Effective 10/27/99

ORIGINAL
MAKE YOUR RETURN ON THIS WRIT AND FORWARD TO DEPT OF CIVIL PROCESS AT INDEPENDENCE

IN THE CIRCUIT COURT OF JACKSON COUNTY, MISSOURI
AT INDEPENDENCE

LAWRENCE E. DORMAN, D.O.
9120 E. 35TH Street
Independence, MO 64052

Petitioner

v.

STATE BOARD OF REGISTRATION
FOR THE HEALING ARTS
3605 Missouri Boulevard
P.O. Box 4
Jefferson City, MO 65109

Respondent

Case No. 99CV223364

STAY OF EXECUTION OF ORDER

Execution of the Disciplinary Order of the State Board of Registration for the Healing Arts, State of Missouri, ordered on October 27, 1999, against Petitioner Lawrence E. Dorman, D.O., is hereby stayed until November 18, 1999, At 1:30pm on Nov. 18, 1999 this court shall hold a hearing with the interested parties to determine if any terms or limitations should attach to said stay until the court reviews and renders its decision of judicial review on this order and the underlying Memorandum and Order of the Administrative Hearing Commission of the State of Missouri issued in case number 96-002599HA on June 29, 1999.

C. William Frazier
Judge

COPY - ATTES
CIRCUIT COURT OF JACKSON COUN
COURT ADMINISTRATOR'S OFFI
DEPARTMENT OF CIVIL RECOR
A Hoffman

IN THE CIRCUIT COURT OF JACKSON COUNTY, MISSOURI
AT INDEPENDENCE

LAWRENCE D. DORMAN, D.O.,	)	
	)	
Petitioner,	)	Case No. 99CV223364
	)	Division 17
vs.	)	
	)	
STATE BOARD OF REGISTRATION,	)	
	)	
Respondent.	)	

ORDER

On this date the Court takes up the **Plaintiff's Petition for Review** filed the 27th day of October, 1999. After consideration of said Petition and opposition thereto,

The Court finds that the findings and orders of the Administrative Hearing Commission are supported by competent and substantial evidence; that the findings and orders of the Administrative Hearing Commission are not arbitrary, capricious or unreasonable; and that the Administrative Hearing Commission did not abuse its discretion in making its respective findings and orders in Dr. Dorman's case.

The Court will enter judgment to this effect within fourteen (14) days from the date of this order unless otherwise prohibited from doing so by the Appellate Court.

6/29/2000
Date

C. William Kramer
C. WILLIAM KRAMER, JUDGE

cc:
Glenn Allen Hall
312 Midland Bank Building
740 N.W. Blue Parkway, Suite 312
Lee's Summit, Missouri 64086

Glenn E. Bradford
1150 Grand, Suite 230
Kansas City, Missouri 64106

IN THE CIRCUIT COURT OF JACKSON COUNTY, MISSOURI
at INDEPENDENCE

LAWRENCE D. DORMAN, D.O.	)	
	)	
	)	
Plaintiff ,	)	
	)	
vs.	)	99CV223364
	)	
STATE BOARD OF REGISTRATION	)	
Defendant.	)	

ORDER

IT IS HEREBY ORDERED that the stay order entered January 21, 2000, is continued in effect until July 28, 2000, at which time it shall be reviewed by the Court to determine whether a further extension is appropriate.

6/23/2000
Date

C. William Kramer
C. WILLIAM KRAMER, JUDGE

cc:
Glenn Allen Hall
Edward F. Walsh

cc:
Glenn Allen Hall
312 Midland Bank Building
740 N.W. Blue Parkway, Suite 312
Lee's Summit, Missouri 64086

Glenn E. Bradford
1150 Grand, Suite 230
Kansas City, Missouri 64106

IN THE CIRCUIT COURT OF JACKSON COUNTY, MISSOURI
at INDEPENDENCE

LAWRENCE D. DORMAN, D.O.	)	
	)	
	)	
Plaintiff ,	)	
	)	
vs.	)	99CV223364
	)	
STATE BOARD OF REGISTRATION	)	
Defendant.	)	

ORDER

IT IS HEREBY ORDERED that the stay order entered January 21, 2000, is continued in effect until June 23, 2000, at which time it shall be reviewed by the Court to determine whether a further extension is appropriate.

4/20/2000
Date

C. William Kramer
C. WILLIAM KRAMER, JUDGE

Glenn Allen Hall
Edward F. Walsh

IN THE CIRCUIT COURT OF JACKSON COUNTY, MISSOURI
at INDEPENDENCE

LAWRENCE D. DORMAN, D.O.)
)
Plaintiff,)
)
vs.) 99CV223364
)
STATE BOARD OF REGISTRATION)
Defendant.)

ORDER

IT IS HEREBY ORDERED that the stay order entered on the 27th day of October, 1999, is continued in effect until April 21, 2000, at which time it shall be reviewed by the Court to determine whether a further extension is appropriate.

1/21/2000
Date

C. William Kramer
C. WILLIAM KRAMER, JUDGE

Glenn Allen Hall
Edward F. Walsh

MISSOURI
DEPARTMENT OF ECONOMIC DEVELOPMENT

Bob Holden
Governor

Division of Professional Registration
Marilyn Taylor Williams, Director

Joseph L. Driskill
Director

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 Missouri Boulevard
P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
573-751-3166 FAX
800-735-2966 TDD
Website: http://www.ecodev.state.mo.us/pr/healarts

Tina Steinman
Executive Director

January 25, 2002

Re: Lawrence E. Dorman, D.O.
Missouri License DO32325

To Whom It May Concern:

Based upon the Missouri Court of Appeals denial of Motion for Hearing and Motion for Transfer, Stay of Board's disciplinary order of October 27, 1999, is dissolved.

License is Revoked with no application for reinstatement for a period of two (2) years and one (1) day.

Effective January 24, 2002.

Mandate

Missouri Court of Appeals

Western District

JANUARY SESSION, 2002

LAWRENCE E. DORMAN, D.O., APPELLANT,	)	
vs. (JACKSON)	)	WD 58840
	)	CIR. CT. 99-CV-223364
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS, RESPONDENT.	)	

Now on this day the judgment of the circuit court affirming the decisions of the Administrative Hearing Commission and the State Board of Registration for the Healing Arts is affirmed. The Respondent shall recover against the Appellant the costs and charges herein expended, and shall have execution therefor.

Opinion filed.

STATE OF MISSOURI – Sct.

I, TERENCE G. LORD, Clerk of the Missouri Court of Appeals, Western District, certify that the foregoing is a full, true and complete transcript of the judgment of the Missouri Court of Appeals, Western District, entered of record at the January Session thereof, 2002, and on the 9th day of October, 2001, in the above entitled cause.

Given under my hand and the seal of the Court, at Kansas City, Missouri, this 24th day of January, 2002.

Terence G. Lord

TERENCE G. LORD, CLERK

cc: Circuit Court Clerk
Attorneys of Record

FAXED

Effective 10/27/99

IN THE CIRCUIT COURT OF JACKSON COUNTY, MISSOURI
AT INDEPENDENCE

LAWRENCE E. DORMAN, D.O. 9120 E. 35TH Street Independence, MO 64052 Petitioner	)	
v.	)	Case No. 99CV223364
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS 3605 Missouri Boulevard P.O. Box 4 Jefferson City, MO 65109 Respondent	)	

STAY OF EXECUTION OF ORDER

Execution of the Disciplinary Order of the State Board of Registration for the Healing Arts, State of Missouri, ordered on October 27, 1999, against Petitioner Lawrence E. Dorman, D.O., is hereby stayed until November 18, 1999, At 1:30pm on Nov. 18, 1999 this court shall hold a hearing with the interested parties to determine if any terms or limitations should attach to said stay until the court reviews and renders its decision of judicial review on this order and the underlying Memorandum and Order of the Administrative Hearing Commission of the State of Missouri issued in case number 96-002599HA on June 29, 1999.

C. William Frankel
Judge

qm

IN THE CIRCUIT COURT OF JACKSON COUNTY, MISSOURI
AT INDEPENDENCE

LAWRENCE D. DORMAN, D.O.,	)	
	)	
Petitioner,	)	Case No. 99CV223364
	)	Division 17
vs.	)	
	)	
STATE BOARD OF REGISTRATION,	)	
	)	
Respondent.	)	

ORDER

On this date the Court takes up the **Plaintiff's Petition for Review** filed the 27th day of October, 1999. After consideration of said Petition and opposition thereto,

The Court finds that the findings and orders of the Administrative Hearing Commission are supported by competent and substantial evidence; that the findings and orders of the Administrative Hearing Commission are not arbitrary, capricious or unreasonable; and that the Administrative Hearing Commission did not abuse its discretion in making its respective findings and orders in Dr. Dorman's case.

The Court will enter judgment to this effect within fourteen (14) days from the date of this order unless otherwise prohibited from doing so by the Appellate Court.

6/29/2000
Date

C. William Kramer
C. WILLIAM KRAMER, JUDGE

BEFORE THE
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
STATE OF MISSOURI

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS,	)	
Petitioner,	)	
v.	)	Case No. 96-002599HA
LAWRENCE E. DORMAN, D.O.	)	
Respondent.	)	

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCIPLINARY ORDER

The Administrative Hearing Commission is an agency of the State of Missouri created and established pursuant to § 621.015, RSMo, for the purpose of conducting hearings and making findings of fact and conclusions of law in cases in which disciplinary action may be taken against a licensee or certificate holder by certain agencies, including the Missouri State Board of Registration for the Healing Arts.

1. On June 29, 1999, the Administrative Hearing Commission of the State of Missouri issued its Memorandum and Order in the case of *State Board of Registration for the Healing Arts v. Lawrence E. Dorman, D.O.*, Case No. 96-002599HA. In its Memorandum and Order, the Administrative Hearing Commission found that Respondent's license to practice the Healing Arts is subject to disciplinary action by this Board for violation of § 334.100.2(4) and (5), RSMo Supp. 1987-1989 and § 334.100.2(4)(e), RSMo Supp. 1987-1993.

2. This Board has received the record of the proceedings before the Administrative Hearing Commission and the Memorandum and Order. The Memorandum and Order issued by the Administrative Hearing Commission in Case No. 96-002599HA is incorporated herein by reference as if fully set forth in this document.

3. This Board set this matter for disciplinary hearing and served notice of the disciplinary hearing upon Respondent by hand delivery in a proper and timely fashion.

4. Pursuant to notice and § 621.110, RSMo 1994 and § 334.100.3, RSMo Supp. 1997, this Board held a hearing on October 21, 1999, for the purpose of determining the appropriate disciplinary action against Respondent's license. Respondent was present for the hearing and was represented by Glenn Allen Hall, Attorney at Law. The Board was represented by Board Attorney Glenn Bradford.

5. Each member of this Board who participated in this decision certified on the record that he or she read the Administrative Hearing Commission's Memorandum and Order. All the members of this Board were present throughout the hearing and participated in the Board's deliberations, vote and order.

6. Lawrence E. Dorman, D.O., Respondent, is licensed by the Board, license number D032325. Respondent's license is current.

CONCLUSIONS OF LAW

1. This Board has jurisdiction over this proceeding pursuant to § 621.110, RSMo 1994.

2. Respondent's license is subject to disciplinary action by this Board pursuant to § 334.100.2(4) and (5) RSMo Supp. 1987-1989 and § 334.100.2(4)(e) RSMo Supp. 1987-1993.

ORDER

THEREFORE, having fully considered all evidence before this Board, and giving full weight to the Memorandum and Order of the Administrative Hearing Commission, it is the ORDER of this Board that upon the effective date of this Order the license of Lawrence E. Dorman, D.O., to practice the Healing Arts is hereby REVOKED. The Board of Registration for the Healing Arts further ORDERS that Respondent shall not apply for reinstatement of his license for a period of TWO (2) YEARS and ONE DAY from the effective date of this ORDER. Respondent is directed to immediately return to the Board his wall-hanging certificate, license and pocket card, and all other indicia of licensure.

IT IS SO ORDERED, effective this 27 day of October, 1999.

STATE BOARD OF REGISTRATION
FOR THE HEALING ARTS

Tina M Steinman

Tina Steinman
Executive Director

Before the
Administrative Hearing Commission
State of Missouri

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS,	)	
Petitioner,	)	
vs.	)	No. 96-2599 HA
LAWRENCE E. DORMAN, D.O.,	)	
Respondent.	)	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

On December 11, 1996, the State Board of Registration for the Healing Arts filed a complaint seeking this Commission's determination that the medical license of Lawrence E. Dorman, D.O., is subject to discipline for treating patients with chelation therapy, for failure to keep adequate records, and for substandard care of patients.

This Commission convened a hearing on the complaint on June 8 - 12, 1998. Glenn Bradford and Edward Walsh, with Glenn E. Bradford & Associates, P.C., represented the Board. Glenn Allen Hall, with the Glenn Allen Hall Law Firm, represented Dorman.

The parties elected to file written arguments. The matter became ready for our decision on November 30, 1998, the date the last written argument was filed.

Findings of Fact

1. Lawrence E. Dorman, D.O., is licensed as an osteopathic physician and surgeon, License No. DO32325. Such license is, and was at all relevant times, current and active.

2. Dorman practices primarily in the area of family medicine at 9120 E. 35th Street, Independence, Jackson County, Missouri.

Count I

3. Ethylene Diamine Tetra-Acetic Acid (EDTA) is a synthetic amino acid that was invented in the 1930s. In EDTA (chelator) chelation therapy, the EDTA is administered by IV infusion. The chelator wraps around divalent and trivalent ions in the body, such as calcium, iron, magnesium, and manganese (chelatee), in order to make the resultant complex inactive.[1] When the chelator, EDTA, combines with the chelatee, it forms a complex that is eliminated from the body through the urine. Early treatments with chelation therapy carried a risk of kidney disorder or death from renal failure because of the high levels of EDTA used in a short period of time.

4. The Food and Drug Administration (FDA) has approved EDTA chelation therapy for the removal of heavy metals from the body, which is necessary in the case of lead poisoning or hemochromatosis.[2] The American Osteopathic Association, the American Heart Association, the American College of Cardiology, and the American Medical Society do not endorse chelation therapy for any purpose other than the removal of heavy metals. Medicaid and approximately 80 percent of insurance companies will not reimburse for chelation therapy for any purpose other than the removal of heavy metals.[3]

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[1] "Chelate" is defined as follows: "to combine with a metal in complexes in which the metal is part of a ring. By extension, a chemical compound in which a metallic ion is sequestered and firmly bound into a ring within the chelating molecule." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 312 (27th ed. 1988).

[2] A metabolic disorder "due to deposition of [iron-containing pigments] in the parenchymal cells, causing tissue damage and dysfunction of the liver, pancreas, heart and pituitary." DORLAND'S, at 747.

[3] Hearing Tr. at 562.

