

BEFORE THE NORTH CAROLINA MEDICAL BOARD

IN THE MATTER OF ) TRANSCRIPT OF THE  
 )  
RASHID ALI BUTTAR, D.O., ) HEARING  
 ) Respondent. )  
-----

PANEL MEMBERS OF THE BOARD

Janelle A. Rhyne, M.D., President  
H. Arthur McCulloch, M.D.  
William A. Walker, M.D.

April 23 2008, 9:30 a.m. - 6:15 p.m.  
April 24, 2008, 7:00 a.m. - 8:48 p.m.  
1203 Front Street  
Raleigh, North Carolina

BARBARA H. LAXTON, NOTARY PUBLIC

APPEARANCES

For the North Carolina Medical Board:

Mr. Marcus Jimison  
Ms. Katherine Carpenter  
Mr. Thomas Mansfield  
1203 Front Street  
Raleigh, North Carolina 27609

For the Respondent:

Mr. H. Edward Knox  
Ms. Lisa G. Godfrey  
817 East Trade Street  
Charlotte, North Carolina 28202

T A B L E O F C O N T E N T S

<u>Description</u>	<u>Page Number</u>
Motion in Limine	15
Opening Statement by Mr. Jimison	18
Opening Statement by Mr. Knox	28
STEPHANIE KENNY, sworn	
Direct Examination by Mr. Jimison	41
Cross-Examination by Mr. Knox	58
Redirect Examination by Mr. Jimison	78
Recross Examination by Mr. Knox	85
Examination by the Panel Members	87
JERRY MESSINA, sworn (telephone testimony)	
Direct Examination by Mr. Jimison	90
Cross-Examination by Ms. Godfrey	105
Redirect Examination by Mr. Jimison	109
Recross Examination by Ms. Godfrey	115
XXXXXXXXX XXXXXX, Mother of Patient E, sworn (telephone testimony)	

Direct Examination by Mr. Jimison	119
Cross-Examination by Mr. Knox	129
Redirect Examination by Mr. Jimison	139
Recross Examination by Mr. Knox	141
Examination by the Panel Members	142
Further Recross Examination by Mr. Knox	145

MARIE CHURCH, sworn

Direct Examination by Mr. Jimison	148
Cross-Examination by Ms. Godfrey	160
Redirect Examination by Mr. Jimison	169
Examination by the Board Members	170

DENNICE H. HERMAN, M.D., sworn

Direct Examination by Mr. Jimison	171
Cross-Examination by Ms. Godfrey	179
Redirect Examination by Mr. Jimison	183

JOHN L. PETERSON, M.D., sworn

Direct Examination by Mr. Jimison	186
Cross-Examination by Mr. Knox	229
Redirect Examination by Mr. Jimison	274
Examination by Panel Members	276

Videotape Deposition of Emilia Ripoll, M.D. 282

RICHARD HEWITT, sworn

Direct Examination by Mr. Knox 283

Examination by Panel Members 288

Continued Direct Examination by Mr. Knox 293

Examination by Panel Members 293

Cross-Examination by Mr. Jimison 294

Examination by Panel Members 295

Adjournment at 6:15 p.m. on April 23, 2008

\*\*\*\*\*

Reconvene at 7:00 a.m. on April 24, 2008

JOHN L. WILSON, JR., sworn

Direct Examination by Ms. Godfrey 299

Cross-Examination by Mr. Jimison 317

Redirect Examination by Ms. Godfrey 335

Examination by Panel Members 338

Videotape Deposition of Erlene Thomas 357

Videotape Deposition of Ned M. Jarrett 358

RASHID A. BUTTAR, D.O. sworn	
Direct Examination by Ms. Godfrey	359
Cross-Examination by Mr. Jimison	463
Examination by Panel Members	526
Videotape Deposition of William John Hewitt	
	558
NINA NEWTON WALL, sworn	
Direct Examination by Mr. Knox	572
Cross-Examination by Mr. Jimison	581
Examination by Panel Members	582
Redirect Examination by Mr. Knox	582
Videotape Deposition of Ellen Hinshaw	
	583
JANE GARCIA, N.P., sworn	
Direct Examination by Ms. Godfrey	583
Cross-Examination by Mr. Jimison	608
Direct Examination by Ms. Godfrey	614
Examination by Panel Members	616
Recross Examination by Mr. Jimison	632
Further Examination by Panel Members	633

RASHID A. BUTTAR, D.O., REBUTTAL WITNESS

Examination by Mr. Mansfield 633

Closing Statement by Mr. Godfrey 658

Closing Statement by Mr. Jimison 679

Executive Session - Decision 713

\*\*\*\*\*

Phase II

Statement by Ms. Godfrey 714

Statement by Mr. Jimison 718

Statement by Mr. Knox 724

Comments by Dr. Buttar 727

Executive Session - Decision 728

BOARD'S EXHIBITS:

- 1 - Medical Records and Billing of Patient D (76 p)
- 2 - Medical Records and Billing of Patient C (267 p)
- 3 - Medical Records and Billing of Patient B (191 p)
- 4 - Medical Records and Billing of Patient A (158 p)
- 5 - Medical Records and Billing of Patient E (110 p)
- 6 - Expert Review documents from John L. Peterson, M.D.  
(9 p)
- 7 - Curriculum Vitae of John L. Peterson, M.D. (4 p)
- 8 - Curriculum Vitae of Rashid Ali Buttar, D.O. (12 p)
- 9 - Collaborative Practice Agreement for Jane D. Garcia,  
N.P. (4 p)
- 10 - Documents regarding the cost of certain treatments  
administered by Dr. Buttar (3 p)
- 11 - Curriculum Vitae of Jane D. Garcia, N.P. (2 p)
- 12 - Deposition of Rashid Ali Buttar, D.O. (34 p, 2 sided)
- 13 - Deposition of James Robert Biddle, M.D. (17 p, 2 sided)
- 14 - Deposition of Dennice H. Herman, M.D. (19 p, 2 sided)
- 15 - Deposition of John L. Peterson, M.D. (32 p, 2 sided)
- 16 - Deposition of Emilia Ripoll, M.D. (11 p, 2 sided)
- 17 - Deposition of John L. Wilson, Jr., M.D. (19 p, 2 sided)
- 18 - Article from the New England Journal of Medicine (1 p)



- 19 - Article from Memorial Sloan-Kettering Center (5 p)
- 20 - Article from Canadian Interactive Cancer Therapies, Association (5 p)
- 21 - Article from American Cancer society (4 p)
- 22 - Complaint Form regarding Patient C (4 p)
- 23 - Complaint Form regarding Patient B (3 p)
- 24 - Complaint Form regarding Patient A (2 p)
- 25 - 3/24/2008 E-mail from Dr. Buttar re NCMB Hearing (1 p)
- 26 - HOUSE DRH70244-LU-71 (03/20) Bill, Due Process of Physicians (6 p)
- 27 - Session Law 2003-366, House Bill 886, amended, 8/1/2003 (3 p)

RESPONDENT RASHID A. BUTTAR, D.O. EXHIBITS

- 1 - CV of Rashid A. Buttar, D.O. (12 p)
- 2 - CV of Jane Garcia, N.P. (2 p)
- 3 - 1/30/2004 Correspondence from David Henderson (1 p)
- 4 - 3/11/2004 Correspondence to Thomas Mansfield (1 p)
- 5 - Collaborative N.P. Practice Agreement (4 p)
- 6 - Patient A Consent Forms (3 p)
- 7 - 8/12/2006 Letter from John Clements, M.D. (1 p)
- 8 - Review Sheets from John Peterson, M.D. (9 p)
- 9 - Patient A Progress Notes (18 p)
- 10 - Patient A IRR Sheets (3 p)
- 11 - Patient A 7/13/2006 Ralph Freedman, M.D. note (1 p)
- 12 - Patient B Consent Forms (2 p)
- 13 - Patient B Progress Notes, Physical Exam (18 p)
- 14 - Patient B Lab reports (27 p)
- 15 - Medical Dictionary given to Dr. Buttar by Patient B  
(retained by Dr. Buttar)
- 16 - Patient B Estate File (12 p)
- 17 - Patient C Consent Forms (4 p)
- 18 - Patient C Progress Notes (21 p)
- 19 - Patient C, Lab report (27 p)
- 20 - Patient C Medical Records and CT scan (19 p)

- 21 - Patient C Past Treatment Medical Record (1 p)
- 22 - Patient D Consent Form (2 p)
- 23 - Patient D Progress Notes (7 p)
- 24 - Patient D Urine Toxic Metal Labs (12 p)
- 25 - 3/30/2006 Letter to Patient D (2 p)
- 26 - Cost of Selected IVs (3 p)
- 27 - Copy of Sign from Waiting Room (1 p)
- 28 - E-mails from Patient C to Nina Wall (12 p)
- 29 - CV of John Wilson, M.D. (5 p)
- 30 - CV of James Biddle, M.D. (3 p)
- 31 - CV of Emilia Ripoll, M.D. (6 p)
- 32 - E-mail from Patient E's Mother (1 p)
- 33 - Patient C's Death Certificate (1 p)
- 34 - Abstract from New England Journal of Medicine (2 p)
- 35 - CV of John Peterson, M.D. (4 p)
- 36 - Affidavit of Alan Lintala, M.D. and Janet Lintala, M.D.  
(3 p)
- 37 - Affidavit of Greg Provenzano (1 p)
- 38 - Affidavit of Rosi Arrondo (2 p)
- 39 - Affidavit of Margaret C. Hewitt (2 p)
- 40 - Affidavit of Anne Phelps (2 p)
- 41 - Affidavit of Joe Phelps (2 p)
- 42 - Affidavit of Michelle Reed (2 p)

- 43 - Deposition Transcript of Elrene Thomas, M.D.  
(7 p, 2 sided)
- 44 - Deposition Transcript of Ellen Hinshaw (6 p, 2 sided)
- 45 - Deposition Transcript of Ned Jarrett (7 p, 2 sided)
- 46 - Deposition Transcript of Francis Allen (6 p, 2 sided)
- 47 - Deposition Transcript of John Hewitt (11 p, 2 sided)
- 48 - Deposition Transcript of Dr. Ripoll (19 p, 2 sided)
- 49 - Subpoena to Stephanie Kenny (1 p)
- 50 - Deposition Transcript of Patient D (17 p, 2 sided)
- 51 - Deposition Transcript of John Peterson, M.D.  
(32 p, 2 sided)
- 52 - Deposition Transcript of Dennice Herman, M.D.  
(19 p, 2 sided)
- 53 - Deposition Transcript of Martha Biddix (5 p, 2 sided)
- 54 - Deposition Transcript of Stephanie Kenny  
(16 p, 2 sided)
- 55 - Summary of Patient B's charges at Forsyth (1 p)



1 PRESIDENT RHYNE: Good morning. Today is Wednesday,  
2 April 23, 2008.

3 In accordance with Governor Easley's Executive Order  
4 Number 1, it is the duty of every Board Member to avoid  
5 both conflicts of interest and appearances of conflict.

6 Does any Board Member have any known conflicts of interest  
7 or appearance of conflict of interest with respect to any  
8 matter coming before the Board today? If so, please  
9 identify the conflict or appearance of conflict and refrain  
10 from any undue participation in the particular matters  
11 involved.

12 (NO RESPONSE)

13 Thank you.

14 \*\*\*\*\*

15 PRESIDENT RHYNE: I'm Dr. Janelle Rhyne, President of the  
16 North Carolina Medical Board and I'll be presiding at this  
17 hearing.

18 We're here today for a hearing in the matter of Dr. Rashid  
19 Ali Buttar who is charged pursuant to the North Carolina  
20 General Statute 90-14(a)(6) and 90-14(a)(12) based upon  
21 allegations that he practiced below the acceptable  
22 standards of medical practice in the matter of which he  
23 treated Patients A through D and that he provided services

1 in a manner that exploited patients.  
2 Board Members present to my left are Dr. Arthur McCulloch  
3 and to my right, Dr. William Walker.  
4 Counsel for the Board is Mr. Marcus Jimison and Ms.  
5 Katherine Carpenter.  
6 Counsel for Dr. Buttar is Mr. H. Edward Knox and Lisa G.  
7 Godfrey.  
8 Mr. Jimison, are you ready to proceed?  
9 MR. JIMISON: Yes, ma'am, Madam President.  
10 PRESIDENT RHYNE: And the preliminary matters, have we  
11 got that --  
12 PRESIDENT RHYNE: I don't believe there are preliminary  
13 matters at this point.  
14 MS. GODFREY: Well, we have a Motion in Limine.  
15 MR. JIMISON: I think we can deal with the Motion in Limine  
16 as we come to it during the hearing, but if you want to  
17 do it for now. I haven't seen the Motion in Limine.  
18 MS. GODFREY: Okay. Well, I was just going to hand out  
19 copies of it.  
20 MR. JIMISON: Oh, okay.  
21 PRESIDENT RHYNE: Oh, that's all right.  
22 MR. JIMISON: Well, we don't have problems passing out  
23 copies.

1 MS. GODFREY: Madam President, this is a -- a Motion in  
2 Limine is a motion brought prior to the beginning of the  
3 hearing for a pre-hearing ruling on certain matters of  
4 evidence. And we believe that three of the witnesses that  
5 the Medical Board plans to call will be testifying  
6 primarily to hearsay. And attached to the motion are  
7 copies of the North Carolina Rules of Evidence that deal  
8 with hearsay.

9 As you may know, hearsay is an out-of-court statement used  
10 to prove the truth of the matter asserted. In our case,  
11 two of the complaining witnesses in this case never met --  
12 or actually all -- none of the complaining witnesses in  
13 this case ever met Dr. Buttar.

14 The two that are listed here, Dr. Herman and Mr. Messina,  
15 everything they know about Dr. Buttar and his treatment  
16 they know through conversation with other people and that  
17 is why we bring the motion to have anything that they would  
18 have to testify to, that they do not have direct personal  
19 knowledge of, not be allowed to be heard by the Board.

20 In the case of Dr. Herman, the Board has subpoenaed a  
21 witness, Ms. Marie Church, who does have personal knowledge  
22 and we -- we contend whatever evidence she has to give  
23 is a better quality of evidence and not hearsay evidence.



1 With regard to Mr. Messina, he is a witness that has never  
2 been to North Carolina to our knowledge. He lives in Los  
3 Angeles and everything he knows about Dr. Buttar he learned  
4 either from his aunt who is deceased or his mother who  
5 lives in Pennsylvania and that he has no direct personal  
6 knowledge of anything with regard to Dr. Buttar's  
7 practices. And anything that he would have to testify  
8 to, particularly on that witness, we say would be hearsay.  
9 And so I just wanted to preview that from the Board because  
10 we will be objecting to the testimony of these witnesses  
11 and I just wanted to give you a heads-up, so to speak,  
12 as to why and as to why we feel the hearsay evidence is  
13 inappropriate.

14 I have the law for you and I'm not going to belabor the  
15 point. I'm not asking you necessarily to exclude or  
16 include these witnesses at this point, but what I do want  
17 to do is highlight for you the reasons we will be -- be  
18 objecting to their testimony in hopes that we can move  
19 this along.

20 PRESIDENT RHYNE: Thank you, Ms. Godfrey.

21 Did you want to respond to that, Mr. Jimison?

22 MR. JIMISON: Yes. And, you know, per our standard  
23 practice, if it's okay with the Board President I'll remain

1 seated, but I'll stand if you like.

2 PRESIDENT RHYNE: No, please do remain seated at this time  
3 for all counsel.

4 MS. GODFREY: Okay, but I'm used to standing.

5 MR. JIMISON: There -- there are -- I don't want to take  
6 but just a few moments. But the most important thing Ms.  
7 Godfrey says that hearsay is defined as an out-of-court  
8 statement as being asserted for the truth of the matter  
9 asserted. If it is being asserted for some other reason,  
10 such as corroboration or impeachment or -- or basically  
11 just to show knowledge, it is not being asserted for the  
12 truth of the matter.

13 There is a whole slew of exceptions to the hearsay rule  
14 that would cover certain things. And, frankly, I think  
15 when we get to these certain -- when we get to certain  
16 questions, you know, you'll find out what's the purpose  
17 of the question and -- and then you can make a decision.  
18 I don't think we need to make a decision right now, but  
19 there are exceptions. One of which is a dying declaration.

20 Statements made by people who are deceased, who are dying.

21 And as the Board's witnesses will show, these people were  
22 dying, that -- you know, that's an exception -- not  
23 necessarily an exception to hearsay, it's defined as

1 non-hearsay.

2 So, you know, if it's not being asserted for the truth  
3 of the matter, if it's being asserted to corroborate what  
4 another witness has said, then it's asserted for purposes  
5 of corroboration. It's being done to show some -- you  
6 know, some flaw with the witness's testimony for  
7 impeachment purposes, it's defined as non-hearsay.

8 So -- but I think it would be best if we just deal with  
9 those matters as they come out during the hearing and not  
10 right now preliminarily.

11 PRESIDENT RHYNE: We will deal with that as they come up.

12  
13 Now, we'll have the opening statements.

14 Mr. Jimison, would you like to make an opening statement?

15 MR. JIMISON: Yes, Madam President.

16 OPENING STATEMENT BY MR. JIMISON:

17 And for the purpose of, perhaps, Dr. Walker, because I  
18 know I've made this speech before for Dr. Rhyne and Dr.  
19 McCulloch, but the purpose of an opening statement, Dr.  
20 Walker, Members of the Board, is that it's basically  
21 showing a road map of what the evidence is going to show  
22 during the course of this hearing.

23 This is sort of like -- what I actually prefer analogizing

1 to is a story, an outline of a story. What you're going  
2 to hear is a story of patients who are dying of cancer  
3 and their experience with Dr. Buttar. And the purpose  
4 of the opening statement is we basically provide you sort  
5 of a sense of what the evidence is going to show.

6 There are four patients, A through D that the Board has  
7 charged Dr. Buttar with. I'll be focusing mostly on just  
8 the first three, Patients A, B and C, all who had cancer.

9 And there's also what we call the pattern of practice  
10 witness, Patient E, who will be testifying as to certain  
11 things that happened with her experience with Dr. Buttar  
12 that would seem, you know, in the Board's theory of the  
13 case to lend credence to what some of the other people  
14 will be saying. So that's the purpose of an opening  
15 statement and this is mine.

16 The Board's evidence will show the following: Patient A,  
17 a young, beloved wife and mother. She is diagnosed with  
18 cervical cancer, her cancer will spread, she is dying and  
19 soon she will die.

20 Patient B is a young, beloved sister and aunt. She is  
21 diagnosed with ovarian cancer. Her cancer will  
22 metastasize and spread throughout her body, she is dying  
23 and soon she will die.

1 Patient C, a young, beloved husband and father who was  
2 diagnosed with adrenal cell cancer. It will later spread  
3 to his liver and lungs. He too is dying and he too will  
4 soon die.

5 All three of these patients are holding on to life, tumors  
6 are spreading throughout their body, surgery, radiation,  
7 chemotherapy have all failed to halt the progression of  
8 this insidious disease. The question is not whether the  
9 cancer will kill them, the question is when.

10 In these darkest of hours, Patients A, B and C will search  
11 for some hope, some glimmer of hope to stave off the  
12 inevitable march of their disease.

13 They will all find their way to Dr. Buttar. They came  
14 to him because of some of information somewhere that led  
15 them to believe that Dr. Buttar could do something about  
16 their cancer. They came with hope, they came with  
17 optimism, they came in desperation.

18 The evidence will show that Dr. Buttar, and many times  
19 his nurse practitioner, told these patients that they could  
20 help. They can treat them, help them fight their cancers,  
21 help them beat back their cancer. The evidence will show  
22 that this was nothing more than an empty sales pitch.

23 What Dr. Buttar sold these five patients, these dying moms,

1 sisters, aunts, husbands and fathers, was false hope, hope  
2 that he knew to be false. The hope consisted of providing  
3 therapies that were not only not an indicator of cancer,  
4 but had no basis whatsoever in science or any evidence  
5 that it would be effective against cancer.

6 Patients A, B and C all had Stage IV metastatic cancer.

7  
8 Cancer is somewhat of a misnomer as you may know. It is  
9 a single term that describes hundreds of thousands of  
10 different types of malignancies and diseases. Cancer is  
11 a disease with an energy in molecular biology that has  
12 baffled the leading scientists and researchers of the 20th  
13 and 21st Centuries. Billions of dollars going into  
14 research, thousands of the best and brightest minds  
15 dedicated to its eradication and yet despite significant  
16 strides made in the war against cancer, these many diseases  
17 with a single name still persists. It still persists  
18 robbing us of our loved ones, our parents, our children,  
19 our brothers and sisters.

20 The Board's evidence will show that despite the fact that  
21 cancer has baffled the world's best and brightest, Dr.  
22 Buttar and his nurse practitioner have the answers. The  
23 answer, hydrogen peroxide. But not just hydrogen

1 peroxide, the common household solution, but also therapy  
2 such as ozone, intravenous vitamins and minerals, trigger  
3 point injections, chelation therapy and hyperbaric  
4 chambers.

5 These therapies are given to patients over the course of  
6 an eight to ten hour day, five days a week for weeks on  
7 end. And these therapies will beat back cancer that has  
8 defied surgery, radiation, chemotherapy -- chemotherapy  
9 and the latest experimental drugs. And they work -- and  
10 they will work for all cancers, even though it can take  
11 years of research dedicated to the development of a single  
12 drug to fight a single cancer.

13 These therapies administered by Dr. Buttar's nurse  
14 practitioner and nurses given eight hours a day, five days  
15 a week for weeks on end work -- will work where the best  
16 of modern medicine has failed or at least, according to  
17 Dr. Buttar's nurse practitioner.

18 However, in reality, the Board's evidence will show that  
19 these therapies will not fight cancer. They have no effect  
20 on cancer whatsoever. None. They are not effective.  
21 They are science or evidenced based therapies. They have  
22 not been subjected or proven to work at any clinical trial.

23

1 They have not been found to have any effect singularly  
2 or in combination with any other therapies provided by  
3 Dr. Buttar on cancer. They are useless and ineffective.

4 The only real effect is to rob these dying patients of  
5 their precious remaining days and their precious  
6 resources.

7 Dr. John Peterson, a double ABMS board certified physician  
8 in oncology and hematology, will testify that the  
9 treatments that Dr. Buttar provides are not only useless  
10 and ineffective, they are nothing more than rank fraud.  
11 And the evidence will show that these fraudulent therapies  
12 have been enormously profitable to Dr. Buttar. Dr.  
13 Buttar's therapies are administered to patients while he's  
14 out of the office by his nurse practitioner and nurses  
15 because he is out of his office and quite frequently, costs  
16 in excess of \$1,000 a day.

17 Patients A, B and C will all have paid in excess of tens  
18 of thousands of dollars to Dr. Buttar before they died.

19 And when Patients B and C became disaffected with the  
20 care they received from Dr. Buttar and stopped paying him,  
21 Dr. Buttar turned over their accounts to collection  
22 agencies even after they died.

23 In the case of Patient C, Dr. Buttar will refer a \$6,700



1 balance to a collection agency who in turn proceeded to  
2 collect in excessive of \$20,000 from Patient C's estate.

3 Dr. Buttar proceeded to collect in excess of \$19,000 from  
4 Patient B's estate.

5 The records of all five patients will show a distinct  
6 pattern. Patients are not examined or followed by Dr.  
7 Buttar. All five patients, not just the cancer patients,  
8 were seen primarily in some instances exclusively by Dr.  
9 Buttar's nurse practitioner.

10 Dr. Buttar would order numerous tests and lab work that  
11 had no rational medical relationship to the patient's  
12 cancer diagnosis. Many tests and labs that were ordered  
13 by Dr. Buttar were never adequately justified, never linked  
14 to the patient's diagnosis or clinical condition.

15 There is no evidence that any of the extensive tests and  
16 lab work were used for treatment decisions. And despite  
17 the fact that cancer is a heterogenous disease, Patients  
18 A, B and C were treated with an indistinguishable arbitrary  
19 protocol as if one size fits all.

20 Patient E is a pattern-in-practice patient. Patient E  
21 is an eight-year-old school girl who is severely autistic.

22 Her mother contacted the Board after receiving a  
23 solicitation from Dr. Buttar to support him in this matter.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23

Like the -- like the cancer patients, Patient E's mother came across information that Dr. Buttar could help her child's autism. And without ever seeing the doctor, without ever traveling to North Carolina, Patient E was sent a kit to -- to basically self-administer a chelation therapy on her own daughter.

And when things started going -- deteriorating for Patient E, Patient E's only interaction with Dr. Buttar was through his nurse practitioner or other staff members in his office.

And the nurse practitioner who essentially, from the medical records, as you will see, made all decisions about the treatment and diagnosis of this child's autism across state lines without personally seeing the patient, has no formal training in autism or oncology, much like Dr. Buttar who does not have any formal training in oncology or autism.

Yet, nonetheless, they convinced Patient E's mother to take the child off of her medication so that he can apply a transdermal chelation cream on the child. A cream, not so coincidentally, that is developed and invented and sold directly by Dr. Buttar to his patients.

1 The mother did as instructed and took her daughter off  
2 her medication and applied Dr. Buttar's transdermal  
3 chelation cream. Her daughter began to deteriorate. The  
4 child began to have violent tantrums. She couldn't leave  
5 the house or attend school. During the weeks and months  
6 as the child deteriorated, Dr. Buttar never followed the  
7 child.

8 And when the mother did not get a satisfactory responses  
9 to her concerns, she called the office, made an appointment  
10 to see Dr. Buttar and drove her family to North Carolina.

11 However, when she got to North Carolina, she did not see  
12 Dr. Buttar, only the nurse practitioner.

13 And the result of that meeting was that the nurse  
14 practitioner attempted to convince the patient -- the  
15 patient's mother that the child needed to be converted  
16 to a more aggressive intravenous form of chelation therapy.  
17 The evidence will show that Patient E's situation mirrors  
18 that of the other patients. Little or no physician  
19 involvement with the patient. Patients are seen  
20 primarily, if not exclusively, by the nurse practitioner.

21 The patients have serious illnesses and Dr. Buttar and  
22 his nurse practitioner have no formal training in those  
23 illnesses.

1 The patients are prescribed expensive treatments that come  
2 straight out of their pocket because insurance does not  
3 pay for the treatments. The treatments are arbitrary,  
4 one size fits all. They have no basis or evidence of  
5 science. The therapies are ineffective and not been  
6 subjected to clinical trials and are potentially unsafe.  
7 Patients are deprived of their remaining days and  
8 significant amounts of money before they tragically and  
9 inevitably pass away. And at least in the cases of two  
10 patients, after they passed away, Dr. Buttar stays a  
11 presence in their life of their surviving loved ones by  
12 seeking to collect thousands of dollars from their estates  
13 through collection agencies.

14 In sum, the Board's evidence will show that Dr. Buttar  
15 prays on people in the darkest hours at a time when they  
16 are most desperate. He provides therapies to dying  
17 patients that have not been shown to be effective and  
18 charges thousands of dollars a day for what he knows will  
19 not work and he does this with a North Carolina medical  
20 license hanging on his wall.

21 Thank you.

22 PRESIDENT RHYNE: Mr. Knox or Ms. Godfrey, would you like  
23 to make an opening statement?

1 **OPENING STATEMENT BY MR. KNOX:**

2 Mark Twain once said that the stories of my death are  
3 grossly exaggerated. If that was the evidence, I will  
4 tell you, it's been embellished. It looks like as you  
5 indicated yesterday you would take ten minutes to make  
6 this argument and that's been over extended.

7 I do want to say this to the Board. Dr. Buttar is here  
8 with me this morning. He is a bright, intellectual,  
9 capable, good doctor. He loves his patients. He believes  
10 in the fact that we don't have to give up on everybody  
11 because traditionally they say it's time to give up.  
12 He is a strong person who desires to be as innovative as  
13 he can to help people with their immune system as  
14 alternative methods. He believes strongly in the freedom  
15 of choice for people to have this type treatment.  
16 He's lectured across the world. He's testified before  
17 the United States Congress. He's published many articles  
18 and wrote books. He's a leading authority on autism and  
19 treating the immune system.

20 As a side note, in 2003 Dr. Buttar, President of the North  
21 Carolina Alternative Society, went before the legislature  
22 to talk about changes and what an integrative doctor was.  
23

1 Notwithstanding that Mr. Buttar is not going to testify  
2 -- he will testify less than three weeks later he received  
3 a report from this Board saying, come to Raleigh and talk  
4 to us about your practice. That would have been fine,  
5 but at the bottom of this, though, it says you are advised  
6 of your Miranda rights and anything you tell us might be  
7 used against you.

8 Now, he's going on. Dr. Buttar is here to talk about these  
9 three cases and this has been a moving target. Mrs. XXXXXX  
10 (Mother of Patient E) was added in the last eight to ten  
11 days.

12 MR. JIMISON: Objection. At this point I'd like to just  
13 remind everyone that we refer to patients as A, B, C, D  
14 or E.

15 MR. KNOX: She is not a patient.

16 MR. JIMISON: Well --

17 MR. KNOX: I'm sorry.

18 PRESIDENT RHYNE: Let's still use --

19 MR. KNOX: Okay. I understand.

20 The burden of proof in this case is not on Dr. Buttar.  
21 He doesn't have to say a word. The burden is on Mr. Jimison  
22 to prove to you that Dr. Buttar has failed to follow the  
23 standards of the alternative doctor, not an oncologist

1 as their expert is.

2 Their expert has testified there's been no harm to any  
3 of these patients, physical harm. So the test for you  
4 is going to be the efficacy of this treatment, does it  
5 have merit.

6 The North Carolina General Statutes specifically says --  
7 it defines integrative medicine as a diagnostic or  
8 therapeutic treatment that may not be considered a  
9 conventionally accepted medical treatment and that a  
10 licensed physician, in the physician's professional  
11 opinion, believes -- the word believes -- may be a potential  
12 benefit to the patient, so long as the treatment poses  
13 no greater risk of harm to the patient than the comparable  
14 conventional treatments.

15 As I indicated, the expert says there's been no physical  
16 harm. So the test for you is going to be what is the  
17 standard of an integrative doctor.

18 Now, there were four cases, Patient A, B, C and D. There  
19 of these patients are cancer patient and Patient D was  
20 a person treated for heavy metal toxicity who came to Dr.  
21 Buttar as a latter patient with a pre-diagnosis of lead  
22 toxins and was asked to be treated with chelation therapy.  
23 Dr. Buttar did not see her. She only took chelation

1 therapy. But the end result is, she was upset about her  
2 bill and I won't go into the circumstances of the bill,  
3 but that's what brought her charges to the Board.

4 Now, after I took her deposition, they -- they sort of  
5 dismissed her as a part of this case and reached out to  
6 get one more person, Patient E, to help build up the case.

7 This case is not about the patient. It's not about the  
8 patient's complaint. It's about beneficiaries who are  
9 unhappy that they got bills and were taking money out of  
10 this estate.

11 Dr. Buttar will offer three doctors, alternative doctors.

12 And one doctor, Dr. Ripoll, who is a  
13 neurologist/oncologist, an alternative medicine doctor,  
14 will testify that he met the standard of care in the  
15 treatment of these patients.

16 The timing of the treatment and acting on the complaints  
17 is highly important for you to consider. For example,  
18 Patient A was last treated in June of '06. Neither the  
19 patient nor her daughter who went with her to every visit  
20 complained about the treatment by Dr. Buttar.

21 The daughter coincidentally works for Dr. Herman who is  
22 a complaining witness who never ever told her employee,  
23 by the way, I'm going to file some complaint to the Medical



1 Board. She's down the hall and never asked her about the  
2 treatments and then called her as a witness when she doesn't  
3 want to be involved. The point I make is, in that instance,  
4 it's about people who objected outside of the patient or  
5 the daughter who was there.

6 Patient B is treated for her immune system. She was an  
7 ovarian cancer patient. She was only treated about three  
8 weeks by Dr. Buttar and she was discharged for  
9 non-compliance.

10 Now, the Board's attorney wants to use not what she said  
11 about the treatment rendered by the doctor, but they want  
12 to use a heir, a nephew who is the sole heir of Patient  
13 B's estate who never saw Patient B during the treatment.

14 Patient B died five months later after the treatment.  
15 And the boyfriend who came with her to every treatment,  
16 they never sought him out as a witness, but he and Patient  
17 B never complained to Dr. Buttar.

18 Patient C is an adrenal cancer patient who had undergone  
19 extensive surgery and took 16 of 28 radiation treatments  
20 in February of '04, over four years ago. The sole  
21 complainant is his wife, the sole beneficiary of his  
22 estate.

23 Now, when this patient was going to Dr. Buttar, he paid

1 and every one of these pages signed -- patients signed  
2 a consent. We don't get insurance, that's between you,  
3 we'll keep our family doctor involved. Dr. Buttar does  
4 not grant -- guarantee anything about the therapy and they  
5 all signed written consents acquiescing that they knew  
6 exactly what they were doing.

7 Now, Patient C's wife, after he left Dr. Buttar, had went  
8 to Mexico for further alternative treatment, called up  
9 and canceled a \$5700 check which the patient had written  
10 to Dr. Buttar and which he had not complained about. The  
11 patient stopped treatment with Dr. Buttar in June of '04,  
12 almost four years.

13 We think he was as happy a patient -- he went from being  
14 nauseated and vomited and fatigued, unable to do anything  
15 after the radiation, and Dr. Buttar built him up where  
16 he was walking two miles a day, going to his games and  
17 his vitality improved. And we say that the therapies was  
18 what helped him.

