Draft Minutes

STATE OF NEVADA
BOARD OF HOMEOPATHIC MEDICAL EXAMINERS

MINUTES

TELEPHONE BOARD MEETING

TUESDAY MAY 12, 2009
5:30 p.m.

Location of Meeting

RENO INTEGRATIVE MEDICAL
6110 Plumas Street, Suite B
Reno, Nevada 89509

MEMBERS OF THE BOARD AND STAFF: The following persons are either members of the Board or staff, and were present or absent as designated:

Cyrus Pourzan, MD, HMD, Member and President , Present
Robert Eslinger,DO, HMD Member and Vice President, Present
Bruce Fong , DO, HMD, Member and Secretary-Treasurer, Absent
Diane Kennedy, Member, Present
John Diamond MD, HMD, Member, Present
Leticia Gardea, Member, Present by phone (phone malfunction) was unable to hear the meeting
KJ Smith, Member, Present
Executive Director, Nancy Eklof, Present
Robert Bryant, Deputy Attorney General, Counsel to the Board, Present

MEMBERS OF THE PUBLIC;

Carol Mathers
Renate Lawrence, RN

1,

A./B The meeting was **called to order at 5:41 p.m. Pacific Time** by Cyrus Pourzan President, and a roll call was taken to determine a quorum. A quorum of 5 members was present.

C .Nancy Eklof, Executive Director confirmed the posting of the meeting
D. Dr. Pourzan welcomed the visitors to the meeting
E, Approval of the Agenda for the meeting.

Motion: Bob Eslinger moved to approve today's agenda
Second:KJ Smith
Action: Approved by unanimous vote

2, The Swearing in of new Board Member Dr. John Diamond. Note: Dr. Diamond replaces Fuller Royal. Cyrus Pourzan recited the Oath of Office to Dr. Diamond.

3. The meeting was conducted under Robert's Rules of Order, 10th Edition

4. Approval of Meeting Minutes from the following Board Meetings: 1/31/09, 2/11/09, and 2/19/09

Motion: KJ Smith made the motion to approve the Minutes for all meetings listed.
Second: Robert Eslinger seconded
Action: Approved (Dr. Diamond abstained as a new board member)

5. Disciplinary Matters – Presentation by Investigative Committee Chair Cyrus Pourzan and Deputy Attorney General Robert Bryant. The identity of the provider(s) were confidential under requirements of state law. Please note each numbered Complaint listed below. The Investigative Committee consists of Dr. Pourzan, Member Diane Kennedy, and Member Leticia Gardner and pursuant to state law, they were not eligible to vote. Voting members included Dr. John Diamond, Dr. Robert Eslinger, and Member KJ Smith.

A. Presentation by the Nevada Attorney General, Deputy Attorney General Robert Bryant, concerning case number 029. Deputy Attorney General Bryant presented the following:

Complaining Parties Alleged as follows: A family of four, mother father, teenager, and a child under the age of 10 presented to the providers at the clinic.

- Clinic alleged told them that they would be cured of Lyme Disease
- Younger child treated, they believed for Lyme, with negative test results
- Mother had reaction to IV medications
- Physician not present in clinic room (and mother asserts she never saw provider)
- Took home medications
- Mother asserts floaters, liver pain, sore hips from shots
- Whole family worse after treatment
- Use of unlicensed provider (even prescribing when licensee not present) and that the individual at appeared in a picture with provider and APH which stated "Our Doctors".

Summary:

Family appeared at the clinic with the wife. Blood testing was completed on all four of the family members.

FATHER: With respect to the husband, blood testing results were received prior to patient being seen. He had a highly elevated Lyme disease IgM and a moderately positive IgG Western Blot blood test, but was negative to Lyme Dot Blot Antigen test in urine. Provider noted no symptomotolgy at the time of presentation. Patient had completed full initial paperwork which included a disclaimer that microscopic viewing of blood specimens was only for education and demonstration purposes (i.e. will not be used as a basis to recommend treatment, the viewing is at no cost, can compare normal blood cells with patient's blood cells. No recommendation is made concerning any CLIA issue as I do not believe that the homeopathic board would have jurisdiction in the first instance to make a CLIA determination (it would have to be the CDC or any designated state agency). A medical history signed by the physician is in the file. As are testing results for Lyme disease and other serologic tests. Based upon the laboratory tests and discussion with the patient, treatment was begun. Treatment generally consisted of IV infusion of phoshpatidyl choline (organ detoxification), bio-oxidative treatments (Blood ozonation and hydrogen peroxide IV), and high dose Vitamin C. Checked with electro-dermal screening for IV ingredient compatibility. IV chart shows ten treatments over a two week period.

Based upon review of file regarding the treatment of the father with the investigative committee, there was not a breach of standard of care and the case as it relates to the father should be dismissed.