5. The Missouri Board of Healing Arts has no rule, regulation, or position paper concerning chelation therapy.[4]

6. When a doctor uses a medicine or therapy that has been approved for one use, but it is used for a different use, it is called "off-label" use. Off-label use of a drug or treatment is not *per se* illegal or improper.[5] Several state statutes require insurance companies to provide coverage for certain off-label uses such as cancer treatment.[6]

7. There are many drugs currently used in which the mechanism of the drug's action within the body is unknown.[7]

8. Dorman has used EDTA chelation therapy to treat atherosclerosis and other vascular diseases since the early 1980s (all future references to EDTA chelation therapy will refer to its off-label use unless otherwise noted).

9. The American College for Advancement in Medicine (ACAM) is an organization of approximately 1,000 to 1,500 physicians.[8] ACAM's position is that chelation therapy is a valid course of treatment for occlusive vascular disease and degenerative diseases associated with aging such as diabetes and rheumatoid arthritis.

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[4] *Id.* at 494. Unlike many other Boards and Committees, Chapter 334, RSMo, does not appear to give the Board authority to make rules setting forth causes for discipline. Section 334.125, RSMo Supp. 1998, authorizes the Board to promulgate rules to govern its own actions, and 334.157, RSMo 1994, authorizes the Board to promulgate rules relating to vaccines and immunizations. Section 334.100, RSMo Supp. 1998, provides a long list of actions that will be cause for discipline, but chelation medicine or other forms of chelation therapy are not specifically listed other than as the Board alleges – potential instances of incompetent, unprofessional, grossly negligent or negligent acts.

[5] Soffer Depo. Tr. at 50, 69-73. Doctors who prescribed aspirin for cardiovascular problems before the FDA gave approval for that use were prescribing off label. (Mancini Depo. Tr. at 48.) The Board's expert, Dr. David G. Meyers, testified that it was not ethical to prescribe off label. However, he emphasized that this was his personal opinion. (Hearing Tr. at 303-04.)

[6] Conn. Gen. Stat. Ann. §§ 38a-492b and –518b; R.I. Gen. Laws § 27-55-2(a); Ala. Code § 27-1-10.1.

[7] Mancini Depo. Tr. at 49.

[8] Dorman's expert, Dr. Charles Rudolph, estimates the percentage of chelation therapists as two percent of doctors. (Hearing Tr. at 494.)

10. Dorman gives all of his patients a brochure from the American Medical Preventics Academy that discusses the positive and negative aspects of chelation therapy and possible side effects. He also suggests that they read a paperback book about chelation therapy and discusses with them the information that they have read. Many patients go to Dorman specifically for chelation therapy. He tells his patients that the therapy does not work on everyone, and that the treatment will work better if the patient follows the diet, exercise and nutritional supplements that are recommended. Dorman does not perform chelation therapy without informed consent from the patient.

11. Several states have passed laws allowing a doctor to perform any procedure on any patient who consents to it as long as the patient gives informed consent.[9]

12. When used at the dosage levels recommended to chelation therapists, chelation therapy is not dangerous to patients.[10]

13. Other alternative treatments for cardiac disorders have been shown to be effective, but carry certain risks associated with them. In cardiac bypass surgery, there is an operative mortality rate of 2% within 30 days of the operation. The percentage of morbidity (illness caused by the procedure) is approximately 5-6%. Angioplasty has an operative mortality of 0.1% and a

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[9]Sampson Depo. Tr. at 87. *See* Ariz. Rev. Stat. Ann. section 32.1401 (requirements for use of chelation therapy).

[10]Hearing Tr. at 187, 496. Dr. Wallace Sampson testified that he knew of no deaths that resulted from the three-gram dose of chelation therapy. He noted a case report in which the patient suffered from branch retinal artery occlusion, but was unable to determine the dosage given. (Sampson Depo. Tr. at 67-71.) Dr. Alfred Soffer testified that he knew of no deaths that had been reported due to chelation therapy when given according to protocol. He stated that there are reported side effects one out of 200 times when a needle is inserted into the body, but this is a general statistic for any IV injection and is not specific to chelation therapy. (Soffer Depo. Tr. at 122-24.) Dr. Robert Mancini testified that possible side effects could include a hemorrahagic problem (bleeding) and kidney damage, but was unable to testify that these side effects would be probable at the protocol level of EDTA. (Mancini Depo. Tr. at 53-54.)

morbidity rate of 2-3%. However, in the case of angioplasty, 30-40% of the time the area opened becomes narrow again within six months, so the same procedure or another procedure such as a bypass must be performed.[11] Angioplasty treats the symptoms of cardiac disease; there is no evidence that angioplasty prolongs life or prevents heart attacks.[12]

A. Chelation Therapy Studies

14. In order to determine whether a drug is effective for a particular purpose, there are several levels of observations or experiments. The lowest level is the case report, in which a doctor notes something that he or she has observed concerning the drug or therapy. These usually involve one or few people and are uncontrolled. The case series, in which many of these case studies are considered together, is the next level. Next is the longitudinal study, where a group of people who took the drug or therapy are compared over a period of time to a group of people who did not. The clinical trial (double-blind study) is the "current penultimate level of valid scientific experimental data."[13] People for the double-blind study are selected at random from a group with the problem sought to be treated (such as a group with angina). Then the decision is made at random which of the individuals will receive the medicine and which will receive a placebo (inactive substance). The patient does not know if he or she is receiving the medicine or the placebo.

15. It would be unethical to perform a double-blind/placebo study for some medical procedures.[14] There is a difference of expert opinion as to whether it would be feasible or ethical

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[11]Hearing Tr. at 266-68.
[12]*Id.* at 272-73.
[13]*Id.* at 153.
[14]The Board's expert, Dr. David G. Meyers, described the Vineburg experiment performed at the Cleveland Clinic prior to modern heart bypass surgery procedures. This experiment was designed to study a procedure in which the doctors removed the artery behind the breastbone, cut off the end, and inserted it into the heart muscle. The doctors in this study performed this procedure on half of the patients, but for the other half, they operated but performed no procedure. Today this would be considered unethical. (Hearing Tr. at 162-63.) Dr. Soffer also testified that it is not always possible to do a double-blind study. (Soffer Depo. Tr. at 93.)

to perform double-blind studies in chelation therapy. Dr. Meyers testified that there would be no ethical problem in doing so. Dr. Rudolph testified that he could not ethically perform a double-blind study using chelation therapy because he would be denying them a treatment which he believes is helpful. There are also financial considerations. Unless the study is funded, the patient must pay for the therapy (which is not covered under most insurance companies). Therefore, the doctor could not charge for chelation therapy and give only placebo.

16. Most studies in EDTA chelation therapy are of the case report or the longitudinal study type. Many case reports show patient improvement.

17. In 1989, a study on EDTA chelation therapy was performed by Efrain Olszewer, M.D., Fuad Calil Sabbag, M.D., and James P. Carter, M.D., DrPH, in New Orleans, Louisiana (the Olszewer study). This study involved ten male patients (age range 41 to 53 years) with "peripheral vascular disease from diabetes or arteriosclerosis, aggravated by smoking,"[15] who were randomly selected. The study began as a double-blind study in which the ten patients were randomly divided into two groups and given EDTA or distilled water.[16] After ten treatments, one group was improving rapidly, and the doctors "decided to break the code."[17] They determined that only the patients receiving EDTA were improving, and proceeded as a single-blind test so that they could ethically treat all patients for the remaining ten treatments. The study showed improvement with the EDTA chelation therapy. The majority of the medical community does not accept this study because the experiment was not totally blinded, there were few patients, the

[15]Pet'r Ex. 13 at 173.

[16]Dr. Meyers criticizes this study because the experimenters "knew who got what." (Hearing Tr. at 166.) However, Petitioner's Exhibit 13, the report from the study, states that the experiment began as a double-blind study, in that the contents of the ampules given to the patients were in a sealed envelope by the manufacturer. (Pet'r Ex. 13 at 174.)

[17]Pet'r Ex. 13 at 175.

measurements they used for improvement were not precise,[18] and it was not replicated by another investigator.

18. In 1992, B. Guldager, R. Jelnes, S.J. Jorgensen, J.S. Nielsen, A. Klaerke, K. Mogensen, K.E. Larsen, E. Reimer, J. Holm, and S. Ottensen published a double-blind/placebo study (the Guldager study). In this study, 153 patients[19] (all more than 40 years of age who had suffered from stable intermittent claudication[20] for at least 12 months) received 20 intravenous infusions of the EDTA or placebo for five to nine weeks. The study measured the pain-free walking distance, the maximum walking distance, the ankle/brachial blood pressure index, and the systemic and ankle blood pressures. The experimenters performed subjective evaluations and laboratory tests, and investigated the possibility of side effects. The study found that EDTA chelation therapy was not more effective than placebo in treating intermittent claudication.

19. The majority of the medical community accepts the Guldager study. Proponents of chelation therapy (chelation therapists) do not accept this study because the patients were able to determine whether they were in the placebo group or the chelation therapy group because chelation therapy causes some pain at the point of insertion, and placebo treatment does not.[21] Chelation therapists also question whether those who conducted the study were neutral and objective because they were vascular surgeons who "had the most to gain from this study not showing anything positive."[22] The patients were given iron, which chelation therapists maintain was an error because one of the reasons to give chelation therapy is to remove iron from the

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[18]The study measured peripheral vascular signs (skin disturbances, temperature, hair changes), kidney function, blood pressure (BP) and BP index, a Walking Test, a Master "Two Step" Exercise Test and a Bicycle Stress Test. (Pet'r Ex. 13 at 174.)

[19]159 patients were recruited for the study, and 153 patients completed the treatment period.

[20]Absence of pain when a limb is at rest, but pain, tension and weakness upon exercise. DORLAND'S, at 343.

[21]Dr. Soffer testified that it is possible to mimic the side effects of chelation therapy by using magnesium. (Soffer Depo. Tr. at 78.)

[22]Hearing Tr. at 479.

body. Iron causes occurrence of free radical reactions, which chelation therapists assert causes heart disease.[23] Some patients in the Guldager study continued smoking, which is a significant risk factor for heart disease.

20. In 1994, Andre M. van Rij, MD, FRACS; Clive Solomon, BSc(Med), MBChB; Stephen G.K. Packer, MBChB, FRACS; and William G. Hopkins, PhD, published a double-blind random study of 32 patients with intermittent claudication (the van Rij study). In this study, none of the patients were older than 45 years of age, and all of them had peripheral atherosclerotic disease (confirmed by arteriography). They received 20 treatments of chelation therapy or placebo twice per week for a period of 10 weeks. The study measured walking distances and ankle/brachial indices. The researchers monitored cardiac function and measured plasma lipid, lipid peroxides and oxidized low-density lipoprotein levels. The study investigated attitudes related to lifestyle using self-administered questionnaires. The study found no difference in peripheral vascular hemodynamics, functional measures of activity, lifestyle, quality of life or perceptions of health between the two groups.[24]

21. The majority of the medical community accepts the van Rij study. Chelation therapists find the following flaws with this study: not all the patients stopped smoking, and only 20 treatments were given (instead of 30) for very severe, terminally ill vascular patients. They also find fault with the interpretation of the statistical data because one patient in the placebo group was plus or minus two standard deviations from the rest of the group and his data

[23]Dr. Meyers stated that the extra iron would not have affected the study because the iron would not have been absorbed if not needed. Dr. Rudolph stated that absorption could be forced if too much was given. (Hearing Tr. at 481.) The ACAM Protocol also warns against giving the patients iron unless they are initially deficient, stating, "A major benefit of chelation is the removal of unwanted accumulations of freely catalytic, unbound iron." (Pet'r Ex. 8 at 11.)

[24]Pet'r Ex. 14 at 1198.

was not discarded.[25] Dr. Rudolph testified that if discarded, there is clear improvement in the chelation group over the control group. The control group was also given magnesium, vitamin C, and other vitamins (ingredients in chelation therapy except the EDTA) that could have had a beneficial effect on the patients; thus, it was not a true placebo test.[26]

22. From 1981 to 1994, a small number of doctors, including Dr. Rudolph, have published abstracts in journals such as the Journal of Advancement in Medicine, the Journal of the International Academy of Preventive Medicine, and the Journal of Orthomolecular Psychiatry concerning chelation therapy. These abstracts concern case studies or longitudinal studies, rather than double-blind, random studies. In all the studies, the patients were given approximately 30 treatments of chelation therapy.

23. One study showed that chelation therapy lowered cholesterol levels, particularly among the group with high cholesterol.[27] Another study involved serum creatinine (a measure of kidney function) and found that, at the low levels given, there was no negative effect on the kidneys. Some improvement was documented.[28] One study evaluated serum iron levels and found that high iron levels were reduced after chelation therapy.[29] Other studies were conducted to test chelation therapy treatment for fatigue,[30] and to test its effect on ankle/brachial systolic blood pressure,[31] bone density levels (5% improvement in bone density figures for women with osteoporosis),[32] chronic lung disorders (improvement in vital lung capacities – how much air is in lungs – and improvement in FEV 1 – amount of air one can blow out of lungs in one

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[25]Dr. Rudolph testified that discarding such data is good statistical method. (Hearing Tr. at 484.)

[26]Placebo was 1000 ml isotonic saline. The patients were given a multivitamin with magnesium, one tablet daily. (Pet'r Ex. 15 at 262-63.)

[27]Resp. Ex. S at 23-30; 37-42; and 47-50.

[28]*Id.* at 37-42.

[29]*Id.* at 39-45.

[30]*Id.* at 75.

[31]*Id.* at 85.

[32]*Id.* at 147; Hearing Tr. at 528.

second),[33] carotid circulation,[34] blood platelet volume,[35] serum iron,[36]obstructive carotid stenosis,[37] chronic degenerative diseases,[38] disc herniation[39] and Cogan's dystrophy.[40]

B. Chelation Therapy Theories

24. In the 1960s, chelation therapists theorized that EDTA was effective in treating cardiac problems because it chelated calcium from the artery walls. Most chelation therapists do not adhere to this theory because calcium does not precipitate hardening of the arteries, but is an end product "when the artery is so diseased its cells start dying and that dead tissue takes up calcium."[41]

25. EDTA does chelate with calcium, and the resulting complex is eliminated from the body.[42]

26. Chelation therapy may "shuttle calcium from the soft tissue back to the hard tissue."[43] This could benefit people with osteoporosis and joints and arteries that become hard from calcium deposits.

27. Calculations also indicate that chelation therapy does not remove a significant number of calcium molecules within the time of treatment. "And so as far as calcium's concerned . . . it would take two years at five days a week, 50 weeks a year, to remove one tenth

[33] *Id.* at 155; Hearing Tr. at 529-30
[34] *Id.* at 165.
[35] *Id.* at 183.
[36] *Id.* at 189.
[37] *Id.* at 197.
[38] *Id.* at 207.
[39] *Id.* at 215.
[40] *Id.* at 231.
[41] Hearing Tr. at 182.
[42] Mancini Depo. Tr. at 51.
[43] Hearing Tr. at 497.

of the amount of calcium in arterial plaque; and of course the calcium itself represents ten percent or less of the entire plaque."[44]

28. Another theory is that EDTA directly chelates free radicals, but this is chemically impossible.[45]

29. Cholesterol is "a pearly, fatlike steroid alcohol . . . . It . . . occurs in atheroma of the arteries[.]"[46] LDL or "bad" cholesterol causes hardening of the arteries, particularly if it has become oxidized and is not removed from the artery.[47] It becomes oxidized when it is exposed to chemicals called oxygen free radicals.[48] A chemical reaction separates the two oxygen atoms, one of which is a free radical oxygen singlet.[49] The end product of this process is oxidized lipid substances on cell membranes and in the cells.[50] "[I]t is the oxidation of these materials that leads to degenerative diseases. The – the actual chemical reactions are laid out in several texts, and I think most biochemists accept them as the most likely way that that comes about."[51]

30. One theory explaining how chelation therapy acts within the body is that EDTA cuts down free radical mechanisms by scavenging copper and iron. Too much iron can cause injury because iron is released by red blood cells and combines with oxygen, forming free radicals, such as superoxide, which are toxic to the arteries. The iron also breaks peroxide down to hydroxy free radicals, which "hurt the surface layer of the artery and may act as the initial problem when . . .