19 The wife incidentally is complaining about the bill and  
20 she never drove up to see this doctor. She did not go  
21 to the radiation treatments and she did not go to Mexico  
22 even though she admitted that there was nothing to keep  
23 her from doing that. It's all about the money that may

1 have come out of the estate.  
2 Now, someone once said a river never rises higher than  
3 the street. And interesting enough, the Board employed  
4 Dr. Peterson in October of 2007 to review the Board cases.  
5 He's a traditional hematologist and oncologist. And that  
6 may be when I say traditional -- a pretty fair  
7 representation because Dr. Peterson believes that if you  
8 don't use surgery, you don't do chemotherapy or radiation,  
9 the next step is to take pain medication and get palliative  
10 care and give up. Dr. Buttar does not believe you give  
11 up.  
12 Dr. Peterson will testify and has testified in his  
13 deposition that he's not able to define what an integrative  
14 doctor is according to this statute. He will testify that  
15 the standard that he applies is that of an oncologist.  
16 We say that is not the test. The test is, was the treatment  
17 in accordance with an integrative doctor.  
18 Not only has there been this two to four year delay to  
19 proceed on the charges, they all are subject to a number  
20 of visits by the staff to Dr. Buttar's office and every  
21 time he has cooperated with them. I don't know how many  
22 times a doctor could anticipate somebody coming in to their  
23 office from the Medical Board.

1 Dr. Peterson billed that he took hours to review  
2 approximately a thousand pages. He said he wasn't sure  
3 why he was called, but he went through them and wrote down  
4 some information. We think his -- for lack of  
5 understanding about what his role was going to be and lack  
6 of time to review -- he was at -- his investigation and  
7 his opinions were not well thought out.

8 For example, he said Patient D was treated with chelation  
9 therapy for constipation. We took Patient D's deposition.

10 She admitted she came with a lead diagnosis and she asked  
11 to be treated with chelation therapy. No one ever treated  
12 her for constipation, but somehow that was his diagnosis  
13 of what Dr. Buttar did.

14 In Patient C, he indicated that Dr. Buttar had no contact  
15 with the patient. The records are full of information  
16 signed by Dr. Buttar where he did the physical at times  
17 that he gave his patient IRRs. He gave every one of these  
18 cancer patients an IRR injection, three times, so he did  
19 see the patient.

20 Dr. Buttar had no notes of a thousand pages that he wrote  
21 or if he did, he tossed them away.

22 MS. GODFREY: Dr. Peterson.

23 MR. KNOX: -- Dr. Peterson.

1 The point I make is, this is a serious matter that he's  
2 been asked to investigate and to write a report.

3 I'm going to ask you to do this, you're all doctors and  
4 I'm sure good doctors. I'm going to ask you to listen  
5 to this evidence. The Board has the burden of proving  
6 to you that he's failed to follow an alternative standard  
7 of care.

8 And then I want you to listen as they bring forth the expert  
9 and the information. I want you to weigh their credibility  
10 on what the people say and what is their motive for this.

11 Why didn't it come earlier? Why this wasn't part of --  
12 not 2004, 2005, 2006, but in 2007?

13 The lawyers change medical science they got. And doctors  
14 are people that promulgate and bring about change and  
15 that's why we're here. We have a doctor that believes  
16 you go look ahead. But you can't always just say, go home  
17 and die. Thank you.

18 PRESIDENT RHYNE: All right. Now, we're ready to hear  
19 the evidence. Mr. Jimison, I'll call on you to present  
20 the evidence.

21 MR. JIMISON: Thank you, Madam President, and just for  
22 counsel, and typically the practice before the Medical  
23 Board with these quality of care cases are just to go ahead

1 and stipulate into the record the medical records and at  
2 this point I'd like to just go ahead and stipulate into  
3 evidence the medical records of Patients A through E.

4 MS. GODFREY: Well, we're going to object to the medical  
5 records of Patient E. I'm sorry, I keep getting up, it's  
6 just a force of habit. I have to do that in court.

7 Patient E is not in the complaining charges. The complaint  
8 came in, I think, about a month ago. The Medical Board  
9 has not -- not investigated it. There are no formal  
10 charges involving Patient E and we would object to the  
11 wholesale consideration of those records in this  
12 proceeding.

13 If the Board wants to bring a formal complaint about Patient  
14 E, that's fine. If there are particular portions of the  
15 records that might be relevant to the testimony of Patient  
16 E's mother, that would be fine. But the wholesale  
17 admission of the patient in these records, I think is  
18 inappropriate at this time.

19 MR. JIMISON: This matter was as you may recall, Dr. Rhyne,  
20 was in -- was addressed in a pre-hearing conference. You  
21 allowed her as a pattern to practice witness. The medical  
22 records as the Board is very familiar with and is -- is  
23 the best evidence of what's happened with that patient.

1  
2 You're not precluded from introducing medical records or  
3 patient testimony just because it's not part of the charges  
4 if it's part of the pattern to practice. Ms. Godfrey has  
5 not cited any Rules of Evidence or any law that would  
6 prohibit you from considering the medical records when  
7 Patient E testifies if she's testifying as part of the  
8 pattern of practice.

9 So, therefore, it's the best evidence. She's going to  
10 be talking about the care that her daughter received and  
11 the best evidence of the care that her daughter received,  
12 that this Board has historically and traditionally been  
13 aware of, is part of the medical records. Many times when  
14 patients testify on behalf of the doctor, we ask that they  
15 bring their medical records in. So it's not uncommon and  
16 there is no rule of evidence or statute that would prevent  
17 the Board from considering it, nor did Ms. Godfrey cite  
18 one.

19 MS. GODFREY: Since the rule isn't whether or not they  
20 are at all relevant, there's no expert witnesses to examine  
21 the records and give any conclusion. It's just simply  
22 the mother has to testify about whether she heard --

23 PRESIDENT RHYNE: I think we will allow the records.

1 MR. JIMISON: And also without objection, but we can do  
2 it during the hearing, but I would like to amend and  
3 stipulate into evidence Exhibit 7 through 11. Those are  
4 basically just CDs about documents I received from Dr.  
5 Buttar's office and I would like to go ahead and refer  
6 7 and 11 through -- into evidence.  
7 PRESIDENT RHYNE: I'm sorry.  
8 MR. JIMISON: Exhibit 7 through 11, the Board's Exhibit  
9 7 through 11.  
10 PRESIDENT RHYNE: Exhibits 7 through 11?  
11 MS. GODFREY: Seven.  
12 MR. JIMISON: Do you have the list?  
13 MS. GODFREY: I have those, yes.  
14 PRESIDENT RHYNE: Is that one of our notebooks?  
15 MR. JIMISON: This one.  
16 MS. GODFREY: The second notebook.  
17 MR. JIMISON: In the second notebook.  
18 PRESIDENT RHYNE: In the second one.  
19 MS. GODFREY: It's a little smaller.  
20 PRESIDENT RHYNE: Okay. They will be admitted.  
21 MR. JIMISON: And I will deal with Number 6 when we call  
22 Dr. Peterson.  
23 PRESIDENT RHYNE: Six.



1 MR. JIMISON: Okay. At this --  
2 MS. GODFREY: You got one for me. Do I need it?  
3 MR. KNOX: Okay. I'm sorry. We're okay.  
4 MS. GODFREY: I just wanted to keep school.  
5 MR. JIMISON: We would now like to call Stephanie Kenny  
6 to the stand.

---

7  
8 WHEREUPON,

9           STEPHANIE KENNY,  
10           being first duly sworn,  
11           was examined and testified  
12           as follows:

---

13  
14 MR. JIMISON: Actually, before we get started, Dr. Rhyne,  
15 may Ms. Godfrey and I consult?

16 PRESIDENT RHYNE: Sure.

17                   **(BENCH CONFERENCE OFF THE RECORD)**

18 **DIRECT EXAMINATION BY MR. JIMISON:**

19 QWill you introduce yourself to the Medical Board.

20 AMy name is Stephanie Kenny.

21 PRESIDENT RHYNE: Can you turn on the microphone.

22 MR. KNOX: I'm sorry and I apologize, but if you're sitting  
23 that close to her and you're that soft, I'm not going to

1 ever hear you. Do you have your microphone on?  
2 MR. JIMISON: I have my microphone on.  
3 MR. KNOX: Okay.  
4 Q(By Mr. Jimison) Ms. Kenny, do you mind testifying publicly  
5 about this matter?  
6 ANo.  
7 QOkay. So I'll refer to you as Ms. Kenny when we refer to the  
8 Patient C.  
9 Ms. Kenny, where do you live?  
10 AMy address?  
11 QUh-huh (yes).  
12 A2801 Redfield Drive in Charlotte.  
13 QAnd could you describe your family to us?  
14 AI have three children.  
15 QWho are they? Well, you can just give me their first names  
16 and ages or gender.  
17 AWhen I agreed to do-- to go public, I didn't agree to involve  
18 --  
19 QOkay. Do you have boys?  
20 AI have two sons and a daughter.  
21 QOkay. And how old are they?  
22 A17, 16 and 8.  
23 QOkay. Were you married?

1 AYes.

2 QAnd were you married to Patient C?

3 AYes.

4 QAnd how long were you married?

5 ASeventeen plus years.

6 MR. KNOX: I'm sorry, I'm still having trouble hearing  
7 you.

8 WITNESS: Seventeen years.

9 MS. GODFREY: We're all having trouble hearing her.

10 MR. JIMISON: If you could kind of pull up a little closer  
11 to the mike. All right. Maybe that will help.

12 Q(By Mr. Jimison) At some point was your husband diagnosed  
13 with cancer?

14 AYes.

15 QAnd tell me about when you originally learned about your  
16 husband's cancer diagnosis.

17 AIt was in September of '03.

18 QAnd what type of cancer was it?

19 AAdrenal.

20 QAnd how old was your husband when he was first diagnosed with  
21 cancer?

22 AForty-two.

23 QForty-two?

1 AForty-two, yes, sir.

2 AAnd what happened after he was diagnosed with adrenal cancer?

3 AThen came a plan for surgery and after the surgery, radiation.

4 QSo he had the surgery?

5 AHe did.

6 QHe started radiation?

7 AYes.

8 QDid he finish the radiation?

9 ANo, he did not.

10 QAnd why not?

11 AHe just couldn't tolerate it.

12 QAnd what did your husband do after that?

13 AHe --

14 QWhat happened after he stopped the radiation?

15 AHe appeared to be doing well. I mean, it took him a while

16 to get over it, but then he -- he was doing better and

17 he was back to work full-time. He looked much better and

18 had the energy, but then it was rediscovered in another

19 scan in February of '04.

20 QFebruary of '04?

21 AYes.

22 QAnd what happened after that?

23 AWell, at that point, the scan showed a spinal tumor and a speck

1 in the lung, but his oncologist -- his oncologist said  
2 that operating fails at that point. He just encouraged  
3 him to look at quality of life.

4 QAnd so the -- would it be fair to say his cancer was metastatic?

5 AYes, at that point, yes, it was.

6 QAnd it spread through the liver and his lungs? And your  
7 husband's oncologist did not -- did not recommend further  
8 surgery?

9 ANo.

10 QDid he recommend further chemotherapy or radiation?

11 ANo.

12 QAnd what did your husband do after he basically had that  
13 conversation with his oncologist?

14 AHe didn't want them to biopsy it and went to alternative care.

15 QAnd did he ever meet -- did he ever decide to go to Dr. Buttar?

16 AHe did.

17 QAnd how did he hear of Dr. Buttar?

18 AJust through research. He was looking at this at night and  
19 just researching on-line and he seen him in some article.

20 QOkay. And did he -- did he ever have a chance to meet Dr.

21 Buttar, your husband?

22 APrior to becoming a patient?

23 QYeah. Well, I mean, did he ever go see Dr. Buttar at his office?

1 AYes. I'm sorry about that.

2 QWere you there?

3 AI was.

4 QOkay. Was that the first meeting?

5 AIt was.

6 QAnd describe that meeting that you were present at.

7 AWell, we brought all his records. He said he was not concerned

8 with the type of cancer, that he had a 100 percent success

9 rate, that he would be able to turn his body chemistry

10 around to fight the cancer, so it didn't matter what kind

11 it was.

12 QOkay. And did -- did Dr. Buttar make any representations about

13 how successful his therapy would be?

14 MR. KNOX: Objection, asked and answered. She just

15 answered.

16 QAgain --

17 AHe did give -- he said that he had a 100 percent success rate.

18 QHow did you take that? How did you personally take that?

19 ATo mean that he had a 100 percent cure rate.

20 QAnd -- and after that meeting, what did you and your husband

21 decide to do?

22 AHe chose to become a patient as opposed to -- (inaudible).

23 PRESIDENT RHYNE: Excuse me. Chose to go where? We

1           couldn't hear.

2           MR. JIMISON:  Yeah, I'm having a hard time hearing her.

3           Please speak up a little louder.

4           WITNESS:  He chose to continue alternative care with Dr.  
5           Buttar as opposed to going to the Issles Clinic in Mexico  
6           at that time.

7           PRESIDENT RHYNE:  Thank you.

8           Q(By Mr. Jimison)  The treatments were -- did the treatments,  
9           were they explained to you by Dr. Buttar during the first  
10          meeting what he would do?

11          A Not in great detail.  He talked about the nutritional aspect  
12          and the supplements he would have to take, the changes  
13          in diet and he said that, you know, ozone and that kind  
14          of thing, but it weren't discussed in detail.

15          Q Okay.  And when did your husband start going for treatments?

16          A I think it was sometime in late February or early March.

17          Q All right.  Okay.  And how long would the treatments last per  
18          day?

19          A All day, just like a job.

20          Q Describe that day.  When did your husband leave the house?

21          A Well, he would leave between 7 and 7:30, I believe it was,  
22          and it was about a 45 minute drive.

23          Q Okay.  And when would -- sorry.  And when would he return home

1           at night?

2   AAbout 6.

3   QAbout 6:00?

4   AUh-huh (yes).

5   QSo he was there from basically 8:00 to 5:00?

6   AYes.

7   QFive days a week?

8   ARight.

9   QAnd what was his therapy, to your knowledge?

10   AOzone treatments, sauna treatments -- (inaudible) -- some

11        medication. There were two different base lines that you

12        made -- (inaudible).

13   QAnd did your husband, did he talk about IV therapies that he

14        got?

15   AYes, chelations all the time.

16   QAnd so he would go to these therapies for eight hours a day?

17   ARight.

18   QFive days a week?

19   QRight.

20   QAnd how -- how many weeks did he do it?

21   ASixteen.

22   QSixteen weeks?

23   ARight.



1 QWas 16 weeks originally discussed between you and Dr. Buttar  
2 and your husband?

3 MR. KNOX: Objection. I'm sorry.

4 PRESIDENT RHYNE: I'm sorry, did you object?

5 MR. KNOX: No, I withdraw it.

6 PRESIDENT RHYNE: Withdrew it.

7 AIt was supposed to be a six week plan when Jeff started there.

8 QOkay. So after the sixth week he continued until the sixteenth  
9 week?

10 ARight.

11 QAre you familiar with how much it costs per day for the  
12 treatments?

13 ANo.

14 QOkay. I'd like to turn your attention to the first big binder  
15 in your notebook. And if you can turn to --

16 PRESIDENT RHYNE: This is the big notebook?

17 MR. JIMISON: Yeah. The thick -- thick one, the big thick  
18 one.

19 MS. GODFREY: Is it two?

20 QOkay. If you can turn to page 265.

21 PRESIDENT RHYNE: Is that Tab 2, page 265?

22 MR. JIMISON: Yes, ma'am. Tab 2, page 265.

23 Q(By Mr. Jimison) I wanted you to look at just the entry on

1 the left which says June 1st. Do you see that?

2 AYes.

3 QAnd there's several entries for June 1st until you get to June  
4 11th, correct?

5 AYes.

6 QOkay. And then it actually starts back at June 2nd. But  
7 just -- just focusing on June 1st, we'll focus for June  
8 1st, there is a list of services your husband received  
9 from Dr. Buttar, correct?

10 AYeah.

11 QAnd the first one is a therapeutic or diagnostic injection.  
12 And then there's another therapeutic or diagnostic  
13 injection. And then there are one, two, three, four, five,  
14 six, seven, eight, nine, ten, ten charges for IV infusion  
15 therapies.

16 ARight.

17 QAnd each infusion therapy and it's followed by \$125, \$70 and  
18 then the next one will be 125 and 70 and 125 and 70 and  
19 so on. Then there's a comprehensive metabolic panel that  
20 was taken, a lipid panel that was taken. Something called  
21 iron or iron binding capacity was given, biofeedback  
22 training by any modality for \$150. Something called an  
23 ACP 3 that cost \$100, black walnut \$42, PBIB that cost

1 \$100, chocolate protein powder that charge is \$76. And  
2 then there's a thing called an adjustment for 365. And  
3 then there's basically a check payment for \$1400, correct?

4 ARight.

5 QAnd if you just take time going back to page 259 all the way  
6 through page 267, you will see -- did you go to page 259?

7 AYeah.

8 QAnd if you can just sort of -- sort of skim, you know, quickly  
9 through page 267, there's basically many of the same  
10 entries and charges beginning from April 26th through June  
11 11th. And do you see the balance at the end on page 267?

12 AYes.

13 QAnd how much is that?

14 A\$25,237.41.

15 QWhen your husband first showed up to Dr. Buttar, what was his  
16 emotional state?

17 AHe was glad to find a cure because --

18 QCould you speak into the --

19 AHe wanted to find a cure -- (inaudible).

20 QOkay. Was he seeking hard with the -- I mean, figuratively  
21 seeking some sort of alternative?

22 AYes.

23 QWas he desperate?

1 MR. KNOX: Objection.

2 MS. GODFREY: Well, objection to the meaning of --

3 MR. KNOX: I mean, she's described him as he didn't want  
4 to give up, but he's now characterizing --

5 PRESIDENT RHYNE: Object. Yeah, that's sustained.

6 MR. JIMISON: I'll rephrase.

7 Q(By Mr. Jimison) Characterize to the degree of how he didn't  
8 want to give up.

9 AHe had a wife and three children at home, he had a lot to live  
10 for and he was -- (inaudible).

11 QOkay. And so when he was away from the home, was he spending  
12 time with his children?

13 AHe was home every day. He was home in the evening.

14 QOkay. So he could only see his children during the night?

15 ACorrect.

16 QAnd did you ever see any improvement in your husband's condition  
17 during the time he was with Dr. Buttar?

18 ANo, I did not. He just grew worse quickly.

19 QAnd describe him during this four month period or this several  
20 month period.

21 AHe lost weight, just physically looked ill or was physically  
22 ill and that just perpetuated.

23 QAt some point did your husband stop seeing Dr. Buttar?

1 AHe did, yes.

2 QAnd why was that?

3 AWell, he had -- Dr. Buttar thought he was better and ordered  
4 a CAT scan because the -- it was very apparent that he  
5 was not getting better even though the test results said  
6 that he was and the cancer was breaking up. And, anyway,  
7 that was when he left. That was his last day.

8 MR. KNOX: I object to what Dr. Buttar says she said.  
9 She was not there.

10 QDid --

11 PRESIDENT RHYNE: If she -- your objection is?

12 MR. KNOX: Yes. If she wasn't there that's hearsay.

13 PRESIDENT RHYNE: Yeah, it's hearsay.

14 Q(By Mr. Jimison) At some point, did you ever stop paying Dr.  
15 Buttar for his treatments?

16 AI canceled -- on Jeff's last day, I canceled the last payment.

17 QAnd why did you do that?

18 AI did that when I read the results from the CAT scan.

19 QAnd what were the results of his CAT scan?

20 AThat it had spread to the other side of his liver and it was  
21 completely all over the lungs. And my husband came home  
22 telling me that Dr. Buttar told him there was nothing he --

23 MR. KNOX: Objection.

1 QGo ahead. And your husband came home and you had a conversation  
2 with your husband?

3 AYes.

4 QAnd -- and did your husband continue on with his treatment?

5 ADid he want to continue to?

6 QWith Dr. Buttar?

7 ANo. Not after seeing the report, no.

8 QOkay. And so after your husband was getting treatments from  
9 Dr. Buttar, the therapies that are mentioned in the medical  
10 records which are in evidence, the hydrogen peroxide, the  
11 ozone chelation therapies --

12 ARight.

13 Q-- the biofeedback, the vitamins, his cancer continued to  
14 spread --

15 ACorrect.

16 Q-- according to that CAT scan?

17 ACorrect.

18 QAnd at some point he stopped seeing Dr. Buttar and you canceled  
19 a check. And what happened to that -- how did Dr. Buttar's  
20 office respond to you canceling the check?

21 AThey returned -- well, they sent me a few bills and they went  
22 up in increments and then it was turned over to a collection  
23 agency.

1 QAnd when did your husband pass away?  
2 ASeptember 6th of '04.  
3 QApproximately two or three months after seeing Dr. Buttar?  
4 ARight.  
5 QAnd prior to him passing away, what did he do?  
6 AHe went to Mexico to the Issles Clinic.  
7 QDid he go to Mexico?  
8 AHe did, yeah.  
9 QWhy did he go to Mexico?  
10 AFor further treatment.  
11 QAnd what kind of treatments did he receive in Mexico?  
12 ATheir's was also alternative care.  
13 QAnd describe the day -- did any of that work in Mexico?  
14 AWell, I don't --  
15 MR. KNOX: Well, objection.  
16 MR. JIMISON: Well, to her opinion, she can give her  
17 opinion about whether she thinks it worked. It's well  
18 within a lay opinion.  
19 MR. KNOX: Well, objection. She's not a doctor, she can  
20 say what observation she may --  
21 MR. JIMISON: Lay people can --  
22 PRESIDENT RHYNE: She can -- she can give her observation.  
23 MR. JIMISON: Her observation.

1 Q(By Mr. Jimison) Did -- did the treatments in Mexico seem  
2 to be working on your husband --

3 MR. KNOX: Objection.

4 Q-- from your observations of your husband?

5 AHe came home looking better, but obviously he passed away  
6 anyway.

7 MR. KNOX: Withdrawn.

8 QHow soon did he die after coming back from Mexico?

9 AHe came back from Mexico the middle of July.

10 QOkay. And within a month and a half he had died?

11 ARight.

12 QNow, describe that day when your husband died.

13 AWell, earlier in the day he had his family, he was with our  
14 children and myself and he woke me up I think about 2 a.m.  
15 that morning saying that he didn't feel well and asked  
16 me to call the ambulance. He looked gray and was sweating.

17 So, anyway, we went to the hospital and they wanted to  
18 transfer him downtown to -- (inaudible) -- and he just  
19 never got that far even.

20 QAnd how has this experience with you, your husband and Dr.  
21 Buttar affected you?

22 AIt makes me very angry that he could do this. I understand  
23 that alternative medicine doesn't cure everything, but



1 I think he needs to be honest with his patients, that --  
2 that particularly where a scan should have been done and  
3 he should have been told honestly that it had spread.  
4 And to tell a patient that there's nothing conclusion in  
5 the radiologist report where the radiologist said that  
6 it spread everywhere and to continue with the therapy and  
7 we'll talk then. It's just criminal.

8 MR. KNOX: Well, objection.

9 PRESIDENT RHYNE: I'm sorry.

10 MR. KNOX: I objected to her classification of what the  
11 -- (inaudible).

12 PRESIDENT RHYNE: Sustained. We'll disregard that.

13 Q(By Mr. Jimison) Was your husband still being followed by  
14 an oncologist when he was being seen by Dr. Buttar?

15 AHe was seeing him before and after Dr. Levine.

16 QOkay. And did your oncologist give your husband a life  
17 expectancy when -- when -- when the cancer spread?

18 MR. KNOX: Objection. I mean, he's not here.

19 MR. JIMISON: She knows --

20 PRESIDENT RHYNE: Objection sustained.

21 MR. JIMISON: But if she knows, I mean, we're treating  
22 family, she -- she would have known her husband's life  
23 expectancy.

1 PRESIDENT RHYNE: You can -- you can -- unless you were  
2 there, you cannot. It's hearsay.

3 WITNESS: If I heard the doctor say anything?

4 MR. JIMISON: Okay. I'll withdraw it.

5 PRESIDENT RHYNE: Yeah. Let us know if you heard the  
6 doctor say anything.

7 WITNESS: I did. He said it --

8 PRESIDENT RHYNE: You were present?

9 WITNESS: I was present, yes. And that was a year.

10 Q(By Mr. Jimison) He give him a year?

11 ARight.

12 MR. JIMISON: Okay. Thank you.

13 PRESIDENT RHYNE: Thank you.

14 Ms. Godfrey or Mr. Knox, do you want to cross-examine?

15 MR. KNOX: One of us will.

16 **CROSS-EXAMINATION BY MR. KNOX:**

17 QMs. Kenny, as I understand it, you went with your husband to  
18 the first visit.

19 ARight.

20 QWould you describe Dr. Buttar's office?

21 AIt's just a lot of little rooms on the hallway.

22 QWhat does the physical structure of the office appear like?

23 Is it a one-story or two-story or three-story.

1 AIt is a one-story strip mall.  
2 QOne-story what?  
3 AStrip mall.  
4 QSo he was in a strip mall?  
5 AThat's what I would call it. It wasn't an office complex or  
6 --  
7 QAnd where was he located?  
8 ACornelius on Torrance Chapel Road, I believe.  
9 QYou believe it was? Whereabouts in Cornelius?  
10 AI don't have the address for you because it's been too long.  
11 QHow did you get there?  
12 AMy husband drove.  
13 QAnd what roads did you take from Matthews?  
14 A485 to the interstate.  
15 Q485?  
16 AYes.  
17 QWhat interstate? Would you take 85?  
18 AI don't know. I was not driving.  
19 QYou remember I took your deposition a while back?  
20 AYes.  
21 QCorrect? So I'll be asking you some questions. You were  
22 living at home with your husband at the time he became  
23 ill?

1 AYes.

2 QAnd he was under the treatment of a doctor -- not family  
3 physician -- who was the other one?

4 AHis oncologist?

5 AYes.

6 QDr. Levine.

7 QDr. Levine. So Dr. Levine was treating him. Now, he was  
8 treated with radiation therapy, correct?

9 AYes.

10 QAnd he went through some 16 of 28 injected radiation therapy  
11 treatments and he got deathly ill, didn't he?

12 AIt made him very nauseous.

13 QAnd he was throwing up, he lost weight, he stayed in the house  
14 most of the time, am I correct?

15 AYes.

16 QAnd you all -- he wanted to go see Dr. Buttar and you didn't  
17 want him to go to that office, did you?

18 AI just didn't want him just to decide on Dr. Buttar --  
19 (inaudible) -- I wanted him to -- (inaudible).

20 QYou preferred that he go to Mexico, did you? Or where -- where  
21 did you prefer?

22 AI didn't have a preference. I didn't know about Dr. Buttar  
23 at all. I didn't know about -- (inaudible) -- heard of

1 it.

2 QAnd when you -- when you say that Dr. Buttar indicated that  
3 he would be cured as you said in your initial visit, do  
4 you remember -- you identified for me some signatures of  
5 your husband on some documents; is that correct?

6 AYes.

7 QAnd we went over those documents very carefully about what  
8 it was that Dr. Buttar could do, correct?

9 AUh-huh (yes).

10 MS. GODFREY: Maybe at this point, can we hand the  
11 documents out? We've got -- this is Buttar's Exhibit 17  
12 and we have books for the Medical Board and I've given  
13 the book to Marcus so that you can all follow along.

14 PRESIDENT RHYNE: Okay.

15 MS. GODFREY: We can mark it. You can give that to Ed.  
16 And I've got one for you. Here you go.

17 Q(By Mr. Knox) Have you had a chance to read that, ma'am?

18 ACorrect.

19 PRESIDENT RHYNE: Mr. Knox, can you tell us where you are?

20 MS. GODFREY: Exhibit Number 17.

21 Q(By Mr. Knox) It's called Patient Information and  
22 Registration form. You see it?

23 AYes, sir.

1 MS. GODFREY: And the redaction is not -- on the original  
2 to be removed, if she wants to check on those for the  
3 signature.

4 Q(By Mr. Knox) You notice at the bottom, the signature, but  
5 when we took your deposition you indicated you all went  
6 about in February and that he signed this Patient  
7 Information form, correct?

8 AYes.

9 QAnd so you're sure you were there when it was signed, correct?

10 AI was with him on this first treatment -- not his first  
11 treatment, but I was with him on the first visit in  
12 Dr. Buttar's office, whether this was signed at that time,  
13 I do not know.

14 QOkay. Well, actually he had called about the financial policy  
15 ahead of time, hadn't he?

16 AHe did get information on the --

17 QAnd they had explained to him the financial policy, if you  
18 come to our clinic you'll have to pay cash because insurance  
19 doesn't apply as a rule even though I think some insurance  
20 did apply, didn't it?

21 AThere were certain things that they --

22 QSo if you look at the bottom of this: "I understand that the  
23 safety and efficacy of many such therapies have not been

1 established with controlled studies. Specifically, no  
2 claim to cure cancer with these therapies has been made  
3 to me and Dr. Buttar will not be providing hospital care  
4 or emergency care for me in this clinic and the therapies  
5 received will compliment the care I receive from my primary  
6 care physician and will not replace them."

7 Correct? That's what it says, doesn't it?

8 AIt does.

9 QSo when you say -- there's nothing in that documentation that  
10 your husband signed about 100 percent cure, is there?

11 ANo.

12 QNot a word. Now, in addition to that and I'll ask you to go  
13 next to the financial policy and I believe you identified  
14 that and that should be the one right behind it. You see  
15 that? I think it's Number 18.

16 And this is the financial policy that I assume you were  
17 there and your husband signed this, correct?

18 AYes.

19 QI mean you identified his signature at the deposition?

20 AYes, I did.

21 QAnd that specifically says and talks about the fact that  
22 insurance will not apply, so you both were aware of that?

23 AYes.

1 QAnd you knew you were on a cash basis or a credit card basis,  
2 correct?

3 ACorrect.

4 QAnd your husband paid for every visit timely as he got the  
5 treatment, am I correct?

6 AYes.

7 QAnd after he paid for that sometime subsequently, I believe  
8 he had gone to Mexico and you decided that you would cancel  
9 this \$6700 check that he personally wrote?

10 ANo. I canceled that check on the last day that he saw Dr.  
11 Buttar.

12 QSo you called after that to cancel the check that your husband  
13 had written, correct?

14 AWhen he got home that day, yes.

15 QAnd you had never been, after you went the first time, back  
16 to Dr. Buttar's clinic to watch any of the treatments or  
17 talk to the doctor or to any of the nurses, am I correct?

18 AI only went the first time.

19 QYeah. And your husband brought home lab results and whatever  
20 with him?

21 AYes.

22 QNow, at the same time Dr. Levine had been treating him with  
23 Procrit; is that correct, for iron deficiency?



1 AI don't know. He received a shot at the oncologist's office  
2 -- (inaudible) -- repeatedly -- (inaudible) -- at that time.  
3 QI'm sorry, I didn't hear you.  
4 AHe repeatedly had that, but that was after he got --  
5 QAnd that's what the instructions say, you should stay with  
6 your regular doctor when you come in here to take these  
7 alternative therapies, didn't it?  
8 AThat's what we just said, yes.  
9 QAnd you were not promised that the safety and efficacy of these  
10 therapies had been established, correct?  
11 AIf I had read that and signed that, I could say that. I'd  
12 can only say whatever Dr. Buttar told us.  
13 QIt says that Dr. Buttar would not treat private  
14 hospitalizations.  
15 ACorrect.  
16 QRight.  
17 AIt does say that.  
18 QAnd it said the complimentary treatment that I receive will  
19 assist in my medical care with my regular doctor.  
20 AUh-huh (yes).  
21 QAnd it says that returned checks will be subject to additional  
22 collection fees, doesn't it?  
23 AWhere am I at now?

1 QAt the financial column. We went over this before and you  
2 testified --

3 AYes, it does.

4 Q-- that you understood that, right?

5 AYes.

6 QSo when you canceled payment of your husband's check that he  
7 wrote, you knew that there might be some collection fees,  
8 correct?

9 AYes.

10 QBut it didn't make you happy you, did it? It upset you?

11 AWhat upset me was the lie that he --

12 QSo it upset you about the check and you wrote the North Carolina  
13 Medical Board, am I right?

14 AI wrote to them in a complaint, yes.

15 QYeah. And before you wrote to them, you told the staff people  
16 that you were going to turn him into the Medical Board  
17 because they were issuing it to a financial collection  
18 agency; is that correct?

19 ANo, that I have no recollection of.

20 QSo you don't know whether you told the staff if y'all do this,  
21 I'm going to turn you into the Medical Board?

22 AAs I said in my deposition, I remember calling them about why  
23 the bill was then what it was as opposed to the \$6700.

1 QBut you don't remember when you threatened to send him to the  
2 Medical Board, do you?

3 ANo, no.

4 QCould that be true?

5 ACould what be true?

6 QThat you threatened him.

7 AI think that would be really out of character for me.

8 QBeg your pardon?

9 AI think that would be very out of character for me. I do not  
10 remember doing that.

11 QLet's go back. When your husband finished the radiation  
12 therapy, he had fatigue. We went over that in the health  
13 information, correct?

