SPECT scan?  
7 A. I don't even know who they are.  
8 Q. Okay.  
9 A. So I guess not.  
15:29:31 10 Q. So you're not aware?  
11 A. No.  
12 Q. So -- and I guess my second question is, so  
13 you're not aware that they said -- the Council on  
14 Brain Imaging studies came out and said, you cannot  
15:29:41 15 use a SPECT scan to diagnose chemical sensitivity?  
16 Are you aware of that?  
17 A. I'm not aware of it.  
18 Q. You disagree with that, I take it?  
19 A. Well, I never diagnosed chemical  
15:29:50 20 sensitivity on a brain scan.  
21 Q. Did you use it as part of your diagnosis?  
22 A. Well, of course. But that's not how I  
23 diagnose it. So it would be immaterial, wouldn't it?  
24 Q. I don't know. Would it, Doctor?  
15:30:02 25 A. Yeah.

57 (Pages 222 to 225)

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15:30:02 1 Q. Would you need a SPECT scan?  
 2 A. I like to have SPECT scans, of course.  
 3 Q. So is it immaterial or not, Doctor?  
 4 A. Well, that depends on what you're trying to  
 15:30:10 5 do with the patient.  
 6 Q. Well, you're the one who said it might be  
 7 immaterial. I'm just trying to figure out --  
 8 A. Well, I don't do brain scans on all  
 9 patients.  
 15:30:17 10 Q. And on those you do, you order it for a  
 11 reason?  
 12 A. Of course, yes.  
 13 Q. So you do have some reliance on that?  
 14 A. I do use it as part of my treatment, yeah.  
 15:30:28 15 MR. SIMON: Diagnosis?  
 16 THE WITNESS: Well, both.  
 17 MR. FRESHOUR: Let the doctor answer,  
 18 Mr. Simon. There's no objection on board.  
 19 Q. Can you tell me, do you know what the  
 15:30:48 20 predictive value and the negative predictive value is  
 21 for a SPECT procedure, Doctor?  
 22 A. No. Simon would know that. I don't.  
 23 MR. FRESHOUR: I think we're at a good  
 24 stopping point.  
 15:31:03 25 THE VIDEOGRAPHER: The time is 3:31

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15:31:05 1 p.m. This is the end of tape number five. We are  
 2 off the record.  
 3 (Recess from 3:31 to 3:39)  
 4 (Mr. Cook did not return)  
 15:39:16 5 THE VIDEOGRAPHER: The time is 3:39  
 6 p.m. This is the start of tape number six. We're on  
 7 the record.  
 8 Q. All right. Doctor, when we just got done,  
 9 we were going over a number of different tests you  
 15:39:32 10 use and some statements on the SPECT scan, and I want  
 11 to be clear on the SPECT scan. And you mentioned a  
 12 Nancy Didriksen earlier today. What does she have to  
 13 do with the SPECT scans that you do in your practice,  
 14 Doctor?  
 15:39:57 15 A. Nothing. She's a neuropsychologist and she  
 16 has a battery of tests that will objectively show  
 17 certain areas of the brain that may be dysfunctional.  
 18 Q. Do you know, has Ms. Didriksen ever  
 19 testified in a court case that she -- when she finds  
 15:40:24 20 patients with chemical sensitivities sent from you,  
 21 she anticipates they already have it or you wouldn't  
 22 have sent them to her, and she expects them to have  
 23 chemical sensitivity?  
 24 A. I'm sorry?  
 15:40:35 25 Q. Ms. Didriksen, are you aware -- has

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15:40:38 1 Ms. Didriksen ever testified in a court case that  
 2 when she has a patient referred from you, she expects  
 3 they've already been diagnosed with chemical  
 4 sensitivity when they get there?  
 15:40:52 5 A. I don't know. You would have to ask her  
 6 that.  
 7 Q. Okay. So do you ever send a patient to her  
 8 that you haven't already determined to be chemically  
 9 sensitive?  
 15:41:04 10 A. Yes.  
 11 Q. When was the last time you sent her a  
 12 patient?  
 13 A. I think last week.  
 14 Q. So you're still using her --  
 15:41:11 15 A. Oh, yes.  
 16 Q. -- all the time?  
 17 A. She's very competent.  
 18 Q. Doctor, a while back we were talking about  
 19 differential diagnosis, and we went through a couple  
 15:41:37 20 of different, you know, conditions that can cause  
 21 certain symptoms. I want to talk about some of your  
 22 patients -- and I think several of them in this  
 23 particular case, the five, came in and they had  
 24 either sleep disturbance or some anxiety or  
 15:41:58 25 depression. Do you recall that generally?

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15:41:59 1 A. Yes.  
 2 Q. And suffered from fatigue and sleep  
 3 disturbance. Do you remember that?  
 4 A. Yes.  
 15:42:07 5 Q. I think even a couple of them said they had  
 6 some lethargy, inability to concentrate, memory loss.  
 7 Do you recall that?  
 8 A. Yes.  
 9 Q. Now, when we get to differential diagnosis,  
 15:42:20 10 isn't it true that there are those symptoms, such as  
 11 sleep disturbance, inability to concentrate,  
 12 lethargy, fatigue, sleep disturbance, those are also  
 13 symptoms of certain psychiatric conditions such as  
 14 depression, correct?  
 15:42:41 15 A. Could be.  
 16 Q. And they could be some kind of a  
 17 nonspecified -- or unspecified anxiety disorder,  
 18 correct?  
 19 A. Could be, yeah.  
 15:43:09 20 Q. Now, one of the treatment -- I guess  
 21 treatments you use is what we call heat depuration,  
 22 correct?  
 23 A. Yes, uh-huh.  
 24 Q. Now, I'm not to be derogatory, but that is  
 15:43:23 25 basically a sauna-type therapy, correct?

58 (Pages 226 to 229)

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15:43:27 1 A. Well, it's part of a sauna-type therapy.  
2 It's part of it, yeah.  
3 Q. What is it? Then explain to me what heat  
4 depuration therapy is in total.  
15:43:37 5 A. Okay, number one, the goal of this is to  
6 help the autonomic nervous system get balanced again.  
7 The second goal is that about 2 -- let me say this,  
8 almost every patient we get don't sweat, which is a  
9 function of the autonomic nervous system.  
15:43:58 10 And it also is a function to help the  
11 detox systems work better. For example, you might  
12 want to get more passes of the blood through the  
13 liver so you can detoxify it, or through the lung so  
14 you can detoxify it. Only about 2 percent of the  
15:44:15 15 toxics come out from sweating. So that's a second --  
16 a tertiary issue. And what we do, we have specially  
17 constructed heat chambers that are non-outgassing and  
18 no particulates, so you can contrast some of the  
19 public saunas which have redwood or have formaldehyde  
15:44:40 20 in it or pine or so on like that.  
21 The second, they are meticulously kept  
22 clean so that the individuals don't breathe in other  
23 people's toxics or stuff when they come out.  
24 Thirdly, the patient actually does exercise, if  
15:44:56 25 they're capable of it, for 15 to 20 minutes

15:44:59 1 beforehand. Thirdly, they do the heat therapy with  
2 adequate amount of liquids at the same time. And  
3 then they get massaged to help break out some of the  
4 sequestration of toxics in the body.  
15:45:16 5 Q. How does massage help break up the  
6 sequestrations of the toxics?  
7 A. Well, one of the first responses, when a  
8 pollutant goes in the body, is that the connective  
9 tissue and the muscles grab them. You may have tight  
15:45:31 10 shoulders or tight back muscles or tight leg muscles.  
11 And it's been shown, both in animals and humans, that  
12 one of the responses in the body is to sequester the  
13 toxics so it doesn't kill the individual initially,  
14 you see. So a lot of patients that we see have been  
15:45:51 15 sick for some time, 5, 10, 15, 20 years. And they  
16 have gotten hard areas in their muscles and fascia  
17 that -- where the toxics seem to be sequestered. And  
18 I have biopsied some of those, and definitely this is  
19 true.  
15:46:09 20 So that is your heat therapy when  
21 you -- when it's done. You do it for no more than a  
22 half hour. You start off very gradually, 10 or 15  
23 minutes, depending on how sick the person is, and try  
24 to work up to 20, 30 minutes of good sweating.  
15:46:29 25 Q. Well, let me ask you, there's a couple of

15:46:32 1 points. You're saying that when the toxics go into  
2 your body, they sequester and you get tight muscles.  
3 I mean, do they aggregate in a distinct hard spot,  
4 like pile all up in your arm?  
15:46:46 5 A. Sometimes they do. You've probably  
6 experienced it, everybody does. Like when they get  
7 into something, their neck spasms or a shoulder will  
8 spasm. This apparently is a way to slow down the  
9 toxics so the liver and kidney and lung doesn't get  
15:47:01 10 it all at once and it can handle it.  
11 Q. And you say "this apparently." Do you have  
12 -- have studies shown that it actually is aggregating  
13 in this area?  
14 A. Yes, I do.  
15:47:11 15 Q. You've done the studies or other  
16 individuals --  
17 A. Well, other people have done them, and I've  
18 done biopsies and shown it, yes.  
19 Q. And so explain to me how massaging a hard  
15:47:21 20 spot releases the toxics from your body.  
21 A. Well, what it does is open up the blood  
22 flow, microcirculation. And if you've got a severe  
23 muscle spasm like this and it opens up like that,  
24 then you get a normal physiology that's then able to  
15:47:40 25 be maintained, and the detox systems work better.

15:47:43 1 Oxygenation works better in that particular area and  
2 can detox due to the oxygen that's liberated. Or it  
3 can pick it up and send it to the liver or lung and  
4 get detoxed there.  
15:47:57 5 Q. Well, are there particular spots in the  
6 body that are more susceptible to this aggregation?  
7 A. You know, it's hard to say, because you  
8 can't do brain biopsies, and you don't do heart  
9 biopsies, okay. So you don't really know whether  
15:48:14 10 they sequester there. The only thing you can do is  
11 presume. But you can -- with the skeletal muscle,  
12 you can actually show it.  
13 Q. With a biopsy?  
14 A. Yes, correct, yeah.  
15:48:26 15 Q. Okay. So I'm still not quite clear. So  
16 through aggregating it in your muscles and you  
17 massage them, how is that releasing them from your  
18 body?  
19 A. Well, number one, you're relieving muscle  
15:48:45 20 spasms, which relieves the aggregation, okay. Number  
21 two, you're relieving fascial spasm, which makes up  
22 40 percent of the body, okay. And number three, you  
23 are delivering more oxygen to that area because the  
24 oxygen supply, because of the edema on the small  
15:49:05 25 blood vessels that shut them off, open up. And then

15:49:09 1 the blood can go through.  
 2 Q. Well, if, if this muscle spasm occurs  
 3 because the body can't handle the toxics, if you're  
 4 massaging to release it, aren't you then overloading  
 15:49:24 5 the body, since it couldn't handle it?  
 6 A. Well, you have to be very careful. And you  
 7 don't do that initially on a sick patient. You have  
 8 to wait until their detox systems have gotten better  
 9 before you do that.  
 15:49:35 10 Q. Let me ask you, if most of your patients  
 11 don't sweat, why are you putting them in a sauna?  
 12 Won't that kill them if they don't sweat if they're  
 13 in a sauna?  
 14 A. No. You teach them to sweat. Remember, I  
 15:49:47 15 said you do graded temperatures, where you may only  
 16 go in five to ten minutes at first, and then you go  
 17 to 15, and then maybe 20, and then 25, 30.  
 18 Q. Well, how do you teach someone to sweat? I  
 19 thought that was an involuntary thing with the human  
 15:50:02 20 body.  
 21 A. Well, sweating has to do -- apparently it's  
 22 a very complicated thing. It has to do with the heat  
 23 centers in the brain and also the peripheral blood  
 24 circulation. And the -- these go to the autonomic  
 15:50:21 25 nerves. And what apparently you're trying to do is