TEEN AGE DAUGHTER: Presented with family and had blood work completed. As with her father the physician completed an initial physical examination. The progress report shows seven treatments. Patient had acne and stomach problems and signs of hypothyroid functioning. (Note: Epigastric testing was done for exposure to contaminated well water (Elisa-Act LRA), stool evaluation, and Heidelberg gastogram. Patient was positive on both the IgM and IgG Western blosts and was negative to the urine testing. Patient was evaluated for IV ingredients and showed good compatibility. Rotating treatment of phosphatidyl choline (general detox), bio-oxidative (blood ozonation along with hydrogen peroxide IV and high dose IV vitamin C. Originally 20 to 25 treatments were recommended. Patient was found to begin developing a sulfa based sensitivity (EDS screening) so ingredients were omitted.

Based upon review of file regarding the treatment of the teen age daughter with the investigative committee, there was not a breach of standard of care and the case as it relates to the teen age daughter should be dismissed.

DAUGHTER UNDER 10 YEARS OF AGE: Appointment was set up by the mother. The medical file shows an initial examination by the physician. The patient was negative for Lyme based upon laboratory testing. History indicated that the patient presented with burning type abdominal pain after eating. Multiple testing was conducted including H. Pylori which was negative. Patient had possible hypoglycemic episodes. And presented with a marked left sided lymphadenopaythy (inflammatory change). Multiple allergies were found on ELISA-ACT LRA testing. Progress report charting shows that the patient was treated six times over a period of two weeks. After lab testing came back the physician met again with the mother. Physician felt that patient did not show enough evidence to warrant treatment for Lyme disease. Physician stated he relayed possible issues regarding IV therapies for somebody so young. According to physician the family agreed and came back next day and asked if testing could miss Lyme. The physician indicated that lab testing alone may be insufficient to show Lyme and that it was possible that there was some level of Lyme in the patient's body. Physician started patient for alternating regimen ob bio-oxidative (1/2 dose strength hydrogen peroxide only/no blood ozonation), Vitamin C at ½ dosing strength, and phsphatidyl choline (which was never given). Patient had reaction to peroxide drip which was stopped. Believed to be a sulfa based reaction (negative on EDS). Patient's IV stopped and given saline solution with adrenal extract.

The standard of care issue appears to be twofold. The first is whether the treatment protocols given were appropriate for a child under the age of ten (7). The second is whether the treatment protocol should have been given at all. In review with the investigative committee and other documentation, it did not appear to breach the standard of care in all cases to give a younger child peroxide treatment. With respect to whether the child should have been treated at all, the physician did check for H. Pylori and based upon discussions with the investigative committee, it is believed that Lyme Disease cannot be diagnosed with testing alone. The physician must take the entire picture; including the family history of Lyme. This was a difficult case to review. However, given the lab testing conducted, including H. Pylori, the family history, and the half dosing on a child, the standard of care appears to have been met and this case should be dismissed. Also, to be considered is whether all patient's with Lyme testing will be positive on blot sampling. The answer, as I understand it, is no.

This case should be dismissed as it relates to the daughter under 10 years of age.

MOTHER: Presented with multiple medical complaints to physician. Patient presented with an approximately month old lab result from IGeneX showing a negative result for Lyme disease. (41Kda ++). Physician order, among other tests, additional lyme testing which came back with a negative result. However, based on a clinical picture, and what the physician termed an "equivocal" earlier test, the physician believed that the patient warranted treatment for lyme disease. Physician stated as a possible cause for the testing discrepancy for lyme disease that the patient had been on antibiotic therapy. Patient underwent a course of three treatments with phosphatidyl choline. Patient given then bio-oxidative therapies including blood ozonation outside body, IV hydrogen peroxide, with high dose IV vitamin C. Patient did have certain reaction to sulfa based medication and physician changed orders to IV staff. Five days later patient again had a reaction and somehow the order regarding sulfa based ingredients was missed by staff. Patient recovered but did have a reaction.

Based upon discussion with the Investigative Committee and extensive review, standard of care was met for all but one issue. That being failure to properly supervise and/or ensuring that a changed IV order was missed after it had been changed five days previously. This constitutes a possible violation of NAC 630A.132(2)(f) failure to adequately supervise an APH and/or HA. Recommendation is that no complaint be

filed at this juncture and that protocols of provider be reviewed with a recommendation of possible settlement to be presented to the Board at the next meeting.

General: To the extent that the complaint can be read as being against an APH in the provider's office there was inadequate evidence of any conduct by the APH that would constitute a breach of standard of care. Therefore, allegations against the APH are recommended to be dismissed.

The complaint alleges that an unlicensed person in the office engaged in the practice of homeopathic medicine with the knowledge of provider. There is insufficient evidence to prove that unlicensed activity occurred as conflicting statements were received. Additionally, even if there were evidence of unlicensed activity there is insufficient evidence that the provider knew of any such activity. Provider indicated that staff wear scrub type clothing to ensure compliance with laws relating to health and safety.