14 AYes.

15 QAnd he was not going out of the house?

16 ARight.

17 QHe had been vomiting from the radiation?

18 ACorrect.

19 QHe did nothing with his children at that time?

20 ARight.

21 QHe was losing weight?

22 AYes.

23 QNow, when he went up to -- as a matter of fact, he lost about

1           59 pounds total, didn't he?  
2   AYes.  
3   QAnd when he went up to Dr. Buttar and started taking these  
4           therapies for his immune system, he went from that to  
5           feeling better; is that fair?  
6   AHe was feeling better before he went to Dr. Buttar because  
7           in February what they found on the scan, we were shocked.  
8   QWell, let me explain to you or ask you this question. He took  
9           his last therapy the first weeks of February and went to  
10          Dr. Buttar within a week or two, didn't he?  
11   AYou're talking about radiation?  
12   QYes.  
13   AThat stopped in December.  
14   QOkay. Is it your testimony that he wasn't taking any radiation  
15          past December?  
16   AYes.  
17   QSo when he went to Dr. Buttar, if he checked out the forms  
18          that he was -- he had fatigue, he was losing weight, he  
19          had no energy, was that his condition then?  
20   AWhen he went to Dr. Buttar's office?  
21   QYes. Do you remember going over the form about what he checked  
22          on his health -- his general health form? And we went  
23          over that to show that on a scale of 0 to 5, he had a 5

1 about fatigue? Am I right?

2 AI remember talking about it, I don't remember all that he said.

3 QSo when you say he was feeling very well and he wrote down

4 to Dr. Buttar the history, he wrote down that he wasn't

5 feeling so well, am I right?

6 AI'm saying that from the start to the radiation, yes, he lost

7 a ton of weight, he had massive surgery, had radiation,

8 he started feeling better. When he was seeing Dr. Buttar,

9 he was starting to do better.

10 QWell, I thought you said that he sold his business.

11 AHe did on impulse.

12 QAnd I thought you said that he did nothing. He said that he

13 was fatigued and was unable to do anything when he went

14 to see Dr. Buttar.

15 ANo, that's not true.

16 QAnd then he went --

17 AWhen he finished radiation, he was able to --

18 QI'm sorry. At any event, the therapy that he was taking, he

19 began to do a lot more than he had in the past, am I right?

20

21 I mean, he started walking, you said that. And he started

22 going to the kids' games, things of that nature?

23 AI felt like I'm being put into a corner here. After the

1 radiation he started to do better. He was shocked, we  
2 were all shocked -- (inaudible) -- but that's when we sought  
3 the alternative medicine. He was not on -- (inaudible)  
4 -- at that point.

5 QNow, he died in September of '04; is that right?

6 AYes.

7 QAfter he left Dr. Buttar he went to Mexico to a Mexican  
8 hospital --

9 AYes.

10 Q-- for alternative treatments.

11 AYes.

12 QCorrect?

13 AYes.

14 QAnd you say that's after he realized that Dr. Buttar had not  
15 helped him, he went to the same type of procedure, an  
16 alternative procedure; is that correct?

17 AYes. He wasn't -- when he started with Dr. Buttar.

18 QAnd did he spend funds on that trip?

19 AYes.

20 QFlying?

21 AHe used frequent flyer miles.

22 QOkay. Did he stay in the hospital?

23 AHe did.

1 QDo you have any idea what that cost?  
2 AAbout 25,000.  
3 QAbout 25,000. He was there how long?  
4 AA month.  
5 QMore than what Dr. Buttar charged when he turned him into the  
6 collection department?  
7 AThe \$25,000?  
8 QYes.  
9 AI don't know.  
10 QHow about what your oncologist charged for the radiation  
11 treatment? How much did that cost?  
12 AI don't know.  
13 QYou were subpoenaed to bring some documents with you today  
14 about what the costs were. Did you bring them?  
15 AI did.  
16 QWhere are they?  
17 AUnder my chair.  
18 QHave you looked at them to see what those costs are?  
19 ANo.  
20 QDo you know what the oncologist costs were, I'll take your  
21 word?  
22 ANo. I didn't look at that. I just -- the subpoena --  
23 (inaudible).

1 QAnd that was about \$25,000.

2 Now, was your husband satisfied with the staff at Dr.  
3 Buttar's office? He liked them?

4 AYes, he like the staff.

5 QAfter he came back from Mexico, Dr. Levine saw him again and  
6 recommended that he continue the therapy from Mexico, am  
7 I right?

8 AI believe so.

9 QNow, prior to your filing this claim, you became -- there's  
10 no administration of your estate -- of your husband's  
11 estate --

12 ARight.

13 Q-- correct?

14 ARight.

15 QHe moved everything into your name, correct?

16 AI have nothing to my name. My husband's name was taken off  
17 -- (inaudible).

18 QWell, you sold the house, didn't you?

19 AYes.

20 QAnd you refinanced the houses?

21 AI just sold one of my properties, the first of this year.

22 QThe fact was, there was no estate for which any collection  
23 agency or Dr. Buttar could have collected any money?



1 ARight.  
2 QNow, you did not go to Mexico?  
3 AI did not.  
4 QAnd you had a four-year-old that you had his parents available  
5 to help sit or other relatives that could have kept your  
6 baby?  
7 AI have three children.  
8 QSorry?  
9 AI have three children.  
10 QWell, I understand two of them are --  
11 AMy oldest was -- my middle child is 18 and our youngest was  
12 four.  
13 QBut you had family members you testified to that were available  
14 to stay with your children if you wanted to go to Mexico  
15 with your husband; is that true?  
16 AWhat I testified to was that my husband and I decided it was  
17 best for me to stay home with the children.  
18 QSo you went to one visit at Dr. Buttar's office, correct?  
19 AYes.  
20 QYou never went to Mexico, we agree with that. And finally  
21 you went to see Dr. Levine what, one time?  
22 ANo, almost every time he went to Dr. Levine.  
23 QAnd you never went to radiation, did you?

1 AI went for the original, but, no.

2 QThe staff members of Dr. Buttar came to your husband's funeral,  
3 didn't they?

4 AI remember Michelle being there.

5 QAnd I believe you told me that you had only one conversation  
6 with Michelle and that was at the funeral and she called  
7 the house at one time.

8 AShe did call the house and she was at the funeral.

9 QNow, you wrote that Michelle Reed had indicated that she left  
10 Dr. Buttar because of circumstances surrounding his  
11 practice. Did you write that in that information?

12 AUh-huh (yes).

13 QYes, you never really talked to her except that one time on  
14 the telephone at your husband's house or your house?

15 AAt our house, yes.

16 QAnd the truth of the matter is, you made up the fact that she  
17 allegedly left the practice of Dr. Buttar because you  
18 didn't know that she had come back and spent another two  
19 years with Dr. Buttar after your husband's death, did you?

20 AI didn't make anything up.

21 QOkay. Did you make that statement, yes or no?

22 AWhat statement?

23 QThat Michelle had left Dr. Buttar's practice?

1 AThat's what I was told.

2 QSo that was hearsay from somebody else? But in these  
3 interrogatories by the investigative officer you told him  
4 that you had talked to Michelle Reed and Michelle Reed  
5 told you that, right?

6 AMichelle had called the house and I heard that Michelle talked  
7 to Jerry Messina, Michelle talked to a lawyer that Jerry  
8 had spoken to and I can't tell you exactly which  
9 conversation that came up and it was told to me.

10 QMichelle Reed never told you that, that's true, isn't it?

11 AI can't tell you whether it's true or not.

12 QYou don't remember? Is that your testimony?

13 AI don't know if she told Jeff, I don't know if she said that  
14 to me on the phone, I don't know if she told it to Jerry.

15 QWhen your husband was in -- over in Mexico, did you know that  
16 he was e-mailing Dr. Buttar almost -- his staff almost  
17 daily?

18 ANo.

19 QDo you know that they were e-mailing him back?

20 AI know that there were staff members that kept in touch with  
21 him.

22 QDo you know that his sister was e-mailing him about Jeff's  
23 condition and about his death?

1 AYes.

2 QYou see your in-laws what, at special events like Christmas?

3 AI see them, is that what you said?

4 QThat's what you said, you saw them at special events.

5 AHis sister was -- (inaudible) -- but his father -- (inaudible).

6 QHis what?

7 AHis father on holidays.

8 QOn holidays?

9 AUh-huh (yes).

10 QYou take your children over there on holidays; is that right?

11 AI see them sometimes on holidays.

12 QSometimes?

13 AYes. If I do see them, it would be on a holiday.

14 QHave you talked to Jerry Messina?

15 AYes.

16 QAnd you and he conferred about how this case was going to be  
17 tried, didn't you?

18 AConferred about this case?

19 QYes.

20 AWe've talked about everything that he has -- since we had --  
21 (inaudible).

22 QDo you remember when you filed your complaint?

23 AThe date of the filing?

1 QYes, the date you wrote the letter to the Board.

2 ANo, I don't, it was two and a half years ago.

3 QI'm sorry, excuse me. So you filed this on October -- it was  
4 stamped with the Medical Board October of '05; is that  
5 right?

6 AYes.

7 QAnd when did you get the letter from the collection agency?  
8 Not long before that?

9 AI don't know. I really don't know. I'm sure it was before  
10 that. Not long had gone by.

11 MR. KNOX: I have no further questions.

12 PRESIDENT RHYNE: Mr. Jimison, do you want to redirect?

13 MR. JIMISON: Just a few minutes, Dr. Rhyne.

14 **REDIRECT EXAMINATION BY MR. JIMISON:**

15 QIf you could turn to the thin notebook, please.

16 ATurn to what?

17 QThe Board's thin notebook. Exhibit 22.

18 MS. GODFREY: What number?

19 MR. JIMISON: Number 22.

20 MS. GODFREY: We're going to object to this. The  
21 complaints as put before the Medical Board have lots of  
22 hearsay in them and being this complaint and this witness  
23 has been here to testify about it.

1           PRESIDENT RHYNE: Excuse me, I didn't hear the last  
2 sentence that you said.

3           MS. GODFREY: I'm sorry. We object to the admission of  
4 the complaints themselves because they do have hearsay  
5 in them. This witness has been here -- here and examined  
6 about it so we object to the Board considering the complaint  
7 itself because it does have hearsay in it.

8           MR. JIMISON: Dr. Rhyne, they opened the door to this  
9 complaint. They asked many questions about when did you  
10 file this complaint, they -- they made questions which  
11 made implications that she filed the complaint because  
12 of the collection agency, this being referred, they asked  
13 when she filed the complaint. They clearly opened the  
14 door to this complaint coming into evidence, so they waive  
15 any objection by -- by questioning her on the complaint.

16           They waived all objections at that point. They  
17 completely opened the door.

18           MR. KNOX: That would completely open the door for us to  
19 go back and examine her. I just asked her two questions  
20 about when it was filed and -- and what her chief complaint  
21 was about in the case and that's factual reference.

22           PRESIDENT RHYNE: Yeah, I'm going to overrule the  
23 objections --

1 MR. JIMISON: Okay.

2 PRESIDENT RHYNE: -- the Board can continue. Go ahead.

3 Q(By Mr. Jimison) If you can identify Tab 22, Exhibit 22.

4 Was that the complaint you filed with the Medical Board?

5 AYes.

6 QOkay.

7 MR. JIMISON: At this point, I'd like to enter the Board's  
8 Exhibit 22 into evidence.

9 MR. KNOX: Well, to begin with, we object on the basis  
10 of hearsay that's included in it.

11 PRESIDENT RHYNE: I'm sorry, you object to --

12 MR. KNOX: We object on the basis it's full of hearsay  
13 about what somebody told.

14 MR. JIMISON: And, again, the Board claims they waived  
15 all objections when they questioned her on the complaint.

16 Okay. And also --

17 MR. KNOX: Wait a minute. Is your --

18 MS. GODFREY: She did.

19 MR. KNOX: I mean, if she did, I didn't hear.

20 PRESIDENT RHYNE: I'm sorry, for not speaking in the mike.

21 Q(By Mr. Jimison) And now I hate to keep flipping back and  
22 forth, but they -- they mentioned -- now back to their  
23 exhibit, Patient's Exhibit -- I mean, Dr. Buttar's Exhibit

1 Number 17, could you refer back to that?

2 PRESIDENT RHYNE: This is in their book?

3 MS. GODFREY: Yes.

4 Q(By Mr. Jimison) He asked you many questions about the Consent  
5 to Treatment form, correct?

6 AYes.

7 QThat is fair to say that Consent to Treatment form is about  
8 one paragraph long?

9 AYes.

10 QIs that the bottom of Patient Information and Registration  
11 form?

12 AYes.

13 QI'd like to read to you the first sentence of that, but before  
14 I do, do you recall Mr. Knox asking you about questions  
15 about Dr. Buttar treating your husband's immune system,  
16 correct?

17 AYes.

18 QWell, now I'd like to read the first sentence. "I authorize  
19 the medical and nursing staff of Advanced Concepts in  
20 Medicine to perform diagnostic tests and administer  
21 treatment plans for allergy, immune disorders, nutritional  
22 disorders, cancer and other chronic medical conditions."

23 Correct?



1 AYes.

2 QSo that first sentence is saying that he's consenting to Advance  
3 Concepts in Medicine, the staff themselves, to administer  
4 treatment plans for cancer?

5 ARight.

6 QWas it your understanding that your husband was getting  
7 treatment for cancer when you went to Dr. Buttar's office?

8 MR. KNOX: We'll object to --

9 AYes, absolutely.

10 MR. KNOX: -- this is leading. I mean, just it's him  
11 testifying and we object to the leading.

12 Q(By Mr. Jimison) What was your understanding -- I'll rephrase.

13

14 What was your understanding of what your husband was being  
15 treated for when he went to Dr. Buttar's office?

16 AHe was being treated for his cancer.

17 QOkay. Did -- did Dr. Buttar, during that meeting, say he was  
18 doing any research for cancer treatments?

19 ANo.

20 QDid he say he was doing any experimentations on cancer  
21 treatments?

22 ANo.

23 QDid he say that his treatments were experimental?

1 ANo.

2 QDid he tell you about any of the side effects of hydrogen  
3 peroxide or ozone or chelation therapy?

4 ANo.

5 QDid -- did he mention anything about an Institutional Review  
6 Board that reviews his work?

7 ANo.

8 MR. KNOX: Well, objection. I guess he could ask her if  
9 they discussed anything? To ask these continuous,  
10 repeated --

11 MR. JIMISON: I'm asking about questions that --

12 MR. KNOX: Well, I made my objection, may I be heard?

13 MR. JIMISON: I can respond to his objection.

14 MR. KNOX: Well, you don't have to interrupt.

15 PRESIDENT RHYNE: Yeah. Mr. Jimison, could you -- what  
16 is your line of questioning here?

17 MR. JIMISON: The question is what was not said during  
18 that -- that meeting with Dr. Buttar and that Ms. Kenny  
19 contended because he clearly asked her about what was said  
20 or what this form said. I'm trying to get what was not  
21 said.

22 QDid -- did he --

23 PRESIDENT RHYNE: Yeah. I would say just move on --

1 MR. JIMISON: Okay. Just a few -- few more, just one or  
2 two.

3 Q(By Mr. Jimison) "The therapies will compliment the care I  
4 received from my primary care physician." Did Dr. Buttar  
5 encourage your husband to stay with his oncologist?

6 ANo.

7 MS. GODFREY: Objection.

8 MR. KNOX: Objection.

9 PRESIDENT RHYNE: Ask it again.

10 Q(By Mr. Jimison) It's a question during -- I'm just asking  
11 what he did or did not say. Did he ask about staying on  
12 with your oncologist during that first meeting?

13 PRESIDENT RHYNE: I'm going to overrule your objection  
14 since she was there.

15 MR. KNOX: Okay.

16 Q(By Mr. Jimison) Did he say -- did he encourage your husband  
17 to stay on with his oncologist after -- during that first  
18 meeting?

19 ANo, he did not.

20 MR. JIMISON: That's all.

21 MR. KNOX: Okay.

22 PRESIDENT RHYNE: Objection? Okay.

23 MR. KNOX: Just a couple of questions.

1           PRESIDENT RHYNE: Mr. Knox.

2           RE-CROSS EXAMINATION BY MR. KNOX:

3           QYou fully understood that he signed this Advanced Concepts  
4           in Alternative and Preventive Medicine and initialed it  
5           at every place acknowledging that they explained in detail  
6           the purpose of the chelation therapy, correct?

7           MS. GODFREY: Page 3 of Exhibit 17.

8           MR. KNOX: 17.

9           MS. GODFREY: Buttar's 17.

10          MR. KNOX: All right.

11          Q(By Mr. Knox) You got it?

12          AYeah, I do.

13          QAnd he's initialled his name all the way down there that he  
14          understood that this was -- the chelation therapy was to  
15          help his immune system, and correct me if I'm not right,  
16          you testified that Dr. Buttar explained that the treatment  
17          was to help his immune system. Didn't you say that  
18          previously?

19          AYes.

20          QSo when you -- he did not say the cancer, but he said this  
21          would help -- the chelation would help the immune system  
22          and that may help his condition with the cancer, is that  
23          a fair statement?

1 ANo.

2 QOkay. And notwithstanding all of that, with all of the doctors  
3 aside, he elected to have the therapy, am I right?

4 AHe did elect to have it, yes.

5 QAnd you never went back to object until you got a \$6700 bill --

6 MR. JIMISON: Objection, asked and answered.

7 AI want to say to you that my husband started this when he was  
8 alive. It's not hearsay that I repeated it.

9 QThe last question is it is my informed decision that I accept  
10 chelation treatment as an alternative approach to surgical  
11 and other individual therapies. Okay. Do you read that?

12 It's about midway of the second paragraph.

13 AOn the chelation page?

14 QYeah. Read the second paragraph. Have you read it?

15 AUh-huh (yes).

16 QAnd there's not one word in that paragraph that your husband  
17 signed that talks about curing cancer, correct?

18 ANo, it doesn't in that paragraph.

19 MR. KNOX: That's all I have.

20 PRESIDENT RHYNE: Anything else? Any Board Members have  
21 questions?

22 **EXAMINATION BY THE PANEL MEMBERS:**

23 DR. McCULLOCH: Thanks for being here, Ms. Kenny.

1 You were present at the first visit with Dr. Buttar?  
2 WITNESS: Yes.  
3 DR. McCULLOCH: Correct me if I'm wrong, was it your  
4 testimony that he informed your husband that he has 100  
5 percent success rate in curing cancer?  
6 WITNESS: Yes.  
7 DR. McCULLOCH: A 100 percent success rate in curing cancer  
8 is your --  
9 WITNESS: Yes.  
10 DR. McCULLOCH: Despite what he may have signed or the  
11 papers that are here on exhibit, that's what he said?  
12 WITNESS: Yes.  
13 DR. McCULLOCH: Okay. One other question, it's a little  
14 difficult, but you tried alternative medicine for several  
15 months?  
16 WITNESS: Yes.  
17 DR. McCULLOCH: And in your estimation, it failed?  
18 WITNESS: Yes.  
19 DR. McCULLOCH: Why -- did you and your husband have  
20 conversations about why he would want to continue with  
21 more alternative medicine in Mexico?  
22 WITNESS: Well, he considered the Issles Clinic early on.  
23 Dr. Buttar initially claims that he did exactly what they

1 do there, that he in fact created a lot of things that  
2 they do use there and he wanted to stay in the country  
3 because it was cheaper here. But when that did not work,  
4 he chose to go out of the country and to go there.  
5 DR. McCULLOCH: That's all I have, thank you.  
6 PRESIDENT RHYNE: I just have one question. Were you with  
7 your husband when Dr. Buttar explained the CAT scan that  
8 showed the progression of the disease?  
9 WITNESS: No. My husband just brought that report home.  
10 PRESIDENT RHYNE: Okay. So you were not with him?  
11 WITNESS: Uh-uh (no).  
12 PRESIDENT RHYNE: Okay. We thank you very much for  
13 coming, Mrs. Kenny. We're all very sorry for your loss.  
14 WITNESS: Thank you.  
15 MR. JIMISON: At this point, the Board would like to call  
16 Mr. Messina, but we have to do it by telephone and I need  
17 to get the person in here to do the telephone. I don't  
18 know if the Board Members would like to take a five-minute  
19 break.  
20 PRESIDENT RHYNE: We'll take a five-minute break.  
21 MS. GODFREY: A five-minute break?  
22 PRESIDENT RHYNE: Uh-huh (yes).  
23 MS. GODFREY: Thank you.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23

---

(11:12 A.M. - 11:25 A.M. RECESS)

---

PRESIDENT RHYNE: Okay. Mr. Jimison, do you have another witness at this point?

MR. JIMISON: Okay. We now -- the Board would now like to call Mr. Messina to the stand. Mr. Messina, are you on the telephone?

(DISCUSSION OFF RECORD)

MR. JIMISON: Okay. Mr. Messina, are you there? Hello.

MR. MESSINA: Hello.

MR. JIMISON: Mr. Messina, my name is Marcus Jimison. I'm an attorney for the Medical Board.

MR. MESSINA: Yes.

MR. JIMISON: We're now -- you're now being broadcast to the entire Medical Board. And I would like to now have you be addressed by Dr. Rhyne.

MR. MESSINA: Okay.

PRESIDENT RHYNE: Mr. Messina, I'm Dr. Rhyne and I'm the presiding officer. Drs. McCulloch and Walker are here with me and we will proceed now to swear you in.

Do you solemnly swear that your testimony will be the truth, the whole truth, and nothing but the truth, so help you



1 God.

2 WITNESS: Yes.

3 PRESIDENT RHYNE: You may proceed.

4 MR. JIMISON: Okay. Thank you.

5 **DIRECT EXAMINATION BY MR. JIMISON:**

6 QMr. Messina, could you state your name please for the Board?

7 AI'm sorry?

8 QCould you state your name please for the Board?

9 AJerry Messina.

10 QAnd where do you presently live, Mr. Messina?

11 ALos Angeles, California.

12 QAnd how are you related to Patient B?

13 AShe was my aunt.

14 QAnd describe your aunt for the Board, please.

15 ADescribe her as a person?

16 AYes, sir.

17 QShe's -- she was very caring. She was always there for my  
18 brothers and I, no matter what. She loved us dearly and  
19 she was a very strong woman that wanted to beat cancer.

20 QDid your aunt get cancer at some point in her life?

21 AShe was diagnosed in 2002.

22 QDo you know what her diagnosis was?

23 AOvarian cancer.

1 QAnd how old was your aunt when she got diagnosed?  
2 AFifty.  
3 QOkay. And how was she first treated for cancer, if you know?  
4 AShe was first treated with chemotherapy.  
5 QOkay. And did that cure her of her cancer?  
6 ANo.  
7 QAnd at some point did your aunt continue to receive chemotherapy  
8 for her cancer?  
9 AYes. She had three different chemo treatments.  
10 QDid any of it work?  
11 AThe first one started to work and reduced the cancer a  
12 significant amount. The second one did not and the third  
13 one moderately.  
14 QOkay. Did her cancer spread, to your knowledge?  
15 AI don't know.  
16 QOkay. At some point did your aunt go see Dr. Buttar?  
17 AYes.  
18 MS. GODFREY: Well, I'm going to object unless this witness  
19 has personal knowledge of his aunt's interactions with  
20 Dr. Buttar.  
21 MR. JIMISON: There is an exception to the --  
22 PRESIDENT RHYNE: Wait a minute. Well, go ahead.  
23 MR. JIMISON: If you look at 804 -- Rule 804 about the

1 hearsay, it says: Exceptions to the hearsay rule are  
2 statements of personal and family history and it says the  
3 statement concerning the clearance on adoption, divorce,  
4 marital, family history or other -- or other similar fact  
5 of personal or family history even though declarant had  
6 no means to inquire in personal knowledge, it's an  
7 exception if the declarant was related to, other by blood,  
8 adoption, marriage, what's intimately associated with the  
9 other's family as likely to have accurate information  
10 concerning the matter declared.

11 So essentially it's a matter of family history, what her  
12 medical condition was, it can show the person's related  
13 and have intimate knowledge of this person's medical  
14 history.

15 MS. GODFREY: No. I think he's allowed to testify that  
16 he is her nephew and that he knows that because somebody  
17 told him that at one time in his life. But I don't think  
18 this covers what he's about to get into which is her  
19 interactions with Dr. Buttar. Dr. Buttar's interactions  
20 with her were not family history and not -- and something  
21 that he learned -- unless -- unless he was present, he  
22 learned it by someone else telling him and it could have  
23 been somebody else in the family or his aunt herself.

1 But he didn't -- unless he was present here in North  
2 Carolina of his own personal knowledge whatever he knows  
3 about his aunt's interactions with Dr. Buttar will be  
4 hearsay.

5 MR. JIMISON: Dr. Rhyne, I can hand up the rule that says --  
6 it talks about hearsay exceptions where the declarant is  
7 unavailable.

8 PRESIDENT RHYNE: Can you give us a copy of that rule?

9 MR. JIMISON: Yeah.

10 DR. WALKER: It's actually in the motions.

11 MR. JIMISON: I don't think she had 804.

12 MS. GODFREY: I copied 804. I believe it's in the motion.  
13 Is 804 there?

14 MR. KNOX: And it's a statement of personal or family  
15 history.

16 MR. JIMISON: But if you go back and look up that before  
17 that, you'll see -- you'll see the rule is actually when  
18 the declarant is unavailable. And they talk about under  
19 number 3 --

20 MS. GODFREY: That's the 3. Okay. The statement  
21 against --

22 MR. JIMISON: Is unable to be present or testify at a  
23 hearing because of death. Here we have witnesses who have

1 died, so clearly they can't testify. And then if you go  
2 to the exceptions, the following are exceptions. The  
3 statement under belief of impending death, a statement  
4 made by declarant while believing that her death was  
5 imminent concerning the cause or circumstances -- not just  
6 the cause but the circumstances -- of what he believe his  
7 or her impending death.

8 And then you go to number 4, a statement concerning the  
9 foregoing matters and death also of another person if the  
10 declarant was related to, either by blood, adoption or  
11 marriage or was so intimately associated with the other's  
12 family as to be likely to have accurate information  
13 concerning the matters declared. And all I'm asking is  
14 basically the events leading up to her death.

15 MS. GODFREY: Well, Mr. Jimison has an interesting reading  
16 of this. Traditionally --

17 MR. JIMISON: I think it's just a reading.

18 MS. GODFREY: Traditionally, statements under belief of  
19 impending death, the way it's taught in law school is dying  
20 declarations. And, you know, if somebody gets shot and  
21 they identify their murderer, you know, as they're dying,  
22 then the law allows that hearsay into evidence. This is  
23 not that situation.

1 MR. JIMISON: Well, we haven't gotten that. We haven't  
2 even laid down --

3 MS. GODFREY: Mr. Jimison, I let you speak without  
4 interrupting you. I'd appreciate the same courtesy.  
5 The other thing, the statements of personal or family  
6 history, that's an exception that has to do with what I  
7 said. Mr. Messina knows he's the nephew of Patient B  
8 because somebody told him. But, again, the law says that  
9 that's okay for him to know that by hearsay because  
10 obviously that's the only way he could know it.

11 This does not cover interactions with her doctor that he  
12 was not witness to. He learned that -- he learned what  
13 he learned either through conversations with his aunt or  
14 conversations with his mother who was his aunt's sister  
15 who's not even a witness here. And we would object to  
16 any testimony that he has to offer unless he can say he  
17 came to North Carolina and personally observed.

18 MR. JIMISON: The objection was made before really I think  
19 I asked -- at this point, I have truly forgotten what the  
20 question was, but -- but in any event, I'll rephrase the  
21 questions, lay a foundation, and then you'll see where  
22 I'm going and if there is anything that you believe is  
23 improper, then I'll just withdraw the questions.

1           PRESIDENT RHYNE: All right. We will proceed on that,  
2           but I do agree that he cannot testify as to conversations  
3           between the patient and Dr. Buttar if he was not present.

4           MR. JIMISON: Well, no, just want to ask about their own  
5           conversations between themselves, he and his aunt.

6           MS. GODFREY: Well, again, that's -- that's hearsay as  
7           well.

8           MR. JIMISON: And like I said, I'll lay the foundation  
9           and when we get there --

10          PRESIDENT RHYNE: We'll rule on the individual questions.

11          MS. GODFREY: Absolutely.

12          Q(By Mr. Jimison) Were you -- how often did you have  
13           conversations with your aunt while she -- when she had  
14           cancer? I'm not asking you to tell me what she said, just  
15           how often.

16          AWe talked a couple of times a week, if not almost every day.

17          QI'm sorry, I was still asking the question and I was not done  
18           and I know it's kind of two-fold.

19           I'm not asking you what your aunt said to you, I'm just  
20           asking how often did you have conversations with your aunt  
21           during the time that she had cancer?

22          AA couple of times a week, if not almost every single day.

23          QAnd how close were you to your aunt?

1 AExtremely close.

2 QAnd why was that?

3 AShe was an incredible aunt. Again, when she was -- she would  
4 just take care of us all the time. She was always there  
5 and we were just a close family. She was my mom's only  
6 sibling.

7 QAnd at some point -- when did your aunt pass away?

8 ANovember 13th, 2004.

9 QAnd how -- and did you have a conversation with her prior to  
10 her passing away?

11 AI saw my aunt two weeks before she died.

12 QAnd that was personally?

13 AI'm sorry?

14 QAnd that was personally you saw her?

15 AYes, I went to her in Carolina to -- knowing that she was close  
16 to death and I wanted to say good-bye in person.

17 QAnd describe how your aunt looked when you visited her.

18 AShe was a skeleton with skin.

19 QWas she bedridden?

20 AYes, she couldn't walk any more. We would transfer her out  
21 of bed and into a wheelchair, onto the couch. She -- she  
22 couldn't move herself at all.

23 QAnd how -- how long was she in this condition, if you know?



1 AAt least a month.

2 QAnd -- and what treatments were your -- if you know, what  
3 treatments were your aunt getting for her condition at  
4 that time?

5 AAt which time?

6 QThe time you visited her two weeks before her death?

7 AShe wasn't getting any treatment except for hospice at that  
8 time.

9 QOkay. To your knowledge, had her cancer spread?

10 AYes.

11 QAnd where was her cancer at this point? What body organs was  
12 it affecting?

13 AI don't know. It wasn't something we really discussed. All  
14 I know is that -- they -- my aunt didn't want to worry  
15 her family and, I mean, it was just obvious it was -- it  
16 was all over and I just -- I don't know.

17 QAnd how old was your aunt at this point, 50?

18 AFifty-two.

19 QFifty-two. Did she discuss the circumstances of why she was  
20 dying with you?

21 MS. GODFREY: Well, objection. I mean --

22 MR. JIMISON: I think that's well within the rule. I  
23 mean --

1 MS. GODFREY: She was dying -- she was dying of cancer,  
2 right?

3 Q(By Mr. Jimison) Did she ever discuss her -- her illness with  
4 you during that time when you saw her two weeks before  
5 she died?

6 ANot really.

7 QOkay. During that time, did she ever discuss anything  
8 regarding Dr. Buttar?

9 AYes.

10 QAnd that's two weeks before she died?

11 AEven when she started going to Buttar.

12 QOkay. Well, specifically the moment before she died --

13 AWhen I saw her?

14 QI'm sorry, I didn't hear your response.

15 AWhen I saw her?

16 QYes, sir.

17 AYes. She specifically told me she wished she never started  
18 going to Buttar.

19 MS. GODFREY: Objection to what she told him at that point.

20 MR. JIMISON: I mean, a dying declaration, it's a lot --

21 PRESIDENT RHYNE: Yeah, that's -- it's two weeks before.

22 Yeah, that's -- I'm going to sustain that. Not what

23 Buttar said -- what Dr. Buttar said, it's what she said.

1 Q(By Mr. Jimison) After that conversation with your aunt two  
2 weeks before she died, how did you feel?

3 AThat I was going to lose an extremely important person in my  
4 life.

5 QDid you form an opinion about Dr. Buttar?

6 MR. KNOX: Objection.

7 MS. GODFREY: Well, objection.

8 MR. JIMISON: No, I'm just asking -- I mean, I'm not asking  
9 what his opinion is, just asking if he formed an opinion.

10 ANot at that time.

11 QOkay. At some point did you file a complaint with the Medical  
12 Board?

13 AYes.

14 QAnd why did you file that complaint?

15 ABecause on my aunt's death bed, she said to me she wished she  
16 had never started going, that his treatment rapidly  
17 increased her demise.

18 MS. GODFREY: Well, objection.

19 MR. KNOX: That's what was sustained a few minutes ago.

20 PRESIDENT RHYNE: Well --

21 Q(By Mr. Jimison) Do you know Ms. Kenny?

22 MR. KNOX: Excuse me, did you rule?

23 PRESIDENT RHYNE: Yeah. I -- that is not admissible to

1 say that.

2 MR. KNOX: Thank you.

3 Q(By Mr. Jimison) Okay. Mr. Messina, did you ever talk to  
4 Ms. Kenny about your experience with her?

5 AWith -- who is her?

6 QMs. Stephanie Kenny.

7 AYes, we've spoken.

8 QAnd what did y'all talk about.

9 MR. KNOX: Objection, irrelevance.

10 PRESIDENT RHYNE: Right.

11 MR. JIMISON: There's been -- he asked about in  
12 cross-examination, so he's already waived that.

13 PRESIDENT RHYNE: That is true. That's already been  
14 brought up before.

15 MR. JIMISON: So you mean we can't ask the question?

16 PRESIDENT RHYNE: No, overruled, you can ask the  
17 question --

18 MR. JIMISON: Okay.

19 Q(By Mr. Jimison) The -- what did you and Ms. Kenny talk about?

20 AWell, we talked -- we ended up -- my aunt had mentioned this  
21 man, Jeffrey Kenny, that he was seeing Buttar at the same  
22 time and I guess they had crossed paths in Buttar's office.  
23 And she had given me her e-mail password when I saw her

1 and in her e-mail was the Kennys information and that is  
2 when I decided to call and speak with him, but unfortunately  
3 he had already passed away, so I started speaking with  
4 Stephanie. And we just started discussing how the demise  
5 of our two loved ones had rapidly increased during and  
6 after Buttar's treatment.