15:50:24 1 balance out the sympathetic and parasympathetic  
 2 autonomic nerves so that things can work normally and  
 3 go back to efficient function. And I say "teach,"  
 4 because it seems to be that's what you do. In other  
 15:50:38 5 words, you can't radically do it or, like you say,  
 6 you can wipe them out.  
 7 Q. Well, how do you -- how are you able to  
 8 ascertain the efficacy of the sauna therapy?  
 9 A. Well, we did several blood levels -- and  
 15:51:10 10 published this, by the way -- and of the chemicals in  
 11 the blood before sauna, during sauna and after sauna.  
 12 What you see is you see them at this level, say,  
 13 okay, in the blood. And when you start doing the  
 14 sauna, they go up like this (indicating) and then  
 15:51:30 15 they come down, and they'll either go away or they'll  
 16 get much lower than before. And we did a whole  
 17 series of patients, measuring those.  
 18 Q. And you published that?  
 19 A. I published that in a peer review journal,  
 15:51:45 20 I also published it in my book.  
 21 Q. Do you have the underlying data for that?  
 22 A. I did, yeah. I don't know whether I've  
 23 still got it. We did this about 20 years ago.  
 24 Q. Now, did you do blood testing on any of  
 15:52:19 25 these patients to quantify if it was working? Any of

15:52:22 1 these five.  
 2 A. I don't recall. I don't think so.  
 3 Q. Have you been doing any routine blood tests  
 4 on any of your patients besides the study you did 20  
 15:52:31 5 years ago?  
 6 A. Well, I do chemical levels, yes.  
 7 Q. Do you do blood studies?  
 8 A. That's what I said. I do chemical levels.  
 9 For example, I may do a xylene, toluene, benzene and  
 15:52:44 10 so on. But I do it now before and after treatment  
 11 because I don't -- I want to keep the expense down as  
 12 much as we can. You see, our foundation funded that  
 13 in the past.  
 14 Q. I looked through these five patients. Why  
 15:53:01 15 do you give them glutathione?  
 16 A. Because glutathione is a great antioxidant  
 17 and it detoxifies chemicals.  
 18 Q. How does it detoxify chemicals?  
 19 A. Well, there's two sulphur, I think two  
 15:53:17 20 sulphur molecules on the end of glutathione, and I  
 21 think they grab the toxics and hang on to them and  
 22 put it out of the body.  
 23 Q. Do you think, or that's what chemically  
 24 happens?  
 15:53:27 25 A. No, that's what happens.

15:53:28 1 Q. Do you know that or is that --  
 2 A. I do know that, yes.  
 3 Q. Is it a hypothesis, or have you proven it?  
 4 A. No, no, other people have proven this. I  
 15:53:37 5 mean, all our data and everything we do is a  
 6 composite of the world literature and our experience.  
 7 Q. Why do you give your patients niacin before  
 8 they go into the heat depuration?  
 9 A. Well, we don't for everybody. But some of  
 15:53:54 10 the people that can tolerate it, it dilates their  
 11 vessels and helps them sweat faster.  
 12 Q. Creates a flushing effect on them, doesn't  
 13 it?  
 14 A. Yeah, it does.  
 15:54:03 15 Q. Have you ever told anybody that that  
 16 flushing effect is the toxics coming out of their  
 17 body?  
 18 A. I don't recall. But usually not.  
 19 Q. Have you ever told them that?  
 15:54:12 20 A. Well, I don't know. I don't remember.  
 21 Q. Well, is it true that if they get a  
 22 flushing feeling after taking niacin, that toxics are  
 23 coming out of their body, medically?  
 24 A. No.  
 15:54:23 25 Q. So have you ever told anybody that?



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15:54:25 1 A. Not to my knowledge, I haven't.  
 2 Q. Okay. Do you ever -- I believe I saw some  
 3 of the -- do you ever do any kind of testing of the  
 4 sweat on these individuals to see if anything is  
 15:54:42 5 flushing out of their body?  
 6 A. We have, but I haven't for years. Like I  
 7 say, we didn't have enough money to keep on doing it.  
 8 Q. Okay. Have you ever said that you could  
 9 smell it on their breath after a sauna?  
 15:54:54 10 A. Oh, you can smell it more than on their  
 11 breath, you can smell it coming out of them.  
 12 Q. Well, then how do you -- I guess then the  
 13 question is, if they're sweating it out, how do you  
 14 ever establish or -- how do you make a determination  
 15:55:12 15 that they're at a normal level? I mean, is there  
 16 something that you can correlate it to or compare it  
 17 against?  
 18 A. Yeah, when they've got their energy back  
 19 and they can navigate through society.  
 15:55:26 20 Q. So it's not any -- you can't say it's an  
 21 objective level, it's more just a functional,  
 22 subjective level; is that true?  
 23 A. No, it's not true.  
 24 Q. Then what's the objective criteria you use  
 15:55:39 25 to determine --

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15:55:40 1 A. Energy, energy is the objective criteria.  
 2 If you can't walk across the room and now you can run  
 3 down the hall, anybody can tell the energy has  
 4 improved.  
 15:55:50 5 Q. What besides being able to run down a hall  
 6 do you use as an objective criteria?  
 7 A. Well, that they can now work and remember,  
 8 and -- if they have short-term memory loss. That  
 9 they've got their heart irregularities under control,  
 15:56:06 10 that they don't have muscle spasms anymore.  
 11 Q. So you can cure heart irregularities with  
 12 your treatments?  
 13 A. I don't believe I said that.  
 14 Q. You just said their heart irregularities  
 15:56:20 15 were gone.  
 16 A. That's right. But you asked me how I would  
 17 know objectively. And I'm saying in some patients if  
 18 their heart irregularity is gone, that's how you  
 19 measure objectively.  
 15:56:31 20 MR. SIMON: He didn't say he treats  
 21 heart irregularity with his treatments.  
 22 Q. What's placebo?  
 23 A. Pardon?  
 24 Q. What is a placebo?  
 15:56:42 25 A. Well, you know, that's a good question.

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15:56:45 1 What we think of placebo is saltwater and usually  
 2 water, something that nobody is supposed to react to.  
 3 Q. What do you think a placebo is?  
 4 A. I just said.  
 15:56:56 5 Q. You said "we," I didn't know if that was  
 6 you.  
 7 A. Environmental Health Center, people in  
 8 environmental movements around the country, the 5,000  
 9 physicians that do this.  
 15:57:17 10 MR. SIMON: Try to use you, try to use  
 11 you, limit yourself to you.  
 12 THE WITNESS: Okay.  
 13 Q. Doctor, have you read the -- I'm not sure,  
 14 I think it's the 2009 CDC report on exposure to  
 15:57:30 15 chemicals in the human population? Have you seen  
 16 that?  
 17 A. Yeah, I've only briefly gone over it. I  
 18 haven't had time to really digest it. It's too new  
 19 and I've had too many things to do, you know.  
 15:57:41 20 Q. So this may not -- you probably don't know,  
 21 but are you aware that the first sentence of the  
 22 executive summary under the heading, interpreting the  
 23 data, states, and I quote, the presence of an  
 24 environmental chemical in people's blood or urine  
 15:57:56 25 does not mean it will cause disease or effects? Are

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15:57:59 1 you aware of that?  
 2 A. I'm not aware of it, but I wouldn't have  
 3 any argument with it.  
 4 Q. Okay. That was going to be my next  
 15:58:05 5 question.  
 6 So the mere presence of somebody with  
 7 chemicals is not enough to -- for you to decide to  
 8 treat them; is that true?  
 9 A. Yes, that's true.  
 15:58:19 10 Q. Okay, Doctor, if -- this is a pretty basic  
 11 question, and if I've asked it before, I apologize.  
 12 I don't think I have.  
 13 If you don't know the exact causative  
 14 agent of a disease or the exact chemical causative  
 15:59:02 15 agent for a particular patient's chemical  
 16 sensitivity, how do you make treatment decisions?  
 17 A. Well, with difficulty, of course.  
 18 Q. Beyond that?  
 19 A. Well, you mean if there's no positive  
 15:59:18 20 laboratory data?  
 21 Q. I'm just saying if you don't know the  
 22 causative agent. Let's say, for example -- we'll  
 23 choose any of these patients. Let's choose, I don't  
 24 care, A.R., for example.  
 15:59:29 25 A. Okay.

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15:59:30 1 Q. She says she's exposed to, I think --  
2 wasn't it A.R.?  
3 A. I'll tell you, a better example would be --  
4 MR. SIMON: Let him ask the question.  
15:59:39 5 A. -- would be J.S.  
6 MR. SIMON: Doctor, wait, let him ask  
7 the question.  
8 Q. A.R. comes, says she's had a pain exposure  
9 some 15 years ago, she's had problems after 9-11.  
15:59:53 10 She's got a thyroid condition. She takes Adderall.  
11 She says she's sensitive to everything, and there's a  
12 fairly long litany of exposures. How do you decide  
13 what's the causative agent and how you treat her?  
14 A. Well, at this, at this stage, you can't,  
16:00:12 15 you can't decide what the causative agent is. All  
16 you can do is try to decrease the total load and get  
17 the triggering agents that are predominant and try to  
18 either neutralize them, get, get rid of them, or  
19 treat them with nutrition, and take care of the  
16:00:35 20 problem that way.  
21 Q. Well, when you say treat her total load, if  
22 you don't know what the agents are or how long she  
23 was exposed to any of them, the duration or  
24 concentration, how do you get rid of the load?  
16:00:49 25 A. Well, you go by past history of people who

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16:00:53 1 have had the problem, and her total load is  
2 increased. For example, we know that natural gas  
3 leaks can cause people to see one of them. Ensure  
4 she gets in a place with no natural gas leaks. We  
16:01:07 5 know that pesticides are a big offender in all of  
6 these people, so you get her in a place where she has  
7 no pesticides. We know that drinking water can cause  
8 problems, both the chlorination and if it's well  
9 water, could be arsenic or public water supply. The  
16:01:23 10 last I saw in Dallas, there was 32 different toxic  
11 chemicals. If-- you make sure they have organic  
12 food and as chemically free as possible. Therefore,  
13 you're going to decrease the load, and sometimes that  
14 will help them.  
16:01:42 15 Q. Well, that's great you're going to decrease  
16 their load. But let me ask you this: How do you, as  
17 far as, say, natural gas leak, all you've got to do  
18 is stop the leak, it stops the exposure. So why does  
19 she need treatment from you other than getting a new  
16:02:00 20 gas line, perhaps?  
21 A. Well, because if she lives in a gas house,  
22 the gas has about a 10 percent leak in most houses  
23 and you can't stop it all.  
24 Q. Okay. Looking through this, do you know  
16:02:09 25 what she was exposed to? Natural gas, as far as you

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16:02:16 1 could tell?  
2 MR. SIMON: We're talking about A.R.  
3 right now?  
4 MR. FRESHOUR: Yes.  
16:02:21 5 MR. SIMON: Okay. If you need to --  
6 A. I'm looking here. I --  
7 MR. SIMON: If you need to look at the  
8 actual medical record, you've got to see those,  
9 that's another ballgame.  
16:02:30 10 THE WITNESS: No, no.  
11 A. I don't recall that she was, no.  
12 Q. Do you know if she was exposed to any  
13 pesticides that she articulated?  
14 A. She lived in New York City and had lived in  
16:02:41 15 some apartments that were pesticided, yes.  
16 Q. Do you know that she was exposed to those  
17 pesticides, or are you just extrapolating because she  
18 was living in an apartment in New York City?  
19 A. I think I -- well, I asked her about it.  
16:02:56 20 Q. Did you record that in your medical  
21 records?  
22 A. Probably did, yeah.  
23 Q. How long was she exposed to the pesticides?  
24 A. I don't recall.  
16:03:02 25 Q. What concentration were they?