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[44]Sampson Depo. Tr. at 15.

[45]Dr. Meyers testified that the EDTA chelates only seven or eight divalent and trivalent catides. Since free radicals are not divalent or trivalent catides, EDTA takes the free radicals as chemical deposits. (Hearing Tr. at 184.)

[46]DORLAND'S, at 324.

[47]Hearing Tr. at 182.

[48]Dr. Meyers stated: "Free radicals are akin to bleach. Clorox bleach is made of a chemical that's a free radical. And it oxidizes our clothes just like the Oxydol commercial says. (Hearing Tr. at 183.)

[49]Hearing Tr. at 256.

[50]Sampson Depo. Tr. at 17.

[51]*Id.*

dealing with atherosclerosis."[52] The Fenton reaction is catalyzed by iron, and this increases free radical production.[53] Decreasing the amount of iron would result in the production of fewer oxygen free radicals and less bad cholesterol. The result may only be temporary, however, since the body would reabsorb iron.[54]

31. Anti-oxidant vitamins, such as vitamins A, C, and E, may help to control atherosclerosis.[55] These vitamins are often given during chelation therapy.

C. Patient Benefits from Chelation Therapy

32. Dorman treated Patient R.S., a 61-year-old male, with chelation therapy.[56] R.S. had been seeing another doctor for chelation therapy and went to Dorman when that doctor was killed. At age 54, R.S. had had two strokes within a 90-day period, and the doctors in St. Joseph informed him that he had so much blockage (one carotid blocked 98-100%) that his condition was inoperable. They did not recommend a heart bypass surgery or angioplasty, but prescribed 14 different pills per day. R.S. had also suffered from angina for 17 years and had been given nitroglycerin pills for that period of time, and suffered from diabetes.

33. When R.S. was released on medication, he was unable to walk more than a block, and was suffering from memory loss to the extent that he had to give up his driving privileges. He was very depressed and considered suicide. R.S. had approximately 45 chelation therapy treatments with his previous doctor and about 30 treatments with Dorman.

34. R.S. experienced no adverse side effects from chelation therapy. R.S. continued taking his medication during the beginning of the treatment, but for the last six years he has

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[52]Hearing Tr. at 504.
[53]*Id.* at 308.
[54]*Id.* at 185.
[55]*Id.* at 257.
[56]*Id.* at 679-88.

taken no medication for his heart condition or for his diabetes. He currently feels active enough to go dancing every Saturday night and to take trips with his wife.

35. During the chelation therapy treatments, R.S. followed the doctors' recommendations concerning diet, exercise and vitamins.

36. An airline pilot, with 100% occlusion of his left anterior descending coronary artery and a 30% occlusion of his right coronary artery, had 72 bottles of EDTA. After therapy, his left artery was 35% open, and his right artery was completely open.[57]

37. One patient had 98% blockage in one of her carotid arteries. After 30 EDTA bottles, the artery was 30-35% blocked; at 40 bottles the artery was 25% blocked; and after 60 bottles there was no evidence of plaque in the artery.[58]

38. Other patients' blockage reduced from 54% to 0%, and from 75% to 40% after chelation therapy.[59]

39. One patient, an older woman, had macro-degeneration of her eyes. She was not seeing enough light at certain points in her retina. After chelation therapy, her vision was restored to 20/20.[60]

40. One patient, a 75-year old male, was suffering from long-standing diabetes and gangrenous lesions to the point that his toes were beginning to fall off. After 35 treatments from October to March of 1976, the lesions were healed.[61]

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[57]Hearing Tr. at 514-15. The patients identified in Findings 36-41 were not treated by Dorman, but were provided as examples of patients who had benefited from chelation therapy.

[58]*Id.* at 520-21.

[59]*Id.* at 523.

[60]*Id.* at 525-26.

[61]*Id.* at 538-39.

41. Patients with open ulcers (one with a rotting foot), who had not responded to surgical treatment and traditional measures, experienced healing of the ulcers after differing amounts of chelation therapy.[62]

D. ACAM Protocol

42. ACAM's Protocol sets forth its standards for the safe and effective use of chelation therapy.[63] It assumes that the practitioner has a knowledge of biochemistry, pharmacology, and basic clinical sciences. The Protocol lists potential side effects and toxicity, and what precautions to take to avoid them.

43. The Protocol warns that EDTA is potentially toxic to kidneys and, if given too rapidly, renal damage may result. Serum creatinine levels must be taken before and during chelation therapy, and the treatments should be stopped temporarily if the levels are too high.

44. The Protocol states that patients with limited cardiac function should be weighed frequently to check for fluid retention, because an increased fluid load from the chelation therapy could aggravate heart failure. The Protocol suggests slowing the infusion, reducing the carrier solution, and avoiding unnecessary sodium. The Protocol states: "Most patients with congestive heart failure can be successfully chelated without complications, with improvement of cardiac status after therapy."[64]

45. The Protocol states that the chelation therapist should assess the patient's trace element status by taking a complete dietary history and by testing urine, hair and blood. Patients should take nutritional supplements containing essential minerals and trace elements, and may

[62]Hearing Tr. at 540-41.
[63]Pet'r Ex. 8.
[64]*Id.* at 9.

need to correct poor nutritional status for several weeks before treatment. Supplemental iron should not be given unless the tests show that there is a deficiency.

46. Before beginning chelation therapy, the Protocol instructs the doctor to take a complete medical history and perform a "thorough head-to-toe, hands-on, physical examination."[65] The doctor should request past medical records, including written reports of arteriograms, and should record a complete list of current medications and patient allergies. The doctor should record the quality of arterial pulses, the presence and quality of arterial bruits, the skin temperature of extremities, the hair loss of extremities, the dystrophic nails, and the mental status of the patient. "A recent electrocardiogram with written interpretation should be in the chart. Noninvasive vascular studies, as clinically indicated, should be performed. As [sic] a minimum, segmental Doppler systolic blood pressure recordings of the extremities should be recorded. Weight and blood pressure should be measured before each infusion of EDTA."[66]

47. The Protocol states that the patient's initial evaluation should include: complete blood count with differential, a chemistry panel, a complete urine analysis, thyroid function tests, and a chest X ray. The doctor should get 24-hour urinary creatinine clearance and both a urine and hair analysis. Before and after the first chelation therapy treatment and throughout therapy, the doctor should test a urine specimen for trace and toxic metal levels. The doctor should screen the patient for abnormalities of carbohydrate metabolism (using tests such as glucose loading, postpradian blood sugar or glycohemoglobin). The Protocol states: "Referral for heart valve replacement, aneurysm repair, or other surgery may be needed. If time permits, surgery is better tolerated and less likely to cause complications if a presurgical course of chelation therapy

[65]Pet'r Ex. 8 at 11.
[66]*Id.*

is first administered. If chelation fails, bypass surgery or angioplasty still remain options."[67] The doctor should counsel the patients about risk-factor modification, nutrition, and the dangers of tobacco, alcohol and caffeine use.

48. After a series of treatment, the Protocol recommends that the doctor re-evaluate the patient at 3, 6, and 12-month intervals. Follow-up should include a medical history and physical examination. The doctor should periodically test urine, hair, blood lipids, and iron levels.

49. The Protocol sets forth the chelation therapy solution, which is mixed individually for each patient. The dose of EDTA is 50 mg per kg of lean body weight (to patients with normal kidney function) to a maximum of 5 gm for an unusually large patient. The dose of magnesium chloride or magnesium sulfate is that which will provide approximately 200 mg of elemental magnesium, and the dose of sodium bicarbonate buffer is in a ratio of 10 mg bicarbonate to 3 gm EDTA. The Protocol also states that a local anesthetic, heparin, B-complex vitamins and/or vitamin C may be added. The dose suggested for vitamin C is 4 to 20 gm.[68]

50. EDTA is administered, preferably by a 25-gauge butterfly needle, in not less than three hours. Infusions should never be given more than once in 24 hours. The Protocol states: "Eventual benefit depends on the total number of infusions and is relatively unrelated to the time between infusions. . . . The treatment schedule for each patient will depend on clinical judgement and the results of renal function tests."[69] Minimum treatment is 20 infusions, but for optimal results, the Protocol suggests 30-40. "Occasional patients have received up to 100 or more

[67]Pet'r Ex. 8 at 12.

[68]The Protocol states that the vitamin C is a weak chelating agent and enhances the ability of EDTA to remove lead from the central nervous system.

[69]Pet'r Ex. 8 at 14.

infusions over several years. Full benefit does not normally occur for up to 3 months after a series of infusions is completed."[70]

51. The Protocol states that an emergency kit containing vials of injectable calcium gluconate, a 50% glucose solution, and 10 and 50-ml syringes with needles should be accessible in the treatment area. Oxygen with a regulator should be available in case a cardiovascular patient has a myocardial infarction, stroke, heart failure or other complications.

52. ACAM also offers training manuals, audio cassette tapes, and copies of the references used to create the Protocol.

Count II

53. Dorman began treating 72-year-old A.S. on December 14, 1976, and treated her until August 7, 1991 (treatment period). Approximately ten days before her first visit, A.S. had hit her great toe, and her toenail was loose. She complained of pain in her toe. After taking A.S.'s medical history, Dorman diagnosed that she had a circulatory problem in her feet.

54. Dorman recommended epsom salts treatment and removed the nail on December 29, 1976. Dorman did not perform a complete physical examination on the first visit, but checked her heart rate and rhythm, and her lungs, throat and lymph nodes. This was an adequate examination to allow Dorman to treat A.S.'s great toe.

55. A.S. saw Dorman during her treatment period for high blood pressure (highest recorded 220/105 on January 3, 1986). She took Enduron for the condition. She also saw Dorman for such conditions as the flu, pain in her knees, pedal edema, burning in her stomach, respiratory problems, exertional dyspnea (difficulty breathing), productive cough, sacroiliac pain, and hip pain. She had a systolic murmur that she had had all of her life and that is usually

[70]Pet'r Ex. 8 at 14.

present because of calcification in the heart valves.[71] A.S.'s medical records of subsequent visits and findings indicate that Dorman saw A.S. approximately 183 times[72] during her treatment period. A.S. had 132 visits with Dorman before there was any allegation of misconduct.[73] Most entries include blood pressure, weight, temperature, and other diagnosis or medication note.

56. On December 9, 1986, after treating this patient for ten years, Dorman gave A.S. a chelation therapy treatment. Before administering the treatment, Dorman checked A.S.'s segmental pressures, which indicated that her large arteries were in fairly good shape. The plethysmograph examination showed that A.S. had small blood vessel disease, which is common in older people because of calcification of the capillaries. Dorman performed these tests on August 8, 1984, and on November 25, 1986.

57. The results of the plethysmograph test were not labeled and unscaled, but Dorman was able to interpret the graphs.

58. Dorman began treating A.S. with chelation therapy again on November 18, 1988, for her continuing circulatory problems. This was followed by treatments on December 16, 1986, December 23, 1986, December 31, 1986, and January 13, 1987.

59. Dorman gave A.S. chelation therapy six times from December 9, 1986 through January 13, 1987.

60. Dorman did not give A.S. further chelation therapy treatments at this time because she had made improvements and was feeling better. She wished to stop the treatments, and, because of the small amount of EDTA and the small number of treatments, Dorman did no

[71]Dorman testified that the heart murmur is common in older people because it is the result of rheumatic fever or other diseases that damage the heart valves at a time when there is no effective treatment.

[72]This number does not include duplicate date entries or entries that merely show contact with an insurance company or payment, and was arrived at by counting entries in Petitioner's Exhibit 10.

[73]Hearing Tr. at 281.

follow-up testing. She had no negative side effects to the treatment. A.S.'s veins were frail, which would be a reason to avoid performing intrusive blood tests unless absolutely necessary.

61. Dorman's chelation therapy treatments of A.S. were all in accordance with the Protocol for administration.

62. Dorman injected A.S. with magnesium sulfate on March 21, 1987, March 31, 1987, April 8, 1987, April 24, 1987, May 22, 1987, and June 27, 1989. Dorman injected A.S. with magnesium chloride on January 6, 1987,[74] July 12, 1988, March 14, 1989, and March 29, 1989. Magnesium chloride and magnesium sulfate can have the same function in the body as the medications Verapamil or Diltiazem, in that they can stimulate respiration. Magnesium is a good chelating agent, and Dorman normally uses magnesium instead of Verapamil.[75]

63. After chelation therapy, A.S. experienced relief in her feet, and her toenails stopped falling off. She lived past the age of 90.

Count III

64. Dorman saw patient J.W. between January 17, 1989, and February 8, 1989. J.W. was 78 when he first saw Dorman. J.W. complained of nausea and dizziness, and pain in his left elbow and left knee. The nausea and dizziness were not related to any fever and had begun on December 18, 1988.

65. When Dorman examined J.W., he looked at the fundi (retina of the eye) for arteriosclerotic changes. When he listened to J.W.'s heart, he heard a split-second sound, which

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[74]The Board's brief lists this date as January 6, 1986, but the patient's record shows that the date is January 6, 1987. Pet'r Ex. 10.

[75]The Board's expert also criticized Dorman's use of ACTH with this patient, but this allegation is not found in the complaint and thus cannot be considered as a cause to discipline his license. ***Duncan v. Missouri Bd. for Arch'ts, Prof'l Eng'rs & Land Surveyors***, 744 S.W.2d 524, 538-39 (Mo. App., E.D. 1988).

means that the second sound of the heart, S2, was split. This is common in older people with atherosclerosis. Dorman performed a Doppler test, which showed carotid artery atherosclerosis.

66. In J.W.'s medical chart, under the section for physical examination, Dorman noted "Fundus ASO," and "Heart [illegible] split S2."[76] Dorman used these terms to mean arteriosclerotic eye grounds or retina and split-second sound of the heart. Dorman noted the patient's dizziness and nausea and lack of fever. He noted that the lungs had decreased breath sounds, and he made check marks to show that he had examined the throat, pharynx, tonsils, abdomen, and lymph nodes. J.W.'s temperature was noted at 97 and his blood pressure at 138/70. 138/70 is a good blood pressure for a 78-year old person. Dorman noted "Reflexes DTR ¼," which shows the Doppler test reading.

67. Dorman ordered blood tests on J.W. He discussed the patient's past medical history and discovered that J.W. had a CAT scan and work-up at K.U. Medical Center. They had failed to find any reason for his problem and had released him without treatment.