7 MR. KNOX: Objection.

8 MS. GODFREY: Objection.

9 PRESIDENT RHYNE: Yeah, that's --

10 MR. KNOX: Okay.

11 PRESIDENT RHYNE: We can't go there.

12 Q(By Mr. Jimison) How has the experience with -- between you  
13 and your aunt and Dr. Buttar affected you?

14 AI didn't hear your question.

15 QHow has this experience with your aunt and Dr. Buttar affected  
16 you?

17 MS. GODFREY: Objection.

18 MR. JIMISON: I'm not asking him what anyone said --

19 MS. GODFREY: How has it affected him.

20 MR. JIMISON: -- I'm just asking how it affected --

21 MS. GODFREY: How is that relevant --

22 PRESIDENT RHYNE: Yeah.

23 MS. GODFREY: -- to this?

1 MR. JIMISON: It goes to victim impact. I mean, the same  
2 question was asked of Ms. Kenny without objection. It's  
3 a standard question about how these matters affect people  
4 personally. I mean, you can give it a lot of weight if  
5 you want to, but, I mean, I do think it's relevant.

6 PRESIDENT RHYNE: Go ahead.

7 Q(By Mr. Jimison) Okay. Mr. Messina, how had this experience  
8 with your aunt and Dr. Buttar affected you?

9 MS. GODFREY: Well, objection for the record.

10 WITNESS: Do I continue at this point?

11 MR. JIMISON: Yes, sir.

12 AOkay. Could you repeat the question one more time?

13 Q(By Mr. Jimison) How has this experience affected you?

14 AThis experience has at this point gone on for three and a half  
15 years.

16 I'm sorry, you have to repeat the question one more time.

17 MR. KNOX: Objection --

18 PRESIDENT RHYNE: Let's just move on.

19 MR. JIMISON: I'll just leave it there. Thank you, Mr.  
20 Messina.

21 MR. KNOX: I agree, can we move on?

22 MR. JIMISON: I'll just leave it there. Thank you, Mr.  
23 Messina.

1 Now, the lawyer from the other side is able to ask, so  
2 stay on the phone.

3 WITNESS: Yes.

4 MR. JIMISON: Okay, thank you.

5 MS. GODFREY: Thank you.

6 **CROSS-EXAMINATION BY MS. GODFREY:**

7 QMr. Messina?

8 AYes.

9 QYou are in Los Angeles, correct?

10 AThat is correct.

11 QAnd is your cell phone number 323 --

12 MR. JIMISON: Objection, relevance.

13 MS. GODFREY: Well, I still have --

14 MR. JIMISON: It's just -- it is -- we could attach an  
15 exhibit. Now, everybody in the public is going to have  
16 his cell phone. I think that's an invasion of privacy  
17 and I mean, the witness has privacy rights.

18 MS. GODFREY: Well, I want to just ask him --

19 PRESIDENT RHYNE: I think we could go ahead --

20 MS. GODFREY: -- if he got messages from me and from  
21 members of my office through the weekend --

22 MR. JIMISON: Well, you can ask that question.

23 MS. GODFREY: -- or over the past week to ask -- asking

1           them -- asking him to call us.

2   Q(By Ms. Godfrey) Did you receive any messages?

3   AYes, I did.

4   QOkay. And you didn't call us to talk to us ahead of your  
5           testimony here, did you?

6   AThat is correct and I have the right not to.

7   QOkay. Now, during the whole time that your aunt was treating  
8           with Dr. Buttar, you were in Los Angeles the entire time;  
9           is that correct?

10   ACorrect.

11   QAnd you not only talked to your aunt on the phone, but you  
12           talked to your mother, that's Olga Messina?

13   ACorrect.

14   QAnd she had opinions about your aunt's treatment too, didn't  
15           she?

16   ANo, not necessarily.

17   QOkay. She didn't have any opinions about your aunt's  
18           treatment?

19   AI'm sure she did, but I'm not my -- I'm not Olga Messina.

20   QOkay. Well, she didn't convey anything to you about what she  
21           thought about your aunt's treatment with Dr. Buttar?

22   ANo.

23   QNow, your mother was executor of your aunt's estate, was she



1 not?

2 AYes.

3 QAnd we have marked as Exhibit 16 a copy of your aunt's estate  
4 file and I know you can't see that because you're not here  
5 in the room with us.

6 But it's true that your -- your mother was executor and  
7 she settled with -- with a number of medical providers  
8 after your aunt's death, did she not?

9 AYes.

10 QBut Dr. -- she did not pay anything to Dr. Buttar, did she?

11 ANo, because we had an attorney that put in the 30-day  
12 requirement to contact and Buttar's office did not contact  
13 until after or past the 30 days.

14 QOkay. So nothing was collected from your aunt's estate by  
15 Dr. Buttar; isn't that right?

16 ANot the estate, but while my aunt was alive, yes.

17 QOkay. She paid her -- she paid him some money while she was  
18 alive?

19 AYes.

20 QAre you aware that your aunt was discharged from Dr. Buttar's  
21 practice for non-compliance?

22 ANo, she was not.

23 QOkay. Well, that's your opinion, but you -- you don't know

1 anything about the medical records in this case, correct?  
2 ANo, except for what my aunt told me that she stopped going  
3 to him.  
4 QOkay. So if the medical records in this case reflect that  
5 your aunt was discharged from Dr. Buttar's practice for  
6 non-compliance, you don't have any opinion about that?  
7 ANo, because she told me that she stopped going to him.  
8 QOkay. And are you aware that your -- your aunt was referred  
9 to Dr. Buttar by her family doctor?  
10 AI believe so, but I'm not exactly sure about that.  
11 QOkay. Now, also, Mr. Messina, what year did your aunt die?  
12 A2004.  
13 QShe died in 2004?  
14 AYes.  
15 QOkay. Okay. So it's been four years since her death?  
16 AThree and a half at this point.  
17 QThree and a half.  
18 AIt was late -- it was late 2004.  
19 QAnd you're aware that your aunt died five months after she  
20 stopped treatment with -- with Dr. Buttar; isn't that  
21 right?  
22 AI think it was less than that.  
23 QWell, if the record shows she stopped treatment in June and

1           died in November, that's five months, isn't it?  
2 AOkay. Was it June? I don't know.  
3 QOkay. And you're aware she only went to -- to Dr. Buttar's  
4           clinic for a short period of time?  
5 AThat I do know. It was a couple of months.  
6           MS. GODFREY: Okay. I don't have any further questions.  
7           MR. JIMISON: Dr. Rhyne, I do have --  
8           PRESIDENT RHYNE: Yes, would you like to cross-examine?  
9           MR. JIMISON: Sure, redirect.  
10          PRESIDENT RHYNE: I mean redirect.  
11 **REDIRECT EXAMINATION BY MR. JIMISON:**  
12 QMr. Messina, you heard Ms. Godfrey ask you questions about  
13           whether your aunt was discharged for non-compliance,  
14           correct?  
15 AI'm sorry, repeat that again, I was --  
16 QShe asked you whether your aunt was discharged from  
17           Dr. Buttar's care for non-compliance, correct?  
18 ACorrect.  
19 QAnd she also brought up certain matters about your aunt's  
20           estate?  
21 AYes.  
22 QAnd you said your aunt -- she -- she also mentioned that she  
23           only went there for a couple of months?

1 AYes.

2 MS. GODFREY: Objection.

3 QShe asked you about that, correct?

4 PRESIDENT RHYNE: Well --

5 MS. GODFREY: What I stated was for a short period of time.

6 I think the records reflect the amount of time, but it  
7 wasn't a couple of months.

8 Q(By Mr. Jimison) Well, okay. The question about a short  
9 period of time, correct?

10 AYes.

11 QWhy did your aunt stop going to see Dr. Buttar?

12 AWell, the main reason --

13 MS. GODFREY: Objection.

14 A-- she stopped was because he took off for about three weeks,  
15 I think, for some sort of trip, honeymoon, and the  
16 treatments were still being done the same, at the same  
17 price even though there was -- was no doctor available  
18 except for just nurses. And also because his treatments  
19 to her was extremely rude and frightening to her actually.

20 MS. GODFREY: Well --

21 PRESIDENT RHYNE: I believe that that needs to be --

22 MS. GODFREY: -- objection, move to strike. He could  
23 only know that by what his aunt told him.

1 MR. JIMISON: Well, at this point, Ms. Godfrey asked  
2 questions about why she left the practice. Again, I  
3 believe she's opened the door to this line of testimony.  
4 She's waived all objections.

5 MS. GODFREY: I don't think I waived anything.

6 MR. JIMISON: If -- if she asked about -- if she asked  
7 about her -- this patient being discharged from Dr.  
8 Buttar's practice to this witness, then we have the right  
9 to explore fully why this witness believes that patient  
10 was discharged.

11 MS. GODFREY: Well, I beg to differ. I -- I asked him  
12 if he reviewed the medical records and if he knew anything  
13 about what the medical records reflected that is the reason  
14 the patient was discharged from the practice.

15 MR. JIMISON: She asked -- you said -- she asked a question  
16 that this patient was discharged for non-compliance, thus,  
17 making the implication that this patient was discharged  
18 from Dr. Buttar because she did not do something that Dr.  
19 Buttar asked her to do. Therefore, she put it in play  
20 to explore fully with this witness why she was discharged.

21 MS. GODFREY: Well --

22 PRESIDENT RHYNE: Proceed.

23 MS. GODFREY: -- the -- the medical records are in

1 evidence and the medical records --

2 MR. JIMISON: She didn't have to ask question about this

3 witness --

4 MS. GODFREY: -- excuse me. Excuse me, Your Honor. The

5 medical records reflect that this patient was discharged

6 for non-compliance and that's all I asked, if he was aware

7 of that.

8 MR. JIMISON: But as soon as she asked the question, she

9 opens the door to explore it.

10 MS. GODFREY: Well --

11 PRESIDENT RHYNE: Right.

12 MS. GODFREY: -- I would object.

13 PRESIDENT RHYNE: Go head, move on.

14 MR. JIMISON: Okay. I'll just ask a few questions.

15 Q(By Mr. Jimison) Again, could you finish your answer about

16 why you -- why your aunt stopped seeing Dr. Buttar?

17 MS. GODFREY: Well, objection because everything he knows

18 is hearsay.

19 Q(By Mr. Jimison) If you -- if you can go ahead, Mr. Messina.

20 ASure. She -- she started to become very afraid of Buttar.

21 Again, his treatments were making her extremely weak.

22 It was a far drive for her. At one point she even told

23 me that she felt he was a drill sergeant and she was a

1 cadet. He would just sit there and humiliate her at  
2 points.  
3 And after being gone for the three weeks, she -- she stopped  
4 going during that time that he was gone and wanted -- then  
5 went back after and then that's when she stopped going  
6 after that.  
7 MS. GODFREY: Well, move to strike on the basis of it's  
8 all hearsay, it's all --  
9 MR. JIMISON: Again --  
10 MS. GODFREY: -- it's been told by someone else.  
11 MR. JIMISON: -- same argument, she opened the door, asked  
12 him about why she was discharged, why she left the practice.  
13 He's just explaining. She asked it to this witness, so  
14 this witness --  
15 PRESIDENT RHYNE: I think you need to make it clear in  
16 the record that this -- he was not there --  
17 MR. JIMISON: Okay.  
18 PRESIDENT RHYNE: -- and he didn't hear --  
19 MR. JIMISON: Sure.  
20 PRESIDENT RHYNE: -- this is what his aunt relayed to  
21 him.  
22 MR. JIMISON: Okay.  
23 PRESIDENT RHYNE: But we cannot accept that.

1 Q (By Mr. Jimison) Mr. Messina, what is your -- where did your  
2 aunt live in North Carolina?

3 A Rutherfordton.

4 Q And she drove from -- did she drive from Rutherfordton to --  
5 to Dr. Buttar's office or did she get a hotel room?

6 A She -- for a while, her and her fiance would drive to Buttar  
7 and then at a certain point, I don't remember when, she  
8 got an apartment in -- I believe it was Cornelius.

9 Q Okay. Ms. Godfrey asked you -- and just one or two questions,  
10 Dr. Rhyne.

11 Ms. Godfrey asked you about certain claims that were made  
12 on the estate to you.

13 A Yes.

14 Q Do you know how much money Dr. -- your aunt paid to Dr. Buttar?

15 A I do not know how much she paid him.

16 Q Do you have an idea?

17 MS. GODFREY: Well, objection.

18 Q From -- from your knowledge of the estate.

19 MS. GODFREY: Objection.

20 PRESIDENT RHYNE: Yeah, that's --

21 MR. JIMISON: Okay. I'll withdraw it.

22 PRESIDENT RHYNE: That's needs to be withdrawn.

23 MR. JIMISON: I'm through.



1 PRESIDENT RHYNE: Ms. Godfrey, do you want to recross?

2 **REXCROSS EXAMINATION BY MS. GODFREY:**

3 QYour aunt's boyfriend, his name --

4 AFiancee.

5 QFiancee, excuse me, was Alex?

6 AYes.

7 QAnd Alex supported her in the treatment; isn't that correct?

8 MR. JIMISON: Objection, I mean, this is hearsay.

9 AAlex pushed her.

10 QOkay. And the family disagreed with Alex; isn't that right?

11 AAfter her death. At the time, we wanted anything to help my  
12 aunt and, you know, help her survive and we believe anything  
13 would have worked.

14 QOkay. So but -- but Alex and the family saw things differently  
15 as far as Dr. Buttar's treatment; isn't that right, Mr.  
16 Messina?

17 ACould you repeat that, please?

18 QI'm sorry?

19 AYou're just very soft, your voice.

20 QOkay. Let me repeat the question.

21 Alex and the family saw things differently as -- as to  
22 Dr. Buttar's treatment. Is that a fair statement?

23 AYes, that is a fair statement.

1 MS. GODFREY: Okay. That's all I have.  
2 PRESIDENT RHYNE: Okay. Thank you very much,  
3 Mr. Messina.  
4 WITNESS: Thank you.  
5 MR. JIMISON: We would now like to place another telephone  
6 call witness.  
7 PRESIDENT RHYNE: How many more witnesses are you going  
8 to have at this point?  
9 MR. JIMISON: Unfortunately, they're going slow. We have  
10 five more witnesses including -- that includes Dr.  
11 Peterson, four witnesses and Dr. Peterson. I hope to be  
12 done by 2:00 this afternoon, but, you know, it is slow.  
13 I'll try to go faster.  
14 PRESIDENT RHYNE: How long do you anticipate this next  
15 one? I'm trying to decide --  
16 MR. JIMISON: I will try to make it about ten minutes of  
17 direct.  
18 MS. GODFREY: And this is Ms. XXXXXX (Mother of Patient  
19 E)?  
20 MR. JIMISON: Yeah. Well, at this point I'd like to clear  
21 the courtroom. She wants to testify on behalf of her  
22 daughter which I think makes her standing that she was  
23 the patient and she wants to identify herself only in a

1 closed courtroom, but then she'll be happy to testify  
2 publicly after stating her name.

3 PRESIDENT RHYNE: Yes, sir. If you both attorneys  
4 approach.

5 (BENCH CONFERENCE OFF THE RECORD)

6 PRESIDENT RHYNE: Proceed.

7 MR. JIMISON: We're going to make a request to clear the  
8 hearing room, so the witness can identify herself and then  
9 she'll be willing to testify in public.

10 PRESIDENT RHYNE: Okay. The hearing room will be cleared.

11 (COURTROOM CLEARED)

12 PRESIDENT RHYNE: Counsel, just educate me. When you  
13 clear the courtroom, the record -- the court reporter stays  
14 in?

15 MR. JIMISON: Oh, absolutely, yeah.

16 PRESIDENT RHYNE: Okay.

17 MR. JIMISON: Just -- it just means, you know, people who  
18 are entitled to be here --

19 PRESIDENT RHYNE: Okay.

20 MR. JIMISON: -- or that has to be. Could we have --

21 PRESIDENT RHYNE: Can we get the media person in here to  
22 make sure the camera is off.

23 COURT REPORTER: It's off.

1 (TELEPHONE CONVERSATION WITH MOTHER OF PATIENT E)  
2 MR. JIMISON: Hello, Ms. XXXXXX (Mother of Patient E).  
3 MS. XXXXXX (Mother of Patient E): Yes.  
4 MR. JIMISON: Okay, hi. This is Marcus Jimison, attorney  
5 from the Medical Board. You've been speaking to Ms.  
6 Carpenter and she indicated that you would like to  
7 introduce yourself in closed session, but then testify  
8 in public so long as people refer to you only as Patient  
9 E's mother.  
10 MOTHER OF PATIENT E: Right.  
11 MR. JIMISON: Okay. Well, let me go ahead and start, but  
12 first Dr. Rhyne, President of the Board, needs to swear  
13 you in.  
14 MOTHER OF PATIENT E: Okay.  
15 PRESIDENT RHYNE: Thank you, Ms. XXXXXX (Mother of Patient  
16 E.) Do you solemnly swear that your testimony will be  
17 the truth, the whole truth, and nothing but the truth,  
18 so help you God.  
19 MOTHER OF PATIENT E: I do.  
20 **DIRECT EXAMINATION BY MR. JIMISON:**  
21 QCould you state your name for the record, please?  
22 AXXXXXXXX X. XXXXXX. (Mother of Patient E)  
23 QAnd are you related to Patient E?

1 AI am.

2 QAnd what's your relation?

3 AI'm her mother.

4 MR. JIMISON: Okay. We'll pause now.

5 (WHEREUPON, THE PUBLIC RETURNED TO THE HEARING ROOM)

6 Q(By Mr. Jimison) Ma'am, we're going to move quickly. You  
7 know, I know we've talked about some things, but I'm going  
8 to try to move as quickly as possible.

9 AOkay.

10 QDid your daughter ever see -- did you ever have occasion to  
11 go to Dr. Buttar for treatment for your daughter?

12 AYes.

13 QAnd what was that treatment for?

14 AFor what appears to be metal toxicity relative to her autism.

15 QOkay. And at some point did you start treating your child  
16 with -- with instructions from Dr. Buttar's office?

17 AYes, that's correct.

18 QCould you explain what happened? Just -- just explain what  
19 happened when you started treating your child with  
20 materials from Dr. Buttar's office.

21 AInitially we gave her a regimen of minerals, vitamins for a  
22 period for approximately four to six weeks which went  
23 unremarkably, you know.

1 And following that we began grouping testing in addition  
2 to chelation process where three days a week, we applied  
3 an agent to remove any toxic metals from her system and  
4 the opposite days we reloaded her systems with minerals  
5 and vitamins that were depleted.

6 QWho did the chelation therapy?

7 AWe administered the therapy, her parents.

8 QAnd when did you do this?

9 AThe beginning of -- about the second month of treatment on  
10 Mondays, Wednesday and Fridays.

11 QOkay. And where do you presently live?

12 AState of Michigan.

13 QDid these -- did your daughter ever see Dr. Buttar before you  
14 started these treatments?

15 ANo.

16 QExplain that.

17 AThe understanding was that we were required to see the doctor  
18 at least once in an annual period, but that we could begin  
19 the initial treatment process through phone consultations.

20 QDid you see anyone then from Dr. Buttar's office?

21 ANo, I did not.

22 QSo this transaction occurred how?

23 AOver the phone.

1 QYou started treating your -- your child for -- with chelation  
2 therapy for autism with materials you got from Dr. Buttar's  
3 office, correct?

4 ACorrect.

5 QAnd that's started all through telephone consultations you  
6 had with Dr. Buttar's office?

7 AThat's right.

8 QAnd your daughter never made a personal visit to Dr. Buttar's  
9 office prior to these treatments?

10 AThat's right.

11 QWhen you had these telephone consultations with Dr. Buttar's  
12 office, did -- was it with Dr. Buttar?

13 ANo.

14 QWho was it with?

15 AWith Jane Garcia.

16 QAnd who is Ms. Garcia?

17 AI understand her to be his nurse.

18 QOkay. And is she a nurse practitioner perhaps?

19 AI'm not aware if she is.

20 QOkay. Did Ms. Garcia ever make any recommendations about what  
21 to do with your child's medication she was presently on?

22 AYes. She insisted that we remove my daughter from the  
23 medication or they would not pursue the treatment.

1 QWhat medication was your daughter on?  
2 ALexapro for anxiety --  
3 QAnd -- and how long did -- how long had your daughter been  
4 on Lexapro?  
5 AAbout a period of a year.  
6 QAnd who prescribed that Lexapro?  
7 AHer local pediatrician.  
8 QDid Dr. Buttar's office consult with your local pediatrician  
9 when they recommended that she be taken off Lexapro?  
10 ANo, they did not.  
11 QAnd at some point what happened to your daughter after she  
12 started -- after you started self-administering this  
13 chelation cream?  
14 AInitially, it was uneventful, but she began to deteriorate,  
15 regress is how it's referred to, and the regression was  
16 extremely significant. We were unable to even get her  
17 to come out of the home when she had previously been very  
18 social and happy. She wouldn't wear clothes. She was  
19 no longer sleeping through the night. She wasn't eating  
20 properly and she was extremely restless.  
21 QOkay. And did you consult Dr. Buttar's office about these  
22 issues?  
23 AAbsolutely.



1 QAnd what was the response?  
2 AThat we just needed to continue because this was to be expected,  
3 that she was moving metal and that we just needed to keep  
4 doing what we were doing.  
5 QOkay. And -- and did you continue to do that?  
6 AYes.  
7 QAnd at some -- and how did your daughter respond even after  
8 you continued the -- the treatments?  
9 AShe just continued to get worse.  
10 QAnd at some point did -- what did you do after that?  
11 AWell, we had made an appointment to come to the office in person  
12 and we had hoped at that point, with an in-person physical  
13 examination by the doctor, we would get some remedy and  
14 advice for the significant amount of deterioration we were  
15 experiencing.  
16 QOkay. Prior to -- when -- you started this therapy, I believe  
17 you testified in January of '07, correct?  
18 ARight.  
19 QDid you have contact with Dr. Buttar's office prior to January  
20 of '07?  
21 AYes. Approximately November of '06 was our first contact.  
22 QOkay. Could it have been September -- as early as September  
23 27th of '06?

1 AYes, that's possible.

2 QOkay. You don't have this, but I'll bring it to the Board's  
3 attention, if they can turn to Exhibit 5 on the thin  
4 notebook, Exhibit 5, page 36. If you can look at page  
5 36 on Exhibit 5. We have the medical record of your --  
6 of your daughter that's been admitted into evidence.

7 AOkay.

8 QAnd I'll read to you a note and ask you to comment. It says:  
9 Discussed plan with Jane, concur on issue regarding  
10 Lexapro, reassess patient that worsening is to be expected  
11 due to Herxheimer's response and due to mobilization.  
12 Due to age consider IV challenge for best metal yield.  
13 Is that when you talked -- is that when you and Dr. Buttar's  
14 office began talking about --

15 AI'm sorry, can you repeat that? My phone calling interrupted.

16 QI'm sorry. It says: Discussed plan with Jane, concur on issue  
17 regarding Lexapro. Is that when you had a conversation  
18 about taking your child off Lexapro?

19 AYes, but I hope that's not referring to me concurring.

20 QOkay. And above that there's a typed note that says: Plan  
21 to wean off Lexapro, discussed with Dr. Buttar.  
22 But is -- were you having conversations with Ms. Garcia  
23 to take your child off Lexapro and then start this chelation

1 therapy for your child's autism?  
2 AYes, we had discussed it twice.  
3 QOkay. And -- and then you began the autism treatments in  
4 January, correct?  
5 ACorrect.  
6 QAnd how did the materials get to you?  
7 ABy the mail.  
8 QAnd -- and was there any lab testing involved?  
9 AYes, routine lab testing was urine, stool, hair.  
10 QAnd who did this lab testing?  
11 AEither we did or if it required a blood draw, a local phlebotomy  
12 clinic.  
13 QAnd all this was occurring in Michigan?  
14 AThat's correct.  
15 QAnd when your daughter got the chelation cream, who administers  
16 that?  
17 AWe did, the parents.  
18 QAnd how did you do it? Did you do it pursuant to instructions  
19 from Dr. Buttar's office?  
20 AYes.  
21 QAnd -- and all this is occurring without you ever coming to  
22 North Carolina to see Dr. Buttar or his nurse practitioner?  
23 AThat's correct.

1 QDid you have to send money to Dr. Buttar's office before these  
2 materials were sent to you?

3 AYes.

4 QHow much money did you send?

5 AThe initial was right at \$3,000.

6 QOkay. You talked about your daughter deteriorating and then  
7 you said you made an appointment to see Dr. Buttar.

8 Approximately when was that?

9 AApproximately April.

10 QAnd what happened after you made that appointment?

11 AWe were -- we did another round of testing that was expected  
12 to arrive in the office prior to our visit for a review  
13 on that and other than that, we simply prepared for the  
14 trip.

15 QOkay. When you got to North Carolina what -- did you go to  
16 Dr. Buttar's office?

17 AYes.

18 QWas he there?

19 ANo, he was not.

20 QWho did you see?

21 AMs. Garcia.

22 QAnd did you express that you wanted to see the doctor?

23 AWe were surprised that he wasn't there and --

1 MR. KNOX: Objection, it's not --  
2 A-- but we would led to understand that that was normal.  
3 MR. KNOX: Hold on a minute. That is not responsive to  
4 what was asked. She said, we hoped he would be there.  
5 PRESIDENT RHYNE: Right. I agree, strike that -- that  
6 statement.  
7 Q(By Mr. Jimison) Okay. Did you have a meeting with Ms.  
8 Garcia?  
9 AWe did.  
10 QDid Ms. Garcia examine your child during that meeting?  
11 AShe was in a room, but she didn't have an examination, no.  
12 QOkay. And what was the result of that meeting with Ms. Garcia?  
13 AThe large part of the meeting was the -- for lack of a better  
14 word -- sell -- to first do IV chelation.  
15 QAnd -- and did you do that?  
16 ANo, we did not.  
17 QAnd why not?  
18 AMy daughter was already significantly deteriorating and  
19 appeared to be very sick and there was no way we were going  
20 to go get a more aggressive form --  
21 QOkay.  
22 A-- when we haven't even seen the doctor.  
23 QAnd how is your daughter doing now?

1 AShe's fine, she's much better.

2 MR. JIMISON: Okay. And that's all I have.

3 PRESIDENT RHYNE: Okay. Thank you. Ms. Godfrey --

4 MR. KNOX: Yeah.

5 PRESIDENT RHYNE: -- Mr. Knox, do you want to  
6 cross-examine?

7 **CROSS-EXAMINATION BY MR. KNOX:**

8 QGood morning. I won't be able to call your name for the record,  
9 but good morning to you.

10 AGood morning.

11 QAs I understand it you -- you live in Michigan, do you?

12 AYes.

13 QAnd your child is now being treated by a doctor close by?

14 AThat's correct.

15 QIs that an alternative doctor as well?

16 ANo, but he's not opposed to holistic medicine.

17 QAnd is the child taking any type of a comparable therapy that  
18 was recommended to you by Dr. Buttar like chelation or  
19 minerals and things of that nature?

20 ANot at this time.

21 QDid she take some after you left Dr. Buttar? She did, didn't  
22 she?

23 AOh, probably for about another month, we continued with the

1 minerals and vitamins.

2 QSo as I understand it, you got word that Dr. -- and that doctor

3 is closer that treated you with alternative therapy than

4 Dr. Buttar was, right? Where was that --

5 ARight.

6 QWhere was that doctor?

7 AHe's in Dearborn, Michigan.

8 QAnd how close is that to where you live in -- where do you

9 live?

10 AWe're in Brownstown. It's about a 20 minute ride.

11 QOkay. And it's about 8, 10 hours from where you were to Dr.

12 Buttar's office, correct?

13 AThat's correct.

14 QAnd that was part of the reason you called requesting that

15 some modalities be sent to you, am I right?

16 AAbsolutely.

17 QAnd -- and so Dr. Buttar's nurse or whoever, did you send

18 anything about the child and what her -- write out a summary

19 about her aggressiveness and how she acted out and things

20 of that nature to Dr. Buttar?

21 AI'm sure we did.

22 QOkay. So they had the information of what you knew about your

23 daughter. And what was her underlying problem anyway?

1           What is she?  
2   A She's autistic.  
3   Q Okay.  And you knew doctor -- have you ever used any  
4           across-the-counter medications to help your child?  
5   A Well, for common colds and things of that nature, sure.  
6   Q And so you called down there and they explained to you that  
7           they could send you not intravenous medicines, but some  
8           minerals and things to place on the child's skin, am I  
9           right?  
10   A Right.  
11   Q And so that's what was sent and you applied it?  
12   A And I did what?  
13   Q You made an application of it in accordance to the instructions  
14           that were sent to you, correct?  
15   A That's correct.  
16   Q And your child had been aggressive prior to seeing Dr. Buttar,  
17           is that a fair statement?  
18   A Absolutely.  
19   Q And she had acted out repeatedly?  
20   A In the past, yes.  
21   Q And you had a pediatric physician that was treating you for  
22           that with Lexapro which is a psychological antidepressant  
23           drug?



1 AActually, it was prescribed for anxiety and OCD behaviors.  
2 QAnd you were never told by Dr. Buttar's people to terminate  
3 Lexapro, but to reduce the quantity of it; is that correct?  
4 ANo, that's not correct. I was told to terminate, that it had  
5 to be weaned completely before we would start any  
6 treatment.  
7 QThe point I make is, she was never off of the Lexapro totally?  
8 AYeah, she was.  
9 QAnd did you ever -- was still under the treatment of your  
10 pediatrician?  
11 AOnly for routine things.  
12 QOkay. Well, we would go to the pediatrician -- I'm sorry,  
13 we got these records late. So tell me when you first went  
14 to -- when you first called Dr. Buttar's office. Do you  
15 remember?  
16 AIt was in the last quarter of 2006.  
17 QThe last quarter?  
18 AYeah.  
19 QAnd -- and when did you actually come to his office for the  
20 first time?  
21 AI believe it was right around April. It was in the spring.  
22 QIs that April of '07?  
23 AThat's correct.

1 QNow, I understood you to say that you hoped to see Dr. Buttar,  
2 but you didn't have a prior arrangement to Dr. Buttar  
3 personally, did you?  
4 AWe assumed when we made the appointment that the doctor would  
5 be present.  
6 QI understand.  
7 AThat's usually the way it goes.  
8 QBut you said you had hoped to see him and when you got there  
9 you saw Jane Garcia, correct?  
10 ACorrect.  
11 QAnd you found her to be informative and helpful, that's fair,  
12 isn't it?  
13 AThat's fair.  
14 QOkay. And she spent a good bit of time with your child, but  
15 she also went into the fact that you had to discipline  
16 your child some; is that true?  
17 AMy daughter wasn't acting up that day. She was completely  
18 behaved. So, no, we did not discuss discipline that day.  
19 QShe wasn't banging on the doors and beating on the chairs in  
20 the presence of other people?  
21 ANo, she was not.  
22 QOkay.  
23 AShe was remarkably well behaved that day, oddly enough.

1 QWell, is that different than what it was before you went to  
2 Dr. Buttar that she was better behaved; is that correct?  
3 AThat she was better behaved prior to seeing him?  
4 QWell, she had been on the medication that Dr. Buttar shipped  
5 to you and you said she was behaving remarkably well that  
6 day and that was better than usual.  
7 AIn the office that day --  
8 QWas she still --  
9 A-- not the whole visit down there or in the hotel or -- in  
10 the office that day, she was good.  
11 QAnd was she still on the medication of the mineral supplements  
12 that Dr. Buttar sent to you, yes or no?  
13 AYes.  
14 QNow, what is your training?  
15 AMy training?  
16 QYes.  
17 AI'm a homemaker currently.  
18 QOkay.  
19 AMy background is in finance, if that's what you mean.  
20 QOkay. And what is your husband's training?  
21 AHe's an engineer.  
22 QOkay. And I take it, you checked out the proposals on the  
23 Internet of Dr. Buttar and his treatment plan; is that

1 correct?

2 AThat's correct.

3 QNow, when you went back, right after you withdrew from Dr.

4 Buttar, you went to another alternative doctor. And I

5 don't mean to repeat myself, but who was that doctor?

6 AWe saw Dr. --

7 MR. JIMISON: Well, objection because this kind of goes

8 to identity. I think it's -- you know, discuss some

9 identity issues, but if she could just identify the doctor

10 by an initial, by her/his initials. I mean, I don't know

11 -- because clearly we're not going to be able to call this

12 doctor at this late hour, so I don't know why it helps

13 to probably know this doctor's name one way or the other.

14 QI don't know how that could be personal, but was it DeMio?

15 ABut that -- yes.

16 QAnd he is what we call a D.A.N. doctor, right?

17 ACorrect.

18 QWhat's a D.A.N. doctor?

19 AThey follow a protocol that's laid out by a group of doctors

20 that gathers each year relative to the treatment of autism.