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16:03:03 1 A. Well, you know I don't know that.  
2 Q. Okay. What about other things, what was  
3 her drinking water source? Was she buying bottled  
4 water or was she drinking city water?  
16:03:14 5 A. I think by the time she came to us, she was  
6 doing plastic bottled water.  
7 Q. Okay. And plastic bottled water can come  
8 from a whole variety of different sources, correct?  
9 A. Yes. Plus the fact that the plastics can  
16:03:28 10 contaminate her.  
11 Q. All right. Did you test her for any of the  
12 chemicals found in plastics?  
13 A. I think we did, yeah.  
14 Q. How long had she been drinking bottled  
16:03:46 15 water, do you know?  
16 A. I don't recall.  
17 Q. Are there different kinds of plastics, hard  
18 plastics and soft plastics?  
19 A. Yes.  
16:03:53 20 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 25 Q. Why did -- I'm going to represent to you

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16:04:09 1 that you've prescribed her immunotherapy for -- and  
2 it says unleaded diesel. Why did you do that?  
3 A. Because she was reacting to it.  
4 Q. Did she come in and describe to you any  
16:04:22 5 sensitivities and, specifically, to diesel fuel, when  
6 she presented to you or in your medical records?  
7 A. Yeah, I think she did.  
8 Q. Okay.  
9 A. By the way, we did test her for natural  
16:04:35 10 gas.  
11 Q. What was --  
12 A. She reacted.  
13 Q. I'm looking at her initial history and  
14 physical. And are you aware the only chemical she  
16:04:48 15 put down that she had exposure to was cigarette smoke  
16 and perhaps --  
17 MR. SIMON: Do we need to look at that  
18 record, because we don't have the same record he has  
19 in front of him.  
16:04:58 20 THE WITNESS: No, I think what he's  
21 got is --  
22 A. This may well be true because until --  
23 MR. SIMON: We're not looking at the  
24 same records he's looking at. Do we need to pull the  
16:05:05 25 record for you to answer that?

16:05:07 1 THE WITNESS: I don't think so. I  
2 don't think so.  
3 Q. Why did you prescribe immunotherapy to her  
4 for algae and molds?  
16:05:18 5 A. Because she reacted to them.  
6 Q. Why did you test her for them if she didn't  
7 articulate them in exposure history?  
8 A. Because she was so ill and had been ill for  
9 such a long period of time, we couldn't leave any  
16:05:33 10 stone unturned without testing her.  
11 Q. So although she presented talking about  
12 pain exposure, you went ahead and ended up giving her  
13 antigen therapies, also for feathers. Why feathers?  
14 A. She expressed that she was sensitive to  
16:05:52 15 feathers.  
16 Q. And why propane?  
17 A. Same.  
18 Q. She is sensitive?  
19 A. (Nods head)  
16:05:58 20 Q. She expressed that?  
21 A. Yeah.  
22 Q. Did you put it in your medical record?  
23 A. I think we did, yeah.  
24 Q. Okay.  
16:06:03 25 MR. SIMON: If you don't know what you

16:06:04 1 put in --  
2 Q. Why did you test her for Tide and Bounce?  
3 A. Because she was sensitive to it.  
4 Q. Well, you say she is sensitive to it. She  
16:06:15 5 was sensitive after you tested. But did she come in  
6 and articulate that to --  
7 A. Look, I don't really recall because -- you  
8 have to remember, we have a dynamic relationship with  
9 our patients. This woman is a Ph.D. And once they  
16:06:29 10 get to finding things, it reminds them that something  
11 else may have triggered them that they tried to get  
12 out of their life and they couldn't. And then we let  
13 our testing be guided by that very thing.  
14 Q. I'm going to represent to you that I went  
16:06:51 15 through her immunotherapy records.  
16 A. Okay.  
17 Q. And is it normal -- I'm going to represent  
18 to you, and if we need to look, we can, from 11-24 of  
19 '04 to 12-27 of '04 -- that's a approximately, what,  
16:07:10 20 34-, 33-day period?  
21 A. Yeah.  
22 Q. She had antigen therapy prescribed to her  
23 at a cost of \$11,000. Is that a normal kind of  
24 treatment range for a 30-day period for one of your  
16:07:25 25 patients?

16:07:26 1 A. No.  
2 Q. Now, she kept repeatedly getting sauna  
3 treatments for a diagnosis of headaches. Is  
4 headaches really a specific diagnosis, Doctor?  
16:07:47 5 A. Yes.  
6 Q. Okay. And if she was being treated for  
7 headaches, what are you trying to sweat out of her  
8 for in the sauna that is causing headaches?  
9 A. Well, as I stated before, this doctor was  
16:08:05 10 extremely ill, had been incapacitated, and that she  
11 had an imbalance of her autonomic nervous system,  
12 which most likely caused the headaches. The question  
13 is, what were the triggers? Were they sequestered in  
14 her, or were they from outside? And so we tried to  
16:08:23 15 do the heat therapy to sweat out any toxics that  
16 might be in there.  
17 Q. What do you mean that the triggers were  
18 sequestered in her? If something is sequestered, how  
19 is it a trigger?  
16:08:35 20 A. Well, number one, they're never 100 percent  
21 sequestered.  
22 Q. Well, how do you determine if a trigger is  
23 sequestered in a patient?  
24 A. I think we went over all of that.  
16:08:47 25 Q. Well, I'm sorry, Doctor, I guess I -- I

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16:08:48 1 really guess I'm not understanding how can a trigger  
2 be sequestered in a patient. So if it's already  
3 inside her, I mean --  
4 A. If it's inside her and it's starting to be  
16:09:00 5 released slowly and she doesn't need very much of it  
6 to trigger her blood vessels and trigger her  
7 autonomic nerves to make the blood vessels spasm, it  
8 can happen.  
9 Q. Okay. What were her triggers, then? Do  
16:09:15 10 you know?  
11 A. Well, yeah, we had a whole list of them  
12 here. She was almost pan sensitive, if you want to  
13 look at it that way. Look here, there's three and a  
14 half, four pages of substances that triggered a lot  
16:09:29 15 of her symptoms.  
16 Q. And out of those, all of those substances,  
17 on any of them, could you quantify or qualify the  
18 concentration or the duration of her exposure that  
19 caused her to become sensitive to them? Let's say  
16:09:50 20 natural gas. How long was she exposed and what  
21 concentration, do you know?  
22 A. You can't say. You know I don't know that.  
23 Q. Okay. How about chlorine?  
24 A. Same.  
16:09:59 25 Q. How about ethanol?

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16:10:01 1 A. Same.  
2 Q. Formaldehyde?  
3 A. Same.  
4 Q. Ladies' cologne?  
16:10:06 5 A. Same.  
6 Q. Men's cologne?  
7 A. Same.  
8 Q. Orris root?  
9 A. Same.  
16:10:12 10 Q. Did she have a fireplace?  
11 A. You know, I don't recall.  
12 Q. Okay. Because you tested her for fireplace  
13 smoke. Are you aware of that?  
14 A. She probably complained of it, that it  
16:10:23 15 bothered her.  
16 MR. SIMON: Do you know if she did?  
17 THE WITNESS: I don't know. That's  
18 what I said.  
19 Q. You never went to her home, you don't know  
16:10:29 20 what it looked like, did you?  
21 A. No. She lived in Manhattan.  
22 Q. Did she live in a townhouse in Manhattan?  
23 MR. SIMON: Brooklyn, I think it was.  
24 A. Apartment. I don't know how you define  
16:10:43 25 "townhouse."

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16:10:45 1 Q. Apartment?  
2 A. It was an apartment, multi-person place.  
3 Q. Do you know how old an apartment?  
4 A. I don't.  
16:10:51 5 Q. Do you know the location in Brooklyn? Was  
6 it Brooklyn?  
7 A. No, no, she wasn't from Brooklyn. She was  
8 from Manhattan. All of these patients were in  
9 Manhattan, by the same insurance company, and one  
16:11:06 10 who's noted to turn people in.  
11 Q. Why did you test her for stainless steel?  
12 She wasn't getting an implant, was she?  
13 A. She probably complained of -- that it  
14 bothered her.  
16:11:24 15 Q. How about tin?  
16 MR. SIMON: Did you test her for tin?  
17 A. Tin?  
18 MR. SIMON: Did you test her for tin?  
19 THE WITNESS: Did I test her? Did I  
16:11:33 20 see that?  
21 MR. SIMON: I don't know. Don't take  
22 his word for it.  
23 Q. I'm going to represent to you -- let me do  
24 it this way. make it very easy. I want to represent  
16:11:38 25 to you I'm reading an antigen intradermal testing

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16:11:40 1 sheet in the medical records provided to me from you.  
2 How is that, Dr. Rea, okay?  
3 A. That's a lot better.  
4 Q. How is that? It will make it a whole lot  
16:11:49 5 easier. I'm reading right off the intradermal skin  
6 testing summary sheet.  
7 A. Okay.  
8 Q. You're familiar with those, aren't you?  
9 A. I made them.  
16:11:57 10 Q. Yeah, that's what I meant. You're familiar  
11 with those.  
12 A. Look, if we tested her for tin, most likely  
13 she had tin in her hair, sometimes with tin, because  
14 they use that in hair things.  
16:12:08 15 Q. Okay. Why did you test her for silver?  
16 A. Probably amalgam, silver amalgam.  
17 Q. Same thing for porcelain?  
18 A. Yeah.  
19 Q. Platinum?  
16:12:16 20 A. Yes.  
21 Q. Palladium?  
22 A. Yeah.  
23 Q. What about nickel sulfate?  
24 A. She may have complained of that, of being  
16:12:22 25 sensitive to that.

