

Urso, Gary, MD  
05-2001-124743

NOTE:

JUDICIAL REVIEW HAS BEEN FILED REGARDING  
THIS DECISION; HOWEVER, NO STAY ORDER  
HAS BEEN ISSUED.

BEFORE THE  
DIVISION OF MEDICAL QUALITY  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

In the Matter of the Second Amended )  
Accusation Against: )  
 )  
GARY ORDOG, M.D. )  
Physician's and Surgeon's )  
Certificate No. G 43038 )  
 )  
Respondent )

OAH No: L2003120323

File No: 05-2001-124743

DECISION

The Proposed Decision of Timothy S. Thomas, Administrative Law Judge, dated April 11, 2006, in Los Angeles, is attached hereto. Said decision is hereby amended, pursuant to Government Code Section 11517 (c)(2)(C) to correct technical or minor changes that do not affect the factual or legal basis of the proposed decision. The proposed decision is amended as follows:

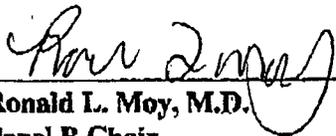
1. Page 52, paragraph 19 - the Business and Professions Code section, subdivision (c) is stricken and replaced with Business and Professions Code section 2234, subdivision (c).

The Proposed Decision as amended is hereby accepted and adopted as the Decision and Order by the Division of Medical Quality, of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on May 26, 2006.

DATED April 26, 2006

MEDICAL BOARD OF CALIFORNIA

  
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Ronald L. Moy, M.D.  
Panel B Chair

BEFORE THE  
DIVISION OF MEDICAL QUALITY  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

In the Matter of the Second Amended  
Accusation Against:

GARY ORDOG, M.D.,

Respondent.

Case No. 05-2001-124743

OAH No. L2003120323

**PROPOSED DECISION**

On February 23, 24, 27, 28, March 1, 2, 3, 6, 7, 8, 9, 14 and 15, 2006, Administrative Law Judge Timothy S. Thomas, Office of Administrative Hearings, heard this matter in Los Angeles, California.

John E. DeCure and Trina L. Saunders, Deputies Attorney General, represented complainant David T. Thornton, Executive Director of the Medical Board of California (hereinafter MBC, or the board).

Henry Fenton and Harry Nelson, Attorneys at Law, represented Gary Ordog, M.D. (hereinafter respondent).

On motion of complainant, paragraphs 26C and 26D, pages 23 and 24 of the Second Amended Accusation, were stricken. At paragraph 26G, line 22 was amended to strike the words "both the September 8, 2001 and," and line 23 was amended so that the word "letter" was substituted for "letters."

At the conclusion of the evidence, complainant moved to amend the Second Amended Accusation to conform to proof. The proposed language sought to add allegations of dishonesty concerning respondent's 1996 curriculum vitae as provided to the board in its investigation of this matter, and as utilized by him in depositions and on his website. Over objection, the motion was granted and new paragraph K, as set forth in Exhibit 62, was added to page 25, following paragraph J.

The matter was submitted on March 15, 2006.

## FACTUAL FINDINGS

1. Complainant David T. Thornton filed the Second Amended Accusation in his official capacity as Executive Director of the board.

### *Background*

2. A native of Canada, respondent attended undergraduate and medical schools at the University of British Columbia, where he also served a rotating internship and a residency in family practice. From 1980 to 1982, respondent received residency training in emergency medicine at Charles R. Drew Medical School (Drew) and the King/Drew Medical Center (King/Drew) in Los Angeles. For two additional years, pursuant to a fellowship granted him, respondent performed clinical research in medical toxicology at King/Drew under the auspices of Drew. In 1984, respondent received another fellowship, and for an additional two years performed clinical research in emergency medicine at King/Drew. Between 1983 and 1989, respondent was the Residency Director and the Director of Emergency Medicine Research for the Department of Emergency Medicine at King/Drew.

3. The board issued Physician's and Surgeon's Certificate Number G 43038 to respondent on August 18, 1980. Respondent became board-certified in Emergency Medicine in 1983 and in Medical Toxicology in 1984. Since 1980, he has served as an emergency room physician at King/Drew, and from 1982 until 1997, respondent performed the same role at Henry Mayo Newhall Memorial Hospital (Mayo) in Valencia, California. In 1990, respondent opened a private practice in toxicology. By 1997, respondent's practice had grown to the point that he relinquished his emergency room duties at Mayo, although he has continued in that role at King/Drew.

4. Respondent was, and is, the primary consulting physician for patients and other physicians in the area of medical toxicology at Mayo. Originally, the practice of toxicology at that hospital was directed from within the Department of Pulmonary Medicine. The hospital formed the Department of Medical Toxicology, and respondent became its Director. Respondent testified that that occurred in about 1995, although the only documentary evidence of the existence of the department and respondent's role as its Director is a Medical Toxicology Department Medical Director Services Agreement dated August 1, 1997. The contract, which was entered into between respondent and Mayo, provided that respondent would serve as the Director for a term of two years. Respondent testified that he believed a subsequent two-year term was agreed upon, but was unable to find a copy of a 1999 contract.

The Medical Toxicology Department at Mayo operated out of an office staffed, furnished and equipped by Mayo. Respondent was issued an identification badge by the hospital that described him as the Director of Medical Toxicology. Respondent testified that Mayo filed for reorganization and bankruptcy law protection sometime near the turn of the century. At that time, Mayo ceased operation of the Medical Toxicology Department. Respondent testified, however, that he continued to occupy the same office space and

assumed financial responsibility for the staff and equipment the hospital had previously provided for the department. In his mind, despite the lack of fiscal or regulatory ties with Mayo, respondent continued to operate as the Director of Medical Toxicology.

5. In 1982, respondent was appointed an Assistant Professor, Department of Emergency Medicine, at Drew. He served in that capacity until 1996. Effective September 1, 1985, respondent also assumed a faculty role as Assistant Professor in Residence at the UCLA School of Medicine (UCLA), an unpaid position. Drew and UCLA were affiliated at that time, in the sense that Drew students and UCLA students attended some of the same classes. Respondent described his faculty appointments as “dual appointments.”

Virtually all colleges and universities employ instructors by ranking them pursuant to the following basic model: entry level teachers (usually right out of residency in the medical school setting) are hired as “assistant professors.” Assistant professors are either promoted after a certain period of time (at UCLA, that time is usually eight years) or their terms of employment are not renewed. If promoted, an assistant professor will become an “associate professor,” who may in turn be promoted to “full professor” (at UCLA, after a period of six to eight years and after having demonstrated excellence in teaching and research), a position of indefinite duration that traditionally carries with it the most prestige, benefits and job-security.

Respondent testified he could not recall whether he was ever promoted by Drew from his position as assistant professor. UCLA received a “dossier” concerning a possible promotion for respondent in 1995, but he was terminated by Drew on July 16, 1996, and by UCLA on March 14, 1997, effective July 16, 1996. The UCLA action was pursuant to that institution’s policy that continuation of a faculty appointment was contingent upon continuance of the faculty appointment of the affiliated institution. Respondent was never reinstated to the UCLA faculty.

6. When respondent was first studying medical toxicology at King/Drew, his fellowship program supervisor was Dr. Matthew J. Ellenhorn. Dr. Ellenhorn, who early in his medical career was the Chief of New Drug Surveillance for the Federal Drug Administration, was engaged in the private practice of toxicology in Beverly Hills for many years. He taught one day per week at King/Drew for 30 years and supervised respondent during respondent’s fellowship training in toxicology. Dr. Ellenhorn was the author of the medical school textbook, Ellenhorn’s Medical Toxicology: Diagnosis and Treatment of Human Poisoning (Ellenhorn’s), first published in 1988. The First Edition was handwritten by Dr. Ellenhorn on yellow legal pads. His wife, Sylvia Ellenhorn, typed her husband’s handwritten text on a personal computer, printed the pages and sent them to the publisher, Elsevier Science Publishing Company, New York.

The writing of the Second Edition of Ellenhorn’s proceeded in much the same way, with Mrs. Ellenhorn typing the book’s text on her personal computer from the author’s handwritten legal pad entries. Her typing of the second edition was accomplished between April of 1995 and January of 1996. Dr. Ellenhorn passed away in February of 1996.

Dr. Ellenhorn had researched the Second Edition with the assistance of three toxicology colleagues at King/Drew: Seth Schonwald, M.D., Jonathan Wasserberger, M.D., and respondent. All three were acknowledged on the title page of the Second Edition hardcover book in such a way as to appear to have been co-authors with Dr. Ellenhorn. Mrs. Ellenhorn complained to the publisher of the second edition, Williams and Wilkins, by letter of April 2, 1997, that her husband had no “co-authors.” The three doctors were referred to instead as “consulting editors” in the later, paperback version of the textbook.

7. Respondent established a medical-legal practice, offering himself as an expert witness in a variety of legal settings, in 1980. He has evaluated civil, criminal and workers’ compensation cases for attorneys representing both plaintiffs and defendants, and for insurance companies. He has testified in deposition and trial more than 100 times concerning issues involving toxicology, emergency medicine, wound ballistics and taser injuries. His clients have included the United States Attorney’s Office, the California Attorney General’s Office, the City of Los Angeles, the County of Los Angeles, and other states of the United States. Respondent currently charges \$975.00 per hour for his expert services. His website offers his curriculum vitae, including a selection of some of his peer-reviewed professional journal articles, for \$47.95.

#### *Quality of Care Issues*

8. In connection with his medical-legal practice, respondent was referred four patients by a Long Beach attorney named Eric Hoerchner<sup>1</sup> for evaluations of workers’ compensation claims his clients made against their employer, ALCOA Vernon Works, in Vernon, California (ALCOA). Each of the patients claimed a compensable on-the-job injury due to exposure to toxic substances. On January 5, 1999, Mr. Hoerchner provided respondent with a copy of a letter, dated December 5, 1998, authored by Mark M. Levin, an industrial hygiene consultant. Mr. Levin had conducted a review of documents, provided him by the attorney, in connection with a similar claim made by another Hoerchner client, Magdalena O.<sup>2</sup> The letter, addressed to Mr. Hoerchner and a copy of which was placed in each of respondent’s four patient files, read in pertinent part as follows:

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<sup>1</sup> Respondent recorded in his charts for these four patients that the referrals were from the patients’ individual treating physicians. In his interview with a board investigator, respondent said, “I believe they made appointments to see me at the Department of Toxicology. It appears they all came in on different dates.” (See Exhibit 21, page 008.) But it is clear from the evidence that all four patients were referred by attorney Hoerchner and that three of them first saw respondent on the same day.

<sup>2</sup> The litigants’ and patients’ names are abbreviated in the interests of their privacy.

I have concluded my review of the documents you sent me regarding Magdalena [O.] and her employment with the ALCOA Vernon Works in Vernon, California. After analyzing these documents, it is my impression that Ms. [O.] may have been exposed to a large number of toxic chemicals during her term of employment at the ALCOA Vernon Works, Aluminum, Ingot Casting, Extrusion, Tubing and Forging Facility in Vernon, California.

Ms. [O.'s] exposure to toxic chemicals may have included asbestos fibers, crystalline silica dust, chlorinated solvents including 1, 1, 1-trichloroethane, petroleum solvents containing aromatic and paraffin compounds and lubricant oils containing lead, tin and cobalt. Her exposure to metal alloy dust and fumes probably consisted of aluminum and common alloying metals including zinc, copper, silicon, magnesium, nickel, chromium, beryllium and titanium. Other chemicals present in the work area included PCB's, chromic acid and various corrosive compounds.

Some of the chemicals mentioned are carcinogens and/or toxic agents to the liver, kidney and blood. Please find attached to this letter, a two page summary table describing the toxic chemicals that Magdalena [O.] may have been exposed to while working at ALCOA.

9. The copies of the Levin report in respondent's files include the two-page summary table referenced by Mr. Levin, but appear to omit other material pertinent to Ms. O., who was not one of the four patients involved in this matter. The summary table included three columns of information: 1) The chemical involved; 2) The "Route of Exposure" (i.e., by inhalation, ingestion or skin contact); and 3) The possible "Health Effect" of the chemical. The chemicals listed, as pertinent here, included aluminum, aluminum alloy, silica, asbestos, chromic acid, nitric acid and Stoddard solvent. The aluminum alloy was said to contain zinc, copper, nickel, chromium and beryllium.

10. Each of respondent's charts maintained for the four patients involved is voluminous and contains the following types of documents: 1) Medical Toxicology Consultation and Treatment form (the long form), which is an 18-page document. It is a "fill in the blank" form respondent uses to address the patient's subjectively-related history of illnesses, surgeries, medications taken, current symptoms, allergies, family history, exposures to toxic substances, personal habits (smoking, etc.), and current complaints. Respondent then performs and records the results of a physical examination. The form further provides for an indication of what tests respondent orders following the consultation,

what treatment he proposes, what medications he prescribes, and his impressions and conclusions regarding likely exposures to toxins. Respondent testified that the long form report is for his use only. 2) Progress Notes, usually a one-page document that consists of vital signs and handwritten notes by respondent on the day of each visit regarding the patient's current complaints and progress since his previous visit. 3) Medical Toxicology Follow-up, a two or three-page typewritten report that is a brief summary of the patient's chief complaint, history of illness, past medical history, medications, allergies, vital signs, physical examination, diagnoses and treatment on a particular date. It is unclear under what circumstances respondent chose to dictate a follow-up report as opposed to recording the visit in a progress note. 4) Workers' Compensation Status Report, a multiple-page, typewritten report intended as a "Medical Toxicology Summary," or "Medical Toxicology Consultation and Treatment Status Report" (Status Report). 5) A typed report, also referred to as a report of "Follow Up Visit," that is cumulative of the information found in all long form reports produced as of the date of the cumulative report.

*Patient Willie C.*

11. Willie C. testified in this matter. He is now 81 years of age and retired. He worked at ALCOA from 1951 to 1986, and initially operated a "sand-blaster." Located in a nine-by-twelve foot room, he utilized an air gun to smooth aluminum parts. Willie C. was thus exposed to aluminum dust and silica for many years. Willie C. also worked as a "trimmer," which he testified exposed him to magnesium, aluminum alloys and aluminum oxide. He did not wear a mask, although he did wear a shield to protect his eyes. After approximately 19 years, Willie C. moved to the "foundry," where he removed graphite off of metal parts by dipping them in an acid the witness referred to as "neuritic acid." While performing this job, Willie C. wore a hood and an apron he believes was made of asbestos. At other times, he worked in the "hammer room," where he put dyes into a press, sprayed the parts with a chemical and used a hammer device to form parts. The spraying involved the use of an aerosol device that discharged the chemical into the air. Exhaust fans vented the area.

12. Willie C. testified he knew Magdalena O., who was a trimmer at ALCOA. For a time, they worked in the same room.

13. Willie C. testified he was in good health prior to going to work for ALCOA. He recalls no complaints of shortness of breath, dizziness, memory loss, serious infections, sinus problems, chronic cough, joint pain, chronic fatigue, abdominal pain or chronic headaches before approximately 1985. He is aware of no other exposures to toxins prior to or since his ALCOA employment. In about 1985, Willie C. began to experience dizziness and nausea. He stumbled for no apparent reason. He had difficulty remembering names. In 1987, he experienced shortness of breath, caught frequent colds and had sinus infections, especially in the wintertime. He developed joint pain and stiffness, abdominal cramping and headaches, three or four times per week.

14. After many years of retirement, his symptoms persisted. Eventually, Willie C. heard that Magdalena O. and others were pursuing legal remedies against ALCOA. He attended a meeting at the union hall and thereafter retained attorney Hoerchner, who referred the witness to respondent. The first visit with respondent was on March 26, 1999. The initial long form was filled out by respondent in a session that lasted between one and two hours. On the form, although the referral was made by Hoerchner, respondent listed Willie C.'s personal physician as the referring individual.