21 QTo treat autism, correct?

22 ACorrect.

23 QAnd they use all types of chelation therapy and minerals and

1 things of that nature to benefit the children that have  
2 autism, correct?

3 AYes, that's correct.

4 QSo when you finally decided to go to another alternative doctor  
5 -- I'm going to read to you since you're on the telephone  
6 and can't see this, this is Exhibit 32.

7 MS. GODFREY: A page from the medical record.

8 MR. KNOX: It's a page of the medical record. Do you have  
9 it in front of you? I know you've got a lot of books.

10 PRESIDENT RHYNE: It's in your book?

11 MS. GODFREY: Our book.

12 MR. KNOX: In our exhibit book.

13 PRESIDENT RHYNE: An e-mail?

14 MR. KNOX: Yes.

15 Q(By Mr. Knox) This is an e-mail from -- and I won't read your  
16 name for the record, but do you remember sending an e-mail  
17 on July the 6th, 2007 and you may not know the time, but  
18 it was about 2:37 p.m. to Kadena Blake? Do you remember  
19 that?

20 ARead it to me and I'll tell you if I remember it.

21 QAll right. It says: Hi, Kadena. I just wanted to give notice  
22 that we were canceling this appointment and will not be  
23 rescheduling. And somehow this is partially written --

1 had gotten so severe that we sought advice through several  
2 sources and decided ultimately to change physicians. She  
3 is now in the care of -- and I'm going to abbreviate that  
4 doctor's name -- Dr. D. of Cleveland, Ohio, a D.A.N. doctor  
5 also with a child that has autism and has made significant  
6 gains in just a short period.

7 Do you remember that?

8 AYes.

9 QAnd you remember that this doctor that you went to had a child  
10 with autism and you certainly wanted -- and -- and then  
11 the next thing that happens is, it says: We think this  
12 is the best course for us and we found him to be more  
13 flexible regarding the individual needs of -- and trying  
14 alternative treatment schedule/substances to meet those  
15 needs.

16 And then down at the bottom, I'm going to read you this  
17 paragraph in the interest of doing it. Your staff has  
18 been very helpful and pleasant and we are grateful. We  
19 are friends with a family who are doing your protocols  
20 successfully. It simply was not working for -- and I have  
21 taken the name out -- and it was most assuredly as your  
22 child and most assuredly not because we failed to  
23 discipline her appropriately, but because her system was

1 not tolerating the protocol.

2 Correct?

3 ACorrect.

4 QWe are sorry it did not work for us, but we are grateful to  
5 all doctors and practices like yours seeking to help our  
6 children live better, healthier lives. Good luck and God  
7 bless. Correct?

8 AThat's right.

9 QYou didn't put one word in that e-mail, you know, we're leaving  
10 you because we don't like Dr. Buttar and he didn't show  
11 up, did you?

12 ANo.

13 QAll right. And you didn't put one word in there about the  
14 fact that you were upset with the methodology and treatment  
15 and the reduction or the termination of Lexapro, did you?

16 AIn a roundabout way. No, I wasn't specific, you're right.

17 QWell, there's not a word about that.

18 AI wasn't specific.

19 QOkay. Well, it's right important that when you sent this  
20 stuff -- this e-mail, you had already selected another  
21 doctor, the same kind of doctor that does chelation  
22 therapy, minerals, etcetera and you had moved on away from  
23 Dr. Buttar. Isn't that fair?

1 AYeah.

2 QThat doctor was about 20 minutes away and Dr. --

3 ANo. He was not about 20 minutes away.

4 QI'm sorry, I thought you said 20. I apologize. I withdraw  
5 that, excuse me.

6 MR. KNOX: And that's all I have.

7 PRESIDENT RHYNE: Mr. Jimison, do you want to redirect?

8 MR. JIMISON: Sure.

9 **REDIRECT EXAMINATION BY MR. JIMISON:**

10 QMa'am --

11 AYes.

12 Q-- when -- when -- how did you -- how did you find out about  
13 this Medical Board case?

14 AI received an e-mail from Dr. Buttar's office.

15 QAnd what was the substance of that e-mail?

16 AThat they were being reviewed for their practices, that  
17 eventually they were going to fight the accusations against  
18 him and they viewed it as a witch hunt, they hoped for  
19 our prayers and support.

20 QOkay. And did they -- was there anything in the e-mail about  
21 Dr. Buttar saying there was -- that the Board had alleged  
22 there was little doctor contact between him and his  
23 patients?



1 AThat's correct, yes.

2 QAnd when you read that what was your response?

3 AWell, that was essentially what intrigued me and our -- our  
4 problem or our -- our complaints or our disapproval was  
5 that we had never seen the doctor in spite of our  
6 description of her extreme regression.

7 And so when we saw that there was obviously other complaints  
8 or there was even acknowledgment that these people hadn't  
9 even seen a doctor that had instructed them or support  
10 that you had mentioned that we hadn't either.

11 QYou had contact with Dr. Buttar's office perhaps as early as  
12 September of '06?

13 AUh-huh (yes). Yes.

14 QAll the way through basically July of '07?

15 ARight.

16 QAnd at any point have you ever physically or personally met  
17 Dr. Buttar?

18 ANo, I have not.

19 QAnd during that time, Dr. Buttar's office was sending you  
20 medicines, transdermal chelation agents, how to test your  
21 daughter without physically seeing your child?

22 MR. KNOX: Objection, been asked and answered.

23 AYes.

1 QOkay.

2 PRESIDENT RHYNE: We'll strike that.

3 MR. JIMISON: Thank you.

4 Q(By Mr. Jimison) Well, let me just say, how many times did --  
5 just one of -- because if there was all this talk about  
6 these other doctors who you've gone to see, have they seen  
7 your child?

8 AAbsolutely.

9 QHow often do --

10 AEvery single time.

11 QHow often do they see your child?

12 ASeveral times a year.

13 QAnd did they start treatment before seeing your child?

14 ANo, they did not.

15 MR. JIMISON: Okay. Thank you.

16 **RE-CROSS EXAMINATION BY MR. KNOX:**

17 QAnd one other question.

18 ASure.

19 QYou never came to North Carolina but one time; is that correct?

20 AThat's correct.

21 QAnd Jane and the employees were always accessible to you when  
22 you called?

23 AThat is correct.

1 MR. KNOX: All right. Thank you.

2 WITNESS: Sure.

3 PRESIDENT RHYNE: Anything else? Any of the Board Members  
4 have a question? Go ahead.

5 DR. McCULLOCH: Thank you.

6 **EXAMINATION BY THE PANEL MEMBERS:**

7 DR. McCULLOCH: Ma'am?

8 WITNESS: Yes.

9 DR. McCULLOCH: This is Dr. McCulloch with the Board.  
10 I have a couple of questions, just real brief.

11 It says in the record that I have in front of me that they  
12 recommended that Lexapro be reduced to a half cc and then  
13 later to a quarter of a cc two times or for two weeks.

14 WITNESS: Right.

15 DR. McCULLOCH: Now, that seems to be in conflict with  
16 what you said that they told you that your child had to  
17 come off the Lexapro altogether.

18 WITNESS: That's correct. I would categorically -- I may  
19 not be able to remember every detail, but that was what  
20 I was told. And I remember so distinctly because we had  
21 objected to it because of how much it had helped our  
22 daughter.

23 DR. McCULLOCH: So it's your testimony despite what it

1 says in this record that Lexapro was just you discontinue  
2 the Lexapro because of their recommendation to you?

3 WITNESS: Absolutely. And the only reason she was weaned  
4 is because we had a second conversation where I still had  
5 not removed her from the Lexapro and I was concerned about  
6 just pulling her off it completely.

7 DR. McCULLOCH: Oh, okay. So this might have been just  
8 early on in the weaning process.

9 WITNESS: Perhaps.

10 DR. McCULLOCH: All right. Now, what was your purpose  
11 of the visit to North Carolina?

12 WITNESS: To identify whether or not my daughter was having  
13 metal toxicity and to treat that toxicity.

14 DR. McCULLOCH: So you never had -- did you have -- you  
15 had -- you obviously had an expectation that you would  
16 meet Dr. Buttar. But did you -- were you ever told that  
17 you would meet the doctor?

18 WITNESS: I don't know that I was specifically told, no.

19 DR. McCULLOCH: All right. I can understand that would  
20 be a reasonable expectation, but that you -- you had no --  
21 there was no arrangement for you to meet with the doctor;  
22 is that correct?

23 WITNESS: That's correct.

1 DR. McCULLOCH: All right. Thank you.  
2 WITNESS: Sure.  
3 PRESIDENT RHYNE: This is Dr. Rhyne and I wanted to ask  
4 you a few questions just following up on that Lexapro  
5 question.  
6 Were you initially told to stop the Lexapro, just stop  
7 it or were you told to wean off of it for a --  
8 WITNESS: I was told to stop it.  
9 PRESIDENT RHYNE: So you were told to stop the first time?  
10 WITNESS: Yes, ma'am.  
11 PRESIDENT RHYNE: And you did not -- you elected not to  
12 stop it; is that correct?  
13 WITNESS: That's correct.  
14 PRESIDENT RHYNE: Okay. Now, did you have laboratories  
15 done showing that your daughter had heavy metal toxicity  
16 either in Michigan or in North Carolina?  
17 WITNESS: Yes, we did.  
18 PRESIDENT RHYNE: And where were they done?  
19 WITNESS: But they were out-of-state labs that they were  
20 shipped to.  
21 PRESIDENT RHYNE: And they were given to Dr. Buttar's  
22 office before you started treatment; is that correct?  
23 WITNESS: Yes. And previous physicians we had seen, we

1 knew that she had toxicity.

2 PRESIDENT RHYNE: Okay. That's -- that's all I have to  
3 ask.

4 MR. JIMISON: Thank you.

5 PRESIDENT RHYNE: Thank you very much.

6 WITNESS: Thank you.

7 MR. KNOX: I'm sorry. I don't want to interrupt the Board.

8 PRESIDENT RHYNE: Go ahead, Mr. Knox.

9 **FURTHER RECROSS EXAMINATION BY MR. KNOX:**

10 QMa'am, there's an e-mail from Kelly to you on October 5 that  
11 said, I was looking over the e-mail I sent to you and I  
12 wanted to clarify it.

13 MR. JIMISON: Objection, Dr. Rhyne. There's -- at this  
14 point we're at the recross and that is limited only to  
15 the questions that you answered. There's not a free reign  
16 after we go to what's called serve recross. So the  
17 rebuttal of any question has to be -- has to be confined  
18 to matters that the Board Members have brought up.

19 MR. KNOX: I just object to him being the intellectual  
20 lawyer that knows all the laws and I --

21 MR. JIMISON: I think that's a true statement.

22 MR. KNOX: May I finish? This is witness's case and has  
23 been, since we started I've been tutored. It's hard for

1 me to accept the result.

2 The point I make is the question I'm about to ask is the  
3 reduction in the Lexapro which she testified to and that's  
4 the exact question --

5 MR. JIMISON: Okay.

6 PRESIDENT RHYNE: Okay, ma'am --

7 MS. GODFREY: Did you identify the --

8 PRESIDENT RHYNE: Mr. Knox, go ahead and ask.

9 MS. GODFREY: -- Exhibit 5.

10 MR. KNOX: Exhibit 5.

11 MS. GODFREY: The Board's Exhibit 5, page 47.

12 MR. KNOX: May I proceed, ma'am?

13 PRESIDENT RHYNE: Please do.

14 Q(By Mr. Knox) Back to this -- this was from Kelly to you and --  
15 and it was dated Thursday, October the 5th. I was looking  
16 over the e-mail I sent to you. I wanted to clarify that  
17 I was referring to the Lexapro as been prescribed again  
18 for your child. Again, keep her at the 1.5 milligrams,  
19 but you may bump it up to 2, if necessary. Do you remember  
20 getting that e-mail?

21 ARight.

22 QThat was notwithstanding, and you said there was -- you  
23 unilaterally -- they told you to stop cold turkey, but

1           you broke it down in two different times, right?  
2 AWhat do you mean I broke it down into --  
3 QIn other words, you did not stop it cold turkey, but you took  
4           her off some amount to start with and then a second time  
5           you took her off a certain amount. Is that true?  
6 AShe was weaned, yes.  
7 QYeah. And so -- and that's exactly what they had told you  
8           at the doctor's office, to reduce it half and then to a  
9           fourth. Am I right?  
10 ANot initially.  
11 QOkay.  
12           PRESIDENT RHYNE: Okay. Thank you very much.  
13           WITNESS: Okay.  
14           PRESIDENT RHYNE: I think at this point, we'll go ahead  
15           and take a break.  
16           MR. JIMISON: I'm sorry.  
17           PRESIDENT RHYNE: It's now 12:35 and we can resume back  
18           1:30. I don't know if that gives you enough time to really  
19           have lunch.  
20           MR. KNOX: Anyway, we can find something to eat.  
21           PRESIDENT RHYNE: Yeah. 1:30 should give you time to get  
22           back.  
23           MS. GODFREY: We'll do that.



1 PRESIDENT RHYNE: Okay.

2

3 (12:35 P.M. - 1:39 P.M. LUNCH RECESS)

4

5 PRESIDENT RHYNE: Okay. Mr. Jimison, are you ready to  
6 proceed.

7 MR. JIMISON: I call Marie Church to the stand.

8

9 WHEREUPON,

10

MARIE CHURCH,

11

being first duly sworn,

12

was examined and testified

13

as follows:

14

15 **DIRECT EXAMINATION BY MR. JIMISON:**

16

QGood afternoon, Ms. Church, could you introduce yourself to  
17 the Board Members, please?

18

A I'm Marie Church.

19

QWould you please use the microphone.

20

A I'm Marie Church.

21

QAnd where do you presently live?

22

A Lenoir, North Carolina.

23

QAnd do you work with Dr. Herman?

1 AYes.

2 QAnd how long have you worked for Dr. Herman?

3 ANine years.

4 QAnd are you related to Patient A?

5 AYes, she's my mother.

6 QAnd at some point was your mother diagnosed with cancer?

7 AYes.

8 QAnd when was that?

9 AThe first time?

10 QYes, ma'am.

11 AI can't remember. I think it was 2003.

12 QAnd how was your mother originally treated -- initially treated

13 after she received that diagnosis?

14 AShe would get a radical hysterectomy and was treated with

15 radiation therapy.

16 QAnd did that stop the cancer from progressing?

17 AAt the time, they said it was gone.

18 QDid it come back?

19 AYes, it did.

20 QAnd after it came back, what did your mother do? How did she

21 get care for the cancer after it came back?

22 AWe had seen a local doctor here and they sent her to an

23 oncologist.

1 QAnd -- and what therapies did that oncologist provide?

2 AWe considered M.D. Anderson and they really couldn't do  
3 anything for her here, so we had -- that her -- my mother  
4 and father went to M.D. Anderson in Texas.

5 QOkay. And what's your understanding of M.D. Anderson as a  
6 cancer center?

7 MS. GODFREY: Well, if she knows.

8 QOnly if you know.

9 AI know they do a lot of experimental things.

10 QOkay. And -- and did the therapies that they tried at M.D.  
11 Anderson, did they work?

12 ANo.

13 QAnd what did your mother do after that?

14 AWe had checked into some alternative therapies that could be  
15 done.

16 QAnd specifically what type of alternative therapies?

17 AThe hydrogen peroxide.

18 QAnd -- and at some point did you -- did your mother go see  
19 Dr. Buttar?

20 AYes.

21 QAnd how did she learn of Dr. Buttar?

22 AWe had her see the book that had information about the  
23 treatments in it and we had called a doctor's office in

1 Canada and they gave us the number of Dr. Buttar.

2 QAnd this hydrogen peroxide therapy, did you know it under a  
3 name of oxygen therapy?

4 AYes.

5 MS. GODFREY: Well, object to the leading.

6 QDo you know hydrogen peroxide under a different name?

7 AWell, we -- it's a type of oxygen therapy, is what it is.

8 QOkay. And did you go with your mother to Dr. Buttar's office?

9 AYes.

10 QDid you go with her the first time she went there?

11 AYes.

12 QDid you see Dr. Buttar on that first visit?

13 ANo.

14 QWho did you see on that first visit?

15 AJane, the nurse practitioner.

16 QWhat's Jane's last name?

17 AWell, at the time it was different. I don't know what it is  
18 now. I don't know what it is now.

19 QWould it be Ms. Garcia?

20 AYes.

21 QWhat did she tell you -- tell me about that conversation that  
22 you and your mother had with Ms. Garcia on that first visit?

23 AWe had explained her situation and she looked over the notes

1 and they told me the type of treatment they did. And she  
2 told us that they could help her at the time of the visit.

3 QDid -- you said the type of treatments that they did. Were  
4 these treatments for cancer?

5 MS. GODFREY: Well, objection.

6 QI mean, if you know.

7 MS. GODFREY: Objection to what --

8 PRESIDENT RHYNE: Wait. What's your objection?

9 MS. GODFREY: Well, I don't know the type of treatments  
10 who gives.

11 MR. JIMISON: Dr. Buttar gives.

12 Q(By Mr. Jimison) Did he say what it was for? Did Ms. Garcia  
13 say what the treatments were for?

14 AThey were for cancer patients.

15 QAnd she said they could help your mother?

16 AThey could help, yes.

17 QWhat -- did you go to your -- with your mother for her therapies?

18 AYes.

19 QDid you go with her every time?

20 AYes.

21 QAnd how did your mother get to Dr. Buttar's office for the  
22 therapies?

23 AI drove. We stayed in a hotel at the time.

1 QYou stayed at a hotel --  
2 AYes.  
3 Q-- while your mother was getting therapies?  
4 AYes.  
5 QAnd how often would she get therapies?  
6 AEvery day.  
7 QFive --  
8 AExcept for Saturday and Sunday.  
9 QSo she would get therapies Monday through Friday?  
10 AYes.  
11 QAnd -- and she received those therapies from Dr. Buttar's  
12 office?  
13 AYes.  
14 QAnd how long would she be in Dr. Buttar's office during those  
15 days?  
16 AAround -- it depended on the day. It was between 8 to 5, or  
17 sometimes we would come in at 9.  
18 QSo basically 40 hours a week?  
19 AYes.  
20 QFive days a week. And how many weeks did she -- she get therapy  
21 from Dr. Buttar?  
22 AIt was -- it was around a month.  
23 QOkay. How often did your mother see or did you see Dr. Buttar

1           when she was there to receive her therapies?

2    AI seen him maybe three to four times.

3    QDid Dr. Buttar ever examine your mother?

4    AI think the first time she met him. I didn't go in the room  
5           at that time.

6    QOkay. Despite your mother's going to Dr. Buttar, did her  
7           cancer still progress?

8    AYes.

9    QDescribe your mother's physical appearance to the caregivers --  
10           during this time she was receiving therapy, describe her  
11           physical appearance.

12   ABeginning or --

13   QAt the beginning and ending.

14   AAAt the beginning of the treatments, she wasn't in real good  
15           shape to begin with and she had swelled some in the stomach  
16           area. During the treatment time, she did, you know, the  
17           first or second week, she went off her pain meds and then  
18           she had to go back on them again.

19           During that time, she kept swelling in her stomach and  
20           fluid kept building up and so we had to have that drained  
21           off one time.

22           And more towards the end, she started swelling a lot in  
23           her legs, but then it progressed from there and she was

1           unable to walk real good, so I had to put her in a wheelchair  
2           at the very end.

3   QWas she jaundiced?

4   AYes.

5   QAnd how -- how did her skin look?

6   AIt was yellow.

7   QWas that visible to the caregivers there at Dr. Buttar's  
8           clinic?

9   ANot at the beginning, but more towards the end, she did turn  
10          jaundice.

11   QOkay. Describe the IV treatments. How -- how long did it  
12          take per day for her to get all the IVs that Dr. Buttar  
13          was giving her?

14   AUsually with this, it was mostly about all day unless they  
15          done the hyperbaric treatments which she didn't do much.

16   QAnd why was your mother not able to have the hyperbaric  
17          treatments?

18   AShe was claustrophobic.

19   QWhat were the IVs, if you know, that were administered to your  
20          mother while you were in there in the office with her?

21   AWhat were they?

22   QUh-huh (yes).

23   AI don't know exactly what all of them were. I know one of



1           them was the peroxide, I think, and one of them was for  
2           her liver and I'm not sure about the other ones. I think  
3           there were some vitamins.

4   QOnly if you can recall, was one of them ozone?

5           MS. GODFREY: Well, objection.

6   QIf you recall.

7           MR. JIMISON: Only if she recalls.

8           PRESIDENT RHYNE: Wait a minute. What is your objection?

9           MS. GODFREY: I'm objecting to the leading, putting words  
10          in the witness's mouth.

11          MR. JIMISON: I'm just asking was one of them an ozone.

12          MR. KNOX: She said she didn't --

13          MR. JIMISON: If she knows.

14          PRESIDENT RHYNE: She said she didn't know.

15          MR. JIMISON: Okay.

16   Q(By Mr. Jimison) So hydrogen peroxide, vitamins?

17   AYes.

18   QAnd how -- how many IVs would he run a day?

19   AWell, they would change the bags out. It was -- I don't know  
20          the exact amount, but it was like three or four maybe.

21          It may have been more. I don't know.

22   QDid your mother get chelation therapy?

23   AShe was getting the drop treatments, yes.

1 QAnd when she was getting these treatments five days a week  
2 for several weeks, did this -- did her physical condition  
3 get better or worse from your observations?

4 AShe never got better as far as the physical condition.

5 QI know this is difficult, but tell me about the day your mother  
6 died.

7 AShe was unresponsive at the time. She wasn't even conscious.  
8 She was at the hospital.

9 QWhich hospital was she at?

10 ALake Norman Medical.

11 QAnd is that a hospital near Dr. Buttar's office?

12 AYes.

13 QAnd was she getting treatments from Dr. Buttar's office up  
14 to the moment she died?

15 AI believe that Thursday was her last treatment and I took her  
16 to the ER that night.

17 QWas she scheduled to come in the next day for treatment?

18 AYes.

19 QSo she finished her treatments on that Thursday and you took  
20 her to the hospital that Thursday night?

21 AYes.

22 QWhy did you take her to the hospital?

23 ABecause she had a lot of pressure on her stomach, the fluid

1 had started building up again. And since they had drained  
2 it off the first time, that's what -- she thought that  
3 what's they could do again, but when we got there, they  
4 were unable to.

5 QAnd did she die -- when you took her to the hospital that  
6 Thursday night, did she die at the hospital?

7 ANo, she died on that Saturday, the 19th of August.

8 QWhere at?

9 AAt Lake Norman.

10 QSo she never left the hospital --

11 ANo.

12 Q-- from when you took her?

13 She was there at Dr. Buttar's office getting treatment  
14 on that Thursday. Did -- did you ever have a conversation  
15 with Dr. Buttar about whether to continue treatment for  
16 your mother?

17 AYes.

18 QAnd what was that conversation?

19 AWell, Jane had come to me about she didn't think the treatments  
20 were helping.

21 And then I went and spoke to Dr. Buttar and asked him --  
22 you know, talked to him about it and asked him what he  
23 thought I should do.

1 And, you know, he -- he said he didn't -- you know, he  
2 wasn't the type of person to give up and I told him I wanted  
3 to do what she wanted to do and she wanted to continue  
4 on with the treatments at the time.

5 QSo your mother wanted to keep on with the treatments at the  
6 time --

7 AYeah, she said we'll discuss it this weekend and I remember  
8 we never got to that weekend because that was the weekend  
9 she was in the hospital.

10 QHow much money did you pay -- did your parents pay Dr. Buttar  
11 for any of the treatments for your mother?

12 AI'm not sure. I know we paid \$12,000 up front, I believe it  
13 was, and then I think it was around six. I'm thinking  
14 it was three to six a week. I can't remember. It was  
15 probably around \$30,000, I'm not sure.

16 QDid you call complaining in this case?

17 ANo.

18 QAnd why did you not call and complain?

19 AI didn't see a need to. I mean, I just --

20 QAre you aware that a complaint was filed on behalf of your  
21 mother?

22 ANot until just recently.

23 QDo you know who filed that complaint?

1 AYes.

2 QWho was it?

3 AIt was Dr. Herman.

4 QWas Dr. Herman your mother's doctor at one point?

5 AYes.

6 MR. JIMISON: I have no other questions.

7 PRESIDENT RHYNE: Do you want to cross-examine,

8 Ms. Godfrey?

9 MS. GODFREY: I do.

10 **CROSS-EXAMINATION BY MS. GODFREY:**

11 QMs. Church, you're here under subpoena today, correct?

12 AYes.

13 QAnd it was your desire not to be involved in these proceedings;

14 isn't that correct?

15 AYes.

16 QAnd sometime about a week or so ago Mr. Jimison called you

17 at work, correct?

18 AYes.

19 QAnd you work as the receptionist in Dr. Herman's clinic?

20 ACorrect.

21 QAnd you've been the receptionist there since 1999?

22 AYes.

23 QAnd Mr. -- even though you didn't want to talk to Mr. Jimison,

1           you did talk to him, correct?  
2    AYes.  
3    QAnd after that conversation, he issued a subpoena for you to  
4           come here to testify today?  
5    AYes.  
6    QAnd that's why you're here, not because you want to be?  
7    ANo, just by subpoena.  
8    QNow, did you accompany your mother to M.D. Anderson?  
9    ANo.  
10   QWhat is -- is your understanding when they came back from M.D.  
11           Anderson, was there anything else that they could do for  
12           her?  
13   AShe had had two treatments at M.D. Anderson and on the last  
14           trip they told her that there was nothing else that they  
15           could do for her.  
16   QOkay. And -- and her -- did your father accompany her down  
17           there?  
18   AYes.  
19   QAnd they flew back and forth to Texas?  
20   AThree times.  
21   QThree times. And they stayed down at M.D. Anderson for a period  
22           of time --  
23   AUh-huh (yes).

1 Q-- in, I guess, a hotel or something down there --  
2 AYes.  
3 Q-- while she was getting chemotherapy treatments at M.D.  
4 Anderson --  
5 AYes.  
6 Q-- is that correct?  
7 And they -- they did that in May and June of 2006, shortly  
8 after her cancer came back?  
9 AYes, when we found out in April.  
10 QOkay. And after -- after she was released from M.D. Anderson,  
11 after they told her there was nothing more they could do,  
12 that was when your father and mother sought out Dr. Buttar?  
13 ACorrect.  
14 QAnd that was their decision to do?  
15 AYes.  
16 QAnd you say your father had some kind of book that -- that  
17 you -- that he found out about Dr. Buttar through?  
18 AYes.  
19 QOkay. During this time was your mother able to make decisions  
20 for herself?  
21 AYes, she was.  
22 QOkay. And when -- when you first went to Dr. Buttar, was your  
23 father with your mother, father --

1 AThe first -- the first visit, yes.

2 QOkay. And you were there?

3 AYes.

4 QAnd the three of you looked over the paperwork that she --

5 that -- that she was to sign?

6 AWe looked over it, but I couldn't tell you anything it said.

7 QOkay. I understand. But -- but your mother and your father

8 were there --

9 AYes.

10 Q-- and they looked over the paperwork?

11 AYes.

12 QAnd she signed it?

13 AYes.

14 QNow, when you met with Jane the first time, she explained to

15 you that -- that they had a different approach than the

16 conventional treatments for cancer?

17 AThat's what I recall, as to what I recall, yes.

18 QOkay. And did she explain to you that their approach was to

19 treat the patient and build up the patient's strength and

20 immune system to help them better battle the cancer on

21 their own?

22 AYes.

23 QOkay. And that was what you understood Dr. Buttar's treatment



1 was directed towards; isn't that right?

2 AThe cancer, yes.

3 QOkay. It was directed to the cancer, but it was directed  
4 towards building the patient's immune system and resources  
5 to be able to better fight the cancer themselves?

6 AYeah, they treated that and metal toxicity as far as the  
7 mercury.

8 QOkay. And was it explained to you that the metal toxicity  
9 on your -- on Dr. Buttar's approach was something that  
10 would -- would help the body better able to fight the  
11 cancer?

12 AYes, getting rid of the mercury would help.

13 QOkay. Now, they never said they would cure the cancer, did  
14 they?

15 ANo.

16 QAnd they never said that there was a 100 percent chance of  
17 success?

18 ANo.

19 QAnd when -- when your mother was treating with Dr. Buttar,  
20 you accompanied her back and forth and your father gave  
21 you the money to pay Dr. Buttar's office?

22 AYes.

23 QAnd at first your mother showed some improvement, did she not?

1 AYeah. The first week or so, she went off her pain meds.  
2 QOkay.  
3 AThat was the improvement she showed, but then she had to go  
4 back on it.  
5 QOkay. So she had a short period of feeling better?  
6 AYes.  
7 QOkay. And at that -- and later on in August, you say you  
8 discussed it with Dr. Buttar and Jane that the treatments  
9 didn't seem to be helping; isn't that right?  
10 AThey had come to me, I didn't go to them. They had come to  
11 me and said they didn't think it was helping her.  
12 QOkay. And at that point your mother was still adamant about  
13 continuing on?  
14 AWhen I -- I talked to her before I talked to them I said, do  
15 you want to just go on home and she said, we'll talk about  
16 it this weekend. I'll go ahead and go to it this week  
17 and we'll talk about it this weekend, is what she told  
18 me.  
19 QOkay. So she wanted to finish out the week, that was her  
20 desire?  
21 AYes.  
22 QOkay. Would you say your mother had a strong will to fight  
23 that cancer?

1 AYes.

2 QAnd a strong will to want to get better?

3 A(Nods head in affirmative response.)

4 QOkay. After your mother's death, did you and your father  
5 return to Dr. Buttar's clinic to return some medications?

6 AYes.

7 QAnd you were given a refund --

8 AWe did --

9 Q-- of about \$2500, weren't you?

10 ACorrect.

11 QOkay. And you and your dad said good-bye to the staff at that  
12 time, did you not?

13 AWell, I had talked to a couple of the nurses that were there.  
14 I cannot recall their names.

15 QOkay. And you were on good terms with the staff at that time?

16 AYes.

17 QOkay. And you never heard anything about a complaint filed  
18 against the medical -- against Dr. Buttar until about a  
19 couple of months ago, did you?

20 AOn our part, yes.

21 QOkay.

22 ANo, I --

23 QLet me rephrase that question because I think it was confusing,

1 I'm sorry.  
2 When did you first find out that a complaint had been filed  
3 against Dr. Buttar?  
4 AFrom Dr. Herman.  
5 QWhen?  
6 AIt was I guess when the Medical Board had requested records.  
7 QOkay. And would that have been in early February of 2008?  
8 A couple of months ago?  
9 AI don't know if it's been that long ago, but I had found the  
10 records, is the reason I knew.  
11 QOkay. So within the last month or two --  
12 ARecently, yes.  
13 QOkay. And that was after your mother died in August of 2006?  
14 ACorrect.  
15 QSo no one ever talked to you at all about -- from the Medical  
16 Board --  
17 ANo.  
18 Q-- between August of 2006 and just this past week or so?  
19 ANo.  
20 QAnd you never knew anything about a complaint?  
21 ANo.  
22 QOkay. And your dad is still alive, right?  
23 ACorrect, yes, he is.

1 QAnd he's not expressed any desire to be involved in this either?  
2 ANo, he doesn't want to be.  
3 QOh. One other question. Dr. Herman is a family practice  
4 doctor, right?  
5 AYes, she is.  
6 QAnd she took care of your mom for a long time?  
7 AYes. She seen her occasionally.  
8 QOkay. And -- but during the time that your mom was undergoing  
9 cancer treatments both at M.D. Anderson -- well, let me --  
10 let me back up and break that up.  
11 After your mom's cancer came back, did she ever see  
12 Dr. Herman?  
13 AThat was when we found out that she had cancer.  
14 QOkay. But after -- after --  
15 ANo.  
16 Q-- she was diagnosed with the -- with the recurrence, did she  
17 ever go back to see Dr. Herman?  
18 ANo. After we got the results, no.  
19 QAnd did Dr. Herman ever see your mother while she was being  
20 treated by Dr. Buttar?  
21 AI don't believe so, no.  
22 QDid she ever come to your house to visit her or --  
23 ANo.

1 MS. GODFREY: Okay. That's all I have.

2 PRESIDENT RHYNE: Mr. Jimison, do you want to redirect?

3 **REDIRECT EXAMINATION BY MR. JIMISON:**

4 QWhen you spoke to me, were you on a conference call to Ms.  
5 Carpenter as well? Do you recall that?

6 AYes.

7 QDid we tell you you had to speak with us?

8 AYou said that we had to, but you said you had thought about  
9 doing a subpoena and that you know that I didn't want to  
10 get involved in it. And after you talked to me, I went  
11 ahead and said, yeah, go ahead and do it because I felt  
12 like you were going to subpoena me anyway.

13 MR. JIMISON: That's all.

14 PRESIDENT RHYNE: Do you want to recross?

15 MS. GODFREY: No.

16 PRESIDENT RHYNE: Any Board Members have any questions?  
17 I have one question.

18 **EXAMINATION BY THE PANEL MEMBERS:**

19 PRESIDENT RHYNE: You said during this time something  
20 about that your mom had some fluid drained off her stomach.

21 WITNESS: Yes. She had had an ultrasound done and they  
22 had drained some fluid after the ultrasound.

23 PRESIDENT RHYNE: Uh-huh (yes). And -- and where was that

1 done? Was that -- did Dr. Buttar do that?