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16:12:24 1 Q. What is nickel sulfate?  
 2 A. It's a metal that's -- can be used for  
 3 nickel earrings, nickel bracelets and so on.  
 4 Q. Mercury?  
 16:12:37 5 A. Definitely.  
 6 Q. Lead?  
 7 A. Yes.  
 8 Q. Gold?  
 9 A. Yes.  
 16:12:42 10 Q. What about news material? Are you talking  
 11 about the print, the paper? What is news material?  
 12 A. Combination of all of that.  
 13 Q. What is ALF?  
 14 A. Autogenous lymphocytic factor.  
 16:13:24 15 Q. What does that mean?  
 16 A. It's an immune booster made out of their  
 17 own blood.  
 18 Q. How do you do that, Doctor?  
 19 A. Well, you draw blood, you put it in a  
 16:13:32 20 culture medium and cells divide every 24 to 36 hours,  
 21 the weak ones die, the strong ones multiply again.  
 22 After about 30 generations, you have very strong T  
 23 cells and then they're processed in a special way,  
 24 and then she gets injections of them every four days.  
 16:13:58 25 Q. Does she self-inject?

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16:14:00 1 A. Yeah.  
 2 Q. Intramuscular?  
 3 A. Subcu.  
 4 Q. Subcu. What does that mean?  
 16:14:05 5 A. Subcutaneously, right underneath the skin.  
 6 Q. And then, what, it's absorbed back into the  
 7 body or into the bloodstream?  
 8 A. Yes.  
 9 Q. Okay. Now, if you give it subcu -- and  
 16:14:18 10 these are blood cells or T cells? What are they  
 11 exactly?  
 12 A. They're -- actually they have all been  
 13 destroyed, they're the lysates of them.  
 14 Q. And so when you do that subcu, do they  
 16:14:32 15 absorb into the bloodstream and that's how they  
 16 fortify, or do they go through some other route in  
 17 the body before they get --  
 18 A. Well, they may go through the lymphatics.  
 19 A lot of this goes through the lymphatics.  
 16:14:48 20 Q. Is that some kind of a -- is that FDA  
 21 approved therapy or --  
 22 A. No. You don't have to have approval for  
 23 it.  
 24 Q. That was going to be my next question. You  
 16:14:56 25 don't have to?

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16:14:57 1 A. Yeah.  
 2 Q. You've got some kind of -- is it a patented  
 3 process or anything to you, Doctor?  
 4 A. No.  
 16:15:06 5 Q. Now, when you send it to them for the  
 6 subcutaneous, do you send them -- is it already  
 7 broken into doses? Do they draw it up? Do they  
 8 inject --  
 9 A. They just draw it up. I mean, if they take  
 16:15:21 10 the substances, you know, like the food shots or mold  
 11 shots, they're already taught to do that. So they  
 12 are taught to draw it up and take it.  
 13 Q. Okay. And I take it, then, it's sent to  
 14 them wherever they may be at that point in time?  
 16:15:40 15 A. That's correct, yes.  
 16 Q. And does it have to be --  
 17 A. Frozen.  
 18 Q. -- refrigerated, frozen, something?  
 19 A. Frozen.  
 16:15:49 20 Q. Frozen, okay.  
 21 Then they have to defrost it or thaw  
 22 it under certain conditions, though, right?  
 23 A. Right.  
 24 Q. And they're all prescribed how to do that?  
 16:15:57 25 A. Yes.

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16:15:59 1 Q. Do you know -- because that's a therapy, do  
 2 they require any kind of a prescription from you for  
 3 the, I guess the injections or the needles or  
 4 syringes to do that?  
 16:16:09 5 A. Yeah.  
 6 Q. Okay. And you provide those with a kit?  
 7 A. No, they can buy the syringes anyplace they  
 8 want. But we give the ALF.  
 9 Q. Okay.  
 16:16:21 10 A. That's what we provide.  
 11 Q. And -- so is that just a one-time series  
 12 that you send them, or do you keep a reserve and  
 13 build more for them? Or how does that work?  
 14 A. Well, it depends on how fast their T cells  
 16:16:34 15 and their other systems respond. We've had about 27  
 16 now that respond on the first shot. The majority of  
 17 them takes about three months, six months to respond  
 18 very well.  
 19 Q. And when you say they respond, what do you  
 16:16:46 20 mean by that?  
 21 A. More energy, more brain function, less  
 22 infections. Usually it will wipe out infections on  
 23 them.  
 24 Q. And since they are, I guess, remote by the  
 16:16:58 25 time they start that, do you observe that, or is this

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16:17:01 1 just anecdotal information they send you?  
2 A. I don't know that that's anecdotal, but  
3 it's information they send me.  
4 Q. You don't observe that, necessarily?  
16:17:10 5 A. No -- well, some around here I do, those  
6 that live around here. Those that live far away, of  
7 course, I just have to take their word for it, or  
8 their physician's word. See, most of these patients  
9 have been sent by physicians.  
16:17:24 10 Q. All right. I want to talk to you a little  
11 bit about patient R.B.  
12 A. Who?  
13 Q. R.B.  
14 A. Ruth Burt, okay.  
16:17:40 15 Q. Yes, Ruth Burt, exactly. Let me get to  
16 her, try to find it here, Doctor.  
17 A. Okay.  
18 Q. You're quicker than I am getting there,  
19 Doctor.  
16:17:57 20 This one, Ms., Ms. R.B., she's the  
21 one -- I'm going to represent to you, she's the one  
22 who got the chelation that we had talked about in  
23 somewhat vague terms in an earlier part of the  
24 deposition. She had some -- she got chelation.  
16:18:23 25 A. Yes, I think we talked about that.

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16:18:25 1 Q. We did generally. And my question is --  
2 MR. SIMON: Do you have that?  
3 THE WITNESS: I've got it right here.  
4 Q. And you do recall that now, right?  
16:18:35 5 A. Yeah, sure I do.  
6 Q. Okay. And --  
7 A. She was the one that had to have the pubic  
8 hair.  
9 MR. SIMON: Let him finish his  
16:18:47 10 question.  
11 Q. But she is the, she is the individual that  
12 we talked about where we had the concern over the  
13 provoked versus the unprovoked comparison, do you  
14 recall that?  
16:18:58 15 A. Yes, yes.  
16 Q. Okay. Now, this is the lady who claimed  
17 that she had -- somebody had attempted to arsenic  
18 poison her in the year or two before, right?  
19 A. Yeah. You see, unfortunately, something  
16:19:13 20 about her family money was being stolen by the mafia  
21 and it got rather mysterious and complicated. And  
22 she didn't know it all because she was -- ran her own  
23 business and she was a professor at the college there  
24 and maybe somewhat naive a little bit. I didn't get  
16:19:33 25 into it, because I didn't want to do anything like

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16:19:35 1 that.  
2 Q. Well, let me ask you, her chief complaints  
3 which she presented to you are swollen ankles or  
4 edema?  
16:19:41 5 A. Yes.  
6 Q. Looks like some water retention, which is  
7 edema, as well, right?  
8 A. That's correct, yes.  
9 Q. Okay. Spots, red blotches?  
16:19:50 10 A. Yes.  
11 Q. Failing eyesight, looks like stiff arm and  
12 neck, itching.  
13 A. Yes.  
14 Q. Fingernails open?  
16:19:59 15 A. Yeah.  
16 Q. Constant urination?  
17 A. Right.  
18 Q. And arsenic poisoning.  
19 A. Well, plus a bunch more that you missed.  
16:20:07 20 Q. Well, but that's her initial presenting  
21 chief complaints that are recorded in your medical  
22 records?  
23 A. Yes, okay. We got more as time went on.  
24 Q. Right. And you say you got more as time  
16:20:17 25 went on. Was this during the initial interview or as

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16:20:21 1 she was longer --  
2 A. No. As we saw her each day. I would see  
3 them each day, every day.  
4 (Mr. Cook leaves the room)  
16:20:26 5 Q. Okay. So her initial -- let me make sure  
6 I've got the right date, Doctor.  
7 So her initial patient questionnaire  
8 is filled out on -- looks like in September of '03,  
9 and it looks like, looks like on September 2 of '03,  
16:20:56 10 and it looks like before the end of that month she's  
11 in for, she gets a heavy metal urine testing. And by  
12 October, she's had a provoked chelation test. Why  
13 was that, Doctor?  
14 A. I think we went over that. We wanted to  
16:21:14 15 decrease her total body burden to see if there was  
16 anything in there.  
17 Q. Isn't it true that most -- almost all of us  
18 anymore, if we are tested, have -- and, I mean, as  
19 the general population, have some DDT or DDE that we  
16:21:31 20 would test positive for?  
21 A. Well, I've never measured the general  
22 population, so I can't really tell you that. I can  
23 tell you about the chemically sensitive population.  
24 Q. They have it.  
16:21:40 25 A. And they -- almost all of them have DDE.

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16:21:42 1 Not DDT much anymore, as a matter of fact, but DDE.  
 2 Q. Now, this patient also had a history of  
 3 arthritis and thyroid, correct?  
 4 A. Yes.  
 16:21:57 5 Q. Family history of diabetes?  
 6 A. Yes.  
 7 Q. And in fact she admitted to being a sugar  
 8 addict, didn't she?  
 9 A. Yes, she did.  
 16:22:05 10 Q. Or worse than, I think was her words,  
 11 right?  
 12 A. I think you're right.  
 13 Q. So we've talked earlier today, conditions  
 14 such as thyroid, diabetes -- although I don't think  
 16:22:18 15 she was a confirmed diabetic, being a sugar addict.  
 16 All of those can manifest with some of the same  
 17 symptoms that you attributed to chemical sensitivity,  
 18 correct?  
 19 A. Well, I guess you would have to say which  
 16:22:33 20 ones you're referring to.  
 21 Q. Well, I think we talked a little bit  
 22 earlier today, things like fatigue and tiredness  
 23 could be diabetes, could be thyroid?  
 24 A. Yeah, we've already talked about it.  
 16:22:46 25 Q. Right. So that's what I'm talking about.

16:22:46 1 That same constellation of general symptoms, correct?  
 2 A. Yes, sure. Of course she didn't have  
 3 diabetes.  
 4 Q. Did you test her?  
 16:23:02 5 A. Yes.  
 6 Q. Okay. But she did admit to a chemical --  
 7 I'm sorry, to being worse than a sugar addict  
 8 correct?  
 9 A. I believe you're right, yeah.  
 16:23:12 10 Q. So even though she may not have tested over  
 11 into the diabetic range, that certainly high intake  
 12 of sugar with a family history could be a  
 13 complicating factor in her diagnosis and treatment,  
 14 wouldn't you agree, Doctor?  
 16:23:28 15 MR. SIMON: Object to the form.  
 16 You can answer the question.  
 17 A. I don't know what you're talking about.  
 18 Could be a complicating factor in what?  
 19 Q. In her treatment.  
 16:23:37 20 A. The fact that she was not diabetic?  
 21 MR. SIMON: Objection, form.  
 22 Q. Well, just generally if you're treating  
 23 her, and when it goes to a differential diagnosis,  
 24 you would have to rule things like that out and --  
 16:23:49 25 A. I did.

16:23:50 1 Q. You did? Okay.  
 2 And how did you rule out her diabetes?  
 3 A. Doing blood sugars.  
 4 Q. Okay. And on this patient, Doctor, did  
 16:24:08 5 you -- why did you test her for lake algae?  
 6 A. Because she lived near a river.  
 7 Q. Did she complain about having sensitivities  
 8 to anything from the river or algae?  
 9 A. I think she may have, yeah.  
 16:25:03 10 Q. Okay. I'm going to represent to you that  
 11 you also tested her for natural gas, didn't you?  
 12 A. Yes.  
 13 Q. What kind -- how long was she exposed to  
 14 natural gas and at what concentrations?  
 16:25:16 15 A. Now, you know I don't know what  
 16 concentrations,  
 17 Q. How long was she exposed?  
 18 A. I don't know how long, because she fled  
 19 back and forth between houses in Manhattan and houses  
 16:25:28 20 across the -- what is it? Across the lake on the  
 21 Hudson River there. But she wasn't sensitive, so...  
 22 Q. Okay. You tested her also for cigarette  
 23 smoke, correct?  
 24 A. Yes.  
 16:25:44 25 Q. Okay. And, again -- let me do it this way.