15. The long form prepared by respondent during the March 26, 1999 visit by Willie C. noted the following facts as having been reported by the patient:

(A) Willie C. was an employee at ALCOA for 15 years, and had been retired for ten.

(B) The patient had experienced shortness of breath for eight years, and had been "stumbling" for ten. He also reported respiratory problems in the form of a cough, but respondent did not complete the blanks to indicate the duration of the problem. Willie C. also responded in the affirmative to questions concerning "asthma-like attacks" and nasal congestion (although respondent did not circle the choice of "house/workplace"). Willie C. denied current symptoms of headache or light headedness, dizziness, forgetfulness, syncope (fainting), generalized weakness, and problems with vision, hearing, depression or other neurological symptoms except memory loss and vertigo. Respondent's chart does not explain the apparent contradiction between a report of memory loss but a lack of forgetfulness, or between the lack of dizziness and the presence of vertigo.

The patient also denied having sinus infections "since exposure." He further denied any cardiovascular, abdominal or orthopedic problems, except finger joint problems.

(C) History for past illnesses, surgeries and medications were essentially negative except for a history of surgery for glaucoma. The patient denied any allergies or relevant family history.

(D) Willie C. had been exposed to "caustics" in connection with his work activity of "sand blasting." He did not wear a mask, but did wear a shield. He said he was exposed to "neuritic acid," when dipping metals. Respondent noted that the patient said he wore an "asbestos suit." Respondent also checked boxes that indicated affirmative answers by the patient to questions regarding exposure to pesticides, although no detail of this exposure was recorded. The patient denied exposure to chemicals away from work. He denied tobacco, drug or alcohol use.

(E) Respondent noted that the patient denied chemical exposure during any previous employment or in connection with any hobby.

(F) On physical examination, respondent recorded that his patient was a 72-year-old African-American male (he was actually 75). Respondent recorded his height,

weight, heart rate, respiration rate and temperature. His blood pressure was elevated at 164/90. He also reported the patient's blood saturation level, tested by pulse oximetry, as 96 percent, which respondent reported did not indicate good oxygenation for a person of Willie C.'s age and gender, assuming no pre-existing pulmonary disease in a non-smoker. Respondent also checked separate boxes indicating the pulse oximetry reading was "borderline" as well as "below normal."

The long form's report of a neurological examination performed by respondent began with respondent checking "N" (for no, or negative) to the following paragraph of findings:

Patient is alert and oriented times 4. In acute distress, very anxious. Glasgow Coma Score was 15 out of 15, normal for an adult. Patient's gait was normal. Cranial nerves 2 through 12 were within normal limits. Hearing and vision were grossly intact. Motor and sensory were normal to all four extremities, and symmetrical. Strength was 5 out of 5, normal for an adult. No sensory loss was noted anywhere. Reflexes were 2 out of 4, all deep tendon reflexes were above normal limits. Pupils were equal and reactive to light, direct and consensual, at 5 mm each. Fundi were normal, discs were sharp. There is no Kernig's sign, negative Brudzinski and Lasegue's signs. The patient is not ataxic. The patient has negative Romberg's sign. The patient has a negative heel-shin test. The patient passed the finger-nose test. The patient had a normal heel-toe testing.

This entry was followed by nine lines that provided the opportunity for respondent to address many of the individual components of the neurological findings noted above. Those lines addressed ataxia, vibration sense, reflexes, fundus examination, nystagmus (involuntary, rapid movement of the eyeballs) and tests for Romberg's (balance), heel-toe, finger-nose and heel-shin. In this way, respondent indicated positive findings for ataxia, Romberg's sign, heel-toe (noting that the patient "falls over"), finger-nose, heel-shin and nystagmus. Under "Mental Status," which heading follows "Neurological," respondent reported the lack of any positive findings except for memory loss. He specifically found the Glasgow Coma Score to be 15 of 15. Respondent added that the "finding" of memory loss was based on the patient's inability to provide significant historical information.

Respondent testified that the initial, all-inclusive paragraph is marked as negative if any of the tests or findings within the paragraph are found to be positive,<sup>3</sup> and that

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<sup>3</sup> This rather confusing system offered by the long form is repeated throughout the form. The reader must be careful to compare the text, which is sometimes phrased in the positive (i.e., "Patient is alert") and sometimes in the negative (e.g., "patient denies dysuria"). The interpretation of the form is

the individual factors included in the initial paragraph are set forth in the lines that follow. However, several of the items contained within the initial paragraph are not separated out in the lines that follow. For example, the long form does not include within the neurological section individual findings for cranial nerves, hearing and vision, motor and sensory tests, strength testing, deep tendon reflexes (although the form did provide for a finding regarding “abnormal reflexes” generally), pupils’ reaction to light, Kernig’s sign, Brudzinski sign, or Lasehgue’s sign.

The “Head and Neck” section of the report of physical examination findings is set up in a similar fashion to the neurological section, in that it begins with a long paragraph that includes many findings, followed by 14 lines of individual findings. In the case of Willie C. on March 26, 1999, all such findings were negative. The “Chest” examination, however, was positive for “shortness of breath or distress noted.” Respondent noted, “↑ exp. phase,” by which respondent meant that the patient had difficulty “getting all of the air out of his lungs.”

Further physical examination of the cardiovascular, abdominal, orthopedic, dermatological and lymphatic systems were normal, except for a mention of the patient’s “mild osteoarthritis” in the fingers.

(G) The next section of respondent’s long form lists 43 separate laboratory, pulmonary, cardiology and imaging tests. For Willie C. on March 26, 1999, respondent ordered a brain and sinus CT scan, chest x-ray, pulmonary function test and 17 different laboratory tests.

(H) According to the long form, on March 26, 1999, respondent prescribed two different “bronchodilators” and “antileukotriene” tablets to help Willie C. with his breathing, pending test results.

(I) Under “Impressions,” respondent made negative findings for all 37 lines provided by the long form for the presence of molds or “evidence” of mold exposure. He did note a positive finding for exposure to metals. Respondent diagnosed “hypoxemia<sup>4</sup> secondary to exposure,” headaches<sup>5</sup> secondary to either a central nervous system disorder or

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further complicated by the juxtaposition of the alternative responses offered by the form (“Y” or “N”), which vary in their positions, left or right. Respondent’s purpose in varying the placement of the “Y” and “N” boxes (actually spaces) is to assure that all positive findings are in the left-hand column.

<sup>4</sup> Hypoxemia is insufficient oxygen in the blood.

<sup>5</sup> Respondent did not explain a diagnosis of headaches in light of the long form’s clear indication that Willie C. specifically denied headaches during the March 26, 1999 visit with respondent. (See Finding 15-B.)

sinus problems, reactive airways disease (RAD), “chemical induced bronchospasm,” vertigo and “toxic encephalitis.” He concluded that Willie C. had “heavy metal exposure and toxicity,” and indicated he would evaluate other possible exposures. Respondent recommended that the patient return in three weeks. Respondent opined that Willie C.’s prognosis was, “Poor, for improvement but guarded at the present time, due to prolonged duration of the illness, exposure, and lack of abatement after having 6 months out of the building. Signs and symptoms of dementia will not resolve with time, and in fact, may be progressive, despite removal of the probable cause source of exposure.”<sup>6</sup>

16. Following the initial visit of Willie C. to respondent’s office, the tests referenced in Finding 15-G were completed.

(A) The brain MRI was normal except for a “mild mucosal thickening in the ethmoid and frontal sinuses.”

(B) The chest x-ray was normal.

(C) A general metabolic screen, which included a hepatic function panel, lipid profile, and complete blood count (CBC), was essentially normal. However, there was a slightly elevated creatinine level, which may have indicated a liver function problem.

(D) Tests for the presence of allergies were negative, except for a slightly abnormal result for “*Aspergillus fumigatus*,” a common but particularly virulent fungus.

(E) A “Lymphocyte Sub-Population” test found the patient’s white blood cell count to be normal, as were his total lymphocyte, T-Cell, T-Helper Cell, Suppressor Cell and Natural Killer Cell results. Each of these types of cell plays a role in the patient’s immune system’s ability to fight infection.

(F) A routine urinalysis was normal.

(G) Tests for pesticides, herbicides, arsenic, lead and mercury were normal. Urine tests yielded positive results for formic acid and phenol, a solvent.

(H) A Pulmonary Function Test (PFT) was done on April 15, 1999. By use of a spirometer, the PFT technician measured changes in lung volume. The data produced was compared by computer to volumes expected (predicted) of a person of the same age, sex, height and weight. For Forced Vital Capacity (FVC), Forced Expiratory Volume in the first second of the test (FEV1) and those tests as a ratio to one another (FEV1/FVC), the tests on

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<sup>6</sup> Although this language was not part of the March 26, 1999, long form for Willie C., as page 17 of the form was missing from his chart, respondent testified that the chosen prognosis, which was checked for patient Charles M., “probably applied to all four patients” at their initial visits.

Willie C. were normal. These tests are considered the most reliable of the many PFT test results. Additional aspects of the PFT done on Willie C. are the subject of dispute among the experts in this case and will be discussed in more detail, *post*. In summary, respondent felt the PFT was abnormal because at least one measurement of Forced Expiratory Flow (FEF) demonstrated 150 percent improvement after the patient used a bronchodilator by inhaler. This result suggested to respondent that the bronchial airways were restricted without the dilator, providing support for a diagnosis of RAD.

17. Between March 26, 1999, and December 3, 1999, respondent saw Willie C. ten more times, and each time filled out a long form. The second long form produced, dated April 23, 1999, was similar to the first, with a notable exception. Under “Impressions: Diagnoses: Conclusions” and “Molds,” respondent completely reversed the findings for all 37 lines that dealt with molds and evidence of molds in the earlier long form. (See Finding 15(I).) Respondent testified there was a history of water intrusion and molds at ALCOA, although proof of that statement is not found in the chart for this patient. Respondent also relied on the positive finding for *Aspergillus* in making his findings regarding exposure to molds.

18. Additional samples of the blood and urine of Willie C. were collected on April 23, 1999. An aluminum serum (blood) test yielded positive results, in that 51 ng/ml (nanograms per milliliter) of the metal were detected. The laboratory that ran the test reported the “therapeutic range” of the metal to be between 2 and 42. By that reference, therefore, the aluminum reading was elevated, or above normal. The lab further reported that, in dialysis patients, an “acceptable” level of aluminum was between 60 and 100. (The reference was made to dialysis patients because, in the process of dialysis, significant, unavoidable exposure to aluminum occurs.) Tests for cadmium and chromium were negative.

19. On April 23, 1999, respondent diagnosed the following for Willie C. (by checking the corresponding boxes in the long form):

(A) “Acute bronchitis, possible pneumonitis, sinusitis; of a type with acute high level solvent, smoke, carbon monoxide, heavy metal and possible cyanide exposure, secondary to exposure, causally and temporarily [sic] related by history.”

(B) “Sinusitis not resolving with medical treatment, related to chemical exposure; to date; related to exposure.”

(C) “Hypoxemia secondary to exposure.”

(D) “Ataxia secondary to exposure.”

(E) “Reactive Airways disease secondary to exposure.”

(F) “Chemical induced bronchospasm.”

(G) “Multiple chemical exposure and toxicity from exposure.”

(H) “Evidence of musculoskeletal pain secondary to exposure.”

(I) “Evidence of fibromyalgia; joint and/or musculo-skeletal pain due to chemical exposure, without evidence of arthritis, inflammation or other injury.”

Respondent prescribed vitamins and antioxidants in addition to the bronchodilators and antileukotriene.

20. In the long form of April 30, 1999, respondent reported the involvement of aluminum and solvents as involved chemicals, and concluded the patient had “heavy metal toxicity,” and “aluminum toxicity.” Inexplicably, the many boxes denoting the presence and involvement of molds were again marked in the negative, and respondent repeatedly made negative findings for mold exposure in the remaining long forms, through December 3, 1999.

21. Pulse oximetry readings were taken at virtually every visit for Willie C., from March 26, 1999, through March 21, 2001. The results ranged between 95 percent and 98 percent.

22. Respondent determined to treat Willie C. by chelation therapy. From April 30, 1999, to May 28, 1999, the patient was given succimer, a chelating agent in capsule form. The process of chelation involves introducing the chosen agent so as to cause metals in the blood to adhere to the agent and be excreted from the body. It is usually used to extract lead and mercury. The experts in this matter disagree on whether the use of succimer was appropriate to treat aluminum toxicity, a subject that will be discussed more thoroughly, *ante*. In Willie C.’s case, a test for aluminum on May 24, 1999, yielded a result of “< 2 ng/ml.” The testing laboratory indicated that normal range was less than 30 ng/ml. However, that test was on the patient’s urine, and did not correlate directly with the earlier, positive finding of aluminum based on a serum, or blood, test. Nevertheless, respondent (and the experts who testified on his behalf) concluded that the chelation therapy had successfully reduced the aluminum levels in the patient’s blood. Indeed, Willie C. testified that his symptoms “got much better” during the treatment, and he gives respondent “100 percent of the credit” for his improvement. Today, Willie C. still experiences shortness of breath, but his other symptoms, including his stumbling, are much improved or non-existent.

23. On December 3, 1999, respondent issued a Status Report to the Workers’ Compensation Appeals Board. Respondent represented that Willie C. had been exposed to “several sources of toxins over the past several years: 1. Heavy metals – including aluminum, chromium, cadmium, titanium, cobalt, by history. 2. I have also been provided with a list of potential chemical exposures, provided by Alcoa Vernon Works, Vernon, California.” Respondent then listed 21 chemicals taken from the Levin report. Respondent next reported his patient’s symptoms to be:

[S]hortness of breath and headache, recurrent infections, out of work, pulmonary infections, memory loss, muscle and joint pains; which continued until treatment was initiated. Recurrent infections, shortness of breath, wheezing, fevers, illness episodes, and fatigue have continued to the present time. These all started from the time of the exposures in and around 1970's and 1980's. The patient was exposed for at least 15 years before. The patient retired due to: a. Shortness of breath; (had for 8 years). b. Staggering and falling due to vertigo: (had for 10 years) on the job. The patient has since had suppression of the immune system with resultant multiple infections of bacterial, viral and fungal etiology. The patient had an elevated aluminum level. The patient had a low and abnormal Pulmonary Function Testing.

24. Respondent reported that Willie C. had been chelated, which had improved his symptoms. He also stated:

The nature of this illness is a chemical burn, injury and toxicity caused by inhalation of aerosolized/vaporized toxic gases, pulmonary irritants, dusts, and other chemicals, and also secondary viral, fungal, and bacterial source. Pulmonary, sinus and airway burns occurred from this, as well as chemical and heavy metal toxicity. This has also led to secondary bacterial infection and sepsis. The patient was on antibiotics, steroids and antihistamines, and inhalational pulmonary medications in 1999. The patient has been treated for multiple exacerbations since that time, and this continues be [*sic*] possible to the present day.

The patient has been retired from permanently and totally disabled for approximately past over 5 years [*sic*]. The patient is currently not able to work, even with rehabilitation or retraining; due to the probability of worsening the current condition on the job.

The patient also requires:

- a. life-long medical treatment related to this,
- b. including the possibility of surgery in the future,
- c. and also requires annual cancer workups, for life.
- d. further evaluation for toxic encephalopathy from insecticides to include but not be limited to memory and cognitive functioning.
- e. disability and compensation for medical illness of pulmonary disease, chemical induced, and toxic

encephalopathy. This requires further evaluation as to extent of damage.