2 WITNESS: Lake Norman.

3 PRESIDENT RHYNE: So it was done at the hospital?

4 WITNESS: Yeah, it was. Yeah, they had ordered an -- well,  
5 he had ordered an ultrasound through another doctor.

6 PRESIDENT RHYNE: I'm sorry, who had ordered it?

7 WITNESS: Dr. Buttar has sent us -- sent us to another  
8 doctor and then they -- we had got an ultrasound after  
9 that.

10 PRESIDENT RHYNE: Okay. So it was another doctor you saw?

11 WITNESS: Yes.

12 PRESIDENT RHYNE: And -- and what kind of doctor was that  
13 doctor?

14 WITNESS: A urologist. I believe that's what he was.

15 PRESIDENT RHYNE: Okay. Thank you. Thank you very much,  
16 Ms. Church, for testifying and we are truly sorry for your  
17 loss.

18 Mr. Jimison?

19 MR. JIMISON: The Board would now like to call Dr. Herman  
20 to the stand.

21

22 WHEREUPON,

23 DENNICE H. HERMAN, M.D.,

1                   being first duly sworn,  
2                   was examined and testified  
3                   as follows:

---

4  
5 **DIRECT EXAMINATION BY MR. JIMISON:**

6 QDr. Herman, could you introduce yourself to the Members of  
7                   the Board, please?

8 AMy name is Dr. Dennice Herman and I'm a family practitioner  
9                   in Lenoir, North Carolina.

10 QAnd how long have you been a family practitioner?

11 AI've been in Lenoir for 19 years. I did about eight and a  
12                   half years of emergency medicine and then went back to  
13                   family medicine about nine and a half years ago.

14 QAre you presently board certified?

15 AYes.

16 QIn what?

17 AIn family medicine.

18 QOkay. And did you know Patient A?

19 AYes.

20 QAnd how did you know Patient A?

21 AI know her both professionally and personally. She did see  
22                   me as a patient on occasions and then I knew her because  
23                   her daughter is one of our employees in the office and



1 I had met her in social settings as well.  
2 QOkay. And did you ever treat her as a patient?  
3 AYes, I did.  
4 QAt some point, did Patient A get cancer?  
5 AYes.  
6 QAnd how did you understand -- how did you learn of that  
7 diagnosis?  
8 AI did not actually diagnose her. She had been seeing a GYN  
9 physician for some pelvic problems and was somewhat  
10 inadvertently diagnosed with cervical cancer. She had  
11 actually had some negative PAP smears and then had some  
12 bleeding and upon re-examination was diagnosed with  
13 cervical cancer.  
14 QAnd did you treat her after that diagnosis of cervical cancer?  
15 AMaybe a couple of times right after her initial treatment for  
16 colds and things like that. I did not -- I certainly was  
17 not involved in her cancer treatment initially.  
18 QAnd Ms. Church, she works for you, correct?  
19 AWell, we both work for the hospital. It's a hospital-owned  
20 practice.  
21 QOkay. And are you familiar with the cancer center, M.D.  
22 Anderson?  
23 AYes.

1 QAnd what's your understanding of M.D. Anderson?

2 AIt is supposed to be one of the premier cancer centers in the  
3 country.

4 QDoes it have the reputation of -- what kind of a reputation  
5 does it have for cancer?

6 AIt's supposed to be very progressive and looking on the cutting  
7 edge, so to speak, of cancer treatment.

8 QAnd at some point did you ever become aware that Patient A  
9 sought treatment at M.D. Anderson?

10 AYes. Actually, what happened and I don't have records in front  
11 of me, but I did bring her chart. At some time I think  
12 it was around April of '06, she had apparently been doing  
13 very well after her hysterectomy and radiation treatment.

14 She came to me with a history of right upper quadrant  
15 pain and some nausea associated with eating. And my  
16 initial impression was, she probably had gallbladder  
17 disease and, therefore, I arranged for her to go for the  
18 initial ultrasound.

19 And do you want me to continue with that?

20 QYes.

21 QThe -- she went to Valdese Hospital for an ultrasound and the  
22 radiologist actually called me right after he did the  
23 ultrasound and said she doesn't have gallbladder disease,

1 but she had multiple liver metastases and also had some  
2 pulmonary or lung metastases as well. And to be honest,  
3 I was very shocked at that. He was very certain at that  
4 point that it was metastases.

5 QOkay. And why don't you treat cancer as a family practitioner?

6 A I'm not trained to treat cancer. I follow my patients along  
7 with oncologists and other physicians who are treating  
8 them for cancer and treat the other chronic problems that  
9 they may have such as diabetes or hypertension, but I have  
10 no training in cancer, therefore, I don't treat it.

11 QWhy is that important for you to only treat those diseases  
12 that you have training in?

13 MS. GODFREY: Well, objection. I think we're getting into  
14 an expert witness area.

15 MR. JIMISON: She's a doctor. I can qualify her, if you  
16 would like.

17 MS. GODFREY: Well, she was not named as an expert witness  
18 and I took her deposition, but it was not with the  
19 understanding that she was going to be asked for her medical  
20 opinions on things. The Board has an expert witness that  
21 they did designate already and they did not designate Dr.  
22 Herman as an expert witness, but simply as a fact witness.

23 MR. JIMISON: There -- there is no -- again, there has

1           been no rule or citation of any rule or statute.  An expert  
2           witness can give an opinion on an ultimate legal matter  
3           like was this within the standard of care.  I'm not asking  
4           her about whether treatments by Dr. Buttar were within  
5           the standard of care for a cancer doctor.

6           The question was, why is it important for you as a physician  
7           to only treat those diseases that you have training in.

8           It's not even -- it's not an expert opinion about the  
9           quality of care.

10          PRESIDENT RHYNE:  Proceed and answer the question.

11          AI'm sorry, what was the question?

12          Q(By Mr. Jimison)  Why is it important for you to treat only  
13               those diseases that you got trained in?

14          ABecause the one thing I remember -- try to remember most  
15               frequently and that is Primum Non Nocere which means first  
16               do no harm.  And I think that when physicians are -- are  
17               treating things that they are not well-trained in, they  
18               may inadvertently do harm.

19           If I might just digress, I was reading in the lobby the --

20          MS. GODFREY:  Well --

21          A-- the copy of the Forum and one of the first things is your  
22               patients build a trusting relationship with you and they  
23               respect your advice and your recommendations for treatment

1 and they expect that they will receive appropriate  
2 treatments.

3 QOkay. As a physician, are you familiar with any of the  
4 following treatments: hydrogen peroxide --

5 MS. GODFREY: Well, objection again. She's not an expert  
6 witness and she says she doesn't treat cancer patients.

7 MR. JIMISON: I'm only asking her if she's familiar with  
8 these treatments.

9 PRESIDENT RHYNE: Okay.

10 MR. KNOX: May I say something?

11 PRESIDENT RHYNE: Yes.

12 MR. KNOX: The Rules of Evidence apply and when you don't  
13 name an expert even in a medical malpractice case, you  
14 cannot subject and alert everybody that you know the truth  
15 is the doctor is an expert. It's clear and the statement  
16 that he's making is absolutely a erroneous statement.  
17 And they never told us that she would be an expert, so  
18 we didn't ask her about her opinion. We asked her about  
19 the observations that she had learned from somebody else  
20 which is hearsay and we would object to.

21 MR. JIMISON: Again, I mean, I don't want to go back and  
22 forth, but it's -- you know, this constant back and forth  
23 between counsel. I'm trying very hard to avoid it. The --

1 their -- the question is, is she familiar with these  
2 therapies and I'm not asking her for her opinion. I'm  
3 asking her as a doctor, are you familiar with these  
4 therapies. An expert witness is designated because they  
5 can give an opinion about therapies. I'm only asking if  
6 she's familiar, that's all.

7 MR. KNOX: Well, the proper question is do you know whether  
8 or not -- do you know what hydrogen peroxide is, but he  
9 puts in a phrase -- phrase as a family practitioner doctor,  
10 so and so, so and so, and that's an absolute erroneous  
11 opinion and --

12 PRESIDENT RHYNE: Mr. Jimison, I would agree that you need  
13 to rephrase your question so that they are not leading  
14 and -- and she was not designated as an expert.

15 Q(By Mr. Jimison) Are you familiar with hydrogen peroxide  
16 therapy?

17 AI am not.

18 QAre you familiar with ozone therapy?

19 ANo.

20 QAre you familiar with hyperbaric chamber therapy?

21 AVery little, mainly not related to cancer therapy.

22 QAnd did you file a complaint with the Board?

23 AI did.

1 QAnd why?

2 AI struggled with this because in my 19 years of medicine, I  
3 never filed a complaint against another physician and it  
4 was very difficult for me to come to that decision.

5 But I felt like that my patient and her family were being  
6 taken advantage of when they were in a very -- very serious  
7 situation.

8 And I was concerned about the therapy that she was receiving  
9 and the fact that it was preventing her from being able  
10 to spend quality time with her family and, quote, get her  
11 affairs in order and deal with life and death and for her  
12 family to do the same.

13 And, therefore -- and also the cost that it was incurring  
14 to the family who are middle class, not wealthy, and that  
15 concerned me as well.

16 MR. JIMISON: Thank you, Dr. Herman.

17 PRESIDENT RHYNE: Would you like to cross-examine the  
18 witness?

19 MS. GODFREY: Yes, thank you.

20 **CROSS-EXAMINATION BY MS. GODFREY:**

21 QDr. Herman, when you -- the information that you got about  
22 what was going on with Patient A, you got that not from  
23 Patient A, did you?

1 ANo.

2 QYou got that from --

3 AOh, I'm sorry, excuse me. You'll have to back up. What  
4 information are you talking about?

5 QYou know that was a terrible question.

6 AIt was.

7 QLet's all start over.

8 The information that caused you to file the complaint with  
9 the Board --

10 AOkay.

11 Q-- you did not obtain that information directly from Patient  
12 A, did you?

13 ANo.

14 QOkay. The information that you obtained was from her daughter?

15 ACorrect.

16 QAnd from the other employees that are sitting in the back who  
17 work in your office?

18 AYes.

19 QOkay. And after you got the information, I guess you were  
20 concerned?

21 A(Nods head in affirmative response.)

22 QIs that -- you have to answer verbally, Doctor?

23 AYes, I was concerned.



1 QOkay. But you did not go and talk to Patient A or her family  
2 about it, did you?

3 ANo, and I'll tell you why I did not. They -- it was just a  
4 very tenuous situation. They were having a very difficult  
5 time dealing with the fact that Patient A was terminal  
6 and I did not want to add to that pain by bringing up this  
7 issue at the time.

8 And Marie was not working at the time. She was going with  
9 her mother to these treatment sessions as you've heard,  
10 so she was on leave of absence at the time. And as they  
11 were gone Monday through Friday every week and so, you  
12 know, the weekends were the only time they had at home  
13 and I -- I just didn't want to impose upon that.

14 QAnd even after Patient A died, you didn't go to the family  
15 and express any concerns to them, did you?

16 AI had talked with Marie briefly on one occasion and I cannot  
17 give you dates or at what point in her treatment that  
18 occurred because I do not remember.

19 But she had come into the office when they were first  
20 beginning this treatment and asked me -- walked into my  
21 office and said, do you know where I can get concentrated  
22 hydrogen peroxide. And I had no clue what she was  
23 indicating and I said no and she started to tell me about

1 this therapy. And I said, I've never heard of that, Marie,  
2 and I don't know what it is.

3 And then she came by the office again on another occasion  
4 and I again expressed to her that I wasn't sure that this  
5 was going to be helpful. But I can't give you dates or  
6 anything like that.

7 QWell, and the question I asked is that you never went to Patient  
8 A or her husband --

9 ANo, and I --

10 Q-- and -- excuse me, can I finish my question?

11 You never went to Patient A or her husband and said, I  
12 have some concerns about the therapy?

13 ANo.

14 QOkay. And with regard to Marie, Patient A's daughter, you  
15 were only seeing -- she was on leave of absence from your  
16 office?

17 AThat's correct.

18 QAnd so I think you testified when I took your deposition that  
19 during the time she was treating -- when Patient A was  
20 treating with Dr. Buttar, you only saw her maybe two or  
21 three times in passing when she would stop by your office  
22 for various things --

23 AThat's right.

1 Q-- isn't that right?

2 You were aware because your office got correspondence from  
3 M.D. Anderson that Patient A had failed her treatments  
4 at M.D. Anderson?

5 AThat's correct.

6 QAnd you were also aware that she did not want to give up hope  
7 for trying to do something for her cancer?

8 AI was aware of that, but most patients are like that.

9 QOkay. And she never came back to see you --

10 ANo.

11 Q-- as a doctor after she returned from M.D. Anderson?

12 ANo.

13 QWhen -- when you filed your complaint with the Board, you told  
14 the investigator that you did not believe that Patient  
15 A's family wanted to become involved; isn't that true?

16 QThat's true.

17 QAnd you told them, in fact, that you thought that -- that Patient  
18 A's family was content with the care they had received  
19 from Dr. Buttar?

20 AAAt the time I had no reason to think otherwise and so I didn't  
21 offer my opinion on that.

22 QOkay. And when Mr. Jimison contacted you about being a witness  
23 at this hearing, you told him that Marie Church did not

1 want to become involved in this, didn't you?

2 AI did.

3 MS. GODFREY: Okay. That's all I have.

4 PRESIDENT RHYNE: Mr. Jimison, do you want to redirect?

5 MR. JIMISON: Yes.

6 **REDIRECT EXAMINATION BY MR. JIMISON:**

7 QDoctor -- Dr. Herman, would you turn to page 38?

8 AOf what?

9 QOf Tab 4 of the big thick notebook.

10 MS. GODFREY: Page 38.

11 PRESIDENT RHYNE: Mr. Jimison, there are two big thick  
12 ones. Are you referring to --

13 MR. JIMISON: The Board's which is the particular one with  
14 four tabs.

15 MS. GODFREY: The one -- yeah.

16 PRESIDENT RHYNE: The one with four.

17 Q(By Mr. Jimison) Are you on Tab 4?

18 ATab 4, I'm sorry. I didn't hear you say Tab 4. Page 38 under  
19 Tab 4?

20 QRight.

21 AOkay. We're there.

22 QAll right. Do you recognize that document? It's already been  
23 introduced into evidence.

1 AYes.

2 QAll right. And what is that document?

3 AThis is a record of Patient A's last visit to M.D. Anderson.

4 QAnd I turn your attention to the first full paragraph, but  
5 it looks like the second paragraph of that -- of that --  
6 of that record.

7 AYes.

8 QWhat is being done here?

9 AEssentially, the physician is telling the patient and the  
10 family that there's no other treatment that would be  
11 beneficial to her and that she's terminal and they actually  
12 recommended hospice.

13 QOkay. There's a sentence there that says the husband was  
14 interested in some type of oxygen therapy.

15 AYes.

16 QWould you read that to the Board, please?

17 AThe husband was interested in some type of oxygen therapy which  
18 we do not have available here and I am unaware of any  
19 legitimate clinical trials that are being conducted with  
20 this approach at this center.

21 QAnd from your previous testimony we know that M.D. Anderson,  
22 in your view, is one of the more progressive and aggressive  
23 cancer centers in the country?

1 MR. KNOX: Objection, it's already been asked about.

2 PRESIDENT RHYNE: Yes.

3 MR. JIMISON: Thank you, Dr. Herman.

4 WITNESS: Thank you.

5 PRESIDENT RHYNE: Ms. Godfrey, do you want to recross?

6 MS. GODFREY: No, thank you.

7 PRESIDENT RHYNE: Are there any Board Members with any  
8 questions?

9 Thank you, Dr. Herman. We appreciate your being here.

10 MR. JIMISON: At this time, the Board would like to call  
11 Dr. John Peterson.

12

---

13 WHEREUPON,

14 JOHN L. PETERSON, M.D.,

15 being first duly sworn,

16 was examined and testified

17 as follows:

18

---

19 **DIRECT EXAMINATION BY MR. JIMISON:**

20 QDr. Peterson, would you introduce yourself to the Members of  
21 the Board, please?

22 ASure. I'm Dr. John Peterson. I am a hematologist and  
23 oncologist. Do you want me to fill in the --

1 QWe'll start. And fortunately I have my index switched here.

2 If you could turn to the thin notebook, Exhibit 15 --  
3 no, I'm sorry, Exhibit 7 in the thin notebook.

4 AYeah, okay.

5 QSo could you go over your formal medical education and training?

6 AYeah. I did my undergraduate at the University of Wisconsin  
7 in Madison, went to the medical school at the University  
8 of Wisconsin in Madison. Did my medical residency at the  
9 Medical School of South Carolina in Charleston.

10 Then I was in my public health service payback for two  
11 years to help finance medical school.

12 And then academic hematology/oncology fellowship at the  
13 University of North Carolina for three years. I spent  
14 some of my time at time Duke, I spent of the time at the  
15 Fred Hutchison Cancer Research Center in Seattle.

16 Following the conclusion of my fellowship at UNC. I did  
17 some additional training in transplant at the University  
18 of British Columbia in Vancouver.

19 And after that I went into private practice in Sanford  
20 and I've been there ever since. I worked for about 7 years  
21 until 1999. I also have clinical faculty position at the  
22 University of North Carolina and continue to have a clinic  
23 appointment at the -- at the Lineberger Cancer Center at

1           UNC.

2       QSo you are associated with the UNC Cancer Center at the  
3           Lineberger Cancer Center?

4       AI still have clinical appointment, but I do not actively  
5           participate in any work there at all now. Since 1999,  
6           I've been in full-time private practice in Sanford.

7       QAnd prior to that, you had a faculty position at UNC?

8       AYes. And I still have the appointment, but it's really not  
9           active.

10      QAre you board certified in any specialties?

11      AHematology and oncology.

12      QAnd how long have you been board certified?

13      AI don't remember. I'm going to say 1995. Is it in there?

14           It looks like 1995 in oncology and 1994 in hematology.

15      QAnd do you stay current with your CME?

16      AYes.

17      QDescribe some of the things you do to the Board. Describe  
18           some of the things that you do to stay current on topics  
19           regarding cancer?

20      AWell, I subscribe to three journal, the Journal of Clinical  
21           Oncology and the Journal of Medicine and the Journal of  
22           Cancer. And I go to at least one or two medical meetings  
23           a year. I typically go to the meeting at Sloan-Kettering



1 every fall. The work I do typically puts on review courses  
2 both at the hematology meeting and the oncology meeting  
3 every summer and I usually go to those. I sometimes go  
4 to breast cancer meetings in San Antonio and they'll be  
5 other conferences and other meeting that I attend at  
6 various times during the year.

7 QAnd do you stay current on your CME hours?

8 AYes.

9 QOkay. Describe cancer for us. In my opening statement, I  
10 mentioned cancer as a single name. Can you describe what  
11 is meant by the word cancer?

12 AYeah. It's unfortunately a vague term. In general what  
13 cancer is, is a growth of -- unregulated cell growth.  
14 To make it simply and highball the cell program becomes  
15 a certain size and it stops growing, but cancer cells are  
16 cells that have lost the signal and they just grow and  
17 form tumors that get in the blood stream and lymphatic  
18 system and migrate through the body and lodge and form  
19 more tumors and you just simply lost the mechanisms that  
20 normal -- normal cells have.

21 QAre all cancers the same?

22 ANo. In fact, one of the biggest problems we are having in  
23 cancer is that it's getting -- it's becoming increasingly

1 -- I guess depressingly clear that finding a treatment  
2 for cancer is going to be really a question of finding  
3 thousands of treatments for thousands of cancers.

4 Even a disease like breast cancer, what you'll find is  
5 there's really hundreds if not thousands of these cancers.

6 I mean, there was a recent report where they just took  
7 one patient's cancer cells and in that tumor they found  
8 they could separate cells and they couldn't find any cells  
9 that actually had identical genetic mutations. When they  
10 got down to that level, what they find is there is no such  
11 thing as just breast cancer. You know, we've tried to  
12 cut and slice and cut and slice.

13 I mean, when I first started to study lymphoma there were  
14 three kinds of lymphomas, there's over 30 now and under  
15 those 30 names, each one of those will have a whole list  
16 of molecular mutations that further subdivide them to the  
17 point that, you know, it's just a tremendous effort.

18 And it's made -- it's one of the things that made such  
19 different cancer disease or diseases so difficult to treat.

20 MR. JIMISON: At this point, I'd like to tender Dr.  
21 Peterson as an expert in the treatment of cancer, oncology  
22 and hematology.

23 PRESIDENT RHYNE: Without objection, accepted.

1 Q (By Mr. Jimison) Describe -- you touched on this, but describe  
2 the research that goes on in the battle against cancer.

3 Describe what kind of research goes on today.

4 A You want it like drug development research or --

5 Q Sure, start with that.

6 A Well, I guess clinically that's what we see. Of course, in  
7 the molecular level there's all kinds of research done  
8 at the lab level.

9 But at the clinical level, you know, they'll find a  
10 substance in the lab that looks like it has anti-tumor  
11 activity in the cell line. There's a whole screen of these  
12 cells lines and now we can kind of standardize for  
13 experimental treatment. There's lung cancer cell lines  
14 and colon cancer cell lines and breast cancer cell lines  
15 and were derived from patients with cancer.

16 And they can set up a million miles where they can actually  
17 get these cancers to grow in rats or mice and then try  
18 these various substances that they found in test tubes  
19 to see what kind of effect they have on a system such as  
20 a rat or a mouse.

21 And then they get pre-clinical data in the animal studies,  
22 they will then move forward with what's called the Phase  
23 I study and the patients have a hard time understanding

1 that.

2 The Phase I study really doesn't necessarily benefit the  
3 patient because at that point all you're doing in a Phase  
4 I study is trying to see what the appropriate dose in a  
5 human is and what the toxicity in a human is.

6 Now, sometimes the drugs work well in some of those patients  
7 on a Phase I trial and will actually get some benefit,  
8 but there's no promissory intention of benefit with the  
9 Phase I trial. It's just an attempt to go literally from  
10 the rat to the human and see are these drugs safe, what's  
11 the toxicity, what would be the appropriate dose in a human.

12  
13 In a Phase I trial they're typically not targeting a typical  
14 tumor. You know, a typical or any tumor and list a bunch  
15 of their failed standard therapy in which standard  
16 therapies are unavailable and with informed consent the  
17 patient can consent to go on these trials, but it's made  
18 quite clear to them that these are experimental.

19 After the Phase I, if they get good data, they're safe  
20 and they got the appropriate dose and it's all under FDA  
21 approval, they can then, after approval, move forward for  
22 a Phase II trial.

23 And throughout all of these trials, these have to go through

1 something called an Institutional Review Board and every  
2 single institution would offer it. It's not just --  
3 because if UNC wants to do a trial that's offered at Duke,  
4 it has to go through the UNC Institution Review Board and  
5 it has to be okayed and it's a panel of people. There's  
6 lay people, there's oncologists, and surgeons on it and  
7 get the data and feel it's ethical, they'll have permission  
8 from IRB to do the trial and offer it to patients.

9 If the Phase I approves, they can go back to the FDA and  
10 NIH and get permission to go on to Phase II and then they  
11 have to design the trial.

12 And, again, the Phase II, it's the same IRB that Phase  
13 I went through to make sure they are safe and appropriate,  
14 the consent form is ethical, the patients have been given  
15 a chance to understand what they're signing on to.

16 At Phase II you start to get some true clinical information  
17 where you'll actually know if it's working. Not only have  
18 they got the doses down, possibly more patients on it now,  
19 and you'll start seeing more side effects and you got more  
20 data. And at that point it's usually when you hope to  
21 get somebody of which tumors this is most active on.

22 From there you'll go to a Phase III trial, again through  
23 the same regulatory standards. You have to show the data.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23

And in a Phase III trial is where you're actually now offering treatment benefit potentially. At this point you've got data, it's working in these cancers. This is the approximate response and you're going to compare it then to standard therapy.

At that portion of the trial, the patient can go to the university or even at some private offices and you can get standard therapy for the trial. And the hope is the new drugs or drug or drugs are superior to the old ones.

And it would be a randomized trial in which you'll have an opportunity to compare the standard therapy to the new therapy and you'll found out which one is superior.

And after that it goes back to the FDA and they get approval for the regimen.

QIn these -- these new drugs that are developed through this -- through these clinical trials and the different stages, what are some of the safeguards that are used in such research?

AWell, they'll have these data monitoring boards -- and I don't really do this work any more, so I'm probably somewhat out of date.

But they'll have data monitoring boards and this data has

1 to be really -- at certain intervals depending on the trial  
2 -- if there's any -- and there's -- the physicians that  
3 have patients on these trials are required to report any --  
4 any adverse reaction. There's a form they fill out.  
5 Any adverse reaction that's reported is immediately  
6 investigated. If there's any indication there's a  
7 problem, a trial can be halted by the state or city  
8 monitoring committee.

9 And in addition to that, all of these institutions are  
10 monitored by the NIH and they come down a couple of times  
11 a years, they withdraw the data on all the patients to  
12 make sure that they aren't having what are called protocol  
13 violation.

14 You can't increase the dose or decrease the dose, very  
15 rigid criteria, for the cancer could affect blood counts  
16 with treatment and you're required mandatory reductions  
17 based on the blood counts and make sure that you are dose  
18 reducing appropriately or dose delaying appropriately or  
19 recording adverse events appropriately.

20 Does that answer --

21 QWell, why are -- why are they necessary? That's -- why are  
22 these safeguards necessary?

23 AWell, you don't want to be giving unnecessary treatments.

1 You want -- you don't want to be offering patients  
2 treatments that do not have proven benefit. And the FDA  
3 is in business in approving drugs only if they have a proven  
4 benefit.

5 QOkay. And I'd now like to turn your attention to Patients  
6 A, B, C and D. Okay. Did you review those records for  
7 the Medical Board?

8 AYes, I did.

9 QAnd do you have an opinion to a reasonable degree of medical  
10 certainty as to whether the treatment provided by Dr.  
11 Buttar to Patients A, B, C and D -- well, let's just go  
12 for A, B and C, to Patients A, B and C was within acceptable  
13 prevailing standards of medical practice for the treatment  
14 of cancer in North Carolina?

15 MR. KNOX: Objection.

16 MS. GODFREY: Objection.

17 PRESIDENT RHYNE: What is the basis?

18 MR. KNOX: The basis of my objection, he's qualified as  
19 hematology/oncologist and not as an integrative doctor  
20 and if I need to, I can at this point, but there's no  
21 evidence to show to the Board that he has qualifications  
22 in his deposition that says he knew nothing about  
23 alternative medicine or integrative medicine.



1 MR. JIMISON: This is a good point for me to respond to  
2 Mr. Knox. The law in North Carolina and I'll read it to  
3 you, is 90-14(a)(6) and during the closing arguments we  
4 argued this case to the Medical Board, we'll be stressing  
5 this and this is important.

6 It says under the disciplinary authority of the Board  
7 90-14(a)(6), it says: Unprofessional conduct, including,  
8 but not limited to, departure from, or the failure to  
9 conform to the standards of acceptable and prevailing  
10 medical practice, or the ethics of the medical profession,  
11 irrespective of whether or not a patient is injured  
12 thereby, or the committing of any act contrary to honesty,  
13 justice, or good morals, whether the same is committed  
14 in the course of the physician's practice or otherwise,  
15 and whether committed within or without North Carolina.

16  
17 They're saying that you have to conform to acceptable and  
18 prevailing standards of medical practice and that the label  
19 you put on your -- the doctor, the doctor's label is  
20 irrelevant. It is totally irrelevant. You have to  
21 conform to acceptable and prevailing medical practices  
22 for the disease that you're treating. That's the law.  
23 Here and with your permission, Dr. Rhyne, I will hand up

1 the Supreme Court case, In Re: Guess.

2 MS. GODFREY: I've got a copy.

3 MR. JIMISON: In the In Re: Guess case, the North Carolina  
4 Supreme Court was confronted head on with the argument  
5 that Dr. Guess who was practicing what's called homeopathy  
6 and could be judged only by homeopathic standards, that  
7 in order for the Board to judge him, he had -- the Board  
8 had to have other homeopaths come in and testify that there  
9 has to be a homeopathic standard and he can only be charged  
10 with -- he can only be judged under the homeopathic  
11 standard.

12 The In Re: Guess said, that, no, the statute permitting  
13 the revocation of a physician's medical license for  
14 unprofessional conduct based on acts which do not  
15 concern -- which do not conform to the standards of  
16 acceptable and prevailing medical practice in North  
17 Carolina.

18 They're just saying, you have to conform to acceptable  
19 and prevailing medical practices in North Carolina. That  
20 is the law.

21 This case has never been overturned.

22 Subsequent to the Guess case, the North Carolina General  
23 Assembly added the following language to the statute.

1 And that statute is that the Board shall not revoke the  
2 license or deny a license to a person solely because of  
3 that person's practice of a therapy that is experimental,  
4 non-traditional, or that departs from acceptable and  
5 prevailing medical practice, unless by competent evidence  
6 the Board can establish that the treatment had a safety  
7 risk greater than the prevailing treatment or that the  
8 treatment is generally ineffective.

9 What the General Assembly is saying is that you have the  
10 right to regulate the practice of medicine so long as  
11 it's -- so long as it's outside, it departs from acceptable  
12 and prevailing practices.

13 What you can't do is revoke the license unless you make  
14 a finding that it's generally ineffective or has a safety  
15 risk. They tie the integrative medicine standard to the  
16 penalty. That's the law as it exists right now.

17 So what you have to decide are, what are the acceptable  
18 and prevailing medical treatments in North Carolina for  
19 the treatment of cancer. You take the patient, the  
20 standard is -- is pointed to the patient and what the  
21 patient has and what the patient is being treated for.

22 You can't slap a label -- a doctor can't slap a label on  
23 himself and say I'm outside the rules now. The statute

1 does not say that. The George -- the In Re: George Guess,  
2 Dr. Guess case does not say that.

3 The only thing that has changed is that before the Board  
4 can revoke a license, they have to make certain findings.

5  
6 Now, Dr. Peterson will also testify as to the other findings  
7 about whether it's generally effective or whether it --  
8 or has a safety risk that's greater than the prevailing  
9 treatment, so he's qualified to testify to both.

10 But the law in North Carolina under this Guess case and  
11 under the way the statute is written right now, is that  
12 you only determine what are the prevailing and acceptable  
13 medical standards in North Carolina for the treatment of  
14 what the patient has.

15 That's what the law is and that law -- the Guess case has  
16 never been overturned and this law as you're aware of,  
17 because we did a wholesale revision to the Medical Practice  
18 Act just a year or so ago where we added additional  
19 disciplinary options. You know, we can do public letters  
20 of concern, we can do censures, we can do fines.

21 So when they changed that act, they left this sentence  
22 in the law saying that, you know, still that tying the  
23 integrative medicine standard or actually it's not

1 integrative medicine standards, this 90-14(a)(6) in the  
2 disciplinary authority doesn't even use the word  
3 integrative.

4 It just says before you can revoke a license that departs  
5 from acceptable and prevailing medical practice, you have  
6 to make a finding of whether or not it's generally  
7 ineffective or it has a safety -- a greater safety risk,  
8 but you can still regulate. You can still regulate the  
9 medicine.

10 The other part of the argument would be that if you cannot  
11 do that, then everything goes. Then everything goes no  
12 matter what goes -- I mean, no matter what happens in a  
13 doctor's office, everything goes so long as, you know,  
14 the doctor can say, well, it's not hurting anyone or I  
15 have some effect.

16 The General Assembly did not say that. They only tied  
17 it to revocation. So -- so the argument that there is --  
18 there is a standard for all other doctors and there's a  
19 different standard for integrative doctors is not  
20 supported by the statute. It's not supported by the In  
21 Re: Guess case.

22 And so the objection is -- is completely incorrect. It  
23 is just a totally incorrect statement of the law under

1 the statute and under that In Re: Guess case.  
2 And so therefore I think the qualification for Dr. Peterson  
3 to testify what are the acceptable and prevailing medical  
4 standards in North Carolina for the treatment of cancer  
5 is well within his authority, well within his expertise  
6 and well within the law. In fact, it is the law. So that's  
7 how I would respond to that objection.

8 MS. GODFREY: With all due respect to Mr. Jimison, I think  
9 he has misquoted the Guess case, first of all. The Guess  
10 case deals with the issue of -- of whether or not there  
11 has to be -- there has to be a showing of harm to the patient  
12 and it's back in 1990 and it went through the courts several  
13 times and finally the Supreme Court said that you can revoke  
14 a doctor's license without showing that they've harmed  
15 the patient. That's the holding of the Guess case.

16 The Guess case does not address this issue of standard  
17 of care and there's been a lot of evolution in the law  
18 since 1990 on the issue of standard of care. We are not  
19 saying that integrative medicine doctors need -- need to  
20 be judged under a special rule.

21 What we are saying is, is that the Medical Practice Act  
22 and the law of North Carolina is that you judge the standard  
23 of care by a doctor with same or similar training.