16:25:49 1 I'll make it real easy, Doctor. I'm going to  
 2 represent to you on your intradermal skin testing  
 3 sheet, you tested her for all the chemicals you list,  
 4 right?  
 16:25:58 5 A. The ones I list.  
 6 Q. The ones you list that are on your standard  
 7 form.  
 8 A. Yeah, I think I did.  
 9 Q. You know what I mean, Doctor.  
 16:26:03 10 A. Yeah.  
 11 Q. Okay. Is it fair to say that under each  
 12 and every one of those chemicals that you tested her  
 13 for, you don't know when she was exposed, the  
 14 duration of the exposure, or the concentration?  
 16:26:16 15 A. I think it's fair to say I don't at this  
 16 time. I probably did before, but I don't now.  
 17 Q. And would you have listed that, if you knew  
 18 it, in your medical records?  
 19 A. Not necessarily.  
 16:26:27 20 Q. Why not?  
 21 A. Because it gets rather burdensome to list  
 22 these things over and over again when you're trying  
 23 to develop a treatment program for somebody who's got  
 24 a very complicated problem.  
 16:26:40 25 Q. And if you did an exposure history on

16:26:43 1 those, since you tested her for those, would you list  
2 those in your exposure history?  
3 A. Yeah, if I could.  
4 Q. Well, let me ask you, Doctor, why couldn't  
16:26:51 5 you or why wouldn't you?  
6 A. Time factor, as I told you.  
7 Q. But if you were trying to -- and I'm trying  
8 to understand that, a time factor. If it relates to  
9 her exposure history and you're treating her because  
16:27:10 10 of her exposures, why wouldn't you take the time to  
11 list that to be able to support the basis for your --  
12 A. Well, I did, because I tested her. I  
13 listed it in the testing.  
14 Q. I know you list it in the testing.  
16:27:22 15 A. That's all I need. Why do I need to list  
16 it someplace else?  
17 Q. Well, if you're going through an exposure  
18 history and she doesn't list all of those, then why  
19 would you test her for those? Those could be  
16:27:33 20 unnecessary tests if it doesn't --  
21 A. Oh, I see. You're driving at unnecessary  
22 testing. We don't ever do unnecessary testing  
23 because we don't have time for it. We try to do the  
24 pertinent things. And as I said before, as we see  
16:27:46 25 patients every day, they realize, hey, I was exposed

16:27:49 1 to this, could I be sensitive, et cetera, and we just  
2 go ahead and do it.  
3 Q. Do you realize -- do they realize or do you  
4 say, hey, don't you think you might have been exposed  
16:27:57 5 to -- do you know how your people are posing that,  
6 the question?  
7 A. They'll come in and they'll say, they say,  
8 it dawned on me that maybe that was a problem.  
9 Q. Well, I'm going to represent to you the  
16:28:09 10 only exposure she checked for chemicals on her  
11 initial sheet for you-all was cigarette smoke. So  
12 why would you test beyond that?  
13 A. I just told you why.  
14 MR. SIMON: Is this the one with the  
16:28:21 15 cigarette smoke?  
16 MR. FRESHOUR: It's R.B., yeah, yeah.  
17 MR. SIMON: R.B.  
18 MR. FRESHOUR: Yeah.  
19 Q. Let's go on and talk a little bit about  
16:28:35 20 E.F. You're familiar with E.F., aren't you, Doctor?  
21 A. I certainly am, yes.  
22 Q. Bear with me. I think I'm to the right  
23 one.  
24 E.F. was -- got some trichothecene  
16:28:51 25 testing by Dr. Croft. Do you remember that?

16:28:54 1 A. Yes.  
2 Q. Her initial presenting complaints were  
3 dizziness, headache, nausea, ringing in the ears,  
4 palpitations and labored breathing. Do you remember  
16:29:03 5 that?  
6 A. I remember that, plus about 15, 20 more.  
7 Q. Well, I'm just talking about --  
8 A. She had 39 total.  
9 Q. Well, Doctor, I'm just talking about her  
16:29:14 10 initial history and physical.  
11 A. Okay. But as I explained to you, we never  
12 get the full history on the initial one. They can't  
13 remember it all.  
14 Q. Right. And so -- and let me ask you,  
16:29:24 15 that's really interesting. They can't remember.  
16 These people, a lot of them, if they're suffering  
17 from chemical sensitivity, they have decreased mental  
18 sharpness and brain fog, how can their history giving  
19 be reliable and credible, in your opinion?  
16:29:39 20 A. Well, they -- I mean, you talk to somebody  
21 and you know whether they're reliable. But you also  
22 know if they've got brain fog, that they're not  
23 remembering all the things that they might if their  
24 memory was tweaked.  
16:29:50 25 Q. And how do you tweak their memory?

16:29:53 1 A. Well, they just do that around the clinic,  
2 and their brain gets sharper as they live in a  
3 controlled environment. They start remembering  
4 things.  
16:30:01 5 Q. And those things they remember, at least in  
6 these two or three patients, appear to be, remembered  
7 further exposure, which allows you to do further  
8 testing and treatment, correct?  
9 A. Yeah, that's right.  
16:30:13 10 Q. Not bad for business, is it, Doctor?  
11 MR. SIMON: I'll object to the form.  
12 You don't have to answer that.  
13 THE WITNESS: I'm not going to. It's  
14 an insult.  
16:30:21 15 Q. Well, let me ask you this, Doctor: She was  
16 also a smoker, correct?  
17 A. Yes, she was -- had been, uh-huh.  
18 Q. And did she cease smoking when she got to  
19 your clinic?  
16:30:31 20 A. Yeah, she did.  
21 Q. Okay.  
22 A. She knew I would throw her out.  
23 Q. And I take it that is across the board they  
24 cease smoking.  
16:30:40 25 A. Yeah.



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16:30:40 1 Q. Do you know, did she resume after she left  
2 your care?  
3 A. No, I don't think so.  
4 Q. You don't know, though, for sure?  
16:30:46 5 A. No, I know because I followed her very  
6 closely over the years.  
7 Q. Okay. Now, the one question I have on this  
8 is, I'm going to represent to you -- and I'm not  
9 going to go way far into it -- is the Immunosciences  
16:31:00 10 Lab test.  
11 A. Yes.  
12 Q. Here, all of this Stachybotrys IG testing  
13 came back within normal limits and so did the  
14 trichothecenes. Are you aware of that?  
16:31:13 15 A. Yeah.  
16 Q. Then why did you send her for trichothecene  
17 testing to Dr. Croft?  
18 A. Because Dr. Johanning, Eckardt Johanning, a  
19 professor at the University of Albany, had already  
16:31:28 20 worked her up for a lot of mold antibodies and found  
21 it. And I think he worked her up for a  
22 hypersensitive lung disease, found positive in that.  
23 And that she had a history of severe exposure to  
24 mold. So I thought it would be a good idea to have  
16:31:46 25 that.

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16:31:47 1 Q. Are you aware that Dr. Johanning, just as  
2 recently as about two years ago, has had all of  
3 his -- had his theories on mold causation struck and  
4 not been allowed to testify in courts? Are you aware  
16:32:00 5 of that?  
6 A. No, I was not.  
7 Q. Are you aware of a case in Austin, Texas  
8 commonly known as the Ballard case versus State Farm  
9 Insurance?  
16:32:07 10 A. Oh, yeah, yeah.  
11 Q. Are you aware he got struck in that case on  
12 all of the causation as it related to the  
13 mold-related illnesses?  
14 A. No. But what's that got to do with this?  
16:32:17 15 Q. I was just asking you, Doctor.  
16 MR. FRESHOUR: We're good here for a  
17 pause.  
18 THE VIDEOGRAPHER: The time is 4:32  
19 p.m. This is the end of tape number six. We are off  
16:32:30 20 the record.  
21 (Recess from 4:32 to 4:36)  
22 THE VIDEOGRAPHER: The time is 4:36  
23 p.m., this is the start of tape number seven. We are  
24 on the record.  
16:37:00 25 Q. Dr. Rea, in the years that you've been

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16:37:05 1 practicing, you've testified in a number of court  
2 cases; is that correct, sir?  
3 A. Yes, I have.  
4 Q. And along with Dr. Johnson, he's testified  
16:37:17 5 in a number of court cases. You're aware of that,  
6 correct?  
7 A. Yes, uh-huh.  
8 Q. Being Alfred Johnson, for clarity.  
9 A. Yes.  
16:37:25 10 Q. Dr. Gerald Ross has also testified. You're  
11 aware of that, correct?  
12 A. Yes.  
13 Q. Okay. And I think we talked about a  
14 Dr. Alan Broughton today. Do you know Dr. Broughton?  
16:37:34 15 A. I don't know if he's testified or not.  
16 Q. But you do know him?  
17 A. I do.  
18 Q. He practices in the area of environmental  
19 medicine, correct?  
16:37:41 20 A. No, he's a laboratory doctor.  
21 Q. Okay. You said you knew Dr. Kaye Kilburn,  
22 correct?  
23 A. Yes.  
24 Q. And a Dr. Janet Sherman, do you know Janet  
16:37:51 25 Sherman -- or Jeanette Sherman?

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16:37:54 1 A. Yeah, I know who she is. I don't really  
2 know her very well. I've met her a few times.  
3 Q. Okay. Well, Dr. Rea, let me ask you, isn't  
4 it true that in the case of Brown -- Bradley V. Brown  
16:38:05 5 in Indiana in 1994 the two federal courts excluded  
6 the testimony of you and Dr. Alfred Johnson because  
7 they found your methodology anecdotal and  
8 speculative?  
9 A. When was this?  
16:38:20 10 Q. 1994, Brown V. Bradley.  
11 A. I don't recall.  
12 Q. Okay. Are you aware in that case they said  
13 as to the general concept of MCS, the court held that  
14 the etiology of it had not progressed from hypothesis  
16:38:38 15 to knowledge capable of assisting the jury?  
16 A. No, I don't remember.  
17 Q. Dr. Rea, isn't it true that in 1990 in the  
18 northern district of Texas in Brandon versus First  
19 RepublicBank Group Medical Plan, Federal Judge Mary  
16:38:55 20 Lou Robinson ruled that the clinical -- the services  
21 of the clinical ecologists William Rea and Alfred  
22 Johnson weren't medically necessary and weren't  
23 coverable under an employee benefit plan? Are you  
24 aware of that?  
16:39:08 25 A. No.