25. In the December 3, 1999 status report, respondent rendered the following 12 diagnoses:

1. Chemical and aerosolized/vaporized gases, metals and dust and liquids addressed in the above list, exposure and inhalation with toxicity.
2. Recurrent Chemical toxicity and secondary bacterial sepsis.
3. Recurrent and chronic Chemical and secondary bacterial sinusitis as a result of #1.
4. Reactive Airways Disease as a result of #1.
5. Hypoxemia and abnormal pulmonary function tests as a result of #1 to 4.
6. Recurrent sinusitis as a result of #1 – 6.
7. Reactive airways disease due to #1 – 8.
8. Chemical induced toxic encephalopathy and neuropathy.
9. Immunological compromise secondary to toxic injury and #1 – 8.
10. Multiple viral, fungal and bacterial infections secondary to #1, 2, 3, 5, 8, 9, 11, 12.
11. Chronic fatigue syndrome – meets criteria – due to #1 – 13; chemical induced.
12. Fibromyalgia – meets all criteria – due to #1 – 14; chemical induced.

*Patient Charles M.*<sup>7</sup>

26. Charles M. testified in this matter. He is a 73-year-old gentleman who was referred to respondent by attorney Hoerchner and, like Willie C., first saw respondent on March 26, 1999. Charles M. worked for ALCOA from 1955 until his retirement in 1994. With ALCOA, he worked in various capacities, including as a trimmer, forger and metal finisher. He was exposed to solvents and metal dust. He wore gloves, an apron and a face shield. He does not recall wearing an asbestos suit. Later in his employment, Charles M. was issued a mask, which he testified made the work “much better.” Prior to his ALCOA employment, Charles M. was in good health, and specifically denied shortness of breath,

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<sup>7</sup> For two reasons, considerably less detail is recounted for the remaining three patients. First, the parties tended to use Willie C. as an example during the questioning of the experts. Secondly, as the symptoms, findings, diagnoses and allegations concerning each patient were very similar, and neither counsel in their cases in chief, nor the Administrative Law Judge in this Decision, find it necessary to provide detailed summaries of the hundreds of pages of medical records entered into evidence in this matter.

dizziness, itchy skin, headaches, asthma, memory loss, chronic nasal congestion, chronic cough, joint pain and abdominal pain. Beginning in 1991, the witness had symptoms that included diarrhea and shortness of breath. In approximately 1995, he experienced difficulty with his balance and became very ill. He also developed a rash, tinnitus, joint pain, back pain, fatigue and headaches after retirement. He did not mention having experienced recurrent infections. Charles M. denied exposures to chemicals in any context other than work, although he regularly smoked cigars until 1985. (At ALCOA, Charles M. was known as “Cigar Charlie.”) He testified that his symptoms improved following treatment with respondent.

27. The long form filled out by respondent for the first visit of Charles M. on March 26, 1999, indicated he elicited a history from the patient that included “29 yr of metal dust/solvent” and “caustic/neuritic acid” exposures. Questions asked by respondent were answered affirmatively regarding a history of symptoms of respiratory problems, cough, shortness of breath, wheezing, frequent asthma-like attacks, nasal congestion, rash and malaise. The patient told respondent he was exposed to asbestos in his clothing at work. Charles M. also complained of memory loss, vertigo, nausea, joint pain, abdominal pain and visual and hearing deficits. The long form did not include a history of recurrent infections. The patient had a history of colitis and a hospitalization for a colonoscopy in 1991 and an endoscopy in 1995. Copies of records of those hospitalizations were provided to respondent by Mr. Hoerchner in July of 2000.<sup>8</sup>

28. On physical examination, respondent took and recorded vital signs and got a pulse oximetry reading of 97 percent. The summary paragraph of neurological findings (set forth in Finding 15(F)) was marked as negative,<sup>9</sup> which entry was contradicted by positive findings on several of the individual entries that followed, including the existence of ataxia and positive Rhomberg, heel to toe, finger to nose and heel to shin tests. Respondent noted that the patient was “falling over” during the Rhomberg and heel to shin tests. Other positive findings on physical examination included abnormal breath sounds, tender abdomen, and joint inflammation and tenderness. He concluded that Charles M. had suffered from solvent and heavy metal exposure in reliance on the patient’s statements and the Levin report. Respondent ordered the same battery of tests that he had ordered for Willie C., but did not prescribe any medications pending the results. Respondent recorded negative responses for

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<sup>8</sup> These were the only records of a medical care provider other than respondent found in any of the four patients’ records. Although respondent testified he attempted to obtain records, there is no evidence of any such efforts in the charts. The fact that the Charles M. records came from the patient’s attorney casts further doubt on respondent’s claim regarding such records.

<sup>9</sup> Respondent actually recorded a “Yes” answer for the paragraph’s description of neurological findings. This is interpreted as a negative finding because the findings themselves are described in the negative, even though one finding (“In acute distress, very anxious”) is not.

all questions relating to mold exposure in the March 26, 1999 long form. As he did with Willie C., however, on the next visit (also on April 23, 1999), respondent recorded positive conclusions for all 37 questions concerning mold exposure and “mold evidence.”

29. The results of imaging studies and laboratory analyses of blood and urine specimens taken from Charles M. on March 26, 1999, were generally as follows:

(A) The brain MRI was normal except for a “mild mucosal thickening present in the ethmoid sinuses bilaterally.”

(B) The chest x-ray was normal.

(C) A general metabolic screen, which included a hepatic function panel, lipid profile, and complete blood count (CBC), was essentially normal.

(D) Tests for the presence of allergies were negative, except for abnormal results for “*Micropolyspora faeni*” and “*Thermoactinomyces spp.*” Respondent argues that these results supply the fungal element later diagnosed by him.

(E) A “Lymphocyte Sub-Population” test found a number of abnormalities, including with the patient’s white blood cell count, total lymphocyte, T-Cells, T-Helper Cells, Suppressor Cells and Natural Killer Cells. Respondent’s experts pointed out that these results indicated a compromised immune system.

(F) A routine urinalysis was normal.

(G) Tests for pesticides, herbicides, arsenic, lead and mercury were normal, except for an elevated value for the herbicide Cyanazine. Urine tests yielded positive results for formic acid and phenol, a solvent.

(H) A PFT was done on April 15, 1999. Like Willie C., Charles M. had normal FVC and FEV1 results, but did improve the FIF function after the use of a bronchodilator. Respondent relied upon the FIF result pre-dilator, which was 61 percent of normal, in his diagnosis of RAD.

30. An aluminum serum test was reported by a laboratory on April 29, 1999,<sup>10</sup> as 38 ng/ml. However, respondent did not prescribe chelation therapy for this patient due to his history of colitis, which respondent felt was “toxic induced.”

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<sup>10</sup> In a Medical Toxicology Consultation and Treatment status report of October 2, 2000, respondent indicated he had obtained a serum aluminum level of 38 ng/ml on March 30, 1999. However, a report of that date is not found in the chart.

31. Pulse oximetry readings were obtained over the course of treatment of Charles M. in the 96 to 98 percent range. On the initial test on March 26, 1999, the patient obtained a 97 percent saturation level, which respondent characterized as “borderline.”

32. In his Status Report of October 2, 2000, concerning patient Charles M., respondent rendered the exact same 12 twelve diagnoses, in identical language, as the diagnoses rendered for Willie C. (See Finding 25.) He also opined that Charles M. had suffered pulmonary, sinus and airway “chemical burn.” In the same report, respondent represented that the patient complained of “recurrent infections,” although the initial long form and the patient’s live testimony in this hearing did not support that entry. (See Findings 26 and 27.) From the records, it appears that respondent saw Charles M. four times: March 26, 1999, April 23, 1999, April 30, 1999 and August 2, 1999.

*Patient Claude J.*

33. Claude J. testified in this matter. He is a 68 year-old man who retired from ALCOA in 1994, because his “legs gave out.” Also, on two occasions at work, he lost consciousness and fell. While employed at ALCOA, Claude J. held at least two different jobs. He was a “loader” of parts into an oven for three years, during which time he was protected from the heat by a fire-retardant suit and gloves. After that assignment, he sprayed parts with a dye. He believes he inhaled dust, fumes and smoke. Claude J. knew Magdalena O., who worked at “the other end” of the plant from him. His health worsened in 1993, when he experienced shortness of breath, dizziness, tinnitus, fatigue, cough, memory loss, nasal congestion and leg weakness. Today, Claude J. ambulates with the use of a walker. He denied exposure to toxins at any location other than ALCOA. Claude J. testified that he “felt better” following his treatment with respondent.

34. Claude J. was referred to respondent by attorney Hoerchner and saw the doctor for the first time on March 26, 1999. In his long form report of that date, respondent noted a history of heavy metal exposure from aluminum and lead. However, he apparently elicited no history that would implicate molds in his analysis, as all 37 questions relating to mold were marked negative for such a finding. Claude J. did present with an additional history of asthma and hypertension. For the latter condition, the patient was being treated by his primary physician, a Dr. Has.<sup>11</sup> Claude J. denied tobacco, drug and alcohol use, but, according to respondent’s record of the visit, complained of a history of headaches, forgetfulness and memory loss, syncope, vertigo, joint pain, generalized weakness, anxiety, visual and hearing deficits, and sensory and motor deficits. Physical examination included a recordation of vital signs, including a blood pressure reading of 170/98. Neurologically, findings were positive for ataxia, and all the balance tests (Rhomberg, heel to toe, etc.). Other findings on physical examination were unremarkable. According to a bracket placed

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<sup>11</sup> Respondent testified that he attempted to obtain Dr. Has’ records for this patient, but was unable to do so. There is no correspondence to Dr. Has in the chart, nor is there any note or order written by respondent regarding the records.

on the form, respondent ordered the same tests he ordered for patients Willie C. and Charles M, plus a CT scan of the abdomen. He indicated that treatment with chelation was “possible.”

35. The results of imaging studies and laboratory analyses of blood and urine specimens taken from Claude J. on March 26, 1999, were generally as follows:

(A) The brain MRI was normal except for a “moderate periventricular deep white matter changes.”

(B) The chest x-ray was normal. A CT scan of the chest identified “old granulomatous disease.”<sup>12</sup> A CT scan of the abdomen found “small bilateral renal lesions, probably cysts,” but was otherwise normal.

(C) A general metabolic screen, which included a hepatic function panel, lipid profile, and complete blood count (CBC), showed a slightly elevated creatinine level.

(D) A “Lymphocyte Sub-Population” test found a number of abnormalities, including with the patient’s white blood cell count, total lymphocyte, T-Cells, T-Helper Cells, Suppressor Cells and Natural Killer Cells.

(E) A routine urinalysis was normal except for the presence of blood in the urine and an elevated protein level.

(F) Tests for levels of metals and solvents were normal for cadmium, chromium, titanium, PCB’s, arsenic, lead, mercury and arsenic. Aluminum was found at 20 ng/ml. Tests were positive for formic acid at a level below the reference range.

(G) A PFT was done on April 27, 1999. Like Willie C. and Charles M., Claude J. had normal FVC and FEV1 results, but did improve the FIF function after the use of a bronchodilator. Respondent relied upon the FIF result pre-dilator, which was only 45 percent of expected prior to use of the bronchodilator, but 89 percent after its use, a 98 percent improvement.

36. Respondent placed Claude J. on a chelation therapy program, using succimer as the chelating agent. The patient’s second visit with respondent was on April 27, 1999. Respondent noted, on the cover sheet to his long form, that Claude J. had been exposed to aluminum, cadmium, lead, titanium and solvents. He described the patient as “completely, totally, permanently disabled.” Aluminum serum level on that date was 20, unchanged from the earlier test. At the visit of June 17, 1999, Claude J. reported he was “still feeling dizzy.” Respondent noted that the aluminum level of 20 was “moderate,” but because the patient was

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<sup>12</sup> Granuloma is a mass that may form in the lungs as the result of chronic infections.

“still symptomatic,” respondent indicated a second chelation course was required, again using succimer.

37. On July 23, 1999, Claude J. reported feeling better, denying his symptoms persisted. Respondent deemed the treatment “successful,” noting “levels below toxic ranges.” However, aluminum level test results are not found for the period between June 17 and July 23, 1999. Results are found in the records for an aluminum urine sample taken on September 1, 1999, which indicate a level of 3 ng/ml.

38. Pulse oximetry readings taken by respondent, or at his direction, between March 26, 1999, and the final report in the file, dated October 5, 1999, ranged between 95 percent and 98 percent saturation.

39. On September 1, 1999, respondent dictated a Status Report regarding Claude J. In it, respondent listed the same 12 diagnoses, using the exact same language, as he had listed for patients Willie C. and Charles M. (See Findings 25 and 32.) Respondent saw Claude J. eight times between March 26, 1999, and October 5, 1999.

*Patient Louis H.*

40. Louis H. did not testify in this matter. Therefore, all information concerning his health history and treatment is taken from the records.

41. Attorney Hoerchner referred Louis H. to respondent, who first saw him on April 15, 1999. The patient presented with a history of tuberculosis in 1986, and reported having a “spot on my lung,” based on x-rays from 1998. Louis H., who was 42-years-old at the time of his first appointment with respondent, worked at ALCOA as a “cut and polish worker” in the manufacture of airplane parts. He stated he was exposed to dust, hardeners, solvents, copper and cleaners. He complained that he experienced shortness of breath since approximately 1992, had frequent asthma-like attacks, nasal congestion and malaise after working at ALCOA from 1989 to 1995. His major complaint was shortness of breath. He denied having any of these symptoms prior to that time. Louis H. denied the use of tobacco, drugs and alcohol.

42. The long form filled out by respondent on April 15, 1999, indicated the patient gave negative responses to all questions concerning neurological, head and neck, chest, cardiovascular, abdominal, endocrinal, dermatological and lymphatic system symptoms. On physical examination, vital signs were normal, as were the neurological, mental status, head and neck, chest, cardiovascular, abdominal, orthopedic, and dermatological examinations. Respondent recorded negative results for all mold and mold evidence questions. Respondent did conclude that Louis H. had suffered metal, acid and solvent toxicity. Respondent did not order any treatment on the date of the patient’s first visit, but did order the usual battery of laboratory and imaging tests.

43. The results of imaging studies and laboratory analyses of blood and urine specimens taken from Louis H. on April 15, 1999, were generally as follows:

(A) An MRI of the brain and/or sinuses was not done on this patient.

(B) An upper-abdominal CT scan was normal.

(C) Chest x-rays found "small regions of patchy abnormal density in the peripheral left upper lobe." A follow-up CT scan of the chest found a left upper lobe abnormality, which was thought to be a "post inflammatory process." Respondent later noted that the "mass" may have represented "old TB," but also felt it could have been caused by his heavy metal exposure. He referred the patient to pulmonologist Dr. Cocco.

(D) A general metabolic screen, which included a hepatic function panel, lipid profile, and CBC, showed several abnormalities, including with respect to the levels of glucose, protein, globulin, hemoglobin and hematocrit.

(E) A "Lymphocyte Sub-Population" test, if done, was not found in the records.

(F) A routine urinalysis showed blood in the urine and abnormal levels of both red and white blood cells.

(G) Tests for serum levels of metals and solvents were within normal limits for arsenic, mercury, cadmium, beryllium, lead and copper. However, in the urine, lead was found at a level of 4.8 ng/ml, above the norm of < 1 ng/ml. Aluminum was found at 34 ng/ml. A test for formic acid yielded a result of 54.6 mg/l, above the reference range of 21 to 26. For hippuric acid, a result of 0.9 g/l was barely over the norm of 0.8 g/l. For phenol, 3.0 mg/l was within the norm of < 10 mg/l. A test for hexanedione was reported as "Positive," but a reference range was not given.

(H) A PFT was done on April 21, 1999. Lung mechanics (FVC and FEV1) were at 84 percent and 72 percent, respectively. The patient improved by 140 percent in FIF after inhaling a bronchodilator. The doctor who read the PFT results concluded, "Minimal airway obstruction is present suggesting small airway disease." Respondent found FEF values in the 50 to 70 percent range significant for RAD.

44. On May 4, 1999, respondent ordered Louis H. placed on chelation therapy with succimer due to the combination of the levels of aluminum, copper, arsenic and cadmium. The treatment, which did not begin until June of 1999, was completed by July 23, 1999. By June 15, the patient reported feeling better and respondent cleared his patient to return to work. A repeat metal screen was done on July 6, 1999, and showed an aluminum serum level of 22. The urine lead and arsenic levels also decreased, although copper was unchanged. A repeat PFT on October 26, 1999, was reported to be within normal limits.