68. Dorman treated J.W. with chelation therapy on January 20, 1989, January 23, 1989, and January 25, 1989.

Count IV

69. Dorman's patient records did not always allow the Board's expert to determine the basis of his diagnoses, or make the distinction between medical histories and his own diagnoses. Dorman's records provide the results of tests, but not always in symbols that could be interpreted by the Board's expert.

[76]Pet'r Ex. 9.

70. Dorman was able to review his medical records and explain his diagnoses, prescriptions, and medical testing. Dorman's records are adequate to allow him to treat his patients.

71. The Health Care Finance Administration has set forth standards for Medicaid patients' medical records, but no Missouri law or regulation sets forth standards or recommendations.[77]

Count V

72. Dorman treated patient F.C. from October 16, 1974 through September 3, 1991. F.C. first visited Dorman with back pain and a pain under his right side. In the patient's records, Dorman noted the presence of a heart murmur on February 3, 1984. This was the only entry because F.C. was being seen elsewhere for his cardiac problems. He had triple bypass surgery at Kansas City University Medical Center. Dorman treated F.C. for such ailments as cellulitis, back and musculoskeletal problems, bronchitis, upper abdominal complaints, and general medical care.

73. On August 21, 1985, Dorman noted the drugs that F.C. was taking. Dorman had not prescribed these drugs. Dorman also noted a diagnosis of ankylosis spondylitis, which was diagnosed by another doctor. Dorman was noting this diagnosis as the patient reported it as part of his medical history.

74. Dorman performed EKG and Holter monitor tests and had these test results in the patient's records.

Count VI

75. Dorman has no special training or qualifications in the field of cardiology.

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[77]Hearing Tr. at 278, 328.

76. On December 9, 1988, Patient E.F.S., a 54-year-old male, consulted Dorman, complaining of a sharp pain that began in his back and radiated to his hands. He did not complain of chest pain. E.F.S. informed Dorman that he had been working on remodeling his church and had been moving heavy carpet, and breathing glue, epoxy or paint fumes. The patient attributed his condition to these factors. Dorman diagnosed a musculoskeletal problem.

77. On this date, E.F.S. had a blood pressure of 125/80, with a normal heart rate and rhythm. Dorman ordered a blood test, but did not perform a complete physical examination or refer E.F.S. to another doctor for cardiac follow-up tests. The results of the blood test revealed that E.F.S. had a cholesterol level of 262, which is relatively high. Dorman was unsure whether E.F.S. had been fasting before the test, and his reading could fluctuate as much as 50 points depending on what he had eaten. Dorman informed E.F.S. of the results of this test.

78. Symptoms such as back pain that radiates to the hand, shortness of breath, and nausea and vomiting are indicative of coronary distress.

79. Dorman was aware that E.F.S. had several risk factors for circulatory and heart disease. E.F.S. had a history of smoking, and his father had died of heart disease in his 50s. Dorman did not document these risk factors in E.F.S.'s chart.

80. On December 13, 1988, E.F.S. and several men carried a 1,000 pound roll of carpet into the new church. He had also loaded three piano dollies, boards and rugs.

81. On December 18, 1988, E.F.S. felt terrible after lifting a box, and stopped lifting heavy items.

82. On December 21, 1988, E.F.S. awoke at 6:00 a.m. with a burning sensation in his back, arms and chest. There was a gurgling sound coming from his chest, and he was in tears from the pain. E.F.S. and his wife, B.S., saw Dorman at approximately 8:30 a.m.

83. Dorman performed an EKG test and took a blood pressure reading (150/ 90). The limb leads on the EKG were improperly placed.[78] Dorman, who was not an expert at reading EKG results, did not find any infarction pattern, and stated that it didn't look too bad. Dorman ordered a hot pack for E.F.S.'s back and gave him an injection of 20 mg Nubain for pain, and of Isoptin as a preventive measure. Isoptin (Verapamil) is a calcium channel blocking agent and is good for preventing anginal episodes. It is used to lower blood pressure and to prevent certain types of atrial arrhythmias. It dilates the coronary arteries and is used to improve coronary flow. Isopril would not be prescribed for any human ailment other than that associated with the heart and blood pressure.[79] Dorman gave E.F.S. sample Isoptin tablets that were past their expiration date.

84. After reading the EKG, Dorman told E.F.S. that E.F.S.'s condition looked like an aneurysm in the aorta, that there was no cure, and that they needed to pray about it. A doctor cannot diagnose an aneurysm from an EKG test.

85. An aneurysm is caused by a thinning and expansion of the heart muscle.[80] It is usually irreversible, but it can be corrected[81] by performing heart surgery, which carries its own risks.

86. On December 21, 1988, at 2:30 p.m., E.F.S. had an appointment with his chiropractor, Wayne Bateman, where he had an adjustment and thoracic X rays were taken.

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[78]Jackson Depo. Tr. at 26.

[79]*Id.* at 29.

[80]An aneurysm is "a sac formed by the dilatation of the wall of an artery, a vein, or the heart." DORLAND'S, at 80.

[81]Jackson Depo. Tr. at 35.

Bateman sent the X rays to Dr. Conley, a chiropractic radiologist, for evaluation, and based on Conley's report, Bateman suggested a consultation with him concerning the condition of E.F.S.'s lungs as shown on the X rays.

87. Conley diagnosed degenerative joint disease, a prominent aortic knob and aortic uncoiling. The latter two are common with the aging process, but also occur with high blood pressure or atherosclerotic disease. Conley also noted a thin, obliquely situated line in the mid-portion of the right lung field. This could be the result of a pulmonary adhesion (scar on the lung) or plate-like atelectasis (small area of lung collapse). Conley stated that further X rays, including chest X rays and comparisons with previous radiographs, were necessary.

88. Bateman made an appointment for E.F.S. with Conley for December 23, 1988. E.F.S. did not keep that appointment. E.F.S. was sick to his stomach and throwing up at this time.

89. On December 23, 1988, E.F.S. took the X rays to Dorman, who stated: "It looks to me like a lot to do about nothing."[82] Dorman said that additional X rays were unnecessary. When informed that E.F.S. had not eaten since December 20, 1988, Dorman stated that he and his wife should not be concerned, and that E.F.S. would eat when he wanted to do so. E.F.S.'s blood pressure on this date was 90/50.

90. On December 23, 1988, Dorman administered to E.F.S. an intravenous solution of peroxide.

91. Dorman told E.F.S.'s wife that he was charting that he had administered vitamin C, but that it was really peroxide. B.S. questioned this treatment, but Dorman informed her that it would help her husband. He stated that he had given it to a patient with shingles ten days prior to that time. He also told B.S. that he had signed an agreement with the Board, stating that he would

[82]B.S. Depo. Tr. at 18.

not use intravenous peroxide, but that it was a good treatment and that the board members were ill-informed about it.

92. B.S. shared this information with E.F.S. and together they decided to go ahead with the treatment because Dorman recommended it.

93. Dorman scheduled a follow-up visit for December 27, 1988, for another peroxide treatment.

94. Hydrogen peroxide has no known or medically recognized use in treating circulatory or respiratory disease.

95. The Bio-Oxidative Medicine Foundation promotes the use of intravenous hydrogen peroxide under the theory that oxygen is a powerful healing element and that this treatment increases oxygen to tissue.

96. On December 24, 1988, E.F.S. called Dorman at home. His office was closed because it was Christmas Eve. E.F.S. and his wife met Dorman and Mrs. Dorman at the office between 8:00 a.m. and 10:00 a.m. Dorman gave E.F.S. M C Isoptin SR 240 mg, Theo-Dur 300 mg, and Organdin Elixir. He prescribed Sorbitrate and scheduled a follow-up visit for Tuesday, December 27, 1988.

97. Dorman made no record of E.F.S.'s visits on December 24, or of any medication prescribed on that date.

98. Theo-Dur is contraindicated in cases of acute myocardial infarction. Dorman failed to monitor E.F.S.'s serum levels after prescribing the drug.

99. On the evening of December 24, 1988, Dorman called E.F.S. at home and spoke with his daughter. She asked Dorman if it was alright to give her father Emetrol for his stomach,

and he said it would be alright. E.F.S. stated that the medication Dorman had prescribed made his heart race and made it difficult to breathe.

100. Dorman failed to diagnose that between December 21 and December 28, 1988, E.F.S. had a serious heart problem and pending myocardial infarction.

101. E.F.S. suffered an acute myocardial infarction more than three days prior to December 29, 1988.[83] E.F.S. suffered two heart attacks, one involving the anteroseptal region, and the second heart attack in the contiguous area of the lateral wall. The first one occurred at some time around December 21, 1988, and the second occurred during the next 24 hours.[84] If E.F.S. had received proper medical care after the first heart attack, the second attack might not have occurred.

102. Dorman did not prescribe nitroglycerine for E.F.S.

103. On December 25, 1988, E.F.S. went to church and, in the afternoon, was able to eat chicken broth.

104. From December 26 through 28, 1988, E.F.S.'s condition appeared to be improving. Dorman called his home several times to check on his condition. E.F.S. took half an Isoptin tablet on the evening of December 26, 1988, but then discontinued the medication because his heart had started pumping rapidly and he could not breathe. E.F.S.'s nausea continued.

105. On December 29, 1988, B.S. called Dr. Gerald Lee, a doctor they knew from the Fairmount Christian Church, and described her husband's symptoms of shortness of breath, chest pain, and the inability to lie flat in bed because of the inability to breathe. Lee told her to take her husband immediately to Dr. Said Mahmoud's office. E.F.S. saw Mahmoud at approximately

[83]Jackson Depo. Tr. at 12.
[84]Lee Depo. Tr. at 52-53.

3:00 p.m. Mahmoud consulted with Dr. Jay Jackson, and E.F.S. was taken by ambulance to the Trinity Lutheran Hospital Intensive Care Unit. E.F.S. did not seem to know what was wrong with him, but went to the hospital when both Mahmoud and Jackson explained the situation.[85]

106. E.F.S.'s diagnosis upon admission to Trinity Lutheran was pulmonary edema[86] with congestive heart failure, cardiac enlargement, and marked increase in the bronchovesicular markings of the lungs.

107. Jackson treated E.F.S. with digitalis, diuretics, oxygen therapy, and IV nitroglycerin. E.F.S. had a cardiac catheterization, which showed a totally obstructed left anterior descending (LAD), a dysfunctional left ventricle, and a possible aneurysm developing at the apex of the heart.

108. On January 4, 1989, E.F.S. had a balloon angioplasty and angiogram of the LAD, which showed that the clot on the inside of the left ventricle had been there for more than 24 hours.

109. E.F.S. was released from the hospital on the condition that he be readmitted on February 23, 1989.

110. On February 23, 1989, E.F.S. awoke feeling very bad, and B.S. called Dr. Lee. She brought E.F.S. to Lee, who again admitted him to Trinity Lutheran. In the Emergency Room, E.F.S. had a rapid Y-complex tachycardia. He was given Verapamil, IV Lidocaine, and IV Procainamide. His blood pressure remained at 70/40, and his cardiac arrhythmia continued. E.F.S. was intubated, was transferred to the cardiac catheterization laboratory for the insertion of an intra-aortic balloon, and was then transferred to the Intensive Care Unit. The doctors did not

[85]Mahmoud Depo. Tr. at 13-14.

[86]Accumulation of fluid in the lungs, usually resulting from failure in the left side of the heart. (Lee Depo. Tr. at 28.)

consider surgery to be a viable option, but maintained the patient on the intra-aortic balloon. His condition was listed as very poor. He was kept alive on life support for approximately 24 hours.

111. Nursing notes from the Intensive Care Unit quote the patient as stating, "I just can't believe it. I eat healthy and take good care of myself." The notes also state, "Family insists that 'God will give him a new heart.' They, esp the wife does not seem to be accepting the fact that he has infarcted."[87]

112. Due to his prognosis, E.F.S.[88] and his family decided to stop further life support measures, and the endotracheal tube was removed. E.F.S. died on February 24, 1989, from damage to his heart caused by acute myocardial infarction. "Death was felt to be due to cardiogenic shock due to advanced coronary artery disease with severe left ventricular dysfunction and multiple cardiac arrhythmias."[89]

Count VII

113. In September of 1988, Dorman signed an agreement with the Board, stating that he agreed to cease and desist the practice of treating ailments and conditions with intravenous hydrogen peroxide therapy until such time as the Board specifically allowed him to do so.[90]

114. On December 23, 1988, when Dorman administered to E.F.S. an intravenous solution of peroxide, he was operating under this agreement.

115. At that time, the Board had not approved this treatment.

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[87]Mahmoud Depo Ex. 9.

[88]According to testimony, E.F.S. was conscious and assisted in the decision to remove life support. Mahmoud stated: "I told you I never had a man or a woman or a patient who was awake and alert on a life support machine and say, Doc, get me off. I want it off. And I told him we're going to lose you. He said, 'I will go to his word.' It's just so – you won't believe, but I have a hard time dealing with it myself." (Mahmoud Depo. Tr. at 30.)

[89]Trinity Lutheran Death Summary. (Mahmoud Depo Ex. 6.)

[90]Hearing Tr. at 612; Pet'r Ex. 29.

Conclusions of Law

This Commission has jurisdiction over the Board's complaint. Section 621.045, RSMo Supp. 1998. The Board has the burden of proof. ***Missouri Real Estate Comm'n v. Berger***, 764 S.W.2d 706, 711 (Mo. App., E.D. 1989). The standard of proof is a preponderance of the credible evidence. ***Harrington v. Smarr***, 844 S.W.2d 16, 19 (Mo. App., W.D. 1992). This Commission must judge the credibility of the witnesses, and we have the discretion to believe all, part or none of the testimony of any witness. *Id.* When there is a direct conflict in the testimony, we must make a choice between the conflicting testimony. *Id.* Our Findings of Fact reflect our determination of the credibility of witnesses.

Constitutional Question

Dorman alleges that, to find his license subject to discipline would violate his constitutional right to due process because there are no Missouri statutes or rules promulgated that would prohibit the use of chelation therapy. Dorman states that the Board has known that Dorman and others have been using chelation therapy for many years, and has never provided any prior notification that this would be considered negligent or incompetent treatment.

The Administrative Hearing Commission does not have the authority to decide constitutional issues. ***Williams Cos. v. Director of Revenue***, 799 S.W.2d 602, 604 (Mo. banc 1990). However, Dorman has properly raised his challenge before us, and he may argue it before appeals tribunals if necessary. ***Tadrus v. Missouri Bd. of Pharmacy***, 849 S.W.2d 222 (Mo. App., W.D. 1993).

Admissibility of Expert Testimony

The Board moved to strike Dorman's expert witness, Dr. Charles Rudolph, and all other testimony about chelation therapy, alleging that the evidence is not admissible under the ***Frye***

rule. In ***Frye v. U.S.***, 293 F. 1013, 1014 (1923), the court stated that, to be admissible, the expert testimony must be based on "well-recognized scientific principle or discovery, the thing from which the deduction is made must be sufficiently established to have gained general acceptance in the particular field in which it belongs."