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16:39:09 1 Q. Did you testify in that case?  
 2 A. I don't have any idea. It's been 20 years  
 3 ago.  
 4 Q. Okay. Dr. Rea, do you recall in Breen and  
 16:39:20 5 Carrasco versus Carlsbad Municipal Schools in New  
 6 Mexico in 1999, that the court excluded evidence from  
 7 you because your treatment was neither reasonable nor  
 8 necessary? Do you recall that?  
 9 A. No.  
 16:39:35 10 Q. Do you recall that the court ruled that in  
 11 fact your treatment had proven to be  
 12 counterproductive and deleterious for the treatment  
 13 of workers' conditions?  
 14 A. No.  
 16:39:52 15 Q. Do you know a Dr. Thomas LaCava?  
 16 A. LaCava?  
 17 Q. LaCava.  
 18 A. Yeah.  
 19 Q. Okay.  
 16:39:58 20 A. Massachusetts.  
 21 Q. All right. Are you aware that in 2000 the  
 22 Massachusetts supreme court ruled that there was no  
 23 evidence that Dr. LaCava's methodology was reliable,  
 24 and he failed to rule out other considerations when  
 16:40:15 25 he claimed a patient suffered from multiple chemical

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16:40:19 1 sensitivity and organic brain syndrome as a result of  
 2 exposure to formaldehyde and cleaning solutions?  
 3 A. No.  
 4 Q. Are you aware in 1990, and then upheld by  
 16:40:34 5 the fourth circuit court in January of 1995, that the  
 6 federal court in North Carolina ruled that the  
 7 lymphocyte and autoantibody testing of Alan Broughton  
 8 lacked the proper factual basis, including no proper  
 9 controls and no alternative causes excluded?  
 16:40:53 10 MR. SIMON: Counsel, what's that case?  
 11 MR. FRESHOUR: It is Carroll versus  
 12 Litton, L-i-t-t-o-n -- t-o-n Systems.  
 13 A. The answer is no.  
 14 Q. Do you recall in the case of Coffey versus  
 16:41:09 15 the County of Hennepin in Minnesota in 1998, the  
 16 federal court excluded your testimony about multiple  
 17 chemical sensitivity, holding that federal courts did  
 18 not consider MCS a scientifically valid diagnosis?  
 19 A. No.  
 16:41:25 20 Q. You don't recall that?  
 21 A. I don't recall.  
 22 Q. Have you recalled any of the cases that  
 23 you've been cited in and I've recited so far?  
 24 A. No. I think most of them we won, so you  
 16:41:37 25 only got the negative ones.

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16:41:39 1 Q. My question --  
 2 MR. FRESHOUR: And I'm going to object  
 3 and ask to strike that.  
 4 Q. My question was, do you recall the cases  
 16:41:46 5 that I am citing to you now?  
 6 MR. SIMON: That was asked and  
 7 answered. He said --  
 8 MR. FRESHOUR: No, he didn't answer.  
 9 Mr. Simon.  
 16:41:50 10 A. I said no.  
 11 Q. You only remember the ones you won, not the  
 12 ones you lost, is that it?  
 13 A. I don't remember any of them, but I've won  
 14 most of them.  
 16:41:57 15 Q. Oh, okay. And how do you know that if you  
 16 don't remember them?  
 17 A. I don't know.  
 18 Q. Okay. Are you aware in 1997 in Frank  
 19 versus the State of New York, the federal court  
 16:42:18 20 excluded the testimony of six experts on MCS, holding  
 21 that it failed to meet the Daubert test of standards  
 22 of testability, peer review and general acceptance?  
 23 A. How does that have to do with me?  
 24 Q. No. I'm just saying, were you aware --  
 16:42:36 25 A. How do would I know that? I don't know.

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16:42:39 1 Q. Are you aware that in 1998 in a case in  
 2 Minnesota that Dr. Kaye Kilburn's testimony was  
 3 excluded related to the claims that chemical exposure  
 4 and polyneuropathy were caused by pesticide exposure?  
 16:42:58 5 Were you aware of anything like that?  
 6 A. No.  
 7 Q. Do you recall the case of Gressel versus  
 8 Ahern, A-h-e-r-n. in Arizona in 1997 that under the  
 9 Frye standard, the court excluded the testimony of  
 16:43:29 10 yourself and Dr. Simon in the use of provocation  
 11 testing?  
 12 A. No.  
 13 Q. SPECT scans?  
 14 A. No.  
 16:43:36 15 Q. Balance tests?  
 16 A. No.  
 17 Q. Controversial diagnosis of toxic brain  
 18 syndrome lacked sufficient controls to be generally  
 19 accepted in the scientific community. Are you aware  
 16:43:47 20 of that?  
 21 A. No.  
 22 MR. SIMON: What's the cite of the  
 23 case again?  
 24 MR. FRESHOUR: It's Gressel versus  
 16:43:53 25 Ahern.

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16:43:54 1 MR. SIMON: What court?  
 2 MR. FRESHOUR: It is in Arizona  
 3 superior court. December '97.  
 4 Q. Are you aware that that same court also  
 16:44:02 5 excluded the neuropsychological testimony of Nancy  
 6 Didricksen as lacking validation?  
 7 A. No.  
 8 Q. Are you aware in that case that the judge  
 9 ruled and stated in his opinion that Dr. Rea -- he  
 16:44:37 10 was talking about clinical ecology and then moving on  
 11 to clinical sensitivity and said, Dr. Rea has changed  
 12 labels but not methods, he has abandoned the label of  
 13 clinical ecologist, he has also attempted to avoid  
 14 the use of clinical ecology's most discredited  
 16:44:55 15 theories. However, he continues to espouse the same  
 16 baseless theory under new names in search of  
 17 credibility. Were you aware of that?  
 18 A. No.  
 19 Q. Were you aware of the case in 1999, Guimond  
 16:45:11 20 versus Fiberglas Canada, that Dr. Gerald Ross of  
 21 Dallas -- it was a Canadian court -- held the  
 22 theories of MCS had not been adequately tested, and  
 23 excluded it?  
 24 A. No.  
 16:45:29 25 Q. Were you aware that in 1999 in Hannan

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16:45:32 1 versus Pest Control Services, Incorporated in  
 2 Indiana, the court excluded the testimony of  
 3 Dr. Alfred Johnson, Michael Kelly and Doris Rapp  
 4 regarding pesticide application, and that MCS was  
 16:45:50 5 caused by that application?  
 6 A. No.  
 7 Q. Were you aware that the court held the  
 8 experts failed to file generally accepted methodology  
 9 of, one, identifying the substance at issue; two,  
 16:46:02 10 determining the duration and level of exposure;  
 11 three, determining the dose; four, analyzing the  
 12 relevant literature; and five, ruling out other  
 13 causes? Were you aware of that?  
 14 A. No.  
 16:46:17 15 Q. Were you aware that the Workers'  
 16 Compensation Division in North Carolina in August  
 17 2003 rejected the testimony of William Meggs  
 18 regarding multiple chemical sensitivity RADS as not  
 19 being scientifically valid? Were you aware of that?  
 16:46:39 20 A. No. Professor Meggs, I doubt that.  
 21 Q. Were you aware that the court found that  
 22 these diseases are not recognized by technical and  
 23 medical community, therefore, aren't generally  
 24 recognized?  
 16:46:57 25 A. No, it's simply not true. They may have

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16:47:01 1 found that.  
 2 Q. So -- and are you aware that in 1996 in the  
 3 case of Hundley versus Norfolk and Western Railroad,  
 4 that the federal court excluded yours and  
 16:47:14 5 Dr. Johnson's testimony concerning an exposure to  
 6 herbicide as a cause of MCS?  
 7 A. Yeah, I believe I do remember that.  
 8 Q. Were you aware that in Koch versus Shell  
 9 Oil in Kansas in 1999 -- well, let me first ask you  
 16:47:46 10 this. Do you know Dr. Gunnar Heuser?  
 11 A. Yes.  
 12 Q. Okay. Are you aware in 1999 that the court  
 13 excluded the testimony of Dr. Gunnar Heuser and  
 14 Aristo Vojdani under a Daubert standard when they  
 16:48:00 15 claimed that a larvicide had caused  
 16 immunodysfunction?  
 17 A. I certainly wasn't.  
 18 Q. Do you recall that in -- do you know an  
 19 Alan Lieberman?  
 16:48:18 20 A. Sure.  
 21 Q. Were you aware that in 1997 in Maxwell  
 22 versus Sears, Roebuck in Florida, Dr. Lieber's (sic)  
 23 testimony -- do you know Alan Roberts, D.O.?  
 24 A. Yeah.  
 16:48:33 25 Q. Do you know Susan Franks, Ph.D.?

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16:48:35 1 A. Yes.  
 2 Q. Did you know that their testimony --  
 3 MR. SIMON: What about Lieberman?  
 4 MR. FRESHOUR: All three of them.  
 16:48:42 5 Q. You know them. Do you know that their  
 6 testimony was excluded based, that the -- they were  
 7 unable to bring forward proof of the basis for the  
 8 opinions of the chemical sensitivity outside  
 9 Lieberman, Roberts and Franks testifying to each  
 16:48:58 10 other's testimony?  
 11 A. No.  
 12 Q. And they further found that multiple  
 13 chemical sensitivity is theoretical and lacking  
 14 scientific proof? Were you aware of that?  
 16:49:06 15 A. I wasn't. I don't see what that's got to  
 16 do with me, but that's fine.  
 17 MR. SIMON: He's just asking you if  
 18 you're aware of these things.  
 19 Q. Are you aware -- in 1993 in a case called  
 16:49:16 20 Mullenax versus McRae, are you aware that the  
 21 Mississippi Workers' Comp Division denied a multiple  
 22 sensitivity -- multiple chemical sensitivity claim  
 23 based on workplace exposure to solvents, and that you  
 24 were the physician who was appearing on behalf of the  
 16:49:35 25 claimant?

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16:49:36 1 A. Yes, I knew that one.  
 2 Q. Okay. And the commission found that your  
 3 unorthodox methodology failed to establish any causal  
 4 connection. And they even went further to say, even  
 16:49:47 5 if you were to accept his theory that the exposure to  
 6 one chemical can cause this, there were other  
 7 legitimate explanations that weren't excluded. Were  
 8 you aware of that?  
 9 A. No.  
 16:50:03 10 Q. Were you aware in 1995 the Texas court of  
 11 appeals in North Dallas Diagnostic Center versus  
 12 Dewberry, the appeals court ruled that Dr. Ross'  
 13 testimony -- and that's Dr. Gerald Ross of the  
 14 Environmental Health Center in Dallas, Texas --  
 16:50:23 15 holding there was no evidence that intradermal skin  
 16 testing could reliably detect sensitivity to a  
 17 contrast dye? Were you aware of that?  
 18 A. No.  
 19 Q. In Oppenheimer versus United Charities of  
 16:50:39 20 New York, the superior court of New York in 1998, the  
 21 court --  
 22 MR. SIMON: Supreme court.  
 23 MR. FRESHOUR: Supreme court. What  
 24 did I say?  
 16:50:48 25 MR. SIMON: Superior court.