45. Pulse oximetry readings were very good during the patient's visits to respondent. Except for one reading in July of 1999 and again in July of 2000 (which were both 95 to 96 percent), the results were in the 97 to 100 percent saturation range.

46. On October 27, 1999, respondent authored a Medical Toxicology Consultation and Treatment Status Report on Louis H. Respondent rendered the exact same 12 diagnoses, using exactly the same language, as he had for the other three ALCOA patients discussed, *ante*. In the case of Louis H., respondent added two diagnoses:

13. Heavy metal toxicity, multiplicity of metals; including aluminum, lead, arsenic, (inorganic), copper.

14. Solvent toxicity – formic acid and phenol, hexandione and hippuric acid.

The same diagnoses were listed in another Status Report of December 14, 1999. Respondent saw Louis H. 11 times between April 15, 1999, and July 25, 2000.

#### *Expert Witness Testimony Concerning Quality of Care Issues*

47. Thomas Ferguson, M.D., was called as an expert witness during complainant's case-in-chief. Dr. Ferguson received his M.D. in 1987, from the University of California, Davis (UC Davis), School of Medicine, after having earned his undergraduate degree in zoology at Humboldt State University and a Ph.D. from the Department of Environmental and Occupational Health Sciences at UCLA. He completed a residency in internal medicine, a fellowship in occupational and environmental medicine, and a medical toxicology fellowship, all at UC Davis. Dr. Ferguson became board-certified in internal medicine in 1990, and in medical toxicology in 1997. He is licensed to practice in California and Oregon.

48. Dr. Ferguson is now the Medical Director of the Cowell Student Health Center at UC Davis. He was the Director of Employee Health Services there from 1993 to 2001. From 1993 to 1998, the witness was an Assistant Clinical Professor of Medicine at UC Davis. From 1998 to the present, he has taught as an Associate Clinical Professor. As Director of Student Health, Dr. Ferguson oversees the provision of health services to 30,000 students. In addition, he is a Deputy County Health Officer for Yolo County and volunteers his services at the County's Poison Center, providing telephone advice regarding toxicological matters state-wide. Dr. Ferguson does not currently do any workers' compensation consulting work. He has been a reviewer for MBC for 10 years.

49. Complainant's expert is critical of respondent's care and treatment of the four involved patients in several respects, and, in all cases, his opinions are that respondent's departure from the standard of care were extreme and in some cases demonstrated incompetence. The areas of criticism, which apply uniformly to the treatment of all four patients, may be generalized as follows: a) Respondent failed to take adequate histories concerning the actual exposures of the ALCOA workers to toxic chemicals; b) Respondent

ordered “every conceivable test” be performed, including tests that had no, or inadequate, medical indication;<sup>13</sup> c) Treatment by chelation therapy was not medically indicated; and d) The entire array of identical diagnoses ultimately rendered for each patient was unsupported by the medical evidence.

50. The following observations are attributed to Dr. Ferguson in support of his opinions:

(A) A medical toxicologist, when attempting to determine whether a patient has suffered a toxic exposure to some potentially dangerous chemical, must conduct an investigation that confirms the exposure and its causal relationship to symptoms, to the exclusion of more common causes of the symptoms. In each case under consideration, respondent merely accepted representations made by patients, three of whom were elderly, and one of whom had been away from the plant for 13 years. In addition, respondent’s reliance on the Levin environmental report as confirmation of the exposures was misplaced. First, the report merely concluded that Magdalena O. *may* have been exposed to toxic chemicals at ALCOA, which *may* have included certain specific substances. Secondly, no effort was made by respondent (at least none was recorded) to confirm whether any individual patient had the same or even similar exposures to which Magdalena O. was subjected. The investigator-physician should endeavor to determine precisely what the patient’s job was, what shift he worked, what protections he had on the job, how long each type of exposure lasted, precisely when the symptoms began, and which symptoms coincided with which exposures. And rather than rely on a patient’s bare denial of exposures in other facets of his life, the physician should question him more specifically about the history of his living conditions, activities, hobbies and previous employment. Where appropriate, the medical records concerning the patient from other healthcare providers should be obtained.

(B) The types and numbers of tests ordered by respondent for these patients were not medically justified. For example, there is no documentation in any chart of the first visits to require laboratory testing for fungicides or herbicides. Even the many tests for the presence of metals were not indicated absent better information that these workers were actually exposed to the chemicals for which the tests were being conducted.

(C) Chelation therapy is principally intended to remove lead from one’s system, and succimer is the appropriate chelating agent for that purpose. The use of succimer carries the risk of certain side-effects, including liver damage and an increased chance of infection. Aluminum toxicity, if present, may be treated using deferoxymine (DFO), but not succimer, as its use may cause the unwanted removal of needed iron. DFO should be used only if the aluminum level in the blood is greater than 100 ng/ml. None of the patients whose treatment is at issue here showed aluminum levels nearly that high.

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<sup>13</sup> Although Dr. Ferguson opined that respondent ordered too many tests for each patient, the Second Amended Accusation does not specifically cite this observation as a negligent act for which discipline is sought. Therefore, it is not included in the ultimate analysis at Findings 98 and 99.

(D) Not one of the 12 (or 14, in the case of Louis H.) diagnoses rendered for each patient was medically justified.

1) Chemical and aerosolized/vaporized gases, metals and dust and liquids addressed in the above list, exposure and inhalation with toxicity. As set forth in subparagraph (A), above, respondent did not conduct an investigation or elicit a history sufficiently supportive of this diagnosis. Furthermore, neither laboratory test results, imaging studies nor PFT results confirmed the diagnosis of chemical toxicity. With regard to laboratory and imaging test results, it is noted that nearly all tests for all patients were within normal limits and the values that were not normal were not significantly outside of normal ranges. (See Findings 16, 29, 35 and 43.) Aluminum toxicity should not be diagnosed in the absence of symptoms causally related to an exposure, and probably not then unless the serum Aluminum level is over 100. Only in Willie C.'s case was a single test outside the "therapeutic range" defined by the testing laboratory of between 2 and 42. For Willie C., a sample collected on June 17, 1999, was 51 ng/ml, which was "not a worrisome result," and the symptoms attributed to the patients would not result from aluminum levels of this magnitude. Moreover, all urine test results should be disregarded, as urine levels for metals are notoriously inaccurate.

2) Recurrent Chemical toxicity and secondary bacterial sepsis. The term "bacterial sepsis" has a specific medical meaning. It refers to a systemic condition, potentially fatal, that requires hospitalization. To equate "sepsis" with "infection" is to misunderstand the term and grossly overstate the condition of a patient who may have a sinus infection.

3) Recurrent and chronic Chemical and secondary bacterial sinusitis as a result of #1. Sinusitis is an infection of the sinuses. A diagnosis of sinusitis secondary to chemical exposure requires a history of chemical injury and positive imaging study findings. The histories elicited here were insufficient to conclude a causal relationship to sinus problems. In the case of Willie C., an MRI finding of "mild mucosal thickening" of the sinuses is a common finding and not supportive, by itself, of a diagnosis of chronic sinusitis.

4) Reactive Airways Disease as a result of #1. This diagnosis would likewise require a more reliable history of chemical exposure, as well as positive x-ray findings. Respondent's reliance on PFT results reflected a misunderstanding of the test reports' actual results. Each patient's PFT results were normal based upon the lung mechanics values reflected by FVC, FEV1 and FEV1/FVC. The values relied upon by respondent (primarily FEF and FIF) are known to be much less reliable. Moreover, when RAD results from toxic exposure, in the typical case, it is from an overwhelming, massive exposure requiring hospitalization within hours of the exposure.

5) Hypoxemia and abnormal pulmonary function tests as a result of #1 to 4. Hypoxemia refers to deficient oxygenation of the blood. It is measured by means of a pulse oximeter. Each patient whose condition is at issue here was measured for oxygen

saturation levels multiple times. No patient registered lower than 95 percent pulse oximetry and nearly all readings for all patients were in the 97 to 99 percent range, entirely normal.

6) Recurrent sinusitis as a result of #1 to 6. This diagnosis is essentially duplicative of number 3.

7) Reactive Airways Disease due to #1 to 8. This diagnosis is duplicative of number 4.

8) Chemical induced toxic encephalopathy and neuropathy. These are really two different diagnoses, although both refer to changes due to chemical exposure, the first involving changes in the brain, and the second to degenerative changes to the nervous system. In order to confirm a diagnosis of encephalopathy, one would expect a positive MRI of the brain. To confirm a diagnosis of neuropathy, one would expect positive findings in an electromyogram (EMG) or nerve conduction studies, but neither test was done on any patient. Only Claude J. showed any finding that could be interpreted as positive for brain change on MRI. His showed “moderate periventricular deep white matter changes,” but the body of the MRI report more fully described the finding as, “moderate areas of abnormally increased signal intensity in the periventricular deep white matter in a pattern most compatible with age related deep white matter vessel ischemic change.” Thus, the MRI findings are more consistent with small vascular changes consistent with age and the patient’s history of high blood pressure. The brain MRIs for Willie C. and Charles M. were normal, and respondent did not order a brain MRI for Louis H.

9) Immunological compromise secondary to toxic injury and #1 to 8. There is no support in the record for this diagnosis. One would expect to see evidence of recurrent infections and laboratory confirmation of this diagnosis, particularly in the white blood cell count. The white blood cell count of each of these four patients was within normal limits.

10) Multiple viral, fungal and bacterial infections secondary to #1, 2, 3, 5, 8, 9, 11, 12. There is no support in the record for this diagnosis. There was no history of viral, fungal or bacterial exposure found in the record. The laboratory finding of the presence of *Aspergillus fumigatus* in Willie C. should not be considered significant, in that it is a common fungus and no historical data gathered by respondent supports the theory that it was acquired by the patient 13 or more years earlier while working at ALCOA.

11) Chronic fatigue syndrome due to #1 to 13; chemical induced. This diagnosis overlaps with number 12, *ante*, and is a diagnosis of exclusion. In other words, there may be many plausible explanations for a complaint of fatigue and only if they are all ruled out should one consider this as a diagnosis. Furthermore, respondent did not establish a “biological link” between complaints of fatigue and any chemical exposure.

12) Fibromyalgia due to #1 to 14; chemical induced. Fibromyalgia generally involves pain of the musculoskeletal system and soft tissues of the body and

denotes a condition for which there is no other explanation. Women are more often sufferers of this condition than men. It is often accompanied by chronic fatigue. There is a system in widespread use to diagnose fibromyalgia, which involves “mapping” of 18 points on the body. If the patient responds with pain at 11 of the 18 points, the diagnosis may be made. There is no evidence in the patient files that respondent engaged in any mapping of any patient.<sup>14</sup>

13) Heavy metal toxicity, multiplicity of metals; including Aluminum, Lead, Arsenic (inorganic), Copper. (This diagnosis was made for patient Louis H. only.) Louis H. did not suffer from metal toxicity. His blood levels of arsenic, lead, aluminum and copper were all within normal limits.

14) Solvent toxicity – Formic Acid and Phenol, Hexandione and Hippuric Acid. (This diagnosis was made for patient Louis H. only.) The lab results for phenol and hippuric acid were normal, and the results for formic acid and hexandione were not significant.

51. Respondent offered the testimony of two experts in his defense. The first, Jonathan Wasserberger, M.D., attended medical school at the University of Miami, graduating in 1971. His internship in emergency medicine was completed at the Medical College of Pennsylvania, a residency in anesthesiology at the Sacramento Medical Center, and a fellowship in emergency medicine at San Francisco General Hospital in 1978. Dr. Wasserberger has been licensed in California since 1972. He is board-certified in emergency medicine and is a Fellow of the American College of Medical Toxicology. Dr. Wasserberger practiced as an emergency room physician at King/Drew from 1980 until 2000. He was appointed an Assistant Professor of Surgery at Drew in 1980, an Associate Professor of Internal Medicine at UCLA in 1993 and a Professor of Emergency Medicine at Drew in 1996. Dr. Wasserberger is now a medical toxicologist, practicing at Mayo. He shares an office with respondent.

52. Gunnar Heuser, M.D., has practiced medicine in California for over 30 years. Born in Germany, he attended medical school at the University of Cologne, Canada, earning his M.D. degree in 1952, and a Ph.D. from the University of Montreal in 1957. He became an American citizen in 1965, after serving as a research assistant at UCLA in 1959. Dr. Heuser was an Assistant Professor of Medicine (Endocrinology) in Residence at UCLA from 1964 to 1970, and an Assistant Clinical Professor of Medicine at UCLA from 1970 to the present. His private practice focuses on the treatment of Parkinson’s Disease, headaches and toxicology. Dr. Heuser has testified as an expert in excess of 200 times, usually on behalf of plaintiffs.

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<sup>14</sup> Respondent did claim, during his interview with a board investigator in 2003, that he tested the patients for “tender points” and that they all met the criteria of 11 or more points.

53. Both Dr. Wasserberger and Dr. Heuser testified favorably to respondent regarding all quality of care issues addressed by the Second Amended Accusation and by Dr. Ferguson. According to each of them, at no time did respondent fall below the standard of care in his care and treatment of the four involved patients. Dr. Wasserberger testified in much more detail than Dr. Heuser, who often was unable to recall the particulars of the individual patient's case. But as their final conclusions on the issues were essentially identical, the summary that follows is intended to reflect their shared or composite testimony, except when their individual opinions are specifically referenced.

(A) The documentation prepared by respondent is extensive and inclusive of a more-than-adequate history of chemical exposure by these patients. The occupational history for each patient appears to be complete. Dr. Heuser, in particular, was impressed with the sheer volume of material in respondent's charts. According to Dr. Wasserberger, the long form is "organized and efficient," and "obsessively complete," providing an opportunity for good interaction with the patient. The Levin letter is significant because it appears to be temporally relevant to conditions experienced by the patients. It is acceptable practice to rely upon reports such as this one.

(B) The tests ordered by respondent were reasonably necessary as part of the process of differential diagnosis undertaken. In other words, in order to narrow the possible causes of the patients' symptoms, it was important to look at various possible causes. There was a history of metal and solvent exposures, necessitating laboratory tests for those substances. With respect to tests for pesticides and herbicides, Dr. Wasserberger testified that there may have been toxic byproducts of the aluminum production process to isolate. He was also of the understanding that herbicides were used in the area around the Vernon plant. Not to test for these substances would be below the standard of care. To test for immune function deficiency was important because compromise of the immune system is a common injury following exposure to toxic metals. In fact, tests on these patients consistently showed low levels of natural killer cells and T-helper cells, demonstrating an active and ongoing infectious process. Low test results for interleukin-2 production may also be consistent with RAD and hypoxemia. Tests for fungicides were also necessary due to a history of dampness in the environment, and because chronic sinusitis often is accompanied by a fungal infection.

(C) Chelation therapy was appropriately prescribed for the three patients who received the therapy as their aluminum levels were in excess of known, toxic ranges for the metal, and they were symptomatic. The threshold level for aluminum toxicity is 10 ng/ml. The lab reports in these cases do indicate that an acceptable range is 60 to 100 ng/ml, but that range is specifically tolerated by dialysis patients who are exposed to aluminum in the tubing used in that process. It is also true that the therapeutic reference range for the rest of the population is cited in the reports as between 2 and 42, but the literature supports the 10 ng/ml cutoff point. Willie C. had an aluminum level of 51 initially. Charles M. had 38 (although he was not treated). Claude J. was at 20 and Louis H. 34. All who received the therapy improved, that is, their symptoms subsided and their aluminum levels dropped. It is true that Aluminum is commonly found in healthy individuals. Dr. Heuser agreed that even Willie C.'s level of 51 serum aluminum "may not be alarming," but pointed out that Willie C. was

exposed to other metals as well. The experts cited the theory that low levels of multiple metals have a synergistic effect. In other words, while the presence of one metal in an amount not toxic is not a matter of concern, low levels of more than one metal may act together to create a toxic effect.