Dorman argues that ***Frye*** has been overruled by ***Daubert v. Merrell Dow Pharmaceuticals, Inc.***, 509 U.S. 579 (1993), which, based on an amendment to Fed. Rule Civ. Pro. 702, requires a court to consider whether the "expert is proposing to testify to (1) scientific knowledge that (2) will assist the trier of fact to understand or determine a fact in issue." *Id.* at 592.

The ***Daubert*** court suggested examining such factors as (1) the qualifications of the expert, (2) whether the theory or technique has been tested, (3) whether the theory has been subjected to peer review and publication, (4) the known or potential rate of error and the existence of standards, and (5) general acceptance within the scientific community. With regard to the last factor, the Court stated:

> To summarize: 'General acceptance' is not a necessary precondition to the admissibility of scientific evidence under the Federal Rules of Evidence, but the Rules of Evidence—especially Rule 702—do assign to the trial judge the task of ensuring that an expert's testimony both rests on a reliable foundation and is relevant to the task at hand. Pertinent evidence based on scientifically valid principles will satisfy those demands."

Id. at 597.

Therefore, general acceptance, which was the main consideration under the ***Frye*** test, is only one consideration under ***Daubert***. Courts have found the ***Daubert*** test more flexible than ***Frye***, stating, "It is clear the [Supreme] Court did not intend for a trial judge to automatically exclude relevant evidence if one of these conditions was not fully satisfied." ***Jenson v. Eveleth Taconite Co.***, 130 F.3d 1287, 1298 (8th Cir. 1997), *cert. denied,* 118 S. Ct. 2370. *See also*

Hose v. Chicago Northwestern Transportation Co., 70 F.3d 968 (8th Cir. 1995). In ***Jenson***, the Special Master had ruled that testimony from psychiatrists and psychologists concerning mental anguish in a sexual harassment case was inadmissible.[91] The 8th Circuit Court looked at both the ***Daubert*** test and the federal rule and stated, "The record indicates the opinion evidence offered by the plaintiffs' expert witnesses was thorough and meticulously presented. The methodology for arriving at their opinions was laid out clearly by each witness." ***Jenson***, 130 F.3d at 1298.

In Missouri, section 490.065.1, RSMo 1994, states that:

> if scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise.

Dorman argues that ***Daubert*** overrules ***Frye*** because the Missouri statute is similar to the federal rule discussed in ***Daubert***.

The Western District Court of Appeals notes that the Missouri Supreme Court has not decided which standard should be used to determine the admission of expert testimony. ***Whitman's Candies, Inc. v. Pet Inc.***, 974 S.W.2d 519, 528 (Mo. App., W.D. 1998). The Missouri Supreme Court has adopted the Frye test. ***Callahan v. Cardinal Glennon Hosp.***, 863 S.W.2d 852, 860 (Mo. banc 1993). But the Missouri Supreme Court has also ordered the lower court to follow the statute to determine whether the expert's testimony should be admitted. ***Lasky v. Union Electric Co.***, 936 S.W.2d 797 (Mo. banc 1997). Because of the uncertainty, the ***Whitman*** court looked at the requirements under both tests and found that the plaintiff's expert, a consumer psychologist, satisfied both the ***Frye*** and ***Daubert*** tests. ***Whitman's***, 974 S.W.2d at 528.

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[91]The Special Master is quoted as stating, "Experts' . . . know no more than judges about what causes mental changes—which is to say that they know almost nothing." ***Jenson***, 130 F.3d at 1297.

We find that the testimony in this case also satisfies both tests. Dr. Rudolph has a PhD in biochemistry from Oklahoma State University, and a Doctor of Osteopathic Medicine degree from Texas College of Osteopathic Medicine. He was certified to perform chelation therapy by the American Board of Chelation Therapy in 1982. He lists 20 publications, including a lab manual for clinical biochemistry and many articles about his clinical chelation therapy studies.[92] Chelation therapy has been tested by both proponents and opponents as noted in our findings. There are specific standards set forth in the studies that support chelation therapy, and the methodology is clearly stated. Dorman's expert explained the problems with performing the double-blind studies because of (1) ethical concerns - failing to provide helpful treatment, and (2) practical concerns – time span of therapy and funding. The Board's expert acknowledged these limitations in the case of surgery and stated that no double-blind studies should be performed, but denied that these problems exist for chelation therapy. While acknowledging the limitations of these studies, as noted by the Board's expert, we find that the studies of chelation therapy pertain to scientific knowledge and assist the trier of fact to determine the facts at issue.

The Board argues that the ***Frye*** test and the last prong of the ***Daubert*** test would render testimony about this treatment inadmissible. We disagree. Approximately 1,000 to 1,500 doctors treat patients with chelation therapy for disorders other than heavy metal poisoning. They are organized into the American College for Advancement in Medicine, which performs studies, publishes articles, and has established a protocol for treatment. While the majority of doctors do not use chelation therapy in this way, it is an innovative use of a treatment by a minority of

[92]Resp. Ex. R.

doctors. The off-label use of drugs is generally accepted by the medical profession. These facts indicate an "honest difference of opinion" under Missouri case law.[93]

The testimony is certainly relevant since Dorman's defense against the Board's charges rests on his assertions that chelation therapy is appropriate treatment for conditions other than that for which it has been approved by the FDA. It will also aid this Commission in making our determination as to whether Dorman's use of chelation therapy would subject his license to discipline as the Board maintains.

We deny the Board's motion to exclude all testimony on chelation therapy as used in treatment other than to remove heavy metals from the blood.

Count I

The Board alleges that there is cause to discipline Dorman's license under section 334.100.2 RSMo Supp. 1987-97,[94] which provide that the following are grounds for discipline:

> (4) Misconduct, fraud, misrepresentation, dishonesty, unethical conduct or unprofessional conduct in the performance of the functions or duties of any profession licensed or regulated by this chapter, including, but not limited to, the following:
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> * * *
>
> (c) Willfully and continually performing inappropriate or unnecessary treatment, diagnostic tests or medical or surgical services[.]
>
> (5) Any conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public; or incompetency, gross negligence or repeated negligence in the performance of the functions or duties of any profession licensed or regulated by this chapter. For the purposes of this subdivision, "**repeated negligence**" means the failure, on more than one

[93] *See* ***Ladish v. Gordon***, 879 S.W.2d 623 (Mo. App., W.D. 1994).

[94] Because Dorman has been using chelation therapy since the early 1980s, and continued to do so up until the time of the hearing, we cite the 1997 version of the statute.

> occasion, to use that degree of skill and learning ordinarily used under the same or similar circumstances by the member of the applicant's or licensee's profession[.]

The Board argues that the use of chelation therapy for any purpose other than for the removal of heavy metals from the body, such as is necessary in the case of lead poisoning, is unprofessional conduct, incompetency, gross negligence, and repeated negligence. The Board argues that Dorman's use of chelation therapy is harmful and dangerous to the mental and physical health of his patients and the public.[95]

Incompetency is a general lack of present ability or lack of a disposition to use a present ability to perform a given duty. ***Missouri Bd. for Arch'ts, Prof'l Eng'rs & Land Surveyors v. Duncan***, No. AR-84-0239 at 116-17 (Mo. Admin. Hearing Comm'n Nov. 15, 1985), *aff'd*, 744 S.W.2d 524 (Mo. App., E.D. 1988). Misconduct is "the willful doing of an act with a wrongful intention[.]" ***Duncan***, at 125. Gross negligence is "an act or course of conduct which demonstrates a conscious indifference to a professional duty" which constitutes "a gross deviation from the standard of care which a reasonable person would exercise in the situation." ***Duncan v. Missouri Bd. for Architects, Prof'l Eng'rs and Land Surveyors***, 744 S.W.2d 524, 533 and n.6 (Mo. App., E.D. 1988). We may infer the requisite mental state from the conduct of the licensee "in light of all surrounding circumstances." *Id.* at 533. The standard of care must usually be established by expert testimony. ***Dine v. Williams***, 830 S.W.2d 453, 456 (Mo. App., W.D. 1992).

Dorman has been treating patients with chelation therapy since the early 1980s and continues to do so. The Board argues that the therapy does not meet the standard of care when used, as Dorman uses it, in the treatment of atherosclerosis and other vascular diseases. The

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[95]For a discussion of chelation therapy as a cause to discipline a doctor's license, see Cohen, *Holistic Health Care Including Alternative and Complimentary Medicine in Insurance and Regulatory Schemes*, 38 Ariz. Law Rev. 83, 113-18 (1996).

Board's complaint alleges that Dorman's treatments constitute unprofessional conduct, incompetency, gross negligence, and repeated negligence, and are harmful and dangerous to the mental and physical health of a patient or the public. We disagree.

The Board cites many federal cases that have found that chelation therapy will not be covered by Medicaid or other private insurance companies. However, many treatments are not covered by insurance funds, but do not constitute incompetent or negligent treatment. Other states have dealt with the issue of disciplining doctors for using chelation therapy.[96]

In ***Rogers v. State Bd. of Medical Examiners***, 371 So.2d 1037 (Fla. Dist. Ct. App. 1979), the Florida Board ordered Rogers to stop chelation therapy and put his license to practice medicine on probation for one year. Rogers appealed. The court found that the authority to discipline the doctor's license must have a reasonable relationship to the public safety, health, morals and general welfare, and that the Board's actions condemning chelation therapy did not. The court stated:

> [I]t is relevant to note that neither BCMA [Brevard County Medical Association], the hearing officer nor the Board has made any finding that chelation therapy is in any respect harmful or hazardous to the patient. Rather, the Board's decision appears to have been based upon the hearing officer's administrative determination that chelation therapy is 'quackery under the guise of scientific medicine.'

Id. at 1040. The court noted that the "record clearly reveals that chelation therapy is widely used as a 'treatment' for arteriosclerosis, though by a definite minority of the medical profession." *Id.*

[96] An interesting twist on the issue is found in ***Moore v. Baker***, 989 F.2d 1129 (11th Cir. 1993). In this case Moore, a patient who suffered permanent brain damage following a carotid endarterectomy, claimed that Dr. Baker violated Georgia's informed consent law by failing to advise her that chelation therapy was available as an alternative to coronary surgery. The court found that there was no duty to inform because it is not recognized by a majority of physicians as a standard alternative treatment for blockage of the left carotid artery. *Id.* at 1133-34.

It was also considered important that Rogers never claimed that this would cure his patients' conditions, and fully disclosed that this was not a "mainstream" treatment.

The court considered evidence that chelation therapy had benefited certain patients.[97] Because the court found that there was some benefit and that the doctor fully disclosed the nature and risks of the treatment, it stated that the patients had the right to choose such treatments and that the doctor's license could not be disciplined for providing them.

In ***Vance v. Fordham***, 671 P.2d 124 (Utah 1983), Vance's osteopathic physician's license was revoked for failing to complete physical examinations before treatment, prescribing chelation therapy for atherosclerosis, prescribing laetrile, and using kinesiology and Kirlian photography. The district court and the Supreme Court affirmed the Department's revocation, finding that testimony that chelation therapy and laetrile therapy were not standard accepted medical treatments was credible and that the Department's decision was not arbitrary and capricious.

Two other cases focused not on chelation therapy itself, but on an agreement not to use it and on the type of doctor who could use it. In ***Sletten v. Briggs***, 448 N.W.2d 607 (N.D. 1989), a doctor had entered into a settlement stipulation forbidding the use of chelation therapy. He treated with chelation therapy, and the Board revoked his license. The court stated: "We do not determine the efficacy of chelation therapy, which is, according to the evidence, at best controversial." *Id.* at 609. The court affirmed the discipline because the doctor had violated the stipulation. In ***DeHart v. State Dep't of Licensing and Reg.***, 293 N.W.2d 806, 809-10 (Mich. Ct. App. 1980), the court upheld license revocation of a podiatrist who was practicing chelation therapy because it constituted the practice of medicine rather than podiatry.

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[97]The Board had refused to hear any patient testimony. One board member stated: "I think that having a string of patients come up with anecdotal stories about how much better they felt the next day or the next year would not be admissible in any scientific inquiry into the effectiveness of any mode of treatment, and I think that that would not be helpful, nor would it protect the rights of the petitioner, or the health of the patients . . . . Patients themselves are not competent to make those judgements." ***Rogers***, 371 So.2d at 1041.

In the present case, the Board's experts testified that treatment with chelation therapy for anything other than removal of heavy metals was below the standard of care because it has not been shown to be effective to treat anything else. Dorman's expert and most of the Board's experts agree that chelation therapy is safe when used according to ACAM Protocol, and we have so found. (Finding 12.) Therefore, the argument that this treatment is below the standard of care relies on testimony that it is not effective in treating the particular ailment and that providing this treatment keeps the patient from seeking more established treatment methods.

We find that Dorman has provided us with evidence that chelation therapy treatments provide relief to some people and cause physical harm to no one. Studies, whether the perfect double-blind studies or something less than those, show patients whose statistics in certain areas are definitely improving. (Findings 17 and 23.) Something – chelation therapy alone, or chelation therapy combined with the nutrition and exercise regime – is making these patients feel better, walk farther, and experience less pain. These reports and studies are based on, not just one patient or ten patients, but thousands of patients. These patients are not being used as guinea pigs because they are fully informed about the treatment, and they are not the victims of a hoax or fraudulent practice because this treatment does benefit some patients.

The Board attacks chelation therapy because doctors cannot agree on the exact method by which it might produce the desired effect within the body. However, the Board's own expert testified that this is true of many other drugs.[98] Rudolph testified as to the proposed method of action by which chelation therapy aids in the treatment of circulatory disorders. When asked if he accepted this hypothesis, the Board's expert stated, "It is chemically and biologically plausible

[98]Mancini Depo. Tr. at 49.

but there is currently not a shred of evidence to say that it's true."[99] We accept that it is a plausible explanation of the action of chelation therapy in the body.

The argument that proponents of chelation therapy are keeping patients from treatment that is potentially more beneficial is unfounded. Dr. Rudolph testified that many of his patients and the patients in the chelation therapy studies chose the option of chelation therapy **after** they had exhausted the options offered by more traditional medical treatments. R.S. testified that his doctors informed him that his condition was inoperable, and left him with 14 pills a day, the inability to walk more than a block, and memory loss. In addition, the ACAM Protocol states that referral for surgery may be needed. (Finding 47.) Dorman also testified that he would refer patients to hospitals for further treatment if necessary.

The Board asks us to find that the use of chelation therapy is incompetent, grossly negligent, inappropriate, dangerous to the public, and constitutes misconduct. We have found gross negligence, incompetence and/or conduct that might have been harmful to a patient in the following cases: ***Board of Healing Arts v. Barker***, No. 87-000117 HA (Mo. Admin. Hearing Comm'n Aug. 12, 1997) (failure to refer and incompetent treatment of a particular patient); ***Board of Healing Arts v. Bever***, No. 94-000970 HA (Mo. Admin. Hearing Comm'n Sept. 22, 1997) (failing to diagnose a condition, failing to perform tests, and delaying transfer); ***Board of Healing Arts v. Butcher***, No. 95-002229 HA (Mo. Admin. Hearing Comm'n July 9, 1997) (prescribing controlled substances without sufficient medical records or histories); ***Board of Healing Arts v. Colom***, No. 94-000984 HA (Mo. Admin. Hearing Comm'n Dec. 17, 1998) (prescribing excessive medication for an excessive period of time, failing to warn of dangers of medication).