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16:50:49 1 Q. Oh, supreme court, I'm sorry.  
 2 The court excluded your testimony as  
 3 untested and not generally accepted in the medical  
 4 community? Were you aware of that?  
 16:50:58 5 A. No.  
 6 Q. In the case of Phillips versus Velsicol  
 7 Chemical Corporation in 1995, were you aware that the  
 8 court excluded your testimony and that from Accu-Chem  
 9 Laboratories?  
 16:51:17 10 A. No.  
 11 (Mr. Cook enters the room)  
 12 Q. For -- they excluded your testing, your  
 13 double-blind testing, which purportedly confirmed a  
 14 chlordane exposure? Were you aware of that?  
 16:51:29 15 A. No.  
 16 Q. Were you also aware that the court excluded  
 17 the back calculations of exposure by Dr. Robert Simon  
 18 in that case, as unscientific?  
 19 A. No.  
 16:51:41 20 Q. Do you know a Dr. Michael -- is it DeWitt  
 21 or LeWitt?  
 22 A. No.  
 23 Q. You don't?  
 24 A. No.  
 16:51:49 25 Q. Okay. Do you know a Dr. Elaine Panitz,

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16:51:52 1 P-a-i-t-z (sic)?  
 2 A. No.  
 3 Q. Do you recall in the case of Summers versus  
 4 MoPac -- Missouri Pacific Railroad, eastern district  
 16:52:11 5 of Oklahoma 1995, that the court excluded  
 6 Dr. Johnson's testimony to distinguish chemical  
 7 sensitivity from MCS and clinical ecology as  
 8 unpersuasive, and they also rejected the use of  
 9 Dr. Simon's SPECT testing? Were you aware of that?  
 16:52:35 10 A. No.  
 11 Q. Were you aware of the case of McNeel versus  
 12 Union Pacific Railroad in Missouri in 2006 that --  
 13 there was a motion to limit your testimony, that of  
 14 Dr. Simon and that of Nancy Didricksen? Do you  
 16:54:03 15 recall that case?  
 16 A. No.  
 17 Q. Okay. Do you recall in that case that  
 18 Nancy Didricksen also testified that Dr. Rea does not  
 19 refer patients to her unless he already believes that  
 16:54:15 20 they have toxic encephalopathy?  
 21 MR. SIMON: We went through that  
 22 before.  
 23 THE WITNESS: Yeah, we went through  
 24 that before.  
 16:54:22 25 MR. FRESHOUR: Did we?

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16:54:23 1 MR. SIMON: Yeah.  
 2 MR. FRESHOUR: On the McNeel one?  
 3 THE WITNESS: Yeah.  
 4 Q. Were you aware in there -- and do you know,  
 16:54:29 5 does Dr. Didricksen still prescribe to the tenets of  
 6 field therapy that postulates by tapping certain  
 7 parts of the body that correspond to meridians that  
 8 can rid one of anger and post-traumatic stress  
 9 syndrome disorder?  
 16:54:45 10 A. I don't know what you're talking about.  
 11 Q. Okay.  
 12 MR. SIMON: Say that twice fast.  
 13 MR. FRESHOUR: Exactly.  
 14 Q. Doctor, in that very same case one of the  
 16:55:10 15 questions that was asked was, how can you arrive at  
 16 the conclusion that it was the odor that caused all  
 17 of these problems simply because it occurred during  
 18 that event? Dr. Rea responded, it seems to me that's  
 19 the most logical thing, isn't it? Do you recall that  
 16:55:24 20 testimony?  
 21 A. No.  
 22 Q. All right. Doctor, we have covered a lot  
 23 of information and territory today. Would you agree?  
 24 A. Yes, I would.  
 16:55:39 25 Q. Okay. And, Doctor, you understand that

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# Ken Owen & Associates, L.P.

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16:55:45 1 this is -- matter is scheduled to go to hearing in  
2 August of this year, correct?  
3 A. Yes.  
4 Q. Now, I know you can't say for sure, but if  
16:55:55 5 I were to ask you generally the same type of  
6 questions in the same form today, I could anticipate  
7 more or less you would answer in the same fashion; is  
8 that fair?  
9 MR. SIMON: What?  
16:56:06 10 A. Well, I don't know.  
11 MR. SIMON: Object to the form.  
12 Q. Okay. Doctor, let me ask you this: The  
13 questions I've asked you today, have you understood  
14 them?  
16:56:12 15 A. I think --  
16 Q. For the most part?  
17 A. For the most part, I have, yeah.  
18 Q. And on those that you did not, Doctor, did  
19 you ask me for clarification?  
16:56:20 20 A. I tried to, yes.  
21 Q. And did I attempt at my best to rephrase or  
22 describe what I was trying to get from you as best I  
23 could?  
24 A. I think you did.  
16:56:27 25 Q. And did I allow you to give full and

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16:56:29 1 complete answers and not interrupt you or cut you  
2 off?  
3 A. Yes.  
4 Q. All right. And on those questions where  
16:56:43 5 you did ask for explanation and we did kind of go  
6 back and forth, you answered them to the best of your  
7 ability, as I tried to clarify, correct?  
8 A. Yes, of course I did.  
9 MR. FRESHOUR: I think I'll pass the  
16:56:54 10 witness at this time.  
11 MR. SIMON: No questions at this time.  
12 THE VIDEOGRAPHER: The time is 4:57  
13 p.m. This is the end of tape number seven. Going  
14 off the record.  
16:57:06 15 (Proceedings concluded at 4:57 p.m.)  
16  
17  
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16:57:06 1 CHANGES AND SIGNATURE  
2 PAGE LINE CHANGE REASON  
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16:57:06 10  
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16:57:06 25

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16:57:06 1 I, WILLIAM J. REA, M.D., have read the foregoing  
2 deposition and hereby affix my signature that same is  
3 true and correct, except as noted above.  
4  
16:57:06 5  
6 WILLIAM J. REA, M.D.  
7  
8 THE STATE OF \_\_\_\_\_  
9 COUNTY OF \_\_\_\_\_  
16:57:06 10  
11 Before me, \_\_\_\_\_, on this day  
12 personally appeared WILLIAM J. REA, M.D., known to me  
13 or proved to me on the oath of \_\_\_\_\_ or  
14 through \_\_\_\_\_ (description of  
16:57:06 15 identity card or other document) to be the person  
16 whose name is subscribed to the foregoing instrument  
17 and acknowledged to me that he/she executed the same  
18 for the purpose and consideration therein expressed.  
19 Given under my hand and seal of office on this  
16:57:06 20 \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.  
21  
22  
23 NOTARY PUBLIC IN AND FOR  
24 THE STATE OF \_\_\_\_\_  
16:57:06 25 My Commission Expires: \_\_\_\_\_

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16:57:06 1 SOAH DOCKET NO. 503-07-4032  
 2 LICENSE NO. D-2294  
 3 IN THE MATTER OF THE )  
 4 COMPLAINT AGAINST ) BEFORE THE  
 5 WILLIAM REA, M.D. ) TEXAS MEDICAL BOARD  
 6  
 7 REPORTER'S CERTIFICATE  
 8 ORAL VIDEOTAPED DEPOSITION OF WILLIAM J. REA, M.D.  
 9 May 21, 2010  
 10 I, Cheryl Duncan, Certified Shorthand Reporter  
 11 in and for the State of Texas, hereby certify to the  
 12 following:  
 13 That the witness, WILLIAM J. REA, M.D., was duly  
 14 sworn and that the transcript of the deposition is a  
 15 true record of the testimony given by the witness;  
 16 That the deposition transcript was duly  
 17 submitted on \_\_\_\_\_ to the witness or to the  
 18 attorney for the witness for examination, signature,  
 19 and return to me by \_\_\_\_\_.  
 20 That pursuant to information given to the  
 21 deposition officer at the time said testimony was  
 22 taken, the following includes all parties of record  
 23 and the amount of time used by each party at the time  
 24 of the deposition:  
 16:57:06 25

16:57:06 1 FURTHER CERTIFICATION UNDER TRCP RULE 203  
 2  
 3 The original deposition was/was not returned to  
 4 the deposition officer on \_\_\_\_\_.  
 5 If returned, the attached Changes and Signature  
 6 page(s) contain(s) any changes and the reasons  
 7 therefor.  
 8 If returned, the original deposition was  
 9 delivered to Mr. Scott M. Freshour, Custodial  
 10 Attorney.  
 11 \$\_\_\_\_\_ is the deposition officer's charges  
 12 to the Texas Medical Board for preparing the original  
 13 deposition and any copies of exhibits;  
 14 The deposition was delivered in accordance with  
 15 Rule 203.3, and a copy of this certificate, served on  
 16 all parties shown herein, was filed with the Clerk.  
 17 Certified to by me on this \_\_\_\_\_ day of  
 18 \_\_\_\_\_,  
 19 \_\_\_\_\_  
 20  
 21 Cheryl Duncan, CSR  
 22 Texas CSR 3371  
 23 Expiration: 12/31/10  
 24 KEN OWEN & ASSOCIATES, L.P.  
 25 Firm # 115  
 801 West Avenue  
 Austin, Texas 78701  
 512.472.0880  
 512.472.6030 fax  
 16:10:04 25

16:57:06 1 Mr. Scott M. Freshour (5 hours, 34 minutes)  
 2 Attorney for Texas Medical Board  
 3 Mr. Jacques G. Simon (00 minutes)  
 4 Attorney for Witness  
 5 That a copy of this certificate was served on  
 6 all parties shown herein on \_\_\_\_\_ and  
 7 filed with the Clerk.  
 8 I further certify that I am neither counsel for,  
 9 related to, nor employed by any of the parties in the  
 10 action in which this proceeding was taken, and  
 11 further that I am not financially or otherwise  
 12 interested in the outcome of this action.  
 13 Further certification requirements pursuant to  
 14 Rule 203 of the Texas Code of Civil Procedure will be  
 15 complied with after they have occurred.  
 16 Certified to by me on this \_\_\_\_\_ day of  
 17 June, 2010.  
 18  
 19 \_\_\_\_\_  
 20 Cheryl Duncan, CSR  
 21 Texas CSR 3371  
 22 Expiration: 12/31/10  
 23 KEN OWEN & ASSOCIATES, L.P.  
 24 Firm # 115  
 801 West Avenue  
 Austin, Texas 78701  
 512.472.0880  
 512.472.6030 fax  
 800.829.6936  
 25

A				
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SOAH DOCKET NO. 503-07-1032

LICENSE NO. D-1294

IN THE MATTER OF  
THE COMPLAINT AGAINST  
WILLIAM REA, M.D.

BEFORE THE  
TEXAS MEDICAL BOARD

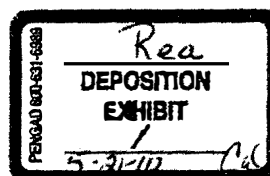
NOTICE OF INTENTION TO TAKE THE ORAL VIDEOTAPED DEPOSITION OF  
WILLIAM J. REA, M.D. AND SUBPOENA DUCES TECUM

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: 

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State Bar No. 00789299  
Texas Medical Board  
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Fax: 512-305-7007

CERTIFICATE OF SERVICE

I hereby certify that on this the 13<sup>th</sup> day of May, 2010, a true and correct copy of the foregoing Notice of Intention to Take the Oral Videotaped Deposition of William L. 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.

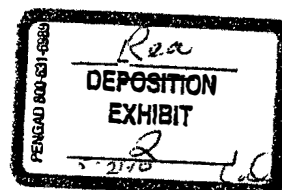
6. All tangible reports, compilations of data, or any other materials prepared by you in anticipation of deposition or trial testimony. This should include copies of all draft reports, notes or other communication, writings and any other materials you received or reviewed in preparing your opinions. 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.