Aluminum at toxic levels resides in the bones and “leeches” into the blood. Chelation introduces an agent to which the metal in the blood attaches and is then excreted with the urine. It is not a cure for metal toxicity but, if successful, will relieve the patient of his symptoms, hopefully for years. Succimer was appropriately chosen as the chelating agent in these cases. Dr. Wasserberger testified that DFO is used in acute dialysis patients to stop seizures. He considers succimer to be a safer, milder drug that carries less risk and milder side effects than DFO.

(D) The medical diagnoses rendered by respondent were supported by the evidence.

1) Chemical and aerosolized/vaporized gases, metals and dust and liquids addressed in the above list, exposure and inhalation with toxicity. The Levin list of likely exposures, combined with the histories given by the patients, was sufficient to conclude these patients had suffered the exposures described. As described above, the positive tests for metals, particularly aluminum, were also confirmatory. Urine tests are perfectly acceptable, although one should be careful not to compare such results directly with serum test results.

2) Recurrent Chemical toxicity and secondary bacterial sepsis. The patients were exposed on a daily basis for years, thus justifying the description, “recurrent.” The evidence also supports the diagnosis of “secondary bacterial sepsis,” in that the abnormal results for killer cells and T-helper cells indicated an inflammatory process was ongoing in these patients. Dr. Heuser defined the term as, “an infection” (as did respondent). Dr. Wasserman defined “sepsis” as, “an infection plus an inflammatory marker,” and distinguished the term as used by respondent from “septicemia,” referring to an infection in the blood, and “septic shock,” which has a 90 percent mortality rate.

3) Recurrent and chronic Chemical and secondary bacterial sinusitis as a result of #1. The patients had symptoms of sinusitis, which was confirmed by MRI. In any event, a diagnostician can make the diagnosis clinically, even if not confirmed by an imaging study.

4) Reactive Airways Disease as a result of #1. This is also a clinical diagnosis, requiring the judgment of the clinician. The diagnosis requires: a) Exposure to toxins; b) A history of difficulty breathing; c) A history of wheezing; d) Bronchoconstriction; e) An abnormal PFT; and f) A temporal relationship between the symptoms and the insult to the lungs. The PFT should be done twice, the second time after use by the patient of a bronchodilator. Should the improvement after such use be significant, then constriction of the airway is shown and RAD is diagnosed. Each patient here involved

qualified for the diagnosis. However, Dr. Wasserberger admitted that the FEV1 test is the most important of the lung mechanics' tests and was unsure when questioned about whether the FIF was unreliable. Dr. Heuser opined that the FVC, FEV1 and their ratio are the most "basic" values and that the ones relied upon by respondent in these cases are more "subtle," but disagreed that they are not reliable.

5) Hypoxemia and abnormal pulmonary function tests as a result of #1 to 4. Pulse oximetry saturation levels below 90 percent qualifies a person for Medi-Cal-funded oxygen assistance. Dr. Heuser testified that while above 90 percent is technically "normal," the level should be 98 to 100 percent saturation. Therefore, findings in these patients of around 95 percent are somewhat low. Dr. Wasserberger opined that "normal" is 96 to 99 percent. He described a reading of 94 percent as an indication of "mild hypoxemia."

6) Recurrent sinusitis as a result of #1 to 6. This diagnosis is essentially duplicative of number 3.

7) Reactive Airways Disease due to #1 to 8. This diagnosis is duplicative of number 4.

8) Chemical induced toxic encephalopathy and neuropathy. By history, physical examination and imaging studies, this diagnosis was justified as to each patient. It is not necessary for a physician to spell out in text his entire thought process as he makes a differential diagnosis. For example, if an MRI rules out a tumor as a cause of ataxia or stumbling, it is not necessary to record that precise conclusion. But as respondent continued to rule out other causes, his conclusions that the toxic exposures had caused brain and nervous system symptoms as the only possible causes were supportable. In the case of Claude J., the MRI that showed white matter abnormalities was supportive of leuko-encephalopathy. Willie C.'s MRI was likewise consistent with a toxic exposure, although it could be age-related.

9) Immunological compromise secondary to toxic injury and #1 to 8. The patients' immune systems were compromised, as evidenced by abnormal laboratory findings for killer cells and T-helper cells. These findings, coupled with histories of recurrent infections, were consistent with aluminum toxicity as a cause of the immunological compromise.

10) Multiple viral, fungal and bacterial infections secondary to #1, 2, 3, 5, 8, 9, 11, 12. Toxins impair the immune system and make the exposed individual more susceptible to infections from all of these sources. Dr. Wasserberger recalled symptoms of cough and runny nose as supportive of the viral component of the diagnosis. Dr. Heuser could not recall any evidence of viral infection and he was unsure about the source of bacterial exposure. In fact, Dr. Heuser testified, "This is not a mold case." Both doctors, however, referred to the diagnoses of sinusitis to support a finding of fungal infections. According to Dr. Wasserberger, 93 percent of sinusitis cases result in a fungal infection.

11) Chronic fatigue syndrome due to #1 to 13; chemical induced. This is a “diagnosis of exclusion.” After eliminating other causes of reported fatigue, such as anemia, low blood sugar or abnormal kidney function, respondent was justified in making this diagnosis. Dr. Heuser testified that he presented a paper on this subject, concluding that toxic exposure can cause fatigue, and it was within respondent’s clinical judgment to so conclude in these cases.

12) Fibromyalgia due to #1 to 14; chemical induced. According to Dr. Wasserman, this diagnosis was also justified based upon a process of elimination, or the exclusion of all other causes for pain. According to Dr. Heuser, this diagnosis should only be made as a matter of clinical judgment and by reference to the 18-point pressure test.

13) Heavy metal toxicity, multiplicity of metals; including Aluminum, Lead, Arsenic (inorganic), Copper. (This diagnosis was made for patient Louis H. only.) Louis H. did suffer from metal toxicity. Although his blood levels of arsenic, lead and copper were all within normal limits, his aluminum level was 34 ng/ml, and in combination with lead at 4.8 ng/ml, a “toxic soup” was created by means of a synergistic effect of the combined metals.

14) Solvent toxicity – Formic Acid and Phenol, Hexandione and Hippuric Acid. (This diagnosis was made for patient Louis H. only.) The lab results for all four of these solvents were noted by the lab to be “positive” for this patient. In combination with metal toxicity, these results may be significant for their synergistic effect as well.

54. In rebuttal, complainant called Daniel Sudakin, M.D., a board-certified medical toxicologist, who is licensed to practice in Oregon and Washington. He is an assistant professor at Oregon State University and also maintains a private clinical consulting practice specializing in occupational, environmental and pharmaceutical toxicology. He serves as an expert witness for both plaintiffs and defendants. In that capacity, Dr. Sudakin has been retained by a defense attorney who has opposed, and deposed, respondent numerous times. In fact, that attorney, William M. Slaughter, retained Dr. Sudakin to assist him in researching respondent’s credentials as an expert. Dr. Sudakin was the expert opposed to respondent in the Geffcken matter, discussed *post*.

55. Dr. Sudakin, who was provided with transcripts of the trial testimony of respondent in this matter, made the following points in rebuttal as relevant to the standard of practice:

(A) Succimer is not an FDA-approved drug as a chelating agent for Aluminum toxicity and, contrary to respondent’s claim, Ellenhorn’s Second Edition does not recommend its use. Indeed, page 1536 of Ellenhorn’s presents an “algorithm” for the treatment of aluminum toxicity, which contemplates treatment with DFO if the patient’s aluminum level is greater than 100 micrograms per liter (100 µ/l, which is the same as 10

ng/ml), or if it is less than 100 µl with symptoms. Respondent argues that he followed this algorithm since the patients who were treated with chelation therapy were symptomatic.

(B) The literature does not support the theory espoused by respondent and his experts that low levels of metals work in a synergistic fashion to create a “toxic soup.” It is very common to find low levels of many metals in the normal population, and this is especially true of aluminum. In fact, the presence of one metal may serve to negate the presence of another, i.e., be antagonistic to one another. Respondent points to an article by Bae and others, published in 2001, which documents both synergistic and antagonistic effects of mixtures of heavy metals. The antagonistic effects, in their study, did occur at higher doses of the metals. The study does not appear to have involved Aluminum, however.

56. Complainant also called Andrew Saxon, M.D. Dr. Saxon is a 1972 graduate of Harvard Medical School. He is head of the Department of Microbiology and Immunology at UCLA School of Medicine and a full professor. He reviewed the records of the four patients involved in this matter, as well as transcripts of the testimony of respondent and Drs. Wasserberger and Heuser. He offered the following in rebuttal to respondent’s case in chief:

(A) The PFT results for these patients did not support a diagnosis of RAD. The FIF readings (forced inspiratory flow, or breathing in) have nothing to do with RAD. Rather, it is a test for asthma and he disagreed with an article shown him on cross-examination that said asthma and RAD are terms being used synonymously by clinicians.<sup>15</sup> In the case of Willie C., the tests showed “air trapping,” which is a sign of emphysema, not RAD.

(B) The pulse oximetry readings for these patients did not support a diagnosis of hypoxemia. The test is “quick and easy,” and a suggestion of hypoxemia should be confirmed by blood gas testing. All readings for these patients were normal, especially for the ages of the patients.

(C) Findings of immune deficiency were “way off base.” White blood cell counts, the most reliable indication of immune deficiency, were all normal.

(D) There is no evidence of fungal infection with any of the patients. The histories do not indicate chronic sinusitis, which, in any event, is not evidence of fungal infection.

(E) Sepsis is no mere infection; it denotes an infection with systemic consequences.

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<sup>15</sup> In fact, the article’s point is that RAD is a “highly nonspecific [term that has] no clinical meaning,” is a “form of diagnostic laziness” and should not be used. (See Exhibit XXX.)

(F) The diagnosis of bacterial sinusitis is not supported by the evidence, which must include a finding of 6 mm of mucosal swelling and other criteria.

(G) The diagnosis of chronic fatigue syndrome is not supported by the evidence. This diagnosis should be used only if there is no other explanation for chronic fatigue. According to respondent, each patient had ten or more other reasons for being fatigued.

(H) Fibromyalgia was not confirmed by a pressure test.

(I) The “check-the-box” record keeping method may suffice as a screening tool, but does not provide the entire history that should have been gathered in these cases.

### *Allegations of Dishonesty*

#### The Gelderbloom Matter

57. In connection with his forensic practice, respondent provided expert witness services for many plaintiffs who claimed to have suffered personal injury due to exposure to toxic substances, including molds. One family, named Gelderbloom, lived in a townhouse in Santa Clarita and claimed in a Los Angeles Superior Court action against a homeowner’s association in 2003, that the association failed to timely repair a leaky roof, resulting in significant mold contamination and resultant personal injuries. Their lawyer referred the Gelderblooms to respondent, who examined them and recommended they move out of their home. Mr. Kevin Gelderbloom testified that, at the association’s expense, he, his wife and children lived in a hotel for four months, from September of 2001, to January of 2002, while their home was cleared of mold and repaired. Respondent later authored a letter, dated March 8, 2002, “to whom it may concern,” which recommended the Gelderblooms be evacuated from their home because of “fungal exposure.” The letter further represented that respondent’s patients were suffering from “fungal toxicity and related illness,” including “toxin induced leukoencephalopathy,” and that “[t]he family members were less symptomatic when staying at a hotel during the remediation of the water intrusion and mold problem, but the symptoms have returned and worsened when they were returned to the house.” A copy of the letter went to the family members’ personal physicians. The letter was introduced into evidence in a jury trial over which Superior Court Judge Barbara Scheper presided.<sup>16</sup>

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<sup>16</sup> Judge Scheper, who testified in this matter, is the individual who referred respondent to the MBC as a result of her concerns of possible insurance fraud. The jurist did not express an opinion in the complaint or this hearing about the validity of the charge. Her testimony was considered only as it provided authentication for the trial transcript and corroboration of selected portions of respondent’s answers given at the trial.

58. In fact, the Gelderbloom family's symptoms completely abated during their hotel stay, and never returned. Respondent admitted in a deposition in the Gelderbloom matter, and again at this hearing, that the March 8, 2002 letter was a form letter that he signed but may not have read. In the Gelderbloom trial, respondent testified he was aware the form letter was intended for persons or entities that would be asked to pay damages, including moving expenses, allegedly incurred by his patients. He testified here that the date on the letter is "a mistake," but does not know how the mistake occurred. He has also admitted that his patients were improving by March 8, 2002, contrary to the content of the letter. Respondent testified at this hearing that the form letter was used by him to help facilitate removal of a patient from the affected building, as this was what he considered the "primary treatment" for mold exposure cases. Respondent has handled many medical-legal mold cases and has used the letter "hundreds" of times.

59. On cross-examination, respondent identified two documents representing progress note chart entries for Bryan Gelderbloom, presumably one of the Gelderbloom children. Both documents are dated March 8, 2002, and establish that respondent saw at least one family member on that date. There is no discernable reference in either document to a direction by respondent that a form letter be generated.

60. Respondent's mold form letter contains a statement in its introductory paragraph that represents respondent is "a residency and fellowship trained and Primary Board Certified Medical Toxicologist." There was never any residency program offered in medical toxicology, and respondent admits that fact. He testified that he was referring to his residency in family medicine and emergency medicine, which included a rotation in medical toxicology. He agrees the language was ambiguous and no longer uses it.

### Ellenhorn's Textbook

61. The findings in paragraph 6, above, establish the background for complainant's allegations that respondent has consistently misrepresented his role in the publication of Ellenhorn's Second Edition. In a December 2, 2002 deposition in a civil matter styled Bress v. USAA Casualty Insurance Company (Bress), a Los Angeles Superior Court action, respondent, an expert witness for the plaintiff, testified he wrote "approximately the last half of" the Second Edition of Ellenhorn's. More specifically, he testified, "I believe my chapters of contribution included [page] 971 to the end," or page 1955, in response to a question about which chapters he had authored.

62. At this hearing, respondent testified he did not recall saying in a deposition that he was "the author" of the second half of the textbook. Instead, he admitted to actually writing "only a small part" of the text. He explained that the book was a compendium of "snippets" and references from many other sources on the subject of medical toxicology. He testified that after Dr. Ellenhorn passed away in February of 1996, Dr. Wasserberger, who was more directly involved with Dr. Ellenhorn in the editing process for the Second Edition, asked respondent to assist him in completing the textbook by taking the materials given him

by Mrs. Ellenhorn and finishing the second half of the book.<sup>17</sup> He did so by “cutting and pasting” the many “snippets” of information contained in the boxes of references handed over to him. He also added references, and deleted others, estimating that he “strung together” over 50 percent of the textbook’s reference material in the second half of the book. He testified he worked on the book every night for six months and that he dealt directly with the publisher, not Mrs. Ellenhorn. Respondent testified the publisher sent the work back to him twice for further editing work. Respondent did not, however, offer evidence of any correspondence or other corroboration of these exchanges with the publisher.

63. In a March 22, 2004, 402 hearing<sup>18</sup> in a civil matter entitled Geffcken v. D’Andrea, filed in the Santa Barbara Superior Court, respondent testified he was a friend of Sylvia Ellenhorn and that he had contributed fees from his work on Ellenhorn’s to her.

64. Mrs. Sylvia Ellenhorn testified credibly in this hearing that she had, indeed, typed all of the Second Edition from her husband’s handwritten text. She sent “hard copies” of her work product to the publisher and never dealt with respondent at all. She denied that respondent had any authorship role in the book. She denied receiving any fees, royalties or payments from respondent.