FINAL RECOMMENDATION: That a motion be made to dismiss all claims against the APH. That a motion be made to dismiss all claims against the physician but for the claim of possible failure to supervise and that the AG be directed to work with provider on a possible resolution for presentation to the Board.

Member KJ Smith asked DAG Bryant if he would for certain report back concerning the alleged failure to supervise and DAG Bryant answered in the affirmative.

Motion: KJ Smith motion to dismiss all claims but for alleged failure to miss a chart reading with respect to the mother, and directed the Attorney General to work with provider on the issue of possible failure to supervise for missed chart reading and to report back to the Board.
Second: Dr. Eslinger seconded the motion
Action: Passed by unanimous vote.

B. Case Number 038: Chairman Pourzan presented the Complaint Committee recommendation as follows:

The complaining party generally alleged that a homeopathic injectible medication, prepared by the provider and/or staff was contaminated with capnocytophaga species (testing unopened vials) and that the patient involved was diagnosed in a different state with infective endocarditis, Klebsiella bacteremia. The hospital laboratory found the capnocytophaga contamination but results from the state laboratory were not able to confirm the findings.

Recommendation: The oral glyoxal used, according to the manufacturer, was not guaranteed as sterile. Provider cooperated with the investigative committee and health officials in reviewing samples and procedures. State of Nevada health officials tested 42 specimens from the provider and none showed any results of capnocytophaga. Bacterial growth of sphingomomonas clorophenolica/yanoikyae, variovorax paradoxus, and relsonia pickittii were found in some samples provided by the physician. State board of health found (of the 42 samples) positive with coag. negative staph, positive with gram negative rod, 3+ gram negative rod, -2+ gram negative rod all others negative. Stenotrophomonas maltophilia was found on some surfaces in the providers' office. There is no causal connection that at this juncture can be found between the patient's illness and the injectible provided by the physician. Further, only the hospital laboratory identified capnocytophaga which was not confirmed by the state lab in Arizona or by subsequent testing in Nevada.

The provider has voluntary agreed to continue to provide samples for testing through and independent lab and to keep the investigative committee apprised of the results and will coordinate as necessary to ensure patient safety.

Motion: Dr. Eslinger moved to dismiss the complaint
Second: Dr. Diamond seconded the motion.
Action: Passed by unanimous vote

C. **050 Chairman Pourzan presented the finding of the Complaint Committee with recommendation to the Board to dismiss based on the committee's findings**

Female patient received treatment from December 21st through January 26th. Main provider was an APH with a physician providing supervision. Physician indicated that he consulted with APH after the initial encounter of the APH with the patient and that APH would report to him as needed.

Complaints Alleged (Against Physician and APH):

1. Allegedly told that she would be cured during treatment or within 3 months afterword.
2. Claims the APH and/or physician failed to diagnose Lyme Disease
3. Claims APH advised that patient could continue treatments even if she became pregnant. That she worsened after becoming pregnant and being advised to stop homeopathic medications
4. Claims that antibiotics taken after Lyme diagnosis have confined her to bed.

Recommendation: Insufficient evidence to find that APH advised patient that she would be cured. Patient submitted with multiple conditions, provider denied accusation, and there are no independent witnesses. Insufficient evidence to determine that APH and/or physician missed the diagnosis of Lyme based upon laboratory findings which were negative for both IgM and IgG Western Blot tests and for Lym Dot Urin Antigen testing. Insufficient evidence that APH advised that patient could continue treatments if she became pregnant. The allegation is inconsistent with the fact that the APH stopped treatment after patient became pregnant. Patient felt worse after leaving clinic. This could obviously be related to pregnancy, but unknown if related to stopping homeopathic medications.

This complaint should be dismissed.

Motion: Dr. Eslinger moved to dismiss the complaint
Second: KJ Smith seconded the motion.
Action: Passed by unanimous vote.

D. 062 Chairman Pourzan presented the finding of the Complaint Committee with recommendation to the Board to dismiss based on the committee's findings

The complaining party alleged as follows:

She suffered from COPD and asthma since birth. Patient was treated by physician and APH for a period of 10 months. Asserts that APH provided her with high doses of prednisone to combat pulmonary failure. That she traveled to southern California at the recommendation of the APH and did not get better. Asserted that she had to go to the ER and that the ER physician advised that she had developed a reaction to prednisone which put her in a state of psychosis. After 10 months of treatment patient went to the office of the APH and gave him a thank you card. She asserts that she was frustrated with her condition. She states that the APH called police and paramedics believing that she was suicidal. She was escorted to the hospital and released five hours later. Asserts that she faces dual hip replacement as a result of heavy prednisone usage.