**Protocol for Car Exhaust**  
**January 1995**

1. 300 cc of coca's solution ( $\text{NaCl} =$  amounts of  $\text{NaCO}_3$ ).
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  $\frac{1}{2}$  - 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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- 4. Dilute with 300 cc of coca's solution.**
- 5. Run through a ceramic Millipore filter (smallest size) for sterility.**
- 6. Dilute with saline  $\frac{1}{4}$  - this is the concentrate. Dilute  $\frac{1}{5}$ ,  $\frac{1}{25}$ ,  $\frac{1}{625}$ , 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.**

## **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 ZEPHIRAN 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:

[illegible]

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.



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## 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:

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## 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 it may crack upon thawing and freezing during storage. Fill only up to the bend in the vial's neck.

## Notes:

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## 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:

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## **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:**

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### Notes:

This image shows a single sheet of white paper with horizontal black ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

40 cc = 400 cc Coca's

**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

- Place sterile funnel into sterile flask with the rubber stopper so it fits very tightly.
- Place a C.80U filter into sterile Buckner funnel.
- 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

- Place sterile funnel into sterile flask with the rubber stopper so it fits very tightly.
- Place a 4x4 gauze sponge into sterile funnel.
- Attach the rubber tubing pipe one end to the flask and the other end attaches to the Nalgene hand-operated vacuum pump.
- 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 gauge 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 gauge 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](http://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](http://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](http://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](http://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](http://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:**

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### ***Instructions for Using the Air Sampling Machine***

1. Open the case, remove the packing material and the three glass bottles containing the Cogas 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 valve; 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	
Diprovon 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	
Methronidazole 50mg	1800MD	
Norvasc 10mg	1800N	
Penicillin VK 500mg	1800P	
Xanax	1801X	
Ativan (Lorazepam)	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	
Ibuprofen 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	
Xalatan 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 Pharmaceutical)	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)	8000FI	
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	

[illegible]

**Protocol for Car Exhaust**  
**January 1995**

1. 300 cc of coca's solution ( $\text{NaCl}$  = amounts of  $\text{NaCO}_3$ ).
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  $\frac{1}{2}$  - 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 Modifier) 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	
Mosquito 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-2Box 1-1,FZ-3Box 1-1	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 Phosphphate	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	
Polyethylene 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	
Nitrofurantoin	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	
Chondroitin 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	

[illegible]

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	Freedra	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	
***Eggsentials 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	
Linoleic 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 Chondroitin	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	Freedra	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	

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**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 <del>Polyester Suture</del> (braided)	Ethicon	X 833	30,060	2.9.09	2.13.09	10 cc	N/G		4
Glyburide 1.25 mg	Ambraams Royal	6040876	30,061	2.13.09	2.20.09	50cc	N/G		4
Glimepiride 1 mg	Abrams Royal	6040874	30,062	2.13.09	2.20.09	50cc	N/G		4
Ket Levothyroxine	Abrams	6044256	30,063	3.6.09	3.9.09	35cc	N/G		UB
Mitigard 100 Plus	Perque	60442	30,064	3.9.09	3.16.09	35cc	N/G		UB
Carbimide Tartrate Powder	(JFH) DePue Health		30,065	3.9.09	3.16.09	2x35cc	N/G		UB
Beef	Clinic		1059	3.13.09	3.16.09	10x35cc	N/G		UB
Tuba	Clinic		1071	3.13.09	3.16.09	10x35cc	N/G		UB
Cucumber	Clinic		1113	3.19.09	3.24.09	6x50cc	N/G		UB
Celery	Clinic		1023	3.19.09	3.24.09	6x50cc	N/G		
Lettuce	Clinic		1042	3.19.09	3.24.09	6x50cc	N/G		UB
Zucchini	Clinic		1077	3.19.09	3.24.09	6x50cc	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. eyed peas				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 Syrup				1126	4.9.09	4.10.09	2x35cc	N/G		UB
Chloramphenicol		Abrams		30,067	4.10.09	4.13.09	3x35cc	N/G		UB
Butylated Hydroxy- Anisole (BHA)		Abrams		<del>30,066</del> 1307	4.10.09	4.13.09	2x35cc	N/G		UB
Doxycycline		Abrams		1807	4.10.09	4.13.09	2x35cc	N/G		UB
Sagebrush Oil		Chase		1135	4.10.09	4.13.09	3x35cc	N/G		UB
Lad. Cologne		Dep. Store		05016	4.10.09	4.10.09	3x50cc	N/G		I.C
Men's Cologne		Dep. Store		05017	4.10.09	4.10.09	3x50cc	N/G		I.C

**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	
Canada Oil	E	Clinac		1144	4.10.09	4.13.09	2x35cc	N/G		U
Apple		Whole Foods		1003	4.13.09	4.16.09	5x50cc	N/G		F
Cashew				1020	4.13.09	4.16.09	5x50cc	N/G		
Grapefruit				1036	4.13.09	4.16.09	3x50cc	N/G		
Orange				1046	4.13.09	4.16.09	5x50cc	N/G		
Citrus fruit peel				1273	4.13.09	4.16.09	2x50cc	N/G		
Molybdenum piccoland		Thorne		30,068	4.20.09	4.24.09	3x50	N/G		
Design for Health Super liquid folate		DFH		30,069	4.20.09	4.24.09	3x35cc	N/G		
Enb Cal, filling mat. for dent. work		PH		30,070	5.16.09	5.21.09	1x10cc	N/G		U
Dental mat. Pain-A-A-B		PH		30,071	5.18.09	5.21.09	1x10cc	N/G		U
Norwegian Cod Liver Oil		Carlson		30,072	5.18.09	5.22.09	1x35cc	N/G		U
Rx Vitamins Lecithin		Rx Vitamins		30,073	5.18.09	5.21.09	3x35cc	N/G		U



**ENVIRONMENTAL HEALTH CENTER – DALLAS  
IMMUNOTHERAPY DEPARTMENT  
PERSONAL ANTIGEN CONCENTRATES WORKSHEET**

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**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	Abrams 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		U
Agave Nectar		Madhava		30.086	6.15.09	6.19.09	2x35cc	NG		U
Gilcinu Glycinate		Carlson		07246	7.10.09	7.13.09	2x35cc	NG		U
Mimosa flowers				0518	7.10.09	7.13.09	2x35	NG		U
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 botrys					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 <sub>+</sub>
								Negative	Positive	
Park				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	Readi sorb		30,087	8.3.09	8.6.09	3x30	NG		+
EHC-D	Reduced L-Glutathione	K12.re		<del>30,088</del> 07303	8.6.09	8.10.09	2x35	NG		+
EHC-D	Glucosamine sulfate & chondroitin	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 o.i	NUTIVO		30,090	8.14.09	8.17.09	3x30	NG		+
EHC-D	Filterk ESRE	3M		30,091	8.21.09	8.24.09	1x10	NG		+
EHC-D	Topiramate 25mg	Abrams Pharm		30,092	8.24.09	8.24.09	2x30	NG		+
EHC-D	Tree milk	1013		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 Biologicals		0114	09-04-09	09-07-09	2x30	Neg		+
EHC-D	Mm 3	International Biologicals		0103	09-11-09	09-18-09	2x50	Neg		+
EHC-D	B-12	Freeda		30,093	09-21-09	9-25-09	3x40	Neg		+
EHC-D	Cardiac 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 resp	Patient Deloris Ham.		30,095	10-2-09	10-5-09	1x10	Neg		+
EHC-D	Garlic	Whole Food		1114	10/06/09	10/09/09	3x50	Neg.		+
EHC-D	Beet Sugar	Reys		1011	10/06/09	10/09/09	2x50	Neg.		+
EHC-D	Plantain Baraka	WF		1240	10/06/09	10/09/09	2x50	Neg.		+
EHC-D	C. Grape	WF		1029	10/06/09	10/09/09	3x50	Neg.		+
EHC-D	Alligator	Nate's Restaurant		30096	10/09/09	10-12-09	4x50	Neg.		+
EHC-D	Cauliflower	Nate's Restaurant		03052	10/09/09	10-12-09	5x50	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	D-3 Cholesterol citrate	BioTech		07301	11/6/09	11/9/09	1x50	neg		G
EHC-D	Post-undecrown Dental material	Dentist		30097	11/9/09	11/21/09	1x50	neg		G
<del>EHC-D</del>	<del>Glycine</del>	<del>Thorne</del>		<del>07253</del>	<del>11/12/09</del>	<del>11/16/09</del>				
EHC-D	Glycine	Thorne		07253	4/13/09	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
Chen EHC-D	Tick	Pt. Dixie Peterson		30099	4/23/09	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	2x50	Neg		G
EHC-D	Sheep's Cheese (mashed)	Whole Foods		30101	12/14/09	12/17/09	1x50	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		
								Negative	Positive	
EHC-D	Anchovies	Whole Foods	Crown Prince Nutrition	30103	12/14/09	12/17/09	1X50	Neg		C
EHC-D	Lithium Carbonate	Abrams		1890	1/5/10	1/8/10	1X50	Neg		C
EHC-D	Rely X	North Park Dental Associates		0937	1/5/10	1/8/10	1X50	Neg		C
EHC-D	Trichophyton mentagrophytes	IBI	F2031	0139	1/8/10	1/11/10	3X50	Neg		C
EHC-D	<del>Abrams</del> Thymus	Abrams		011410-10	1/24/10	2/1/10	2X50	Neg		C
EHC-D	Aerobic H <sub>2</sub> O	AETF		30104	2/4/10	2/4/10	2X50	Neg		C
EHC-D	Red Palm oil			30105	2/5/10	2/9/10	1X50	Neg		C
EHC-D	Acqua Panna Water	AETF		30106	2/15/10	2/15/10	2X50	Neg		C
EHC-D	Clinic Air	EHC		30107	2/19/10	2/19/10	1X50	Neg		C
EHC-D	Monilia sitbonila	IBI	18486		2/22/10	2/25/10	3X50	Neg		C
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		C

**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.		1
EHC-D	Flea spores	Dr. Rea		30111	3.18.10	3.22.10	2x50	neg.		1
EHC-D	Partridge	S. Haag			3.18.10	1	2x50	neg.		2
EHC-D	Clad. Heebge	IBI	18852		3.18.10	1	6x50	neg.		1
EHC-D	Almond	Whole Foods	#	1002	4.6.10	4.9.10	3x50	neg.		2
EHC-D	Bounce	Dr. Gaffney		30112	4.6.10	1	2x50	neg.		2
EHC-D	Mm-2	IBI	F198 18411, 18287	0102	4.6.10	1	5x50	neg.		2
EHC-D	Yerba mate	Estell's		30113	4.9.10	4.12.10	1x50	neg.		1
EHC-D	Hormodendrum hoedri	IBI	16564	0112	5.4.10	5-7-10	3x50	neg.		6
EHC-D	Soy Beans	WF	1064		5.13.10	5/17/10	3x50			6
EHC-D	Wheat	WF	1075		5.13.10	5/17/10	3x50			6
EHC-D	Cinnamon	WF	1210		5.13.10	5/17/10	1x50			6

**ENVIRONMENTAL HEALTH CENTER – DALLAS  
IMMUNOTHERAPY DEPARTMENT  
PERSONAL ANTIGEN CONCENTRATES WORKSHEET**

[illegible]



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
Olra	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	
Peanut	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



Turneric 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