[99]Hearing Tr. at 184.

The Board asks us to equate these doctors' conduct with Dorman's conduct in this case, that of giving patients a treatment that has provided benefit to many patients, harms no one, and is given with informed consent and the information that this treatment may not work on all patients. This is a very different situation than the cases we have decided in the past. Despite the Board's experts' testimony that there is no benefit to be derived from chelation therapy, the evidence shows that patients are being helped. (Findings 17, 23, 32-41.) We cannot state that an entire treatment method that provides benefits to patients without harming them constitutes incompetent, inappropriate, grossly negligent, or negligent treatment. Nor can we say that this treatment is misconduct, unprofessional, or a danger to the public.

We find no cause to discipline Dorman's license under Count I.

Count II

The Board alleges that there is cause to discipline Dorman's license for his treatment of patient A.S. under section 334.100.2, RSMo Supp. 1987 and 1989,[100] which provided that the following were cause for discipline:

> (4) Misconduct, fraud, misrepresentation, dishonesty, unethical conduct or unprofessional conduct in the performance of the functions or duties of any profession licensed or regulated by this chapter, including, but not limited to, the following:
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> * * *
>
> (c) Willfully and continually performing inappropriate or unnecessary treatment, diagnostic tests or medical or surgical services[.]
>
> * * *
>
> (5) Any conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public; or incompetency, gross negligence or repeated negligence

[100]The language is the same in both supplements.

> in the performance of the functions or duties of any professional licensed or regulated by this chapter. For the purposes of this subdivision, "**repeated negligence**" means the failure, on more than one occasion, to use that degree of skill and learning ordinarily used under the same or similar circumstances by members of the applicant's or licensee's profession[.]

The Board's complaint alleges that Dorman treated A.S. with chelation therapy without determining the presence of heavy metals in the blood. Dorman was using chelation therapy for the treatment of vascular disease, not for the treatment of heavy metal poisoning. Therefore, there was no need to test for heavy metals in the blood, and Dorman's license is not subject to discipline for failing to do so.

The Board's expert testified that Dorman treated A.S. for atherosclerosis without any basis for that diagnosis. Dorman stated that he based his diagnosis on years of treating this patient. He testified that she had experienced respiratory problems and difficulty breathing. He described testing that he had performed, his discussions with the patient, and his own knowledge of her condition, which was developed over the treatment period. He stated that A.S. had a systolic murmur, a history of circulatory problems in her feet, and respiratory problems. These are consistent with a diagnosis of atherosclerosis.

We find that Dorman had a basis for his diagnosis of atherosclerosis.

The Board's complaint alleges that the use of chelation therapy for the treatment of A.S.'s arteriosclerosis is cause for discipline. We have determined that the use of chelation therapy for other purposes than the removal of heavy metals is not *per se* cause to discipline Dorman's license.

Meyers testified that Dorman failed to meet ACAM protocol for administering chelation therapy because of insufficient diagnosis and testing before the treatments. Dorman testified that he did perform sufficient examinations during the two periods of chelation therapy. He had been

treating A.S. for ten years before the first chelation therapy treatment. He performed specific testing before administration, even if he did not document a full physical examination. All of his dosage amounts of EDTA were within the Protocol amounts. His lack of follow-up was explained by the small amounts of EDTA given, the small number of treatments, and the patient's fragile veins. The Protocol also states that follow-up is required after a longer series of chelation therapy than A.S. received at either therapy period. Dorman continued to treat A.S. after each chelation therapy period and was able to follow her progress. He stated that he stopped the treatments because the patient was feeling better and could not justify continuing the treatment when the patient was asymptomatic.

We find that Dorman adhered to the ACAM Protocol in administering chelation therapy to A.S.

The Board's complaint also alleges that Dorman's treatment of A.S. was cause for discipline because he injected A.S. with magnesium sulfate and magnesium chloride without documenting the reason for doing so.[101] Dorman explained the rationale for choosing to use magnesium rather than a drug such as Verapamil. He stated that it has the positive effects of Verapamil without the negative side effects and that it acts as a good chelating agent. Dorman testified that his patients had suffered no negative side effects from the magnesium except for a slight stinging at the site of injection.[102]

We find no cause to discipline Dorman's license under Count II.

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[101]The Board's expert also disagreed with Dorman's use of vitamin C injections and medications that Dorman prescribed for high blood pressure, but there is no allegation in the first amended complaint that these are cause to discipline Dorman's license. The Board does not argue in its brief that these are cause for discipline. In addition, Dorman described the benefits of vitamin C injections and counters the expert's criticisms of the medication.

[102]Hearing Tr. at 403.

Count III

The Board alleges that there is cause to discipline Dorman's license for his treatment of patient J.W. under section 334.2(4)(c) and (5), RSMo, Supp. 1987 and 1989, as quoted in Count II.

The Board's complaint alleges that Dorman treated J.W. with chelation therapy without determining the presence of heavy metals in the blood. Dorman was using chelation therapy for the treatment of vascular disease, not for the treatment of heavy metal poisoning. Therefore, there was no need to test for heavy metals in the blood, and Dorman's license is not subject to discipline for failing to do so.

The Board's expert testified that Dorman treated J.W. for arteriosclerosis without any basis for this diagnosis. Dorman testified about his tests, observations and diagnosis as we have noted in our findings. (Findings 65 - 67.) Dr. Meyers testified that these symptoms would not indicate a vascular disease, but could indicate a condition such as an inner ear problem, too little calcium in the blood, or high blood pressure. Dorman testified that dizziness in an older patient indicates a significant likelihood of a circulatory problem. Dorman had also determined that J.W. had very good blood pressure. (Finding 66.) Dorman also testified that his examination of J.W.'s retina and heart and the results of the Doppler test indicated a vascular problem.

We find that Dorman had a basis for his diagnosis of carotid artery atherosclerosis.

The Board's complaint alleges that the use of chelation therapy for the treatment of J.W.'s arteriosclerosis is cause for discipline. We have determined that the use of chelation therapy for other purposes than the removal of heavy metals is not *per se* cause to discipline Dorman's license.

Meyers testified that Dorman failed to meet ACAM Protocol for administering chelation therapy because of insufficient diagnosis and testing before the treatment. Dorman testified that

his blood test confirmed good kidney and renal function and that his physical evaluation fell within the Protocol standards. He noted the weight, blood pressure, and Doppler test reading. While there is no evidence that Dorman requested medical records from other facilities, he did discuss J.W.'s medical history and prior testing with him.

The Protocol recommends three grams of EDTA, which is equivalent to 20 cc. Because J.W. was an older patient, Dorman started him on 5 cc of EDTA, which is one fourth of what is considered safe, then increased the amount of EDTA, while staying within the Protocol limits. Meyer testified that Dorman did not provide adequate follow-up as required by the Protocol, but Dorman testified that the man took his treatments, felt better, and did not return for follow-up. He also had had only four treatments, and the Protocol mandates the follow–up after 10 to 30 treatments.

We find that Dorman adhered to the ACAM Protocol in treating J.W.

We find no cause for discipline under Count III.

Count IV

The Board alleges that there is cause to discipline Dorman's license for failing to maintain medical records and for keeping incomplete medical records.[103] The Board claims that Dorman's records are inadequate as to symptoms, diagnosis, histories, test results and prognosis, and that this is cause for discipline under section 334.100.2(4)(a), which provides:

> (4) Misconduct, fraud, misrepresentation, dishonesty, unethical conduct or unprofessional conduct in the performance of the functions or duties of any profession licensed or regulated by this chapter, including, but not limited to, the following:
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> (a) Obtaining or attempting to obtain any fee, charge tuition or other compensation by fraud, deception or misrepresentation; willfully and continually overcharging or overtreating patients; or

[103]The Board dropped paragraph 40 in Count IV at the hearing. (Hearing Tr. at 89.)

> charging for visits to the physician's office which did not occur unless the services were contracted for in advance, or the services which were not rendered or documented in the patient's records[.]

The Board's complaint alleges that Dorman filed claims with insurance companies for services not performed or for greater fees than were actually charged to patients. That allegation was dropped at the hearing. The evidence presented and argued on the remainder of Count IV deals with the allegation that Dorman's records fall below the standard of care for accurate record keeping. Section 334.100.2(4)(a) addresses the allegation that was dropped, but does not appear to address the standard of care issue (which is addressed in (5)). In his brief, Dorman asks us to dismiss Counts IV and V for this reason.

The complaint must set forth the course of conduct and the law providing discipline for such conduct. ***Duncan v. Missouri Bd. for Arch'ts, Prof'l Eng'rs, & Land Surveyors***, 744 S.W.2d 524, 538-39 (Mo. App., E.D. 1988). On June 4, 1998, the Board filed a motion for leave to file a second amended complaint, which would have charged that Dorman's conduct is cause for discipline under section 334.100.2(5), RSMo Supp. 1987-97, for failure to keep adequate records. We denied the motion by order dated June 5, 1998. We noted that the motion was filed one year and five months after the original complaint was filed, and that June 4, 1998, was the Thursday before the Monday morning hearing. The Board also asks us to amend the complaint to conform to the testimony that purports to prove that Dorman is subject to discipline under subsection (5). We deny this request.

However, we will consider Dorman placed on notice that the allegation that his method of record keeping fell below the standard of care under section 334.100.2(4) was an allegation of unprofessional conduct in the performance of the functions or duties of a profession regulated by the chapter. Dorman addressed this allegation in his cross-examination and in his brief. We deny

Dorman's motion to dismiss Counts IV and V. Unprofessional conduct is conduct that does not conform to the technical or ethical standards of the profession. MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY 930 (10th ed. 1993).

Dorman argues that he must have scienter – an intent to keep substandard records – in order to be subject to discipline under subdivision (4)(a). However, we are deciding whether his record keeping constitutes unprofessional conduct, and a doctor can unintentionally fail to conform to the technical or ethical standards of his profession and still be subject to discipline.

In reviewing Dorman's patient records, Meyers testified that he was unable to determine the patient's medical histories, symptoms, physical examinations, diagnoses, testing, and documentation of follow-up therapy. Dorman refuted each of these claims, describing his diagnosis and treatments from his patients' medical records, some of which are over 20 years old. In the medical records offered in evidence before this Commission, Dorman has noted dates of visits, and in most cases, a blood pressure reading, temperature reading, and a reason for the visit. The reason for the visit may be the notation of a medication given or a note such as "sore throat – sinus."[104]

From A.S.'s medical records, we were able to see that she saw Dorman during her treatment period for high blood pressure and that she took Enduron for the condition. She also saw Dorman for such conditions as the flu, pain in her knees, pedal edema, burning in her stomach, respiratory problems, exertional dyspnea (difficulty breathing), productive cough, sacroiliac pain, and hip pain. She had a systolic murmur that she had had all of her life and that is usually present because of calcification in the heart valves.[105] A.S.'s medical records of

[104]Pet'r Ex. 11 at 4 (February 5, 1976).
[105]See fn. 70.

subsequent visits and findings indicate that Dorman saw A.S. approximately 183 times[106] during her treatment period. Most entries include blood pressure, weight, temperature, and other diagnosis or medication note.

In J.W.'s medical chart, under the section for physical examinations, Dorman noted "Fundus ASO," and "Heart [illegible] split S2."[107] Dorman used these terms to mean arteriosclerotic eye grounds or retina and split second sound of the heart. Dorman noted the patient's dizziness, nausea, and lack of fever. He noted that the lungs had decreased breath sounds and made check marks to show that he had examined the throat, pharynx, tonsils, abdomen, and lymph nodes. J.W.'s temperature was noted at 97 and his blood pressure at 138/70. Dorman noted "Reflexes DTR ¼," which shows the Doppler test reading.

Dorman admits that his record keeping was not perfect, but he maintains that it has improved over the 28 years he has been practicing medicine. It is clear that Dorman uses a lot of shorthand notations to remind himself of specific diagnoses and treatments, which may make it difficult for another doctor to interpret his records. However, the Board admits that there is no rule in Missouri that attempts to set forth what records must be kept by a doctor in order to constitute professional conduct. There is no rule setting forth an objective standard for a doctor to follow regarding medical record keeping. Meyer testified that the record keeping fell below the standard of care of the profession and definitely fell below the standard currently set by the HCFA for Medicaid patients. Dorman testified that his record keeping fell within the standard of care and allowed him to adequately treat his patients.

The most disturbing example of Dorman's record keeping that was presented to us was that Dorman had not charted one visit with E.F.S. (December 24, 1988) and the medication that

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[106]This number does not include duplicate date entries, or entries that merely show contact with an insurance company or payment.

[107]Pet'r Ex. 9 at 3.

was given and prescribed. Dorman denies that this meeting occurred, but, as noted in our Findings of Fact, we resolve this issue of credibility against him. He stated that his office was not open because it was Christmas Eve, but this is not inconsistent with the testimony of B.S., who stated that she had called the doctor at his home, and he and his wife had traveled to his office to see E.F.S. The failure to document the consultation and medication given is an example of negligent record keeping. However, we do not find that this one incident proves that Dorman's record keeping constituted unprofessional conduct.

We find no cause to discipline Dorman's license under Count IV.

Count V

The Board alleges that there is cause to discipline Dorman's license for failure to maintain adequate medical records for patient F.C. with regard to symptoms, diagnosis, histories, test results and prognosis.[108] The Board cites the same statute as in Count IV, which appears to address the issue dropped better than it addresses the issue that remains in the count. As noted above, we consider that Dorman received sufficient notice of this charge.

The Board's expert testified that Dorman's record keeping fell below the standard of care with regard to F.C. because a heart condition is diagnosed, but no follow-up information is provided and no indications supporting the diagnosis are given. Dorman testified that the patient was being treated for his heart condition by another doctor. Therefore, the diagnosis was in the nature of patient history. Dorman also refilled prescriptions that another doctor had ordered without noting the reason for doing so.

[108]The Board dropped paragraphs 46 and 47 in Count V at the hearing. (Hearing Tr. at 89.) The Board's brief argues that Dorman's treatment of F.C. falls below the standard of care, but the complaint only presents allegations against Dorman's record keeping for this patient. (Pet'r brief at 41.)

Meyer testified that a doctor reviewing the patient's record should have been able to determine such facts from Dorman's records, and, as noted above, the sparseness of the record and Dorman's use of abbreviations and shorthand do make it difficult for another doctor to interpret his records. However, Dorman noted the patient history and medications that the patient was taking, although the diagnosis and prescriptions came from another doctor. Dorman testified that his record keeping fell within the standard of care and allowed him to adequately treat F.C.

We cannot find that Dorman's record keeping for patient F.C. was unprofessional conduct. We find no cause to discipline Dorman's license under Count V.