65. As she performed her clerical duties for the Second Edition, Mrs. Ellenhorn backed up her personal computer hard drive files onto diskettes, which she kept. She turned the 19 diskettes over to Deputy Attorney General DeCure at the time he interviewed her in January of 2006. During trial, after respondent testified his contributions were much greater than Mrs. Ellenhorn’s testimony implied, counsel directed a paralegal with the Attorney General’s office to compare the text from the diskettes to the published version of Ellenhorn’s Second Edition. Due to the press of time, and the great number of pages involved, paralegal Elaine Gyurko printed out every other chapter from the diskettes. The end product nevertheless totaled 519 pages. Ms. Gyurko presented the results of her assignment in rebuttal to respondent’s testimony. She found additions to the text typed by Mrs. Ellenhorn had been made to 12 of 519 pages. The additional text ranged from a few words to a few sentences each. She did not check for deletions of text.

66. Complainant next called computer forensics expert Erik Laykin in rebuttal. Mr. Laykin established that the 239 files on Mrs. Ellenhorn’s 19 diskettes were created or

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<sup>17</sup> Dr. Wasserberger testified similarly. He said he had assisted Dr. Ellenhorn with the First Edition. After the author died before completing the Second Edition, Dr. Wasserberger testified he completed the middle third of the book and gave materials representing the final third of the textbook to respondent to organize and re-write. He testified the work on the second half of the textbook was “done, but not organized,” and required “re-writing.”

<sup>18</sup> Under Evidence Code section 402, a hearing was held to explore certain foundational matters regarding respondent’s proposed testimony as an expert in a mold case.

last modified between April of 1995 and January 4, 1996. The last chapter in the textbook, chapter 74, was created or last modified on December 4, 1995, two months before the author's death.

67. Respondent demonstrated on surrebuttal that a significant number of passages or references did not appear in chapter 52 of the final textbook that did appear in the printout of text taken from Mrs. Ellenhorn's diskettes, thus supporting his testimony that he had edited out passages that were scientifically outdated. He testified he considers deletions as well as additions a form of "authorship."

68. In the Gelderbloom form letter of March 8, 2002, respondent wrote:

The presence of fungi should not be taken lightly. Only those knowledgeable about mycotoxicosis should be assigned to this case. Only those experienced in mold and mycotoxin decontamination and remediation should be assigned to the house. Further discussion of these toxins appears in a book I wrote: *Ellenhorn's Medical Toxicology – Diagnosis and Treatment of Human Poisoning*: Williams and Wilkins: New York.

Likewise, in the Medical Toxicology Consultation and Treatment status reports submitted by respondent in the cases of the four ALCOA workers, respondent attributed author status to himself: "[S]ee – Ordog et al: *Ellenhorn's Medical Toxicology*; Williams and Wilkins, 1997."<sup>19</sup>

69. Respondent testified at this hearing that there are 54 references to him in the Second Edition of *Ellenhorn's*. When Dr. Sudakin searched a digital copy of the book, he found but six direct references to respondent. Respondent, in a similar exercise, subsequently found 20 references, although nearly half of them were indirect, such as "Wasserberger and colleagues," or "et al." Some referred to Wasserberger only, but respondent counted them as references to himself if he collaborated on the work.

70. In his bibliography, Dr. Wasserberger lists 150 peer-reviewed research papers (published and submitted), textbooks, chapters in textbooks, letters to the editor, reviews, editorials, abstracts of published papers, and magazine and newspaper articles that he has authored or co-authored. Respondent is listed as a co-author 103 times in the bibliography. At page 17 of his curriculum vitae, the witness includes *Ellenhorn's* Second Edition among his textbook contributions. He lists himself first, as "Wasserberger, J. (clinical ed.)," and Dr. Ellenhorn second, as (Ellenhorn, M.J. (ed.)." Respondent is not mentioned.

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<sup>19</sup> See, e.g., Exhibit 7, page 007.

## Status as Director of Medical Toxicology

71. Finding 4, *ante*, supplies the background for complainant's charge that respondent has misrepresented his status as the Director of Medical Toxicology at Mayo. In deposition testimony given by respondent on December 2, 2002, in the Bress matter, respondent testified that he was the Director of Medical Toxicology at Mayo as of that time and had served in that capacity since 1982. In a deposition in a Federal District Court matter entitled Krutsinger v. Pharmacia Corporation (Krutsinger), respondent testified on November 19, 2003, that he had been the Director of Medical Toxicology at Mayo from 1982 "to date." At that deposition, he also authenticated a curriculum vitae that was headed, "Gary J. Ordog, M.D., Medical Director, Department of Toxicology and Emergency Medicine." In a matter filed in the Los Angeles Superior Court entitled Briones v. Batliner (Briones), respondent testified in a deposition on February 9, 2004, that the Department of Medical Toxicology at Mayo "was moved out of the hospital and is in my office."

72. Respondent continues to insist that he was the "functional" Director of Medical Toxicology even after the department ceased to exist within the hospital. Respondent draws a distinction between the hospital's financial support of the department and his functioning as a director, without admitting a difference between the two circumstances with respect to the question of whether a department of the hospital actually existed. Respondent also believes that because he was "on-call" for medical toxicology consultations at Mayo, he was *ipso facto* operating the department as its director.

73. Roger Seaver is the President and CEO of Mayo, having served in that capacity for the last five years. He is familiar with all operations of the hospital since 2000. Mr. Seaver's testimony established that there was no Department of Medical Toxicology at Mayo as of the 2000-2001 fiscal year. He confirmed that respondent and the hospital had entered into a contract that made respondent the Director of Medical Toxicology, for a two-year term, on August 1, 1997, and established that no renewal of that contract, nor any subsequent contract for those services, occurred at the termination of the 1997 agreement. Mr. Seaver further established that although it is not uncommon for the hospital to operate a department off-site, that is, not within the hospital building, but only where the hospital leases space and supplies furniture, equipment and staffing. The hospital has never sponsored or permitted the operation of a department within the private offices of a physician on staff.

74. In 2003 or 2004, having learned of the representations being made by respondent regarding a non-existent Department of Medical Toxicology when defense counsel in various civil matters subpoenaed documents and hospital staff members, Mr. Seaver held a meeting with respondent and Dr. Wasserberger. At the meeting, the hospital CEO clarified that it was not consistent with hospital policy or operations for respondent to claim to be operating a hospital department out of his office. Respondent argued that because he considered himself on-call "24/7" for toxicology consultations, the hospital made him the functional equivalent of a department head. Mr. Seaver informed respondent and Dr.

Wasserberger that they were not required to be on-call 24/7 and to cease making representations regarding the existence of a department and respondent's status as a director.

75. Since the Seaver meeting, respondent has been less clear in his testimonies about his status as Director of Medical Toxicology. Despite his representation about the department moving into his office made in the Briones matter, later in the same deposition he denied claim to the title. He testified instead that he ceased being the director "financially" in 2000, but "functionally, I would say just recently," in a clear reference to the Seaver meeting.

#### Status as a Professor of Medicine

76. Reference is made to Finding 5 regarding the factual background of this issue. Complainant charges that even after respondent's dismissal from Drew and UCLA as an assistant professor, he continued to hold himself out as a "professor of internal medicine" at UCLA, and even though he was never a full professor.

77. A publication called, "Legal Expert Pages," 2002 edition, included a listing for respondent in several categories, including emergency medicine, medical malpractice, medical toxicology and trauma. Each listing was essentially identical. It listed respondent as an expert in "Emergency Medicine/Trauma/Toxicology" and represented that he was Medical Director, Department of Medical Toxicology at Mayo. The description of his experience included the following: "Position: Professor of Internal Medicine, UCLA," without clarifying the status by relevant dates.

78. In the Briones matter, respondent testified on February 9, 2004, that he had been a professor of internal medicine at UCLA. He had made a similar representation in the Krutsinger matter.

79. Respondent testified that the Legal Expert Pages listing was placed by the public relations staff at Mayo, which wanted more publicity, although respondent admitted his motivation for the listing was to bolster his forensics practice. He thinks he provided a copy of his resume to the staff before 1997, which then fashioned the listing. Respondent testified he cannot recall if he paid for the listing. Respondent acknowledged in this hearing the differences in the rankings of professors and that he was never more than an assistant professor at UCLA, and further acknowledged his dismissal from UCLA in 1997. In fact, respondent appealed that dismissal. Respondent testified that he used the term "professor" in a general, generic sense, and that he should have been more precise in his description of his status with UCLA.

Respondent also testified that the faculty promotion process at UCLA was "automatic," in that he did not institute it or pursue it. He testified in the Geffcken 402 hearing that either UCLA or the County of Los Angeles prepared his CV for use in that process. Dr. Andrew Saxon, who has been a professor at UCLA since 1977, testified that the

school does not prepare such documents and that the candidate for promotion must sign off on every page of a CV.

### Representations Made in 1996 Curriculum Vitae

80. In the 2002 Bress and the 2003 Krutsinger depositions,<sup>20</sup> respondent authenticated copies of his curriculum vitae, dated April 1, 1996. He supplied the same CV to an MBC investigator in this matter, and offered it on his website. That document is 78 pages in length and includes a list of 439 articles, peer-reviewed research papers, research papers “in press,” research papers “submitted,” textbooks (including Ellenhorn’s Second Edition), textbook chapters, letters to the editor, responses to letters to the editor, reviews, editorials, abstracts of published papers, and television and radio show appearances.

81. Many articles listed in the 1996 CV are duplicated within the same document.

(A) Number 213, “Outpatient Management of 357 Gunshot Wounds to the Chest, *J. Trauma*, 23:832-35 (1983),” is the same article as number 215, except that “J. Trauma” is spelled out as “The Journal of Trauma.”

(B) Number 214, “Use of Naloxone in CPR, *Annals of Emergency Medicine*, 12; 8: 519-520, August (1983),” is the same as number 216.

(C) Number 223, “Rat Bites: 50 Cases, *Annals of Emergency Medicine*, 14: 126-30 (1985),” is the same as number 232, except that the title is listed as “Rat Bites – A Study of 50 Patients.”

(D) Number 226, “The Effect of Heparin on Arterial Blood Gases, *Annals of Emergency Medicine*, March (1985),” is the same as number 234, except that the latter listing includes the citation, “14:233-38.”

(E) Number 227, “110 Bullet Wounds to the Neck, *The Journal of Trauma*, 25: 238-246, (1985),” is the same article as number 233, except for a slight difference in the manner of page citation as “238-46.”

(F) Number 235, “Iatrogenic pulmonary overpressure accident, *Annals of Emergency Medicine*, 15(8): 947-951, August, (1986),” is the same as number 244, except for the use of capital letters in the later-listed article and manner of page citation.

(G) Number 237, “Coagulation abnormalities in traumatic shock, *Critical Care Medicine*, (1986),” is the same as 246, except for the use of capital letters in the second article, and the addition of a page number.

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<sup>20</sup> The Krutsinger deposition also included a 2002 eight-page update of respondent’s CV, which neither added to nor subtracted from the list of publications in the 1996 document.

(H) Number 241, "Dealing with sudden death of the emergency patient, Canadian Family Physician, 32:797-803, (1986)," is the same as number 245, except for the use of capital letters in the second-listed article.

(I) Number 248, "TENS-PAC versus Tylenol #3 in Acute Traumatic Pain: A Double-Blind Controlled Study. American Journal of Emergency Medicine, January 1987," is the same as number 252, "Transcutaneous electrical nerve stimulation versus oral analgesic: A randomized double-blind study in acute traumatic pain. American Journal of Emergency Medicine, 5:6-10, (1987)."

(J) Number 255, "Intravenous prochlorperazine for the rapid control of nausea and vomiting in acute myocardial infarction. American Journal of Emergency Medicine. 5:153-156, March (1987)," is the same as number 258, except the second citation is to "5(2):153-156, (1987)."

(K) Number 257, "Pediatric Gunshot Wounds. The Journal of Trauma, October (1987)," is the same as number 263, except that the latter listing indicates volume and page numbers.

(L) Number 264, "Shotgun wound ballistics. The Journal of Trauma. 28:5; 624-632, (1988)," is the same as number 270 and number 274, except that the month of May is included in listing number 270.

(M) Number 271, "Gunshot wounds in children under 10 years of age, A new epidemic. American Journal of Diseases of Children. 142:618-622, June (1988)," is the same as number 272 and number 275, except that in listing number 275 the title words are capitalized and the publication's name is abbreviated to "AJDC."

(N) Number 273, "Shotgun 'Birdshot' Wounds to the Neck Journal of Trauma 28:4 491-497. (1988)," is the same as 278, except for the non-use of capital letters and the pagination as 491-498 in the second listing.

(O) Number 267, "Phenytoin toxicity: A review of 94 cases. Veterinary and Human Toxicology. 30:4 page 348, August (1988)," is the same as 279, except that in the latter listing, the page number is 438.

(P) Number 283, "Phenytoin toxicity: A review of 94 cases. Human and Veterinary Toxicology. 31;2:164-165, April (1989)," is the same as number 298, except the name of the publication is back to "Veterinary and Human Toxicology."

(Q) Number 276, "Why endotracheal and oxygen tubing might become disconnected. Canadian Medical Association Journal. 139:372, September (1988)," is the same as number 281, except the second listing includes a day in the date (September 1).

(R) Number 285, “Violence in an [*sic*] Community Emergency Room. Archives of Emergency Medicine, 6, 226-264 (1989),” is the same as number 297, which reads, “Violence in a community emergency room. Archives of Emergency Medicine. 6:266-269, 1989.”

(S) Number 292, “Urban violence in Los Angeles in the aftermath of the riots. A perspective from health care professionals, with implications for social [*sic*] reconstruction. JAMA. December 15, 270(23):2833-2837, 1993,” is the same as 300, except the pages are listed as “2833-7.”

(T) Number 293, “Extremity gunshot wounds: Part one – Identification and treatment of patients at high risk of vascular injury. J Trauma. March:36(3):358-368, 1994,” is the same as 303, except that the month appears after the page numbers and before the year.

(U) Number 295, “Civilian gunshot wounds – Outpatient management. Journal of Trauma. 36,1:106-111, 1994,” is the same as 312 and 317, except that the month of January is specified in 312, and the page designation in 317 is “106-11.”

(V) The complete wording for entry number 448 is, “Depression and hypertension JAMA 256:13 1803-4 (1986).” In fact, on page 1802 of volume 256, no. 13 of the Journal of the American Medical Association, appears a one-paragraph question sent in by respondent and Dr. Wasserberger, which was answered by a psychiatrist and an endocrinologist.

82. Respondent testified that he did not intend any duplication of articles in his resume. He indicated that someone on staff at Drew typed the document from information he provided. However, some of the duplications persist in respondent’s 2006 CV. In the case of some of the articles compared above, respondent speculated that they may have represented editorial responses to comments on the original article. He did not explain, however, how such a response could have appeared in the same volume as the original article or why such responses would not be listed with other responses to letters to the editor. Moreover, in rebuttal testimony, Dr. Sudakin testified that he researched and found the articles in question and confirmed that they were all duplications.<sup>21</sup>

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<sup>21</sup> Dr. Sudakin also researched whether 30 articles listed as having been “submitted” to the Annals of Emergency Medicine and 24 articles submitted to the Journal of Trauma had actually been published. He found that only one of the 54 articles had been published. Although complainant added these facts in its amendment conforming the Second Amended Accusation to proof, it is found that as respondent did not represent that any of the articles in question had in fact been published, the facts, while relevant to the overall question of respondent’s credibility, do not constitute grounds for discipline.

### *Evidence of Reputation for Ability and Honesty*

83. Albert MacKenzie, M.D., a dermatologist, has known respondent since 1997, and referred many patients to him. All of those patients have been pleased with the care rendered by respondent. Dr. MacKenzie testified he considers respondent a very skilled practitioner who displays a high concern for his patients. He further testified that respondent's reputation for honesty is "unimpeachable."

84. John Scaramella, D.D.S., is an oral surgeon who offices near respondent and has worked in the Mayo emergency room with him on many occasions. Dr. Scaramella has collaborated with respondent on a few toxicology cases as well. According to Dr. Scaramella, all patients speak very highly of respondent's care. The witness testified he believes respondent to be highly skilled and intelligent, and very honest.