1 We are familiar in the medical malpractice arena that a  
2 general practice doctor cannot be held to the same standard  
3 of care for diagnosis and treatment of any condition as  
4 a neurosurgeon or any other kind of specialist.  
5 And what we are saying is the way the Medical Malpractice  
6 Act is structured and the way the law of North Carolina  
7 is structured and the way those words are interpreted under  
8 the law of North Carolina, you have to judge each medical  
9 specialty by the standards of care of that medical  
10 specialty. It only makes sense.  
11 And what we are saying is that although Dr. Peterson may  
12 be well qualified to judge the conduct of an oncologist  
13 treating cancer, we do not believe that he is well qualified  
14 to judge the conduct of Dr. Buttar who is not an oncologist,  
15 who is a doctor practicing integrative medicine which is  
16 defined by the statute and recognized by the statute as  
17 the diagnosis or therapeutic treatment that may not be  
18 a conventionally accepted medical treatment.  
19 By it's very definition, integrative medicine is outside  
20 Dr. Peterson's standard of care because Dr. Peterson  
21 treats patients under the conventionally accepted medical  
22 practice. And that's fine, but sometimes the  
23 conventionally accepted medical practice fails.

1 And what we're saying is that patients have a right to  
2 seek an integrative medicine doctor who practices outside  
3 conventionally accepted medical practice and that doctor's  
4 right to practice his type of medicine ought to be protected  
5 the same as Dr. Peterson's is.

6 And so for that -- that's the basis of our objection to  
7 him testifying against this doctor.

8 They don't have another expert. They don't have an  
9 integrative doctor here, they have an oncologist and he  
10 has an opinion and he's entitled to that opinion, but his  
11 opinions should not be the standard upon which we judge  
12 Dr. Buttar because he's in a different field.

13 MR. JIMISON: If I can just respond quickly to that because  
14 I handed the case out to you and if I can draw the Board's  
15 attention to just some of the language in the case, I think  
16 it would be very instructive.

17 If you can turn to page 5, to what's called Head Note 1.

18 I've highlighted it on my copy so you can follow along.

19 MS. GODFREY: What page are you on, Marcus?

20 MR. JIMISON: Page 5.

21 MS. GODFREY: Okay.

22 PRESIDENT RHYNE: And I can give you a copy of mine. It's  
23 Headnote 1. It says -- and this is the North Carolina



1 Supreme Court talking. The provision of the statute in  
2 question here is reasonably related to the public health.

3 We conclude that the Legislature in enacting 90-14(a)(6)  
4 -- for which Dr. Buttar has been charged with -- reasonably  
5 believe that a general risk of endangering the public is  
6 inherent -- and it quotes and italicized -- any practices  
7 which fail to conform to the standards of acceptable and  
8 prevailing medical practice in North Carolina.

9 We further conclude that the legislative intent was to  
10 prohibit any practice departing from acceptable and  
11 prevailing medical standards without regard to whether  
12 the particular practice itself could be shown to endanger  
13 the public.

14 Our conclusions are buttressed by the plain language of  
15 the statute which allows the Board to act against -- and  
16 again it italicizes it -- any departure from acceptable  
17 and medical practice irrespective of whether or not a  
18 patient is injured thereby.

19 By authorizing the Board -- and this is a Medical Board  
20 case -- they're talking about this Medical Board.

21 By authorizing the Board to prevent or punish any medical  
22 practice departing from acceptable or prevailing  
23 standards, irrespective of whether a patient is thereby

1 injured or injured thereby, a statute works as a regulation  
2 which tends to secure the public generally against the  
3 consequences of ignorance, in any capacity, as well as  
4 deception and fraud, even though it may not immediately  
5 have that direct effect in this particular case.

6 Therefore, the statute is a valid exercise of the police  
7 power.

8 If you turn over to Page 6 on the second column and this  
9 is Dr. Guess arguing that, well, he's a homeopathic doctor,  
10 he should be judged only by homeopathic standards. It  
11 says: Dr. Guess strenuously argues that many countries  
12 and at least three states recognize --

13 MS. GODFREY: Excuse me, Marcus. We have a different  
14 version of the -- of the case than you do. Can -- can  
15 you give me your version because we can't follow where  
16 you're -- you're on page 6?

17 MR. JIMISON: Uh-huh (yes).

18 MS. GODFREY: At what headnote?

19 MR. JIMISON: Number 4, second column, midway down where  
20 it says, Dr. Guess strenuously.

21 It says: Dr. Guess strenuously argues that many countries  
22 and at least three states recognize the legitimacy of  
23 homeopathy.

1 While some physicians may value the homeopathic system  
2 of practice, it seems that others consider homeopathy an  
3 outmoded and ineffective system of practice. This  
4 conflict however interesting, simply is irrelevant here  
5 in light of the uncontroverted evidence in the Board's  
6 findings and conclusions that homeopathy is not currently  
7 an acceptable and prevailing system of medical practice  
8 in North Carolina.

9 While questions as to the effectiveness of homeopathy and  
10 whether its practice should be allowed in North Carolina  
11 may be open to valid debate among members of the medical  
12 profession, the courts are not the proper forum for that  
13 debate.

14 Then Ms. Godfrey talked about, well, patients should be  
15 able to have the right to chose whatever treatment they  
16 get outside of conventional standards.

17 If you turn to page 7, the Supreme Court addressed this  
18 issue very much as well. Headnote 6, right before you  
19 get to -- in the second column right before you get to  
20 Head Note 7, it's kind of up here. It says -- well, I  
21 actually have to start -- it starts at the very bottom  
22 of the first paragraph on Headnote 6.

23 It says: Regarding Dr. Guess's claim that the Board's

1 decision invades his patient's right to select a treatment  
2 of their choice, we initially note that he has no standing  
3 to raise his patient's privacy interest in this regard.  
4

5 The most -- the next sentence is the most important, after  
6 you get through the cites of cases.

7 Further, we have recognized no -- no fundamental right  
8 to receive unorthodox medical treatment and we decline  
9 to do so now. There is no right to seek any kind of  
10 treatment you want from anybody, any time, anywhere in  
11 North Carolina.

12 That's the law in Dr. Guess's case. It was a Medical Board  
13 case. It's from 1990. It's never been overturned. The  
14 statute has the exact same language as it did then.

15 The only change has been is that when we get to Phase II,  
16 if there is a Phase II and the Board decides they want  
17 to revoke Dr. Buttar's license, then and only then does  
18 it become relevant as to the two findings that you have  
19 to make about whether it poses a greater safety risk or  
20 whether it's generally ineffective. Both factors can be  
21 addressed by Dr. Peterson.

22 And there's nowhere in this case that says that specialties  
23 can only testify against other specialties and

1 non-specialties or this specialty.

2 They're talking about what are acceptable and prevailing  
3 treatments for patients in North Carolina. So if a patient  
4 comes to a doctor with cancer, what is the acceptable and  
5 prevailing treatment for cancer for that doctor. And if  
6 that doctor is of a specialty, he still has to treat it  
7 within those acceptable standards of care. So --

8 PRESIDENT RHYNE: I'm going to overturn this objection.

9

10 Mr. Jimison, if you would proceed.

11 MS. GODFREY: Okay.

12 MR. KNOX: Would you reserve us an objection to every time  
13 the question is asked or we can just notify the court  
14 reporter as we go through, if that's okay, without  
15 interrupting?

16 PRESIDENT RHYNE: That'll be fine.

17 MR. JIMISON: I agree to that.

18 Q(By Mr. Jimison) Okay. Dr. Peterson, do you remember the  
19 question?

20 ANo, I don't.

21 QLet me rephrase the question. Let me re-ask the question.

22 Do you have an opinion as to whether the treatments provided  
23 by Dr. Buttar to Patients A, B and C were within acceptable

1 and prevailing standards of -- wait a minute.

2 Do you have an opinion to a reasonable degree of medical  
3 certainty as to whether the treatment provided by Dr.  
4 Buttar to Patients A, B and C was within acceptable and  
5 prevailing standards of medical practice for the treatment  
6 of cancer in North Carolina?

7 AYes.

8 QAnd what is that opinion?

9 AThat they were below the standard.

10 QOkay. Do you have an opinion as to whether the treatment  
11 provided by Dr. Buttar to Patient D was within acceptable  
12 and prevailing medical standards of --

13 MR. KNOX: Objection.

14 Q-- of medical practice?

15 AWhich one is D?

16 QThe non-cancer patient?

17 AYes.

18 QAnd what is that?

19 AIt was below the standard.

20 QOkay. Going back to Patients A, B and C, why is it your opinion  
21 that the treatment that was provided by Dr. Buttar in these  
22 three patients was below the standard of care?

23 AWell, he gave them treatment that had no proven benefit in

1 cancer. There's no clinical trial ever published that's  
2 shown ozone or hydrogen peroxide therapy or chelation for  
3 heavy metals has any effect -- has any known effect at  
4 all on cancer or the patient's life.

5 QDr. Peterson, if you could turn to the exhibits in the thin  
6 notebook, to Exhibit 6.

7 MS. GODFREY: Exhibit, I'm sorry, what?

8 MR. JIMISON: Exhibit 6.

9 Q(By Mr. Jimison) Do you recognize those documents?

10 AYeah. I think these are the -- these are my notes and my --  
11 the form I filled out from the review of the charts.

12 QYou reviewed the medical cases for the -- for the Medical Board  
13 and you filled out forms, correct?

14 ACorrect.

15 QAnd these are these forms.

16 ACorrect.

17 QAnd you sent in a cover letter regarding your forms to Mr.  
18 Ellis, the director of investigations?

19 AThat's correct.

20 QAre these a true and accurate copy of the documents that you  
21 sent to the Medical Board?

22 AYes.

23 MR. JIMISON: At this point, Dr. Rhyne, I'd like to enter

1 the Medical Board's Exhibit 6 into evidence.  
2 PRESIDENT RHYNE: Okay. Proceed.  
3 MR. KNOX: We have the same objection as it includes his  
4 opinions.  
5 PRESIDENT RHYNE: So noted.  
6 MR. KNOX: Thank you.  
7 Q(By Mr. Jimison) Okay. As to Patient A, Dr. Peterson, what  
8 did -- what did patient -- what was Patient A's diagnosis?  
9 AI assuming that's the patient that has ovarian cancer, if it's  
10 the same one I'm looking at.  
11 QYes.  
12 AOkay.  
13 MS. GODFREY: No, Patient A had cervical cancer.  
14 MR. JIMISON: Okay.  
15 WITNESS: That's the second one.  
16 MR. JIMISON: Yes.  
17 WITNESS: Yeah, they're not labeled A in here. Patient  
18 A had cervical cancer.  
19 QPatient A would be -- the last name starts with an O.  
20 AYeah. What was the question again?  
21 AWhat -- what was her diagnosis?  
22 AWell, cervical cancer, metastases.  
23 QAnd what treatments did she receive from Dr. Buttar from your



1 review of the records?  
2 AI'd have to pull this chart. I think -- I think he gave her  
3 -- I don't -- my recollection is the chelation therapy  
4 and hydrogen peroxide. I'd have to look in the records.  
5 QOkay. And Tab 4 in the big notebook under Tab 4.  
6 AAll of this is the records of Patient A?  
7 QYes, sir.  
8 ALet me see. The flow sheets. It looks like vitamin C, GSH  
9 and hydrogen peroxide, something called adrenal 5 cc,  
10 something called PALT amino, EDTA, that is chelation  
11 treatment I believe, something called HZM1, DMPS, adrenal.  
12 I'm not sure what that is over there. And then something  
13 I can't read -- I can't read that. Scratched out and written  
14 over. It looks like it has been scratched out. And then  
15 there's something that looks like WFAM, SM2. It looks  
16 like that's what she was treated with.  
17 QPatient B with the last name starts with K.  
18 AOkay.  
19 QWhat was her diagnosis?  
20 AMetastatic ovarian cancer.  
21 QOkay. And -- and she would be in Tab 3.  
22 AOkay.  
23 QAnd just look -- maybe I can speed things along. Does it appear

1 that she received the same therapies as Patient A?  
2 MS. GODFREY: What exhibit are you in?  
3 MR. JIMISON: Tab 3.  
4 AThe vitamin C, GCH, DMPS, so and so and so and so, EDTA, MSP.  
5 Yeah, it looks more about the same. Hydrogen peroxide  
6 here, vitamin C --  
7 QOzone?  
8 AYeah, it looks like the same.  
9 QOkay. And Patient A, what was Patient A's diagnosis?  
10 AWhat was that?  
11 QIt ends with K-E. It's the middle patient.  
12 AOkay. Adrenal cell cancer.  
13 QOkay. And the therapies and he would be in Tab -- Tab 2.  
14 Did he get the same as those previous Patients A and B?  
15 AYeah, has vitamin C and DMSP, yeah, DMPS, PSH and it looks  
16 like ozone. Yeah, it looks like the same treatment.  
17 QOkay. The hydrogen peroxide for Patient B as well?  
18 AYes.  
19 QThese treatments, hydrogen peroxide, ozone, EDTA, DMPS,  
20 vitamin C, are any of these -- hyperbaric chambers, are  
21 any of these therapies indicative for the treatment of  
22 cancer?  
23 ANo.

1 QDo you use any of these therapies in your -- in your practice?

2 ANo.

3 QAre you aware of any oncologists or cancer doctors using any  
4 of these therapies in their practice?

5 ANo.

6 QNow, turn to again Exhibit 6 in the thin notebook.

7 AAll right, I'm there.

8 QIf you could turn to your cover sheet -- your cover letter.

9

10 AYeah.

11 QYou wrote -- starting with the paragraph beside. Do you see  
12 that paragraph?

13 AYeah, the third one down.

14 QCould you read that to the Board Members, please?

15 AYeah. Beside the obvious fallacy of using EDTA, chromium and  
16 co-enzyme-Q, etcetera, to treat cancer patients which in  
17 my opinion is clearly rank fraud, there is the issue that  
18 none of these people were being managed for their other  
19 medical problems, as evidenced by the lack of physician  
20 involvement.

21 QRank fraud is kind of a strong term, Dr. Peterson. Why did  
22 you use that term?

23 AWell, because these people are being offered treatments that

1 don't work, to me it suggested fraud. I mean, it's  
2 dishonest. It tells someone you've got treatment when,  
3 in fact, it has no effect.

4 QCould -- did these patients who went through the diagnosis --  
5 at some point, did they all become Stage IV metastatic  
6 cancer patients?

7 AYeah, they were all Stage IV when they presented to Dr. Buttar's  
8 office.

9 QWe spoke earlier on and then we had sort of a thing with --  
10 with the lawyers arguing in front of the Medical Board,  
11 but I'd like to draw your attention back to that earlier  
12 testimony about clinical trials.

13 Have any of these therapies that you have reviewed for  
14 the Medical Board for Patients A, B and C, have any of  
15 them been proven effective in any clinical trials that  
16 you're aware of?

17 MR. KNOX: Well, objection. He -- at that deposition,  
18 he referred to and said he didn't know what any of these  
19 medications were. I don't know how you presuppose he would  
20 know what's been tested or not been tested. He cannot  
21 identify any of them.

22 MR. JIMISON: I think Dr. Peterson should answer his own --  
23 the question instead of --

1 MR. KNOX: Well, I'm making an objection and I --

2 MR. JIMISON: I mean, Mr. Knox is answering the question  
3 for Dr. Peterson.

4 Q(By Mr. Jimison) Are you aware of any clinical trials --

5 PRESIDENT RHYNE: You can answer.

6 MR. JIMISON: Okay.

7 QAre you aware of any clinical trials that have shown that any  
8 of these therapies have proven effective for cancer?

9 MR. KNOX: Objection.

10 ANo, I'm not. And I would know about them because alternative  
11 therapies that are -- trials that are done through the  
12 NIH are published in the Journal of Clinical Oncology.  
13 In fact, there have been numerous ones published and none  
14 of these have.

15 QWhat are some of the alternative medicine therapies that have  
16 been published as a result of clinical trials?

17 AOne of them is called shark cartilage and we actually tried  
18 it for a while and there was -- the National Cancer Center  
19 does have an office of alternative medicine trials and  
20 they do, in fact, do trials in alternative medicine just  
21 because of all the pressure.

22 And the initial trials showed there's about a 15 percent  
23 response rate to shark cartilage and I actually had some

1 patients that would go and buy it. It's not a prescription  
2 drug. You can buy it from the GNC Nutrition Stores. But  
3 subsequently the clinical trials showed it was a failure.

4 QSo clinical -- there are people who do -- who treat cancer  
5 and do research cancer for conducting clinical trials  
6 regarding alternative therapies, correct?

7 AThat's correct. And there's another one actually, I forgot  
8 about this. There was herbal supplement in China. It  
9 was initially called PCC but they changed the name and  
10 right now I forgot what they call it now. But it -- it's  
11 an interesting story if you care about it.

12 QSure.

13 AThere was a research scientist in Los Angeles whose father  
14 had prostate cancer and they were Chinese-American and,  
15 you know, stating there was a working association linked  
16 to China and she went to China and she came back -- and  
17 in fact her father responded and because of that fact she  
18 ran -- (inaudible) -- and in fact works and it's not a  
19 prescription drug, but it is available and patients can  
20 buy it and I have prescribed it to patients.

21 We think the reason it works is because it actually contains  
22 Coumadin or -- (inaudible) -- Coumadin, the blood thinner.

23 Well, Coumadin actually does have anti-tumor effect.

1 In fact, back when I was a fellow at the University of  
2 Kentucky, they had a clinical trial using Coumadin to treat  
3 cancer. There are some responses but the responses are  
4 poor, but that's probably why that herbal supplement works.  
5

6 So, yeah, they do do trials on these things and when they  
7 work, we are going to use them. As though the chairman  
8 of the oncology at the Virginia of Medicine, Charles Smith  
9 has a whole clinic up there and he's had quite a few  
10 experiments with using herbal supplements for prostate  
11 cancer and he's got proven clinical results in that showing  
12 that the clinical trials do work.

13 QOkay. Are you familiar with the American Cancer Society?

14 AYes.

15 QHave -- are you familiar with whether they may have taken a  
16 position regarding the recommendation of oxygen therapy  
17 for cancer patients?

18 AMy understanding is, yeah, they've said it does not work and  
19 should not be used.

20 QAre you familiar with the Sloan-Kettering Memorial Institute?

21 AYes.

22 QWhat is Sloan-Kettering?

23 AIt's a -- it's a cancer research treatment hospital in New

1 York City. It's actually was founded by Alfred Sloan,  
2 who was the head of General Motors and Kettering was Charles  
3 Kettering. I don't know if you care about this, but he  
4 was the guy who invented the first electric-started  
5 Cadillac in 1912 and they gave the money and started  
6 Sloan-Kettering Memorial Cancer Center in New York City.

7 QWhat's its reputation for cancer research and cancer treatment  
8 in the country?

9 AWell, it's outstanding. It's one of the leading cancer centers  
10 in the world.

11 QHas it taken a position regarding oxygen therapies, that you  
12 know of?

13 AI'm not aware of it.

14 QIf you could turn to Exhibit 19.

15 MS. GODFREY: Well, objection. He's just said he's not  
16 familiar with Sloan-Kettering's position on oxygen therapy  
17 and we would object to Number 19. It's not going to --

18 MR. JIMISON: I can ask him to review the document.

19 MS. GODFREY: Well, I guess he could, but we would object  
20 under the Rules of Evidence that if he's not familiar with  
21 it, he's not entitled to testify to it.

22 PRESIDENT RHYNE: So he cannot testify to it, but he can  
23 examine it.



1 MR. JIMISON: No. He can examine the document and under  
2 Rule 803, if Ms. Godfrey is not familiar with Rule 803,  
3 expert witnesses can testify to medical references that  
4 they consider authoritative. And -- and I can bring you  
5 that rule.

6 Q(By Mr. Jimison) In fact, I hate to have you go back and forth,  
7 but -- while we're doing this, Dr. Peterson, can you just  
8 review Exhibit 19?

9 AYeah, sure. It's the same document I was referring to before.  
10 The American Cancer Society urges cancer patients not  
11 to seek treatment with hydrogen peroxide, ozone therapy,  
12 or other, quote, hyperoxygenation therapies. Oxygen  
13 therapies should not be recommended.

14 MR. KNOX: That's means he testified while you were looking  
15 up the rule.

16 MR. JIMISON: Well, let me -- let me just -- I'll move  
17 on. I don't want to --

18 PRESIDENT RHYNE: Just -- just move on.

19 Q(By Mr. Jimison) Do you recommend oxygen therapy to your  
20 patients?

21 ANo.

22 QWhy not?

23 ABecause it doesn't work.

1 QAnd is Dr. Buttar using these therapies to treat cancer from  
2 your review of the records --

3 AHe was in these three patients, yes.

4 QWhat are some of the risks associated with Dr. Buttar's  
5 therapies?

6 AWell, I don't know if there's -- I don't know of any risks.

7 The biggest -- I don't know if there is any risk so much  
8 as the downside as you're sitting there 40 hours a week  
9 in a chair and wasting your time and your money on something  
10 that's going to be for no good and you've lost all that  
11 time.

12 QFrom your review of the charts, who seemed to be the primary  
13 caregiver to these patients?

14 AThe nurses.

15 QDid you see physician contact between Dr. Buttar and the  
16 patients in the charts?

17 AI couldn't see any that was documented. It doesn't mean that  
18 it didn't happen, but I could not find any in the records  
19 that I was provided.

20 QDid you see the number of labs that Dr. Buttar ordered?

21 AYes.

22 QCould you characterize them as a small amount of labs or a  
23 large amount of labs? How would you characterize them?

1 AIt was a lot of labs. Most of them made no sense to me. I  
2 don't know what the purpose of checking them was. I mean,  
3 there was some legitimate chemistry labs that made sense,  
4 but a lot of them were in my opinion just bogus labs.

5 QWas there any evidence in the record that any of these lab  
6 tests were indicative for a cancer diagnosis?

7 AWell, no. I mean, he had some the standard chemistry which  
8 you would monitor anybody getting any kind of therapy,  
9 the creatinine and those sorts of things.

10 QIf you could speak up a little bit, Doctor. I think -- I'm  
11 having trouble hearing you and I think the Board --

12 AIf I look up you can't, so I have to talk to this thing.

13 There were standard blood tests you monitor now on any  
14 patient, just renal function tests and, you know, glucose  
15 and certain whatnot, but then there were all these other  
16 tests, aluminum levels, antimony, arsenic levels,  
17 beryllium, bismuth, cadmium, lead, mercury levels and I  
18 mean, these have nothing to do with cancer.

19 QWas there any evidence in the records that you reviewed that  
20 any of these tests were linked to clinical decisions?

21 AIf it was, I couldn't see it.

22 QWas there any evidence in the records that any of the tests  
23 were even interpreted by Dr. Buttar himself?

1 ANot that I could see in the record, no.

2 QDid you review the cost of these treatments?

3 ANo, I did not.

4 QOkay. Turning to Patient D, did you see -- the non-cancer  
5 patient, did you see physician contact between Dr. Buttar  
6 and Patient D?

7 ANo. No, not that I recall, no.

8 QAnd from your review of the record, could you discern whether  
9 Dr. Buttar made a diagnosis for Patient D?

10 AWell, my recollection is that it looked like he came in for  
11 constipation although I heard earlier today --  
12 (inaudible).

13 QIf you could speak up, sir.

14 MR. KNOX: I cannot hear a word.

15 PRESIDENT RHYNE: Yeah, I couldn't hear that either.

16 AFrom my -- this thing is not working. I can tell you I feel  
17 like I'm yelling here.

18 My recollection of the chart was that she came there for  
19 consultation, but I had heard earlier today they disputed  
20 that she come for lead toxicity, but I did not see that  
21 reflected in the record that I reviewed.

22 QOkay. Is there any evidence in the record that Dr. Buttar  
23 personally made a treatment plan for Patient D?

1 ANot that I could see.

2 QYou mentioned -- how were people tested for metal toxicity  
3 in all four of these patients?

4 AWith urine tests.

5 QDo you have -- what is the standard for measuring metal toxicity  
6 in a patient?

7 AYou measure serum levels. Urine levels have -- do not  
8 necessarily mimic at all. For instance, if you would  
9 check -- the simplest example I can give you, and that  
10 is we check urine for protein. People with all kinds of  
11 renal problems will have elevated proteins in their urine.  
12 We cannot conclude they've got too much protein based  
13 on that, but the conclusion is the kidneys are wasting  
14 the protein.

15 So what's in your urine is not an accurate way to diagnose  
16 a toxicity of mercury or lead or iron. If you want to  
17 know those levels you measure the serum levels.

18 QDo you consider urine -- urine screening for toxicity reliable?

19 ANo.

20 QIn your opinion as a physician doing hematology and oncology,  
21 what is the standard test for metal measuring toxicity  
22 in a human?

23 AIt's the serum test.

1 MS. GODFREY: Objection.

2 QOkay. We discussed earlier on in the discussion between  
3 counsel whether there are acceptable and prevailing  
4 standards of medical practice for the treatment of cancer  
5 and I want to go back to those cancer patients. In your  
6 opinion, is there a universal standard for what's  
7 acceptable and prevailing for the treatment of cancer?

8 AYes.

9 QAnd what is that -- what is that standard?

10 MS. GODFREY: Objection.

11 AWell, it would depend on the cancer as to what the standard  
12 is. But say ovarian cancer, the treatment for what she  
13 received which is chemotherapy, carboplatin, cisplatin,  
14 Taxol base chemotherapy. If those don't work, second line  
15 therapies are things like Toxil, thoraxcine, taxon tier,  
16 gypsum, (phonetic) and combinations. There's also work  
17 done with intraperitoneal cisplatin and peritoneal --  
18 (inaudible).

19 QOkay. Now, going back to what Dr. Buttar administered,  
20 hydrogen peroxide specifically. Is hydrogen peroxide  
21 therapy within the acceptable and prevailing standards  
22 of treatment for cancer patients in North Carolina?

23 ANo.

1 QHave you known hydrogen peroxide to have been proven effective  
2 in any clinical trial?

3 ANo.

4 QOn a scale from zero to 10, 10 being a cure, that the treatment  
5 provides a cure for patients for cancer and zero being  
6 they have zero effect whatsoever, what -- how would you  
7 rate hydrogen peroxide therapy on a scale from zero to  
8 10 for -- for cancer?

9 AZero.

10 QAnd when I say cancer, I mean, all three cancers that these  
11 patients had, adrenal, liver, lung, ovarian, cervical.

12 Is it still a zero for all those cancers?

13 AIt would be a zero for all of them, yes.

14 QWhat about the ozone, on a scale from zero to 10, what effect  
15 does it have on cancer?

16 AZero.

17 QVitamin -- intravenous vitamin C?

18 AZero.

19 QIV minerals?

20 AZero.

21 QTrigger point injections?

22 AZero.

23 QIs trigger point injections specifically called an IRR?

1 ARight. It has no efficacy.

2 MR. KNOX: Objection, he also testified he never heard  
3 of that.

4 MR. JIMISON: That can be argued. That's not a basis for  
5 an objection.

6 WITNESS: Actually, if I could address the issue. If you  
7 refer to it as an IRR as a trigger point, I know what that  
8 is. It wasn't referred to as a trigger point.

9 Q(By Mr. Jimison) Hyperbaric chambers, what -- on a scale from  
10 zero to 10, how effective is that for cancer?

11 AZero.

12 QChelation therapy, EDTA and EMPS, on a scale from zero to 10,  
13 how effective is that for cancer?

14 AZero.

15 MR. JIMISON: Okay. I have nothing further.

16 **CROSS-EXAMINATION BY MR. KNOX:**

17 QDoctor, looking at your vitae, it appears that you are the  
18 sole practitioner down in Sanford; is that correct?

19 AWell, I'm -- no, I have a part-time doctor, Dr. Kirby who is  
20 now in Chapel Hill.

21 QAnd Dr. Kirby is a doctor with who?

22 AShe works with me.

23 QOkay. But basically you run -- you run two separate offices,



1 do you?

2 ANo, I just run my office in Sanford.

3 QAnd I looked at your -- according to your resume, you're not  
4 doing any research now, correct?

5 ANo, that's correct.

6 QAnd you've not taught since 1999; is that correct?

7 AThat's correct.

8 QAnd you've had two publications listed, one is an abstract  
9 and a book review, both from 1991; is that correct?

10 AThat's correct.

11 QAnd you've not published any reviews or articles at any place  
12 since then?

13 AThat's correct.

14 QAnd have you presented or lectured at a national or  
15 international conference on cancer anywhere?

16 ANo, I have not.

17 QAnd I believe you were asked about, you have not been to any  
18 particular Integrative Medicine Society meetings; is that  
19 correct?

20 AThat's correct.

21 QAnd there are no integrative doctors when you were presented  
22 down there?

23 AThere is a guy down there. I've forgotten his name now. At

1           one point -- I think he's still down there, but I'm not  
2           sure -- I had very little contact --

3   QBut he has never sat down to talk with you --

4   A.No.

5   Q-- or any other integrative doctors about alternative  
6        treatments, have you?

7   A.No.

8   QAs I gather, you're a medical hematologist and oncologist?

9        Did I say it right?

10   AThat's correct.

11   QAnd as a rule you don't treat cervical cancer?

12   A.No, we do, but what will happen is most GYN oncologists don't  
13        give chemotherapy, some do, but typically treatment is  
14        sending them to -- ask the medical oncologist to give the  
15        chemotherapy. But when I treat, it's always in  
16        conjunction with a GYN oncologist and the radiation  
17        oncologist.

18   QSo you always have somebody else and you do the chemotherapy,  
19        is that what it is?

20   AThat would be correct, yeah.

21   QThat's basically what you do, you do chemotherapy on cancer  
22        patients. Is that a fair statement?

23   AWell, in cancer patients, but I also do a lot of hematology.

1           Of course, it's not --  
2 QWe'll talk about it in just a minute.  
3           How may -- how frequently do you treat ovarian cancer?  
4 AWell, I probably see a half a dozen or a dozen cases a year.  
5 QAnd how about adrenal cancer?  
6 AThey're uncommon and I probably treated a half a dozen in the  
7           last ten years.  
8 QSo you don't see many as a rule, correct?  
9 ANo, nobody does. It's a very uncommon tumor.  
10 QIn taking your deposition you talked a lot about you use  
11           chemotherapy, but don't you use many experimental drugs?  
12           Is that correct?  
13 ANo, when a patient needs experimental drugs, I typically refer  
14           them to Duke.  
15 QOkay. And you don't use radiation, you send those people out?  
16 ARight. I'm not a radiation oncologist.  
17 QSo basically what you do is you either diagnose cancer and  
18           treat it with chemotherapy in your office and you do some  
19           hematology work as well?  
20 AThat's correct.  
21 QOkay. Talking about the cost of medical treatment, I believe  
22           you said it's about \$5 million a year that goes through  
23           your office; is that correct?

1 AYeah, that being overhead plus wholesale costs.

2 QOkay. And then you add to that your labor or whatever you  
3 charge seeing people?

4 ARight.

5 QHow many people would you see a year, Doctor, 300 maybe?

6 AAre you referring to new patients?

7 QWell, let's talk about it. How many -- what's your patient  
8 inventory? If I walked in today how many new patients  
9 and old patients would you see?

10 AI'm not sure I -- you mean, per day, per year, per month?

11 QPer day, per month, per year.

12 AI see roughly 300 new consults a year.

13 QAnd so you have \$5 million worth of drug costs that goes through  
14 that office, plus whatever labor costs you have, plus  
15 whatever the value of your services are; is that correct?

16 AThat would be correct.

17 QSo cancer treatment is a very expensive thing in its own right,  
18 am I right? That's a fair statement?

19 AThat's very fair and they're going up. If you care about this,  
20 my drug costs in 1998, the same office, the same set up,  
21 \$750,000 a year; in 2007 it hit a \$4.9 million. To give  
22 an example of the rate of inflation in cancer care, that's  
23 correct.

1 QAnd is that at the Sanford office or -- where is the other  
2 doctor? Does she practice there?

3 AShe practices in my office in Sanford.

4 QAnd in -- and where? You said she practices where?

5 AIn my office in Sanford. She also has a research lab at UNC.

6 QI beg your pardon. When did she come with you, recently?

7 AShe's been -- I'm going to say since 2003.

8 QYou had one doctor recently leave you; is that right?

9 ANo. I worked for a while with Dr. Mark Graham in Cary and  
10 the three of us ran two offices, but I ended that  
11 relationship I'm going to say two years ago.

12 QOkay, I'm sorry. So the two doctors -- I believe you said  
13 you were getting 1099s out the ying-yang and that means  
14 it's very expensive to treat cancer.

15 AIt's very expensive.

16 QAnd I read where there's maybe 240 different cancers. Have  
17 you read that?

18 AThere's over 2,000 in the textbook about cancer and oncology.

19 QAnd they'll changing annually. They're --

20 AWell, they keep subdividing is the problem, so there's no such  
21 thing as breast cancer any more, there's breast cancer,  
22 basal B, basal A, Interleukin-2 negative. I mean, they  
23 keep subdividing and subdividing and subdividing those

1 tumors as we get more molecular information.

2 QSo you don't know how much it cost you to do one treatment  
3 of chemotherapy?

4 AOh, it would really depend on the drugs. Some drugs are dirt  
5 cheap. 588 is one that's from anywhere from a dollar.  
6 Interleukin is \$5,000 or \$6,000.

7 QWell, if a patient has ovarian cancer and you were going to  
8 treat them with chemotherapy, what would it cost and how  
9 many times a week might you give that person some type  
10 of chemotherapy?

11 AWell, currently Platinol Taxol is a typical standard. Those  
12 drugs are now in generics, they're not that expensive any  
13 more. I don't know of the exact cost. I can take a stab  
14 and say one treatment is probably around to \$500 to \$1,000  
15 and you have that every three or four weeks. So roughly --  
16 I'm going to take a stab and say \$1,000 a month or less.