Count VI

The Board alleges that there is cause to discipline Dorman's license for his treatment of patient E.F.S. under section 334.100.2(4) and (5), RSMo Supp. 1987-89, as quoted in Count II:

> (4) Misconduct, fraud, misrepresentation, dishonesty, unethical conduct or unprofessional conduct in the performance of the functions or duties of any profession licensed or regulated by this chapter[;]
>
> (5) Any conduct or practice which is or might be harmful or dangerous to the mental or physical health of a patient or the public; or incompetency, gross negligence or repeated negligence in the performance of the functions or duties of any professional licensed or regulated by this chapter. For the purposes of this subdivision, "**repeated negligence**" means the failure, on more than one occasion, to use that degree of skill and learning ordinarily used under the same or similar circumstances by members of the applicant's or licensee's profession[.]

The Board claims that Dorman was negligent and violated the standards of care in the treatment of E.F.S. as follows:[109]

1. In negligently failing to diagnose an unstable angina and/or myocardial infarction on or before December 29, 1988.

[109]Board's First Amended Complaint.

2. In negligently failing to refer patient E.F.S. to a cardiologist for further evaluation of clear heart-related symptoms and disease.
3. In negligently failing to prescribe a calcium channel blocking agent such as nitroglycerin when he knew or should have known that a myocardial infarction was in progress on December 21, 1988.
4. In negligently utilizing intravenous peroxide upon patient E.F.S. on or about December 23, 1988, when he knew or should have known that such treatment is not a medically recognized cardiac treatment and that he had been previously requested by the Board to discontinue the use of intravenous peroxide previous to utilizing such on patient E.F.S. The intravenous administration of peroxide aggravated the first myocardial infarction on December 23, 1988, and induced a hypotensive episode associated with the intravenous administration of this drug.
5. In failing to advise patient E.F.S. and his wife of the seriousness of patient E.F.S.'s condition, which was life-threatening and accelerating, and failing to advise of the need for further and immediate care and admission to a proper health care institution where patient E.F.S. could be more properly and effectively remedied, managed, and treated, and by so failing to advise the patient E.F.S., rendered him substandard and inadequate care that caused and/or contributed to cause his death.
6. As the direct and proximate result of Dorman's negligence, patient E.F.S. experienced excruciating pain, suffering, and mental anguish in the period leading up to his death, which was caused by Dorman's negligence.
7. Dorman's course of treatment for patient E.F.S. demonstrates a course of treatment that constitutes unprofessional conduct, incompetency, gross negligence, and repeated negligence.

A. Motion to Amend the Pleadings to Conform to the Evidence

As stated earlier, the complaint must set forth the course of conduct and the law providing discipline for such conduct. ***Duncan***, 744 S.W.2d at 538-39. On June 4, 1998, the Board filed a motion for leave to file a second amended complaint, which would have added additional allegations of negligence that were asserted by Dr. Lee in his testimony. We denied the motion by order dated June 5, 1998. We noted that the motion was filed one year and five months after the original complaint was filed, and that June 4, 1998, was the Thursday before the Monday morning hearing. The Board also asks us to amend the complaint to conform to the testimony, arguing that the complaint's allegations of negligence encompasses additional instances of negligence or that Dorman consented to the new allegations because he addressed these allegations in his cross-examination and in his brief.

The Board asks us to add the following, which all allege that Dorman is subject for discipline in the care and treatment of E.F.S., as follows:[110]

A. In prescribing and recommending to patient E.F.S. on or about December 24, 1988, the drug Theo-Dur, or theophylline, which drug is contraindicated by the package insert and the standard of care for use in myocardial infarction, patient E.F.S. having a myocardial infarction on or about the time Dorman prescribed Theo-Dur.

B. In failing to take an adequate history and/or physical examination on December 9, 1988, and at subsequent visits by patient E.F.S. to Dorman.

C. In failing to get a chest X ray, sonogram, or CT to [sic] scan of E.F.S. on December 21, 1988, or thereafter.

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[110]Petitioner's Reply Brief as to Petitioner's Count VI, Count Directed to Respondent's Treatment of Patient E.F.S.

D. In not investigating a blood pressure of 90/60 when E.F.S. presented on December 21, 1988, with his particular clinical picture at that time.

E. In holding himself out as competent to read and interpret an EKG, or electrocardiogram, on December 21, 1988, and thereafter.

F. In giving the drug Isoptin rather than the drug called for by the standard of care – nitroglycerin – on or about December 21, 1988.

G. In ignoring or failing to competently read an X ray taken by Dr. Wayne Bateman and brought to Dorman on or about December 23, 1988, and advising patient E.F.S. that the concern of Dr. Bateman and Dr. Connelly was "much ado about nothing," or words to that effect.

H. In providing patient E.F.S. with office samples of the drug Isoptin that were well past their stated expiration date.

I. In giving the drug Sorbitrate to a patient with a blood pressure of 90/60 and failing to monitor changes in blood pressure after the ingestion of the drug Sorbitrate.

J. In giving a pain shot of the drug Nubain on or about December 21, 1988.

"The doctrine of amendment to conform to the proof is applied to disciplinary proceedings with great caution." ***Duncan,*** 744 S.W.2d at 539. The purpose of the complaint is to inform the accused of the nature of the charges so that he can adequately prepare his defense. *Id.* at 538-39. Our Regulation 1 CSR 15-2.350(2)(A) provides that the complaint must set forth:

> 2. Any act the licensee has committed that is cause for discipline, with sufficient specificity to enable the licensee to defend against the charge at hearing; and
>
> 3. Any provisions of law that render these acts cause for discipline.

We will deal with each of these individually to determine whether the Board's complaint placed Dorman on notice of the allegations.

A. Although the complaint does not set forth the administration of Theo-Dur as specifically negligent conduct, the complaint does list prescribing 300 mg of Theo-Dur as a course of conduct that Dorman performed with regard to E.F.S.[111] The complaint also alleges that Dorman's care of E.F.S. "demonstrates a course of treatment which constitutes unprofessional conduct, incompetency, gross negligence, and repeated negligence."[112] We find that this allegation was sufficiently pleaded in the complaint.

B. The December 9, 1988, visit was not even referenced in the complaint, and the complaint never references history or physical examinations on the other dates.[113] Therefore, we find that there was insufficient notice in the complaint as to this allegation.

C. The complaint alleges that Dorman failed to diagnose the unstable angina and myocardial infarction on December 21, 1988. We find that this allegation puts Dorman on notice that the Board might present evidence of tests that should have been performed to aid in that diagnosis, such as a chest X ray, sonogram, or CT scan.

D. The Board's complaint never cites failure to react to a low blood pressure reading, and the Reply Brief cites the wrong date of the 90/60 pressure. The Board lists the date as December 21, 1988, while Dorman's medical records for E.F.S. state that his blood pressure on December 21, 1988, was 150/90. The low pressure was taken and recorded on December 23, 1998.

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[111]First Amended Complaint, paragraph 57 states: Respondent administered an injection he stated was for the purpose of 'helping lung capacity' and gave patient E.F.S. MC Isoptin SR (Verapamil) 240 Mg and Theo-Dur 300 mg and Organdin Elixir."

[112]First Amended Complaint, paragraph 64.

[113]We have dealt with the general record keeping allegation toward all of Dorman's patients in Count IV.

We find that Dorman was not placed on notice that he could be subject to discipline for failing to investigate E.F.S.'s blood pressure reading.

E. The complaint states that Dorman took an EKG reading of E.F.S. This should place Dorman on notice that the administration and reading of the EKG test might be subject to scrutiny, and might fit into the general allegations found in section 334.100.2(4) and (5).

F. The complaint lists Isoptin as a drug given on December 21, 1988, and states that Dorman should have prescribed a drug such as nitroglycerin. Although the complaint does not set forth the administration of Isoptin as specifically negligent conduct, the complaint does list prescribing Isoptin as a course of conduct that Dorman performed with regard to E.F.S. We find that this allegation was sufficiently pleaded in the complaint.

G. The complaint states that Dorman dismissed the significance of Bateman's X rays. We find that this placed Dorman on notice that this conduct might be argued as cause for discipline.

H. The complaint lists Isoptin as a drug prescribed on December 21, 1988. This places Dorman on notice that prescribing the type and quality of the drug may be argued as cause for discipline.

I. The complaint lists Sorbitrate as a drug prescribed on December 24, 1988, but there is no evidence that E.F.S.'s blood pressure was 90/60 at this time. The 90/60 blood pressure was recorded on December 23, 1988. We find that Dorman was not placed on notice of this allegation.

J. Although the complaint does not allege that the administration of Nubain is specifically negligent, it does state that Dorman gave E.F.S. an injection of Nubain for pain on December 21, 1988. We find that this places Dorman on notice that this conduct may be argued as a cause for discipline.

The Board argues that Dorman has consented to the addition of these allegations because he objected to its motion to amend the complaint to conform to the evidence, stating that the Board's initial complaint was broad enough to support the additional proof offered by Dr. Lee as to additional, unpleaded acts of negligence. The Board quotes the following language:

> MR. HALL: Your Honor, in an effort to save my client some legal fees, could I just state that I really think that it's probably irrelevant for Mr. Bradford to be offering this motion?
>
> If you look at paragraph 62, it's as the direct and proximate result of the negligence of Respondent, Patient [E.F.S.] experienced excruciating pain, suffering and mental anguish in the period leading up to his death, which was caused by the negligence of the Respondent. It's a claim for negligence. All 21 counts of Dr. Lee's are for negligence. And that's why I address those in my case.
>
> And so I think it's redundant, repetitive, needless for him to even offer the amendment, and I would just ask him to withdraw it so we don't have to go through all of the loop.[114]

However, the testimony proceeds as follows:

> MR. BRADFORD: If that's the concession, and if the concession is that my pleading, the first Amended Complaint, was broad enough to include all of Dr. Lee's 21 issues.
>
> What about the Freddie Carroll? Can we have the same agreement on Freddie Carroll?
>
> COMMISSIONER BUSCH: Well, I've already ruled on your motion. I think you gentleman [sic] may need to talk before we proceed.
>
> MR. HALL: You know, I think we're talking about a legal issue, and I think it's something that the judge has to look at with whether or not that the evidence dealt with that issue, and that's all we're dealing with.[115]

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[114]Hearing Tr. at 755-56.
[115]*Id.* at 756.

In addition, when later discussing this same issue, Mr. Hall stated, "I don't want to make any concessions."[116]

Therefore, we do not consider that Dorman agreed that all allegations were contained in the original complaint.

The Board argues that Dorman consented to the allegations even if they were not specified in the complaint because he addressed them at the hearing and in his brief. However, since we took all objections with the case, Dorman had to argue against all allegations, or risk that we would allow them and that they would be unchallenged. We do not find that Dorman waived his objections that Lee testified to matters beyond that which was specified in the complaint.

We find that the complaint placed Dorman on notice as to allegations A, C, E, F, G, H, J, and we will consider these as potential reasons to discipline his license. We find that there was insufficient notice as to allegations B, D, I, find that Dorman has not waived this objection, and deny the Board's motion to amend the complaint to conform to the evidence.

B. Board's Expert Testimony – Substantial, Credible Evidence

Dorman argues that the testimony of the Board's expert, Dr. Lee, should be disregarded in that it cannot be considered substantial, credible evidence by this Commission because it is based solely on the testimony and journal of B.S. Dorman argues that his evidence proves that B.S. is a liar and that her testimony and journal entries are not reliable enough to provide the factual basis upon which the expert bases his testimony. He cites section 490.065.3, RSMo 1994, which states:

> The facts or data in a particular case upon which an expert bases an opinion or inference may be those perceived by or made known to him at or before the hearing and . . . must be otherwise reasonably reliable.

[116]Hearing Tr. at 758.

Although Dorman has shown that there are some discrepancies in B.S.'s testimony and her journal entries, we do not find that they are inaccurate to the point that the entire record would be rendered unreliable. Dorman argues that he has provided several witnesses who called B.S. a "liar." However, it is the duty of this Commission to judge the credibility of the witnesses. We have the discretion to believe all, part, or none of the testimony of any witness, and we make the choice between any conflicting testimony. ***Harrington,*** 844 S.W.2d at 19.

In addition, the Board states that the expert witness also had access to E.F.S.'s medical records, and personally spoke with E.F.S. and B.S. He examined a drug that Dorman had given E.F.S. when B.S. brought the pill bottle to him.

We do not find B.S. to be a completely unreliable witness, and we find that the Board's expert provided credible, substantial evidence upon which we can base our decision. Based on this and other testimony, we have set forth the facts upon which we issue this decision in our Findings of Fact.

C. Letter of Concern

By letter dated April 1, 1991, the Board informed Dorman that it had reviewed his care and treatment of E.F.S.[117] The letter stated:

> It is a matter of utmost concern to the Board of Healing Arts that you did not make a timely diagnosis and refer your patient for appropriate treatment and that you administered intravenous Vitamin C or Peroxide to this patient with these complaints. You are encouraged to seek immediate assistance when your patients present with serious problems.

Dorman argues that, because the Board did not further discipline him at the time, and simply sent this letter of concern, it cannot proceed with Count VI. However, there is nothing that would prohibit the Board from sending the letter of concern and then filing a complaint.

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[117]Pet'r Ex. 30.

Dorman argues that the Board cannot proceed with this count under the theories of waiver and equitable estoppel because of the prior letter of concern. Estoppel is an equitable doctrine, and this Commission has no jurisdiction to enforce equitable principles. ***Soars v. Soars-Lovelace, Inc.***, 142 S.W.2d 866, 871 (Mo. 1940). Even if we had jurisdiction to hear this claim, estoppel is applied to a governmental entity only upon a showing of "manifest injustice," and Dorman has not shown this. ***Newman v. Melahn***, 817 S.W.2d 588, 590 (Mo. App., E.D. 1991).

D. Causes for Discipline

1. Failure to Diagnose

The Board claims that Dorman's license is subject to discipline for failing to diagnose an unstable angina or myocardial infarction on or before December 29, 1988. Dr. Jackson testified that E.F.S. suffered a heart attack prior to December 29, 1988. Dr. Jackson and Dr. Mahmoud testified that, with E.F.S.'s history, signs such as radiating pain, nausea, and vomiting were signs of a heart attack or coronary event. Dr. Jackson was asked what could have been done in the week prior to December 29, 1988, to have prevented his having a heart attack. He testified that a doctor should have recognized that E.F.S. had coronary disease, and should have ordered or referred him for a stress test and cardiac catheterization. Dr. Lee testified that Dorman should have realized that E.F.S.'s failure to eat for several days was due to more than a backache.

We find that Dorman's failure to diagnose E.F.S.'s condition constitutes negligence and incompetence, and is cause to discipline his license. We find that this conduct does not constitute gross negligence.

2. Failure to Refer

The Board claims that Dorman's license is subject to discipline for failing to refer E.F.S. to another doctor. The Board's expert stated that Dorman should have referred E.F.S. to a

cardiologist for evaluation of his symptoms. Dorman testified that he repeatedly advised E.F.S. to see another doctor, but B.S. testified that he had not done so. Dr. Jackson testified that E.F.S. was very surprised when told of his condition. Other doctors were later able to convince him of the seriousness of his condition and that he needed to go to a hospital. Dorman claimed that E.F.S. resisted the idea of going into the hospital because he did not have medical insurance, and continued to maintain that God would heal him.[118] While the record shows that E.F.S. may have had strong religious beliefs, he did accept treatment for his condition.