85. John Cocco, M.D., an internist who practices near Mayo, has known respondent for over 25 years. He testified he refers patients to respondent because he provides "outstanding care of the highest quality." The referred patients are uniformly happy with the care received. Dr. Cocco's opinion is that respondent is ethical and honest.

86. Dr. Sudakin testified during complainant's rebuttal case that respondent has a reputation among their American toxicology colleagues as being dishonest. Specifically, Dr. Sudakin and others in the field contend that respondent's opinions expressed in medical-legal matters on the subject of mold toxicity are "outrageously unsupportable."

87. Dr. Saxon testified that respondent's reputation for honesty among his toxicology colleagues ranges from "shock to revulsion."

88. Attorney William M. Slaughter testified he has spent the equivalent of 25 days in depositions and 402 hearings with respondent, who has been the opposing expert in many of the lawyer's mold tort cases. Mr. Slaughter testified that respondent's reputation for honesty and integrity is that he is "absolutely dishonest," and that he is the "bottom of the barrel" of expert witnesses he has encountered during his 24 years of practice.

### *Discussion*

89. Despite their segregation from the allegations of dishonesty in the formatting of this Proposed Decision, the many issues that are presented concerning the quality of care and the standard of practice cannot be separated from the ethical issues in any perceptive analysis of the charges against respondent. This is so because respondent's shortcomings in his care and treatment of the four former ALCOA workers were due directly to his unbridled zeal to accomplish a legal result rather than a medical result. Respondent is intelligent and competent, but every issue of import to this procedure must be framed and understood in the context of respondent's forensic practice, which had apparently become so important, successful and rewarding that respondent's medical and ethical judgments and decision-making were affected adversely.

90. Therefore, the allegations concerning the quality of care rendered by respondent, as they are pleaded separately, are discussed as discrete issues based upon the expert opinions offered in the case and common sense, but also in the context of respondent's forensic practice.

(A) Respondent did spend considerable time with each of the four patients. Histories were elicited and physical examinations were performed and documented. And while the long form format is not ideally suited to interpretation by others, respondent testified that the form was not intended for any purpose other than his own, and to provide the raw data for more reader-friendly, typewritten reports periodically generated. The problem with that explanation is that when records are copied and/or reviewed by other health care providers, the long forms are part of the package. In most cases, as demonstrated in Findings 15(F), 15(I), 17, 20, 28 and 34, confusing and contradictory findings were made in the long forms.

Unfortunately, confusion also spills over into the cumulative, typed reports. For example, in a report dated March 21, 2001,<sup>22</sup> regarding patient Willie C., respondent, or his typist, went to the trouble of listing 21 examples of "mold evidence," including "Flooding of a building with water," "Water saturated in all areas of the office," and "carpet moldy, also samples sought." The list is preceded by the notation, "negative as of 4/30/99." But that list is preceded by a 13-item list entitled simply, "Molds," which is dated 4/23/99, followed by the notation "negative as of 4/30/99." Under treatment plan, respondent made the following entry: "Disease [not named] is probably caused by an allergic reaction to the mold; does not clinically appear to be myotoxic, but we are awaiting cultures of the mold to see if it is potentially myotoxic." No evidence was presented, either in the form of chart entries or respondent's personal recollection, that a mold sample was taken from the ALCOA work site or sent out for testing. On the contrary, this statement was made in the same report that concluded the evidence as negative for molds.

Another typed, cumulative report for Willie C., dated January 9, 2001, listed heavy metal exposure for him, "by history," that included "aluminum, chromium, cadmium, titanium and cobalt."<sup>23</sup> In fact, this patient mentioned aluminum and magnesium in his first visit with respondent, and subsequent laboratory tests were negative for cadmium and chromium.

Such examples are legion within the records of these four patients. The conclusion is inescapable that respondent's record keeping practice was designed to facilitate his medical-legal work, and for ease in including all statements, findings, and medical conclusions that would support a tort claim for mold and/or metal toxicity.

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<sup>22</sup> See Exhibit 17, page 170.

<sup>23</sup> See Exhibit 17, page 139.

(B) The above finding does not require the additional conclusion that the four patients were not suffering from heavy metal toxicity. There is considerable evidence that they were. All provided histories of exposure to aluminum dust and all showed the presence of aluminum in their blood and urine. Three of the patients were treated with chelation therapy and their aluminum levels went down. More significantly, by chart history and the personal testimony of two of the patients, their symptoms abated following the treatments. It is difficult to argue the lack of a cause and effect relationship between the therapy and the patients' improvement, particularly in the case of Willie C., who had suffered the symptoms for years before seeing respondent.

Respondent's reliance on the Levin report is somewhat troubling, however. As a general source of information, it was helpful, certainly. But it was also non-specific: it applied to a different worker, it did not establish that even that worker had been exposed to any particular contaminant, and the source of the information on which Levin based his report was not his own investigation but was a package of unidentified records provided Levin by the workers' compensation attorney. Respondent made no effort discernible from the records or his own testimony to establish the real source of the information that formed the basis of the Levin report, a copy of which was placed in each patient's file and treated as if it were factual.

(C) Nevertheless, it was not established by clear and convincing evidence that respondent's diagnosis of chemical exposure and inhalation, with toxicity, was not medically indicated. Nor was it established that chelation therapy with succimer was improper. The evidence on the subject of the threshold for aluminum toxicity (whether 10 ng/ml or 42 ng/ml or 100 ng/ml) supplied support for either position and appears to represent a legitimate, professional disagreement among the experts. Likewise, the successful use of succimer was not shown to expose the patients to definably greater risks than DFO would have.

Likewise, it was not established by clear and convincing evidence that the two additional diagnoses for Louis H. were unsupported by the medical evidence. Heavy metal toxicity was a legitimate finding, as indicated above. And the diagnosis of solvent toxicity in Louis H. was appropriate, as his laboratory test results were positive for the four solvents to which this diagnosis related.

(D) The remaining diagnoses rendered by respondent, however, are suspect.

1) While it was established that the patients all suffered from "recurrent chemical toxicity," the additional diagnosis of "secondary bacterial sepsis" was not medically supported. No bacterial source for a systemic infectious process was identified by respondent for any one patient. Moreover, had respondent merely meant to refer to an "infection" when using the word "sepsis," he could, and should have done so. "Sepsis" is a medical term of art that is to be distinguished from the word "infection," and implies a much more serious condition than, by respondent's own testimony, was suffered by any of these four patients.

2) There is evidence of “sinus problems” with each patient, by history taken from the patient. All four patients told respondent of histories of “nasal congestion.” Willie C. and Charles M. had imaging studies (MRI) positive for “mild mucosal thickening.” But even if it could be said that such findings support a diagnosis of chronic sinusitis, neither Claude J. nor Louis H. had such confirmatory test results but received the same diagnosis. Furthermore, there was no analysis done by respondent to tie these vague, common symptoms and findings to chemical exposures.

3) The diagnosis of RAD for all four patients was not sufficiently supported by the evidence, as the values for the most reliable, commonly relied-upon tests were all normal. It is indisputable that each patient showed some improvement in FEF and FIF following the use of a bronchodilator, but that is to be expected. And Dr. Saxon was convincing in his testimony to the effect that FIF, in particular, was not diagnostic of RAD.

4) The conclusion that each patient suffered from hypoxemia was not medically justified. The vast majority of pulse oximeter readings were all in the 96 to 98 percent range. Charles M., for example, did not have a test below 96 percent and Louis H. had only one below 97 percent. Even those at the 95 or 96 percent range were likely normal for the involved patient at the time of the tests. Respondent’s own experts conceded normal range to be 96 percent and above, and that a reading as low as 94 percent was evidence of mere “mild hypoxemia.”

5) Respondent diagnosed disease of the brain (encephalopathy) and disease of the central nervous system (neuropathy) for each patient. Willie C. reported problems with balance and “stumbling,” but his MRI was normal, as were the MRI studies for Charles M. and Louis H. The MRI for Claude J., while abnormal, was consistent with age-related degenerative changes. The histories and particularly the imaging study findings, which are a necessary component of the diagnosis according to Dr. Ferguson, were insufficient to support the sweeping diagnoses of brain disease due to toxic exposure. Chemical induced neuropathy was not supported by any tests designed to confirm such a diagnosis (EMG or nerve conduction) and was not medically justified.

6) The patients did not provide significant or sufficient histories of recurrent infections to justify a diagnosis of “immunological compromise,” despite the mention of nasal congestion by each of them. In at least one case, respondent included a history of “recurrent infections” in his final status report that was not supported by the earlier, working documents. White blood cell counts, the most significant indicator of infection, were normal in all patients.

7) The evidence of actual exposure to bacterial, viral and fungal sources of infection or disease was scant or non-existent. Respondent and his experts referred several times to evidence of water intrusion at the ALCOA plant, and to evidence of pesticide and/or herbicide use in or around the plant, but the actual evidence, or even clear reference to it, was not found in the record. Respondent’s experts were less than confident

about the sources of this information. Their insistence that the supposed sinusitis in all patients was evidence of a finding of fungal infections was weak support for this diagnosis.

8) The experts agree that chronic fatigue syndrome is a “diagnosis of exclusion,” in that it should not be rendered unless all causes of a patient’s complaints of fatigue are ruled out. As pointed out by Dr. Saxon, respondent purported to document multiple other causes for fatigue. Moreover, while Willie C. and Charles M. did complain of fatigue when communicating their symptoms to respondent, neither Claude J. nor Louis H. did.

9) Fibromyalgia, a diagnosis for a patient suffering diffuse pain without any apparent explanation, should be confirmed only upon the use of the 18-point pressure test, according to both complainant’s experts and Dr. Heuser. Respondent did not document the type of diffuse, unexplained pain contemplated by the diagnosis with respect to any of the patients. He recorded no indication that he had performed the pressure test. Given respondent’s claim to meticulous detail and the sheer volume of the record, it must be concluded that the tests were not performed.

91. It was not mere coincidence that the identical 12 diagnoses were rendered by respondent for these four patients, and the coincidence is not adequately explained by the fact that all four patients worked for ALCOA. Each patient deserved respondent’s individual evaluation and honest conclusions regarding their exposures and the effects the exposures did or did not continue to have on them at the time of his examinations. However, it is clear that respondent utilized this “shotgun” approach to diagnosis, through form reporting methods, in order to minimize his own time involved in the process of diagnosis and reporting, and to maximize the patient’s ability to recover benefits. In the end, however, respondent’s approach runs contrary to the professional and ethical requirement that he maintain accurate records. No argument may be fashioned that the inclusion of unsupported diagnoses in a patient’s records will not cause harm to that patient at a later time if the information is mistakenly relied upon by other health care providers, insurance companies or legal professionals. That respondent benefits financially, through the minimization of time and the currying of favor with attorneys who refer business to him, serves only to provide context and rationale for the practice.

92. The use of form recording and reporting methods by respondent was seen again in the Gelderbloom matter. Respondent testified that the letter of March 8, 2002, was a form, which he likely did not read before signing, that was used hundreds of times for the purpose of facilitating the removal of a patient from a building housing mold infestation. Respondent’s reporting in that letter that the Gelderblooms’ symptoms had returned upon re-introduction to the house was simply false. Respondent explained the inaccuracy by claiming the date on the letter was a mistake. But complainant produced records proving at least one of the family members was seen by respondent on the very same date the letter was apparently “written,” March 8, 2002.

Mr. Gelderbloom's testimony at this hearing established that he and his family members all suffered symptoms, some rather severe, from fungal toxicity. Like the four ALCOA workers, it is neither alleged nor found that respondent conjured symptoms or illnesses that did not exist, or was part of a conspiracy to do so. But the Gelderbloom example is further evidence of a careless and cavalier willingness to supply his patients' attorneys with medical opinions and the wherewithal to accomplish the goal of plaintiffs' litigation: remuneration for toxic tort injuries.

93. "Careless" and "cavalier" are also apt descriptions for respondent's various representations made in depositions and elsewhere regarding his role in the publication of Ellenhorn's, his status as Director of Medical Toxicology and his status as a professor at UCLA.

94. Complainant established by clear and convincing evidence that respondent was not an "author" of Ellenhorn's Second Edition. The computer forensics expert established that Mrs. Ellenhorn was accurate when she testified that she typed the entire textbook on her personal computer, prior to her husband's death. The testimonies of Drs. Wasserberger and Ordog, to the effect that, upon the author's death, the book was unfinished and that the second half of the book was nothing more than a mess of notes and references in poorly organized boxes, were not credible. It is not doubted that respondent played a role in editing chapters 52 to 74; he and Ms. Gyurko demonstrated a sufficient number of additions and deletions to qualify respondent as having performed an editing function regarding those sections. But it is not merely a semantics game to distinguish between that role and one of authorship. Dictionaries define "author" as "one who originates or creates,"<sup>24</sup> and "the original writer of a literary work."<sup>25</sup> Respondent was neither the originator, creator nor writer of Ellenhorn's when he testified, under oath in depositions, that he was "the author" of Ellenhorn's, or when he testified he wrote "approximately the last half" of the textbook. Likewise, it was false and misleading to state in the Gelderbloom letter: "Further discussion of these toxins appears in a book I wrote: Ellenhorn's Medical Toxicology – Diagnosis and Treatment of Human Poisoning."

95. Respondent's attempt to create a distinction between a "financial" existence and a "functional" existence of a Department of Medical Toxicology at Mayo is disingenuous. Respondent is a bright and intellectually sophisticated individual who has maintained professional associations with hospitals for over 25 years. Respondent's testimony was not credible when he said that, in 1999 or 2000, after his contract to act as Director of Medical Toxicology expired and the hospital ceased funding for the department, he believed the hospital recognized the continued existence of the department, or that it was proper to continue to hold himself out as its director. That respondent and Dr. Wasserberger made themselves available for "on-call" duty (which was also another source of toxicology

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<sup>24</sup> Miriam-Webster Online Dictionary.

<sup>25</sup> The American Heritage Dictionary of the English Language, American Heritage Publishing Co., 1969.

referral business for them) did not provide a sensible basis for the belief either. Statements made by respondent, under oath and elsewhere, in 2002, 2003 and 2004, to the effect that he was then the Director of Medical Toxicology at Mayo, were false.

96. In terms of respondent's understanding and sophistication level, his several years of professional teaching experience with Drew and UCLA do not equate to his 25 years of professional association with hospitals, however. While careless, respondent's representations in his CV and in deposition that he was a "professor," without employing the modifier "assistant," was not shown by clear and convincing evidence to have been dishonest acts. His continued use of the title after his dismissals from the institutions in 1996 and 1997 in the 2002 publication "Legal Expert Pages," however, is a different matter. Respondent may not escape responsibility for the advertisements by blaming staff at Mayo for the content of the ads. As such, respondent violated Business and Professions Code section 651, subdivisions (a), (b) and (e), by inclusion in the directory of false and misleading statements.

97. The 21 duplications or triplications of listed articles found in respondent's 1996 CV represent additional evidence of carelessness that is troubling. On the one hand, one cannot conceive that respondent, who in fact authored or co-authored several hundred articles that were legitimately listed in his CV, would intentionally "pad" such a CV with a mere two dozen additional listings.<sup>26</sup> On the other hand, as part of a pattern of exaggeration and carelessness that included his use of the titles "professor" and "Director of Medical Toxicology," his claims of authorship to Ellenhorn's, his use of form letters that, at least in the Gelderbloom matter, conveyed false and misleading information, and his willingness to attribute multiple serious, but identical and largely inappropriate diagnoses to four separate patients, combine to support the theory that respondent was at least indifferent to the consequences of his exaggerations and carelessness. One suspects that this indifference is the core reason for the abysmal reputation for honesty that respondent suffers in the medical-legal community. There is, no doubt, an element of professional rivalry and bias among those who testified against respondent concerning his reputation for dishonesty. Scientists, including Drs. Sudakin and Saxon, have assured the attorneys and insurers who retained them that respondent's testimonies in various tort mold cases are false. Those insurers and attorneys uncovered inconsistencies and inaccuracies in respondent's CV, which, despite repeated opportunities, respondent declined to correct. While it is far beyond the scope of this case to determine whether respondent or his adversaries are correct in their respective positions regarding the medical and hence, legal effects of building molds, the opposing experts' and defense counsel's perceptions that respondent has been willing to say or write whatever was necessary to support plaintiffs' claims in order to advance his own professional standing with plaintiffs' lawyers, are understandable and not without some merit.