Recommendation: Patient was on a high dose of prednisone from a previous provider and did continue prednisone for asthma while being treated with antiobiotics. Possible continued usage of alcohol and cigarette smoking possibly aggravating the medical treatment. Patient at time did show erratic behavior therefore the committee did not question the possible need to call emergency personnel. One card presumably from the patient to the provider contained what appears to be information showing concerning thought patterns. Treatment appears to have met the standard of care given the nature of the case.

The complaint should be dismissed.

Motion: Dr. Eslinger moved to dismiss the complaint
Second: KJ Smith seconded the motion.
Action: Passed by unanimous vote.

E. 056 Chairman Pourzan began presenting the findings of the Complaint Committee when Dr. Eslinger recognized the complaining party from the facts starting to be given by Dr. Pourzan

and did not feel comfortable proceeding with that knowledge. Loss of a quorum and the Board moved to the next presentation. Matter tabled for a further meeting.

F. 078 Chairman Pourzan presented the finding of the Complaint Committee with recommendation to the Board to dismiss based on the committee's findings

Teenage patient seen by physician and APH in January of 2006. In February of 2009, patient filed a complaint alleging that she was exposed to Hepatitis B at the clinic through MAH procedure. Complaining party asserts that she never received a hepatitis B vaccination.

Recommendation: At this juncture no causal connection can be found between any procedure at the clinic and the apparent laboratory results. The results may be consistent with vaccination. A review of the physician's notes indicated that patient was uncertain of vaccination for hepatitis B. Notes from a physician assistant who treated patient in 2009 state that patient shows a pattern of immunization and not of infection.

The complaint should be dismissed.

Motion: Dr. Diamond made a motion to dismiss the complaint.
Second: KJ Smith seconded the motion.
Action: Passed by unanimous vote.

G. 011 Chairman Pourzan presented the finding of the Complaint Committee with recommendation to the Board to dismiss based on the committee's findings

Of note is at the time of the subject complaint, the current licensee was working under a medical license in an approved facility to obtain homeopathic training.
Complaining party was a teenager. The complaining party's complaints were:

1. Use of wording in advertising material that was not hers.
2. No bettering of condition.
3. Assertion that patient was told that she would get better quicker because of her age.
4. Claimed that she would have "Lyme" cured
5. Claimed that she developed shingles and chicken pox from treatments
6. Asserts that she still has Lyme and still suffering from treatments
7. Patient describes treatments beginning in August of one year, went back in March of the next year, and returned in April of the next year.

Recommendation: Provider saw patient only twice and then care was transferred to anther provider. There is no independent verification that the complaining party did not approve of the material in the advertisement. Laboratory results received two days after the patient first presented are circled "negative" for Lyme with the initials of the provider. A negative Lyme lab can be seen as inconsistent with the assertion that the provider advised patient that she would be cured of Lyme. Additionally, patient returned to the clinic over a lengthy period of time. Insufficient evidence to determine whether patient's name was used in advertisement with unapproved language or that she was advised that she could be cured of Lyme. Insufficient evidence of breach of standard of care by provider.

This complaint should be dismissed.

Motion: Dr. Eslinger made a motion to dismiss the complaint.
Second: Dr. Diamond seconded the motion.
Action: Passed by unanimous vote.

6. Discusion/Action Report from the Finance Committee regarding board finances, the Attorney General bill, and possible request to change office locations.

Finance Chair Diane Kennedy reported on the effort to work out an arrangement with the Attorney General's office to write off a significant amount of the bill the Board owes. The AG office wants the board to arrange a payment plan prior to making any adjustments or write-offs. In addition the Board office will

move in July 2009 to another location at the same monthly rent ($400) She also reported that the Balance Sheet has been submitted to the Legislative Auditor.
Discussion action/ Finance Committee report

No action

7. Public Comment: No public comment.
8. Discussion/Action Announcements, next meeting dates and date and location of annual meeting. **No action date of annual meeting to be determined.**

9. Adjournment (Discussion/Action)

Motion: KJ Smith to adjourn
Second: Dr. John Diamond
Action: Pass unanimously

Meeting ended at 6:40 P.M. Pacific Time

Phone recording malfunction: The meeting was held for the first time at board member Robert Eslinger's clinic. We (The Board) utilizes Budget Conferencing service to record all telephone meetings. Board Member Leticia Gardea was on the telephone from Las Vegas. The recording was confirmed by Budget Conferencing and we commenced the meeting. WE could not hear member Gardea and Robert Eslinger tried to correct the problem and inadvertedly muted the transmission. At that time I was concerned about the recording and took out a board tape recorder from my brief case. Dropped in a 60 minute tape and it begin to record. Later when checking the tape – there was no recording. There is an email document confirming that Budget Conferencing recorded the meeting and when checked – found it had been muted.