Dorman continued to treat E.F.S. for his cardiac condition, prescribing such drugs as Isoptin and Sorbitrate, when, considering the seriousness of E.F.S.'s condition, he clearly lacked the competence to do so. We find that failing to successfully refer E.F.S. to another doctor and continuing to treat him constitutes negligence and incompetence, and is cause to discipline Dorman's license. We find that this conduct does not constitute gross negligence.

3. Failure to Prescribe Calcium Channel Blocking Agent

The Board claims that Dorman's license is subject to discipline for failing to prescribe a calcium channel blocking agent such as nitroglycerin. Dorman testified that Isoptin is a calcium channel blocker, and Dr. Jackson testified that prescribing Isoptin was not below the standard of care. Therefore, we find that prescribing Isoptin rather than nitroglycerin was not negligent, grossly negligent, or incompetent.

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[118]There is some evidence that E.F.S. and his family did express this belief to some extent. Dr. Mahmoud testified: "they thought God will give him health and a cure and they think really what we're doing as physicians in ICU is, of course, coming through God. You know, all of us believe in that, but they think God will do a miracle to this man to cure him and we are – they don't say we don't believe in you. They never said that, but they think God will do a miracle to this man to cure him." (Mahmoud Depo. Tr. at 26-27.)

4. Using Intravenous Peroxide

The Board claims that Dorman's license is subject to discipline for injecting E.F.S. with hydrogen peroxide on December 23, 1988. Dorman denies giving peroxide to E.F.S, and instead testified that he gave intravenous vitamin C because it "boosts the adrenals [and] helps the pituitary. It helps the microcirculation, the capillaries."[119] We have found that Dorman gave E.F.S. an intravenous solution of hydrogen peroxide; thus, we must determine whether this act was cause for discipline. Despite Dorman's testimony that there is a foundation supporting the use of intravenous hydrogen peroxide, we accept the Board's expert testimony that hydrogen peroxide injections are not appropriate treatment for any medical condition.

We find that Dorman's use of intravenous hydrogen peroxide constitutes negligence and incompetence, and is cause to discipline his license. We find that this conduct does not constitute gross negligence.

5. Failure to Advise of Condition

The Board claims that Dorman's license is subject to discipline for failing to advise E.F.S. of the seriousness of his condition despite his history and symptoms. Dorman testified that he informed E.F.S. of his condition, but B.S. denies that he ever mentioned a potential cardiac problem. Dr. Jackson and Dr. Mahmoud testified that E.F.S. and his family seemed shocked by the news that he had suffered a heart attack.

We find that Dorman's failure to advise E.F.S. of his condition constitutes negligence, but not incompetence or gross negligence.

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[119]Hearing Tr. at 445.

6. Causing Pain in Period Leading to Death

The Board claims that Dorman's license is subject to discipline for causing E.F.S. pain in the period leading to his death because he failed to diagnose E.F.S.'s cardiac condition, failed to inform the family of this, and failed to refer to another doctor. Dr. Lee testified:

> I think because of not really paying attention to all of the warning signs of a heart attack on the 21st and giving the peroxide on the 23rd and the failure to really heed good common sense when it comes to treating acute myocardial infarction, including giving Theo-Dur to a patient, that type of thing, I think Dorman actually caused the second heart attack.[120]

Lee also testified in response to the following question:

> Q. When you say Dr. Dorman caused the second heart attack, would it be fair to say that if he had followed the standard of care, the second heart attack might not have occurred?
>
> A. I would go stronger than that. I would say that the second heart attack would not have occurred.
>
> Q. All right.
>
> A. I think that there are just too many – there's just too many mistakes and there are too many problems in this case. Theophylline, Theo-Dur, and the giving peroxide, and the failure to give some of the things that preserve myocardium, and the retarded approach of treating acute myocardial infarction I think caused the second heart attack.
>
> Q. All right. No. 21?
>
> A. Well, 21 is somewhat repetitious of some of the things we have talked about. Because of the second heart attack, there was so much damage to the pump, parentheses, the left ventricle, the future for [E.F.S.] was made. And despite aggressive therapy by Dr. Jay Jackson, death occurred. It is my opinion because of Dr. Dorman's mistakes and incompetence in failure to refer this patient that [E.F.S.] died of complications of congestive heart failure.[121]

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[120] Lee Depo. Tr. at 52.
[121] *Id.* at 53-54.

We find that Dorman's treatment was harmful to E.F.S. and constitutes cause to discipline his license as conduct that is harmful to a patient and that constitutes negligence and incompetence. We find that this conduct does not constitute gross negligence.

7. Prescribing Theophylline

The Board claims that Dorman's license is subject to discipline for prescribing theophylline on December 24, 1988. The Board's expert testified that this drug is contraindicated in the case of acute myocardial infarction, which E.F.S. was experiencing during this time period. Dorman testified that he does not remember seeing E.F.S. on December 24, 1988, and does not remember prescribing theophylline. Dorman states that his office would not have been open on that date because it was Christmas Eve. However, this is not inconsistent with B.S.'s testimony that they called Dorman at his home and that they all made a special trip to his office. We have found that Dorman prescribed theophylline. (Finding 96.)

We find that prescribing theophylline to someone in E.F.S.'s condition constitutes negligence, but not incompetence or gross negligence.

8. Failure to Get Chest X ray

The Board claims that Dorman's license is subject to discipline for failing to order a chest X ray on December 21, 1988. Dr. Lee testified that, considering E.F.S.'s symptoms on that date, Dorman should have ordered a chest X ray, or sonogram, and that failing to do so was below the standard of care. Based on the X rays sent to him by Dr. Bateman, and that Dorman purported to interpret, Dr. Conley also recommended chest X rays and comparisons with previous radiographs.

We find that Dorman's failure to order chest X rays constitutes negligence, but not incompetence or gross negligence.

9. Holding Out as Competent to Read EKG

The Board claims that Dorman's license is subject to discipline for holding himself out as someone who can competently interpret an EKG reading. Dr. Lee testified that, based on Dorman's answers to questions in his deposition, Dorman could not competently interpret an EKG reading because he admitted that he did not know how to measure the QRS. or the PR and QT intervals, which are the basics of an interpretation. Dorman informed E.F.S. that he had suffered an aneurysm, and, according to Dr. Lee's testimony and Dorman's admission, it is impossible to diagnose an aneurysm from an EKG reading. In addition, the EKG leads were improperly placed – something that Dorman never noted.

We find that this is sufficient evidence that Dorman lacked the skill to competently perform and interpret an EKG reading and that his attempt to do so was negligent and incompetent, and is cause to discipline his license. We find that this conduct does not constitute gross negligence.

10. Prescribing Isoptin

The Board claims that Dorman's license is subject to discipline for prescribing Isoptin. Dr. Lee testified that prescribing this was negligent, but Dr. Jackson and Dorman testified that there was no reason that Isoptin should not have been given. We find that prescribing Isoptin was not negligent, grossly negligent, or incompetent.

11. Failure to Read X Ray Correctly

The Board claims that Dorman's license is subject to discipline for failing to correctly read an X ray. B.S. testified that Dorman purported to interpret the thoracic X rays taken by Dr. Bateman, and he told her and her husband, "It looks to me like a lot to do about nothing"

and stated that additional X rays were unnecessary. Dorman denies stating this, and says he told E.F.S. that he was unable to interpret the X rays.

Dr. Lee testified that Dorman should not have dismissed the X ray, but should have called a radiologist or cardiologist. Dr. Bateman sent the films to be interpreted by Dr. Conley, and stated that he did this when he saw something abnormal or unusual. Dr. Conley provided a report based on the thoracic X rays and recommended additional chest X rays.

We find that Dorman's interpretation of the X ray to E.F.S. constitutes negligence and incompetence, but not gross negligence.

12. Providing Expired Isoptin

The Board claims that Dorman's license is subject to discipline for providing E.F.S. with samples of Isoptin that were six months past their expiration date. Dr. Lee testified that this fell below the standard of care of a competent doctor.[122] Dorman argued that the patient threw the pills away, but this is irrelevant to whether Dorman prescribed improper medication. Dorman testified:

> As for the dating . . . I've been involved in the pharmaceutical business and the dating on those things runs for years. And I used to have people that actually were resellers in the market would buy those products from physicians and sell them in Europe or you can sell them back to the – if you're a pharmacist or something and you want to send them back to the manufacturer, you can, and they just relabel it or reassay it and send it back out. But they last for years.[123]

Dorman acknowledged that there were some drugs, such as nitroglycerin, that cannot be used beyond their "shelf life" because of rapid deterioration, but stated that Isoptin is not one of those drugs. The Board provided no further evidence to contradict Dorman's assertions that

[122]Lee Depo. Tr. at 49.
[123]Hearing Tr. at 582.

Isoptin, unlike a drug like Nitroglycerin, is safe and effective for a period of time beyond its official expiration date. Because the time frame is short – six months – we cannot decide whether prescribing the drug was incompetent or negligent without expert testimony to rebut Dorman's assertions. Because the Board failed to meet its burden, we cannot find that prescribing Isoptin that was six months past its expiration date was negligent, grossly negligent, or incompetent.

13. Giving Nubain

The Board claims that Dorman's license is subject to discipline for giving E.F.S. an intramuscular injection of Nubain on December 21, 1988. Dr. Lee testified that "[t]he pain shot was inappropriate."[124] Dorman claims that Nubain is just an analgesic, was not contraindicated by any of E.F.S.'s other medication and was given at a fairly low dose.

We do not find that the injection of Nubain for pain was negligent, grossly negligent, or incompetent.

14. Repeated Negligence

Because there are several instances of negligent conduct in Dorman's treatment of E.F.S., we find cause to discipline his license for repeated negligence.

Count VII

The Board alleges that there is cause to discipline Dorman's license under section 334.100.2(4)(e), RSMo Supp. 1987-1993, for treating a patient with intravenous hydrogen peroxide after signing an agreement with the Board not to do so unless the Board had approved that treatment, and for misrepresenting to the patient that the treatment would be effective to treat his disorder. That statute provides that there is cause for discipline for:

[124]Lee Depo. Tr. at 46.

> (4) Misconduct, fraud, misrepresentation, dishonesty, unethical conduct or unprofessional conduct in the performance of the functions or duties of any profession licensed or regulated by this chapter, including, but not limited to the following:
>
> * * *
>
> (e) Misrepresenting that any disease, ailment or infirmity can be cured by a method, procedure, treatment, medicine or device[.]

Misconduct is "the willful doing of an act with a wrongful intention[.]" ***Duncan***, at 125. Fraud is an intentional perversion of truth to induce another, in reliance on it, to part with some valuable thing belonging to him. ***State ex rel. Williams v. Purl***, 128 S.W. 196, 201 (Mo. 1910). Misrepresentation is a falsehood or untruth made with the intent and purpose of deceit. *See* ***Missouri Dental Bd. v. Bailey***, 731 S.W.2d 272, 274-75 (Mo. App., W.D. 1987). Dishonesty is a lack of integrity, a disposition to defraud or deceive. MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY 333(10th ed. 1993). Unethical and unprofessional behavior is conduct that fails to conform to the technical or ethical standards of the profession. *Id.* at 930.

B.S. testified that Dorman gave E.F.S. an injection of hydrogen peroxide. Dorman denies that he gave E.F.S. an injection of peroxide, but as noted in our Findings of Fact, we have decided this credibility issue against him. (Finding 90.) Therefore, we must determine if this conduct is cause for discipline under subdivision (4)(e). Dorman told B.S. that the injection of peroxide would help her husband, and that he was giving the treatment in spite of an agreement with the Board in which he promised not to do so. Despite Dorman's testimony that there is a foundation that supports the use of intravenous hydrogen peroxide, we accept the Board's expert testimony that hydrogen peroxide injections are not appropriate treatment for any medical condition. In addition, Dorman charted that he administered Vitamin C when he actually administered hydrogen peroxide.

We find that Dorman's representations that the peroxide treatment would effectively treat E.F.S.'s condition constitutes unprofessional conduct, and that his injection of peroxide despite the agreement with the Board that he would not do so constitutes misconduct and dishonesty. Charting that he administered Vitamin C when he administered hydrogen peroxide constitutes misrepresentation, misconduct, and dishonesty. There was no specific testimony that disobeying an agreement with the Board concerning patient treatment constitutes unethical and unprofessional conduct. However, if the facts are such that we could draw a fair and intelligent opinion without expert testimony, we may do so. ***Perez v. State Bd. of Regis'n for the Healing Arts***, 803 S.W.2d 160, 164 (Mo. App., W.D. 1991). We find that Dorman willingly entered into an agreement with the Board that he would not give intravenous peroxide treatments and then deliberately did so in violation of that agreement, and that this is unethical and unprofessional behavior.

Therefore, Dorman's license is subject to discipline under subdivision (4)(e).

Count VIII

The Board alleges that there is cause to discipline Dorman's license under section 334.100.2(5), RSMo Supp. 1987-1997, as quoted in Count II, because Dorman's conduct as set forth in Counts I through VII constitutes repeated negligence.

We have found that Dorman's conduct was negligent only as to the treatment of E.F.S. There were several instances of negligence in his treatment of that one patient, and we have found that Dorman's license is subject to discipline for repeated negligence under Count VI. We find no other instances of repeated negligence with regard to the other counts, and therefore do not find cause for discipline under Count VIII.

Summary

A. Counts I - V

We find that Dorman's license is not subject to discipline under Count I, Count II, Count III, Count IV, or Count V.

B. Count VI

We find that Dorman's failure to diagnose E.F.S.'s condition constitutes negligence and incompetence, and is cause to discipline his license. His failure to refer constitutes negligence and incompetence, and is cause to discipline his license. His use of intravenous peroxide constitutes negligence and incompetence, and is cause to discipline his license. His failure to advise of E.F.S.'s condition was negligent. Dorman's treatment was harmful to E.F.S. and is cause to discipline his license as conduct that is harmful to a patient. Prescribing theophylline to someone in E.F.S's condition was negligent. His failure to get a chest X ray was negligent. Holding himself out as competent to read an EKG constitutes negligence and incompetence, and is cause to discipline his license. Dorman's interpretation of the X ray was negligent and incompetent, and is cause for discipline. Several instances of negligent conduct constitutes repeated negligence.

We find that Dorman prescribed a calcium channel blocker and that there was thus no failure to do so; therefore, this is not cause to discipline his license. Prescribing Isoptin, prescribing expired Isoptin, and administering Nubain are not acts that constitute cause for discipline.

C. Count VII

We find that Dorman's administration of intravenous hydrogen peroxide after signing an agreement with the Board not to do so, his representations that it would help E.F.S.'s condition, and his conduct in charting one medication when he was giving another medication constitute

misrepresentation, misconduct, dishonesty, and unethical and unprofessional conduct, and are cause to discipline his license.

D. Count VIII

Because we found several instances of negligence in Dorman's treatment of E.F.S. and have found cause for discipline for this under Count VI, we find that Dorman's license is not subject to discipline for repeated negligence under Count VIII.

SO ORDERED on June 29, 1999.

SHARON M. BUSCH
Commissioner