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<sup>26</sup> It is curious, however, that many of the duplicated entries vary from one another just enough to appear different at casual glance.

### *Summary of Findings*

98. As to the charges against respondent concerning the care and treatment rendered all four patients, and each of them, the following findings are made based upon clear and convincing evidence:

(A) Respondent committed acts constituting simple departures from the standard of care by failing to employ a systematic approach to evaluating the possible exposures to occupational/environmental toxins. Over-reliance on the Levin report is the primary factor underlying this conclusion. While such reports may be commonly relied upon, in these cases respondent knew that even Mr. Levin had not surveyed the site or researched its industrial history. Rather, he relied entirely upon data, the source of which was unknown, supplied by the claimants' attorney.

(B) Charges that respondent failed to exclude common causes for the patients' complaints, failed to obtain sufficient histories from them and failed to document those histories are not sustained by clear and convincing evidence.

(C) Charges that respondent diagnosed heavy metal-related illnesses without making supporting factual findings, and/or failing to document said findings are not sustained by clear and convincing evidence.

(D) Taken together, respondent's diagnoses of toxic encephalopathy and neuropathy, bacterial sepsis, multiple viral, fungal and bacterial infections, chronic fatigue syndrome and fibromyalgia were not medically indicated and represented extreme departures from the standard of practice and gross negligence. The departures are deemed extreme departures due to the lack of any colorable, documented indications for their rendering.

(E) Respondent's diagnoses of bacterial sinusitis, reactive airways disease, hypoxemia, and immunological compromise secondary to toxic injury were not medically indicated and constituted simple departures from the standard of practice.

(F) Charges that respondent over-utilized laboratory and imaging tests, failed to review or correctly interpret laboratory test results in an appropriate manner, failed to abstain from treating a patient when not indicated, and engaged in excessive treatment, were not sustained by clear and convincing evidence.

(G) Charges that prescribing chelation therapy and instituting treatment with succimer were not medically indicated and fell below the standard of practice were not sustained by clear and convincing evidence.

(H) Charges that respondent failed to assess the pulmonary mass and tuberculosis history of patient Louis H. were not sustained by clear and convincing evidence.

(I) Charges that respondent demonstrated incompetence were not sustained by clear and convincing evidence.

(J) Respondent's failure to maintain adequate and accurate records for these patients constituted simple departures from the standard of practice. The rationale for this conclusion lies principally with the confusing nature of the long form, and the many inconsistent entries made in them and in cumulative reports derived therefrom.

99. As to the allegations of dishonest or corrupt acts made against respondent, the following findings are made based on clear and convincing evidence:

(A) Respondent committed a dishonest or corrupt act in connection with the March 8, 2002 letter he provided in the Gelderbloom matter. Taken alone, the letter might be dismissed as merely careless. But in the context of respondent's other transgressions, all committed in furtherance of his medical-legal practice, the form letter cannot be dismissed as a mere oversight. Moreover, the letter contains misrepresentations that had significance to his patients' health management and represented a corruption of the legal system.

(B) The evidence does not sustain the charge that respondent committed a dishonest or corrupt act when, in the Gelderbloom letter, he claimed to be "a residency and fellowship trained and Primary Board Certified Medical Toxicologist." The phrase is ambiguous. In light of respondent's testimony that his training included rotations in toxicology, the representation may be read as accurate.

(C) By clear and convincing evidence, respondent was guilty of dishonesty on multiple occasions regarding his claim of authorship of Ellenhorn's.

(D) By clear and convincing evidence, respondent was guilty of dishonesty on multiple occasions regarding his status as Mayo's Director of Medical Toxicology.

(E) The charge that respondent committed dishonest or corrupt acts in connection with his representations that he was a "professor" at UCLA was not sustained by clear and convincing evidence. However, in connection with the advertisements in "Legal Expert Pages," respondent was shown to have made false and misleading statements in the 2002 directory regarding his then-current status as a professor in violation of Business and Professions Code section 651, subdivisions (a), (b) and (e).

(F) The charge that respondent committed dishonest or corrupt acts in connection with the many duplicate listings of articles in his 1996 CV is not sustained by clear and convincing evidence. As set forth in Finding 97, while the carelessness exhibited by respondent's use of the inaccurate document is relevant to the analysis of the whole case, it is concluded that these few incorrect entries were unlikely to have been intentionally included to mislead any recipient of the document.

(G) The acts constituting dishonesty and unprofessional conduct set forth in Findings 99(A), (C), (D) and (E) were substantially related to the qualifications, functions and duties of a physician and surgeon.

### LEGAL CONCLUSIONS

1. The purpose of an administrative disciplinary proceeding is not to punish, but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable or incompetent. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

2. The standard of proof in an administrative action seeking the suspension or revocation of a physician's and surgeon's certificate is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

3. The key element of "clear convincing evidence" is that it must establish a high probability of the existence of the disputed facts, greater than proof by a preponderance of the evidence. Evidence of a charge is clear and convincing as long as there is a high probability that the charge is true. (*People v. Mabini* (2001) 92 Cal.App.4th 654, 662.)

4. "Clear and convincing evidence" requires a high probability. It must be so clear as to leave no substantial doubt and to command the unhesitating assent of every reasonable mind. (See, *Mathieu v. Norrell Corp.* (2004) 115 Cal.App.4th 1174, 1190.)

5. It is not necessary to show patient harm to impose license discipline. With regard to a claim that discipline may be imposed only when patient harm is established, the appellate court stated in *Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757 at 772:

We reject this argument because it overlooks the preventative functions of license discipline, whose main purpose is protection of the public [Citations], but whose purposes also include prevention of future harm [Citation] and the improvement and rehabilitation of the physician [Citation]. To prohibit license discipline until the physician-licensee harms a patient disregards these purposes; it is far more desirable to discipline *before* a licensee harms any patient than after harm has occurred.

6. Business and Professions Code section 2234 provides in part:

The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

[¶]...[¶]

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions or duties of a physician and surgeon.

7. Business and Professions Code section 2266 provides: “The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.”

8. Physicians must exercise that degree of skill, knowledge and care ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care is a matter peculiarly within the knowledge of experts; it presents the basic issue and can only be proved by their testimony, unless the conduct required by the particular circumstances is within the common knowledge of the layman. (*Williamson v. Prida* (1999) 75 Cal.App.4th 1417, 1424.)

9. Expert opinion testimony is required to prove or disprove that the physician performed in accordance with the prevailing standard of care. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 1001.)

10. “Negligence” is conduct falling below the standard of care. The standard of care varies in different situations, but the standard of conduct remains constant, i.e., due care commensurate with the risk posed taking into consideration all relevant circumstances. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997.)

11. “Gross negligence” is “the want of even scant care or an extreme departure from the ordinary standard of conduct.” (*Eastburn v. Regional Fire Protection Authority* (2003) 31 Cal.App.4th 1175, 1185-1186.)

12. “Incompetence” is distinguished from simple negligence in that one may be competent or capable of performing a given duty, but negligent in performing it. A single negligent act is not equivalent to incompetence. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1054-1055.)

13. “Repeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon.” (Business and Professions Code section 725.)

14. Business and Professions Code section 651 reads, in pertinent part:

(a) It is unlawful for any person licensed under this division ... to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. A “public communication” as used in this section includes, but is not limited to, communication by means of mail, television, radio, motion picture, newspaper, book, list or directory of healing arts practitioners, Internet, or other electronic communication.

(b) A false, fraudulent, misleading, or deceptive statement, claim, or image includes a statement or claim that does any of the following:

(1) Contains a misrepresentation of fact.

(2) Is likely to mislead or deceive because of a failure to disclose material facts.

[¶]...[¶]

(5) Contains other representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived.

[¶]...[¶]

(e) Any person so licensed may not use any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a statement or claim that is false, fraudulent, misleading, or deceptive within the meaning of subdivision (b).

15. “Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine . . . which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.” (Business and Professions Code section 2261.)

16. “The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.” (Business and Professions Code section 2266.)

17. With respect to the allegations contained in the First, Third, Fifth and Seventh Causes for Discipline, cause exists to discipline respondent’s certificate pursuant to Business and Professions Code section 2234, subdivision (b), in that respondent committed acts constituting gross negligence and extreme departures from the standard of care with regard to the diagnoses listed in Finding 98(D), based on Findings 8 to 49, 50(D), 53(D)(10) and (12), 56, 89, 90(D) and 91.

18. With respect to the allegations contained in the Second, Fourth, Sixth, Eighth and Tenth Causes for Discipline, cause does not exist to discipline respondent’s certificate pursuant to Business and Professions Code section 2234, subdivision (d), in that it was not shown by clear and convincing evidence that respondent was incompetent, based on Factual Findings 2 to 5, 8 to 46, 51 to 53, 89, 90 and 98(I).

19. With respect to the allegations contained in the Ninth Cause for Discipline, cause exists to discipline respondent’s certificate pursuant to Business and Professions Code section, subdivision (c), in that respondent committed repeated acts of negligence, based on Factual Findings 8 to 49, 50(A), 50(D)(3), (4), (5) and (9), 56, 89, 90 and 98(E).

20. With respect to the allegations contained in the Eleventh Cause for Discipline, cause exists to discipline respondent’s certificate pursuant to Business and Professions Code section 2266, in that respondent failed to keep adequate and accurate records relating to the provision of services to his patients, based on Factual Findings 8 to 10, 15, 17, 20, 23, 25, 28, 32, 34, 39, 41, 42, 46, 49, 50, 56, 90 and 98(J).

21. With respect to the allegations contained in the Twelfth Cause for Discipline, cause does not exist to discipline respondent’s certificate pursuant to Business and Professions Code section 725, in that it was not shown by clear and convincing evidence that respondent engaged in repeated acts of clearly excessive prescribing or administering of drugs or treatment, or diagnostic procedures or facilities, based on Factual Findings 2 to 5, 8 to 46, 51 to 53, 90 and 98(F).

22. With respect to the allegations contained in the Thirteenth Cause for Discipline, cause exists to discipline respondent’s certificate pursuant to Business and Professions Code sections 2234, subdivision (e), 651 and 2261, in that respondent committed acts of dishonesty or corruption substantially related to the qualifications, functions and

duties of a licensed physician and surgeon, based on Factual Findings 3 to 7, 55, 57 to 82, 86 to 89, 91 to 97 and 99.

23. Complainant urges the revocation of respondent's certificate to practice medicine in light of the evidence of dishonesty. The cases provide authority for that action. A physician can be subject to disciplinary action notwithstanding his technical competence or skill under circumstances where his moral character is in dispute. (*Weissburg v. Board of Medical Examiners* (1974) 41 Cal.App.3d 924.) Intentional dishonesty demonstrates a lack of moral character and satisfies a finding of unfitness to practice medicine. (*Matanky v. Board of Medical Examiners* (1978) 79 Cal.App.3d 293.) It is "difficult to compartmentalize dishonesty" so as to divorce it from the "obligation of utmost honesty and integrity to the patients whom the physician counsels, as well as numerous third party entities and payors who act on behalf of patients." (*Windham v. Board of Medical Quality Assurance* (1980) 104 Cal.App.3d 461, 470.)

Many of the appellate cases supporting the revocation of a physician's license for dishonesty involve the submitting of false claims to insurers or governmental program administrators, to the direct financial benefit of the doctor. (See, e.g., *Matanky, ante.*) No evidence was presented in this matter that proved respondent falsified any records, or scientific or medical evidence in order to secure benefits for himself or his patients. However, the exaggerations, misrepresentations concerning his credentials and form reports that contained unsupported diagnoses were disseminated by respondent for the primary purpose of cementing his reputation among plaintiffs' lawyers in the field of toxic tort litigation as someone who will provide needed expert support for their claims. Given the hundreds of litigation matters that have attracted respondent's services and his exorbitant fees, the motivation for the pattern seen here is transparent.

No demonstrable physical harm came to any patient treated by respondent in connection with the facts presented in this matter, although it is likely that financial harm to various parties did result. This factor, coupled with the finding that his transgressions did not result from incompetence, lead to the terms of the within Order that does not provide for outright revocation. It does, nevertheless, represent a strong reaction, deemed necessary for the protection of the public, which has as its principal feature a prohibition on conducting a medical-legal practice during the period of probation ordered.

#### ORDER

Certificate No. G 43038 issued to respondent Gary Ordog, M.D., is revoked pursuant to Legal Conclusions 17, 19, 20 and 22. However, revocation is stayed and respondent is placed on probation for seven (7) years upon the following terms and conditions:

1. As part of probation, respondent is suspended from the practice of medicine for a period of ninety (90) days beginning the sixteenth (16th) day after the effective date of this Decision.

2. Within 60 days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping at the Physician Assessment and Clinical Education Program, University of California, San Diego (PACE), or similar program approved in advance by the Division or its designee. Failure to successfully complete the course during the first six months of probation is a violation of probation. Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after successfully completing the course.

3. Within 60 days of the effective date of this Decision, respondent shall enroll in a course in ethics, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation. Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. Respondent shall be prohibited from engaging in a medical-legal or forensics practice of medicine during the period of probation. Respondent shall immediately notify all attorneys and patients referred to him by attorneys, where the primary purpose of the referral was litigation support, that is, where respondent's retention for medical services was as an expert witness or consultant and/or medical records reviewer, of this prohibition and arrange for the return of any materials and/or unearned fees to the referring attorney or other source of the materials and/or fees. Respondent shall not accept any new assignments or referrals as an expert witness, consultant or reviewer during the period of probation. This term of probation shall not prohibit respondent from complying with subpoenas lawfully issued and served on him that compel him to provide records or deposition testimony in respondent's capacity as a treating physician. In such cases, respondent's testimony shall be limited to that of a percipient, treating physician, and respondent shall not charge a fee greater than is usual and customary for such services.

Respondent shall maintain a log of all patients to whom the notification required by this term was made. The log shall contain the : 1) Patient's name, address and phone number; patient's medical record number, if available; 2) The full name of the person making the notification; 3) The date the notification was made; and 4) A description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, and shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Division or its designee, and shall retain the log for the entire term of probation. Failure to maintain a log as defined, or to make the log available for immediate inspection and copying on the premises during business hours is a violation of probation.

Whenever, after the effective date of this Decision, a patient, attorney or other party seeks the prohibited services presents to respondent, he shall provide a written notification to the party requesting his services that he does not accept medical-legal assignments. Respondent shall maintain a copy of the notification and make it available for inspection and copying on the premises at all times during business hours by the Division or

its designee, and shall retain the notification for the entire term of probation. Failure to maintain the written notification or to make it available for inspection or copying shall be a violation of probation.

5. Respondent shall provide a true copy of the Decision and Second Amended Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days of the effective date of this Decision. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California.

7. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of his business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b). Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

9. Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

10. In the event respondent should leave the State of California to reside or to practice he shall notify the Division or its designee in writing 30 days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which as been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A board-ordered suspension of practice shall not

be considered a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside of California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and conditions 4, 6 and 10.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

11. In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

12. Upon successful completion of probation respondent's certificate shall be fully restored.

13. The failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition or Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

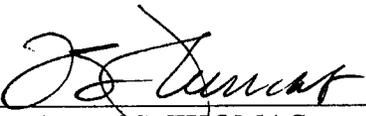
14. Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of his license. The Division

reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificates to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action.

If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

15. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

DATED: April 11, 2006

  
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TIMOTHY S. THOMAS  
Administrative Law Judge  
Office of Administrative Hearings