17 QOkay. But you didn't examine Dr. Buttar's financial records  
18 about these costs, did you?

19 ANo, I didn't.

20 QAnd I assume that you don't have any idea about the relative  
21 costs that he's charted other than you saying that the  
22 services had no value. Is that your testimony?

23 AIt appears so, yes. Not only does it have no value, you're

1 taking 40 hours a week of their time.

2 QWell, how many -- if an ovarian cancer patient had ovarian  
3 cancer or if another person had to have some type of  
4 intravenous treatment, might they sit in your office seven,  
5 eight hours at a time per day?

6 ANo. The longest treatment I would give -- the absolute longest  
7 is tox scan and that's once a month and that could take  
8 six hours. A typical carboplatin Toxol, you can do in  
9 two and a half to three hours and it's once a month, not  
10 every day.

11 QI believe you said 33 percent of your current patients are  
12 hematologic cancer patients; is that correct?

13 AProbably, it's a guess, but probably.

14 QAnd you were talking about the use of experimental drugs, that  
15 you didn't believe in them. There are some you said that  
16 was being used by different people and I believe you said  
17 today there were a lot of experimental drugs being approved  
18 and some of them are used even if they're not FDA approved;  
19 is that correct?

20 ANo, I don't think that's correct. I don't think I ever said  
21 that.

22 QWell, did you say that we know that the FDA is going to approve  
23 it and they'll going on to administer them? Do you

1 remember that?

2 ANo, I don't remember that, but I cannot get a non-FDA approved  
3 drug.

4 QWell, I believe you said you send people up to Duke and they're  
5 doing experimental, of course that's a controlled  
6 environment, but they're doing it even though they may  
7 not be FDA approved.

8 AThose are clinical trials in a process I just described that's  
9 under FDA supervision.

10 QOkay. Have you had any training or experience with  
11 complimentary alternative medicines?

12 AOnly the ones I mentioned shark cartilage and -- (inaudible).

13 QCan you define for me what C-A-M or CAM is?

14 ANo, I cannot.

15 QSo you don't have anybody that's doing the conventional and  
16 alternative medicine simultaneously, nor have you read  
17 about it or seen it occur? Is that fair?

18 AThat would be fair.

19 QNow, the question is, how sick are the people after they have  
20 been in your office anywhere from three to six hours?

21 AWell, some days they really don't get very sick. It's kind  
22 of surprising. About 36 months ago they came out with  
23 two drugs and since they have come out, the nausea and



1 vomiting have almost disappeared. I'd say vomiting with  
2 chemotherapy is only 10 percent now.

3 QOkay. So that's improved some?

4 AIt's improved dramatically. And for instance, the drug  
5 Cisplatin, I just quit using it, it was so -- the vomiting  
6 was so bad we made them switch from Cisplatin. Well, it  
7 came out with new drugs, we've been able to go back to  
8 Cisplatin with minimal toxins.

9 QNow, you say that the integrative concepts of medical drugs  
10 or the alternatives, you can use CAM, didn't provide much  
11 beneficial effect and sometimes that's true of  
12 chemotherapy, isn't it?

13 AIt is true, but we can tell you we have clinical trials that  
14 show there is a proven clinical benefit. We can tell you  
15 what the percent response rate is and the percent of  
16 non-response rate. And in addition, you get two doses  
17 of reassessments not responding and quit, we just don't  
18 keep pouring it in.

19 QOkay. And then you talked about the alternatives like PCSPES  
20 for prostate cancer. You do know about that?

21 AYes.

22 QOkay.

23 AI want to believe that name was changed recently.

1 QThe question was asked you by Ms. Godfrey, do you know what  
2 integrative medicine is and your answer was you did not  
3 know. Is that correct?

4 AI think she asked me to define integrative medicine, but,  
5 anyway, it's -- no, I don't know exactly.

6 QAnd you don't really know what the definition is?

7 ANo, I do not.

8 QDid you hear me read the statute this morning?

9 AYeah, I did.

10 QIs that the first time you had ever seen that or heard it?

11 AI think unless you read -- I think you read it to me during  
12 the deposition.

13 QAnd not to be redundant, but you've never read about integrative  
14 practice?

15 ANo, that's not true. It's in our journals. I mean, they have  
16 articles like I said in the Journal of Oncology book,  
17 there's a whole section on alternative therapy and I read  
18 that.

19 QLet me ask you this question, the question was put to you by  
20 Mrs. Godfrey. Do you know anything about the standard  
21 of care for an integrative medicine doctor and you answered  
22 with no. That's correct?

23 AThat's correct.

1 QAnd you don't profess to offer an opinion about what the  
2 standard of care for an integrative doctors is; is that  
3 true?

4 AYes, it is.

5 QThere are some Phase I vaccines that's been tried by people  
6 as alternatives, correct?

7 AA Phase -- you're speaking of a Phase I trial?

8 QYes.

9 AThat I would not call an alternative under a Phase I trial.

10 QWell, vaccines on the Phase I patients or in Phase I of  
11 therapy --

12 MS. GODFREY: To increase their immune system.

13 Q-- to increase their immune system?

14 AI don't think that's alternative medicine at all. I think  
15 that is standard medicine. I mean, you're trying to use  
16 vaccines to fight cancer for probably 50 years. The most  
17 successful to date has been Interleukin-2. I think we  
18 went into this in deposition that Interleukin-2 is in fact  
19 an FDA approved drug and used in therapy to fight both  
20 renal cell and melanoma and some carcinomas. It's not  
21 terribly effective, but it does have about a 10 percent  
22 response rate.

23 QBut it's given to help the person's immune system?

1 AYes, but it's not an alternative therapy. It's standard  
2 medical therapy.

3 QI guess we can argue about that. My -- my question is, they  
4 give the vaccine to strengthen the person's immune system  
5 so they can help fight the cancer. Is that fair?

6 ANo, it's not fair. When you give the immune therapies that  
7 have been proven to work in clinical trials because we've  
8 shown that they treat the cancer and we document it with  
9 CAT scans.

10 QSo it's your testimony that the vaccines that you use attack  
11 the cancer and do nothing to the immune system or does  
12 it do both?

13 AIt does not do both. The immune system Interleukin-2 --  
14 (inaudible) -- and vaccines are an attempt to stimulate  
15 the immune system to react -- (inaudible). For instance  
16 -- (inaudible) -- spent 30 years on Melanoma vaccine and  
17 never could get one that works, but he tried and tried  
18 and tried. He's retired now.

19 And they continue to do that and there are trials out there  
20 trying to use antigens to stimulate the immune system to  
21 get the body's own immune system to fight the cancer.

22 So far other than Interleukin-2 and -- (inaudible) --

23 Interferon and -- (inaudible) -- and critics out there

1 even try success -- (inaudible).

2 QInterleukin-2 is that given to boost the immune system after  
3 chemotherapy?

4 ANo. It's given to bring the white cells back up after  
5 chemotherapy and it has no anti-cancer effect and it's  
6 never had an anti-cancer effect.

7 QI understand that. But if my white cells go to 10,000 or  
8 15,000, my immune system is ineffective. If somebody  
9 gives me this particular drug to bring my white count back  
10 down, it would probably have to be pretty sick if that  
11 were to happen. The idea is to get my total system in  
12 better condition, isn't it?

13 ANo, it's not.

14 QSo if my white cells go to 15,000 -- and I'm not a doctor --  
15 but if they go to 15,000 and I get Interleukin, that's  
16 going to attack the cancer?

17 ANo.

18 QIt's going to help the immune system?

19 ANo. All that a patient does it's called granulate --  
20 (inaudible) -- immune factor. It does one thing and one  
21 thing only. It brings up the -- (inaudible). It doesn't  
22 do anything to hemoglobin, it doesn't do anything to T-cell  
23 -- (inaudible) -- to bring the white cells up which tends

1 to reduce the incidence of the -- neutra -- (inaudible).  
2 It does not -- (inaudible) --to your immune system.  
3 QWell, let me read what you said. You said, the only two drugs  
4 that have been shown to work in melanoma is -- (inaudible)  
5 -- and Interleukin. Chemotherapy is almost worthless.  
6 Okay.  
7 AWhat was that? I couldn't -- was that about adrenal cell cancer  
8 -- and what was it? I couldn't hear the first part of  
9 what you said.  
10 QI'm sorry. The only two drugs that have been shown to work  
11 in melanoma --  
12 ARight.  
13 Q -- are the Interferon and Interleukin and chemotherapy you  
14 said was almost worthless.  
15 But the next question was, but the mechanism of those  
16 treatments is to boost the immune system of the patient  
17 with melanoma. And you said, that's the idea, yeah.  
18 AYeah. Well, the idea is to -- you're trying to turn this into  
19 an alternative medicine therapy. It isn't to boost the  
20 immune system, it's to trigger the immune system to react  
21 to the cancer cells.  
22 QI'm not trying to turn it any way, I'm just reading you what  
23 you said. Did you say that, yes or no?

1 MR. JIMISON: Well, objection. At some point I think if  
2 he's going to quote Dr. Peterson's deposition perhaps we  
3 should all be following along and give Dr. Peterson a copy  
4 of his deposition to see exactly what he said.  
5 MR. KNOX: Well --  
6 MS. GODFREY: It's in the -- it's in the book.  
7 MR. JIMISON: I know, but if you could turn to us and guide  
8 us to the page you're reading from --  
9 MR. KNOX: It's on page 18, Doctor.  
10 MR. JIMISON: What exhibit?  
11 MR. KNOX: Of his deposition.  
12 MS. GODFREY: Dr. Peterson's deposition is our Exhibit  
13 Number -- it's number --  
14 MR. JIMISON: Actually it is 15 in our notebook.  
15 MS. GODFREY: 51.  
16 MR. JIMISON: Actually, let me ask you to go to --15 of  
17 in the thin notebook and they can turn to page -- turn  
18 to page 18 and there are quarter pages.  
19 WITNESS: And there's all kinds of numbers and books.  
20 It's very confusing.  
21 MR. JIMISON: So you want to look at the top right-hand  
22 corner.  
23 WITNESS: Yeah.

1 MR. JIMISON: And then you want to go to page 18.  
2 WITNESS: Is page 6 on the transcript. Okay?  
3 MS. GODFREY: Yes.  
4 WITNESS: All right. Yeah, I'm with you all.  
5 MR. JIMISON: Okay.  
6 Q(By Mr. Jimison) So under line 10, okay. But the mechanism  
7 of those treatments is to boost the immune system of the  
8 patient with melanoma? And your answer was --  
9 AYeah, that's the idea. But I didn't make the statement, Mr.  
10 Knox, you did, I just responded to the question. I wasn't  
11 -- (inaudible).  
12 QWell, do you think --  
13 PRESIDENT RHYNE: Pardon me. Can you tell me again where  
14 you were in the transcript?  
15 MR. KNOX: I'm on page --  
16 MS. GODFREY: 18.  
17 MR. KNOX: -- 18.  
18 PRESIDENT RHYNE: And is that in your book or in --  
19 MR. KNOX: It's in the thin book.  
20 PRESIDENT RHYNE: It's in your book or Marcus'?  
21 MS. GODFREY: It's in both. It's --  
22 PRESIDENT RHYNE: In both.  
23 MS. GODFREY: Yeah, 51 in our book.



1           PRESIDENT RHYNE:  Okay.

2           MS. GODFREY:  And there's page 18.

3   Q(By Mr. Knox)  And then in the very next line, line 21:  (sic)

4           So taking the vaccine is intended to do what?  And what

5           did you say?

6   AThat's not what I said.

7   QDo you see the answer on page 21.

8   AOn page 21.

9   QI'm sorry, line 22.  I'm going too fast.

10          MR. JIMISON:  Page 21?

11   AI hope he's taking Megace to stimulate their appetite.

12          What cancer are we talking about here?

13          MR. JIMISON:  Colon.

14   AColon cancer vaccine trial.

15   QYes.  And you said that was done to boost immune systems.

16   AYeah, that was probably a poor choice of words.  The more

17          specific would be to prevent colon cancer antigens the

18          immune effective cells hoping that they will trigger the

19          immune system to react to the colon cancer -- (inaudible)

20          -- added on to the vaccine.

21   QNow, I believe you said the National Institute of Health has

22          printed that there are thousands of trials out there of

23          things to do to build up their immune system for cancer

1 patients; is that true?

2 AI don't think I said thousands. There's thousands of trial,  
3 but they're not all for the immune systems. Some are for  
4 chemotherapy, some are for antibodies, some are for  
5 pharmaco-biologic targeted therapies, some are anti --  
6 (inaudible) -- trying to attach mutations. I don't recall  
7 saying there were thousands of --

8 QWell, go to page 23, line 2. Are you with me?

9 AYeah, there's thousands of trials out there.

10 QMay I ask the question, please?

11 ASure.

12 QCan you think of any other cancers where there are studies  
13 that you aware of that are treating it to boost their  
14 patient's immune system. And what did you say?

15 AIf you look at the web site at the National Institute -- the  
16 NIH, there's thousands of trials out there. I'm sure,  
17 if I looked, there will be all kinds of immune trials out  
18 there, but they're all Phase I and none of them are  
19 successful. But I did not say there's thousands of new  
20 trials. It says there's thousands of trial out there.  
21 Period.

22 QOkay.

23 AAnd I want to be clear about that. I did not say that.

1 QBut you said people are still trying it and you said sure,  
2 correct?

3 AAbsolutely they're trying it, but -- but I don't get to do  
4 that in my office. That gets done in a setting, a  
5 controlled trial where they are collecting data and some  
6 of the patients get -- where they are looking for toxicity  
7 and efficacy and it's monitored and it's in a randomized  
8 fashion so we can tell if it's actual fact.

9 That's not the same as me just making up a vaccine in my  
10 backyard and giving it to patients because, oh, I think  
11 it'll help your immune system.

12 MR. KNOX: Well, objection, being unresponsive.

13 MR. JIMISON: I think it was quite responsive.

14 MR. KNOX: Well, I made an objection to the doctor.

15 PRESIDENT RHYNE: Your objection --

16 MR. KNOX: My objection that that was not a responsive  
17 answer, but a voluntary speech.

18 MR. JIMISON: It's his question. The witness is more  
19 than -- more than entitled to explain his answer on  
20 cross-examination. There -- I mean, he's entitled to  
21 explain his answer.

22 PRESIDENT RHYNE: You can ask then, perhaps when you  
23 cross-examine, you should give him an opportunity to

1 explain.

2 Q(By Mr. Knox) Then on page -- page 21 again at the top you  
3 look at it starting at line 10 and you said that they're  
4 trying to use the immune system all the time. I just --  
5 somebody I sent to Duke for a vaccine for colon cancer,  
6 but as a trial, correct?

7 AThat is correct.

8 QThat's -- the idea is to treat the immune system.

9 ANo, again, you keep trying to say that. I don't know how many  
10 times I have to go over this. No, it does not say treat  
11 the immune system. That sentence does not say treat the  
12 immune system.

13 It says use of the vaccine to treat the cancer and the  
14 vaccine is not to change or boost the immune system. It's  
15 to trigger an immunologic response to specific colon cancer  
16 patient.

17 QYou may be right, but go to line 22. See that? So taking  
18 the vaccine is intended to do what? And you said -- read  
19 it.

20 AWe hope it will boost the immune system to fight the cancer,  
21 but it wasn't -- that answer was not given in context that  
22 you're asking me now. It is -- you're trying to imply  
23 that these vaccines sometimes --

1 QI want --

2 A-- sometimes make your immune -- you asked a question, I'm  
3 going to answer it.

4 MR. KNOX: Well, I object to your speaking. Answer the  
5 question.

6 PRESIDENT RHYNE: Just answer the question.

7 AThe answer is the vaccines are not to boost the immune system.

8 The immune system is already very functional. The idea  
9 is to see if you can trigger an immunological response  
10 to specific cancer antigens. It is not the same thing  
11 as saying boost the immune system.

12 QDoes chemotherapy decrease the immune system?

13 AThe majority of it does, yes. Some of the biologic there just  
14 do not, but some of the -- (inaudible) -- antibodies do  
15 not.

16 QAnd there are times when you give people certain minerals and  
17 vitamins to help them with -- to build back up their immune  
18 system?

19 ANo.

20 QYou don't do that at all?

21 ANo.

22 QOkay. You don't give anybody vitamin C even if it shows that  
23 their vitamin C is low when you treat a cancer patient?

1 AI've never seen a low vitamin C level, and if I did, I'm sure  
2 I'd give it to them. But, again, it wouldn't be to boost  
3 their immune system, it would be to treat vitamin C  
4 deficiency which is not the same as an immune depression.

5 QLet's move forward. You said when asked about Dr. Buttar's  
6 treatments that they were below the standard of care.  
7 Yet, you told Mrs. Godfrey you didn't know what an IRR  
8 was, did you?

9 AI'd never heard that acronym.

10 QAnd you didn't know whether he had actually seen any one of  
11 these cancer patients and had injected them with IRR or  
12 another procedure?

13 AI didn't understand that question.

14 QYou didn't know that he had seen or had done a procedure on  
15 all three of these cancer patients?

16 ANo, I didn't see it in the records, so I didn't know about  
17 that. I did not know.

18 QYou have used an ET -- EDTA as a chelated agent for chronic  
19 lead toxicity, haven't you?

20 AYes, I have.

21 QAnd you still do that, correct?

22 AYes. And that's standard medical therapy.

23 QAnd that's used in conventional medicine?

1 AThat's correct, yes. But, of course, for a specific diagnosis.  
2 QYou did not know what EMPS was, did you?  
3 ANo.  
4 QBut yet you said it was below the standard of care to use it,  
5 didn't you?  
6 AThat's correct.  
7 QNever heard of it before, right?  
8 AThat's correct.  
9 QOne of the things you read out there when the lawyer asked  
10 you the question about the other procedures and drugs used,  
11 GHS -- GSH, an antioxidant, you didn't know what that was  
12 either, did you?  
13 AYou know, I know from the deposition, I believe it's glutathione  
14 something along -- I can't remember but that is back with  
15 my biochemistry days. If I remember right --  
16 QBut you had -- I'm sorry, are you through?  
17 AI didn't recognize the acronym, but it's glutathione.  
18 QBut you had no problem to say it's below the standard of care  
19 because the doctor used it, am I right?  
20 AThat's absolutely right because it -- it is not a therapy for  
21 any cancer. I don't have to -- there's lots of -- there's  
22 tons of chemicals out there. I don't pretend to know all  
23 of them. There's probably, who knows, millions of

1 chemicals. I don't pretend to know what they all are,  
2 but I know the ones that are related to cancer and GSH  
3 is not one of them.

4 QBut you have heard of it being used as an antioxidant?

5 ANo.

6 QWell, go down and look at page 42, line 6. Have you ever heard  
7 it as being an antioxidant? And you said, yeah, actually  
8 I've heard that, yeah. Is that correct?

9 AI don't see it.

10 MS. GODFREY: Page 42.

11 AI guess I also heard it at one time, but I don't remember it  
12 now.

13 QDid you say that?

14 AI'm sure I did say that.

15 QAnd then over, do you believe that proper nutrition would help  
16 a person in the fight of cancer; is that correct?

17 AYes.

18 QAnd there's -- I believe you said, it's a whole section in  
19 the Journal of Clinical Oncology that talks about giving  
20 people supportive care to keep their nutrition up.

21 AIS that a statement or a question?

22 QI'm asking you.

23 AWhat was the question?



1 QYou had indicated that there were whole articles in the Journal  
2 of Medical Oncology called supportive therapy --  
3 supportive care. Do you find that supportive care is  
4 essential to cancer patients?

5 AI think it's important, yes.

6 QAnd do you give any type of minerals to anybody that -- that  
7 may be deficient that you've treated with chemotherapy?

8 AWhat do you mean by a mineral?

9 AWell, any type of minerals that you might think might build  
10 up your -- the -- the body of the system of the individual  
11 that's very sick from both the cancer and the chemotherapy?

12 ANo.

13 QOkay. You then say you believed in biofeedback; is that  
14 correct?

15 AI don't recall saying I believed in it. I said I was aware  
16 of it.

17 QWell, do you use biofeedback with your patients?

18 ANo.

19 QNot at all?

20 ANo.

21 QYou never sat down and talked to them about the stress level?

22 ASure, I do, but I don't call that biofeedback. I call that  
23 the practice of medicine.

1 QThe practice of medicine?  
2 AYes.  
3 QAs a matter of fact, you keep a couple of dogs in there to  
4 help people deal with stress, am I correct?  
5 AI do, but I don't bill for the dogs.  
6 QWell, I understand, that's good and I appreciate that. The  
7 point is you're giving intravenous injections in your  
8 office, correct?  
9 AWhat has that got to do with the dogs again?  
10 QWell, may I just finish. You're giving intravenous injections  
11 in your office you say because it takes a long time and  
12 people get stressed out and the dogs help reduce their  
13 stress; is that true?  
14 AOh, I think they probably enjoy the dogs. Does it reduce their  
15 stress? It might.  
16 QLet's go through where you -- you filled out your form, if  
17 I can find it. You filled out the form on your patients  
18 and so if you will turn to those.  
19 MS. GODFREY: They're -- they're number 8 in our book.  
20 MR. KNOX: And briefly, do you have --  
21 PRESIDENT RHYNE: Tab 8.  
22 MS. GODFREY: Tab 8 in our book.  
23 Q(By Mr. Knox) Okay. Just look at your expert sheet and just

1 on Exhibit --

2 MR. KNOX: What's that exhibit?

3 MS. GODFREY: It's our Exhibit 8.

4 Q-- our Exhibit 8. You reviewed Patient A, B and C, all cancer

5 patients, right?

6 ARight.

7 QPatient D who had -- depending on what you say, either polyps

8 or constipation or whatever that you diagnosed, correct?

9 AI didn't diagnose anything. I just reported what I saw in

10 the chart.

11 QAnd you wrote in this letter, of course, this was two hours

12 of time. Thank you, John Peterson, M.D.

13 AActually my office manager wrote that, but that's right.

14 That's right.

15 QAnd you sent that to the North Carolina Medical Board?

16 ARight.

17 QNow, Dr. Peterson, if I could, what did you understand your

18 role to be when this was sent down there?

19 AWell, they just asked me to look at some charts and see if

20 I thought the standard of care was met, so I reviewed them

21 and gave them my opinion.

22 QAnd you had no idea that you would ever be called to testify

23 at a Medical Board hearing to take somebody's privileges

1 to practice medicine, did you?  
2 ANo, I didn't at that time.  
3 QAnd had you known that, would you have spent more time?  
4 AProbably not. It wasn't that hard. I mean, most of these  
5 charts are just labs, there's very little progress notes.  
6 There's almost nothing in the way of x-ray studies to  
7 look at.  
8 QAre you telling this panel that you went through 10,000 --  
9 1,000 pages in two hours?  
10 AAAs I just said, the vast majority were just acts of labs reports.  
11 It wasn't thousands of pages of medical records. In terms  
12 of patient care records, there's -- I don't know how many  
13 there were, but there were less than 100.  
14 QAnd -- and you wrote down on Patient C -- Patient A that --  
15 did I get it right -- that the diagnosis was in the standard  
16 of practice, correct?  
17 AIt's probably -- mine aren't labeled A, B and C, so you're  
18 going to have to read them again.  
19 MS. GODFREY: She's the one who begins with a W.  
20 ACervical cancer?  
21 MS. GODFREY: Yes.  
22 QCorrect.  
23 AYeah.

1 QAnd you wrote down the maintenance of the records were within  
2 the standard, correct?

3 AThat's right.

4 QAnd -- and down at the bottom you put, no physician contact  
5 documented; is that correct?

6 AThat's was my -- I could not see it, that's correct.

7 QAnd do you know that Dr. Buttar actually did an examination  
8 on the patient?

9 AWell, he may have, but I don't have him. I have the records  
10 and the records didn't reflect it.

11 QOkay.

12 AIt doesn't mean it didn't happen. I'm just saying it wasn't  
13 in the records.

14 QNor did you learn that he had done the three IRR procedures  
15 on the patient?

16 AAgain, I only had the records. If it's not documented in the  
17 records, it's not possible for me to know that.

18 QDo you know if these records were written in a different  
19 handwriting from the nurse assistant?

20 AI can't remember, I'd have to look at the records.

21 QAll right. Let's go to the next one. Patient -- Patient B.

22 MS. GODFREY: 51-year-old with ovarian cancer.

23 QAll right. You got that?

1 AYeah, I've got that.

2 QAnd you indicated that he made a diagnosis within the standard  
3 of care, correct?

4 AYeah.

5 QBut you found that his records were below the standard of care,  
6 correct?

7 AThat's what I marked, yeah.

8 QAnd do you know -- are you able to say whether or not Dr. Buttar  
9 actually did a physical exam and wrote the information  
10 in the chart?

11 AIt was -- my recollection on the records, I couldn't see that  
12 he did.

13 QOkay. And -- and there again you said there had been no  
14 physician contact with the patient --

15 ANot that --

16 Q-- documented. I'm sorry.

17 ARight, documented. You know, all I can say is what I saw in  
18 the records. I didn't see it in the records.

19 QWell, would it affect your opinion in any way to know that  
20 he spent time with this patient on more than one occasion  
21 and he did an exam, that he did the three IRR --

22 MR. JIMISON: Objection, it's assuming facts not in  
23 evidence.

1 AYeah, I have no idea if any of those things happened.

2 QWell, if it -- if he had seen her that many times, would that  
3 affect your decision?

4 AWell, it would depend on what he did. I mean, there's no  
5 documentation. I mean, he could have had a phone  
6 conversation in the hallway and called that a physician  
7 visit.

8 QSo you don't know whether he did touch the patient, talk to  
9 the patient or called from the hallway, is that what --

10 AWhat I know is what was in the record. And I didn't see any  
11 history and physical performed by Dr. Buttar in the record.

12 QWell, the way you describe this, the standard of care in each  
13 one of these cases is just to refer the patient down to  
14 hospice without any care, give them some pain medicine;  
15 isn't that correct?

16 AWell, I think you're -- it's not exactly what I said. What  
17 I said was at this point, this patient has two choices.  
18 One is that of hospice for care.

19 Two is going for experimental therapies, Phase I trials,  
20 if she so chose and could do so. Most of the patients  
21 opt not to at this point because the efficacy of Phase  
22 I trials is so poor and when you're this far down and you're  
23 this sick, it usually doesn't do any good. Most patients

1 elect to go to hospice instead.

2 QThey can't do Phase I trials without a protocol, can they?

3 AWell, if they can go -- we've got universities and in Charlotte,  
4 they've got very sophisticated oncology care down there.

5 There's clinical trials in the private practices in  
6 Charlotte.

7 QBut they don't fit into the precise setting that were mentioned  
8 to be treated, do they?

9 AI don't know, it depends on trials that are open.

10 QWell, there are some trials -- you indicated that there was  
11 a couple of patients. You had one from Chapel Hill and  
12 one from Duke that went through their protocols and they  
13 were sent out and terminated the treatment and they came  
14 down to you and you elected to treat them further, didn't  
15 you?

16 AThat's correct because they were still responsive to standard  
17 chemotherapy.

18 MS. GODFREY: Did he try to treat them with experimental --

19 QDid you treat them with experimental drugs or --

20 ANo, I treated them with standard chemotherapy.

21 QSo I guess my question is, if Patient A had been to Indiana  
22 or something and said no further, your acknowledged  
23 standard of care would have been, said, go home, take some



1 pain medication and talk about it with hospice; is that  
2 correct?

3 AThat's what I would have advised him to do, yes.

4 QAnd so it's your decision that -- your opinion that if a patient  
5 wants to -- elected -- elect and have freedom of choice  
6 to go to a doctor of their choice to seek further treatment,  
7 that's below the standard of care for a doctor to treat  
8 them; is that correct?

9 AIt is below the standard of care to do ineffective therapy.

10 These are emotionally, desperate, scared patients and  
11 taking advantage of them under the libertarian argument  
12 that it's a free country and aiding them into this is bogus.

13 We're not talking about the patient's side, we're talking  
14 about the doctors side.

15 QWell, didn't you say that if a patient wanted to go for further  
16 treatment, it was up to them and their freedom of choice?

17 AIt's up to the patient, that's right, but not my freedom of  
18 choice as a physician if I would start giving bogus  
19 treatments. I don't have the right to do that. The  
20 patients can do whatever they chose. I cannot do whatever  
21 I chose.

22 QWell, who do you think brought these patients down to see Dr.  
23 Buttar other than themselves?

1 AI understand what the patient did. It's not what the patient  
2 did. We're talking about what the doctor did.

3 And once again, I am not free to do whatever I want in  
4 my office. I'm a regulated entity of the State of North  
5 Carolina and I cannot give ineffective therapy just because  
6 the patient wants it. Your argument would be you go to  
7 thoracics --

8 QI'm not interested in my argument.

9 AYou asked the question, I think I can answer this.

10 MR. JIMISON: Just a moment.

11 PRESIDENT RHYNE: Oh, you can answer.

12 MR. KNOX: I mean, I'm sorry if he's offended, but --

13 ABut you're not listening to me. I got to tell you, this is  
14 going to drive me nuts. There we go, it's working.

15 (Referencing microphone)

16 You cannot walk in a thoracic surgeon's office and demand  
17 open heart surgery just because you want it. That surgeon  
18 cannot perform surgery unless it's effective. And he  
19 cannot go to coronary and get a completely unnecessary  
20 procedure because the patient wanted it.

21 QIf I walk in after I've been through analysis, I have major  
22 heart problems, I'm going to die in 30 days, you mean to  
23 tell me I can't go to a medical doctor and say, Doctor,

1 is there something you can give me that will help --  
2 AAbsolutely. But what I'm trying to point out and if I can  
3 is what he gave him didn't help them and there's no evidence  
4 that it will. If he had something to help them with, that's  
5 fine.

6 QAnd you don't know what it is, do you?

7 AI know it doesn't work. And there's -- and here's how we know.  
8 It's not my job to prove it doesn't work, it's his job  
9 to prove that it does. First, you have to prove it's  
10 effective before you can give it.

11 QI think it's the Board's job to prove it.

12 ANo, it's not the Board's job. It's the FDA's job to prove  
13 it.

14 QLet's go to the next one. These people that you've treated  
15 from Duke and Carolina have been through their protocol,  
16 right? And they -- they failed for some reason or their  
17 protocol didn't match?

18 AI'm not -- what are you talking about?

19 QI thought you said you had saved somebody that was sent away  
20 from one of the hospitals that didn't meet their protocol.

21 ANo, that's not what I said. What I had was -- I've had patients  
22 that were -- this is most interesting.

23 This was a patient with metastatic ovarian cancer who had

1           been treated by the oncology service at UNC. And Dr. Van  
2           Lee called me and said, you know, we've tried three  
3           different regimens, she's progressed to -- (inaudible)  
4           and we want to send her to you, we don't think there's  
5           much else we can do.

6           And when I got all the records and proceeded to look through  
7           it, it was quite clear to me that she actually had very  
8           obviously chemo responsive disease. Part of the reason  
9           being she was a GYN oncologist and she's not a medical  
10          oncologist.

11          And all I did was go back to the first treatment she used  
12          carbo/Taxol which is really quite responsive and she lived  
13          another seven and a half years and worked full-time for  
14          seven out of those seven and a half years.

15          QSo your treatment saved her life at least some period of time?

16          AIt prolonged it, but I gave, once again, standard chemotherapy  
17          that was with FDA approved drugs.

18          QAnd that was after they told her that it was over and it was  
19          over for her, didn't they?

20          AWell, they were a research institution and they really aren't  
21          interested in treating chronically ill patients for years  
22          and years. Once they've done what they can do, it's not  
23          unusual for them to refer them out to a private practitioner

1 for ongoing care. They're really not in the business to  
2 do what I do.

3 QOkay. Let's go to the last patient, Patient D. And I think  
4 we can move through this. Patient D. I believe you  
5 indicated that the doctor had treated this patient with  
6 chelation therapy for constipation; is that what -- that's  
7 what you wrote on your sheet, isn't it?

8 AYeah, and I got that from the -- from the -- from the record.

9 That was what I understood from the records that were  
10 given to me.

11 QOkay. It says, 46-year-old female with constipation and  
12 essentially --

13 AColonoscopy.

14 Q-- other than polyp was treated by Dr. Buttar for EDTA chelation  
15 for heavy metals and constipation.

16 ARight.

17 QYou ever heard of that in your life?

18 ANo.

19 QAnd you know now that that's incorrect?

20 AWell, I'm not sure. I couldn't tell from the record what they  
21 were doing.

22 QHave you read Patient D's deposition where she acknowledged  
23 when she came to the doctor, she --

1 MR. JIMISON: Objection, just ask him if he read Patient  
2 D's deposition.

3 AI have not read Patient D's deposition.

4 QWell, if the testimony is that she had a prior lead drug analysis  
5 and she came to Dr. Buttar asking for treatment of the  
6 lead problem, that certainly wouldn't be consistent with  
7 treatment for constipation, would it?

8 ANo, it wouldn't.

9 QOkay. So do you think you were a little quick on that opinion?

10 ANo. I -- all I had was the records. I -- I can't do anything  
11 except what the records reflect and if that was in there,  
12 I could not find it and I didn't see any serum lead levels.

13 If you're doing EDTA chelation, you do serum lead levels  
14 to make sure it's working. I didn't see that.

15 QAnd you didn't see the test that she brought, did you?

16 ANo.

17 QOkay.

18 AI'm assuming it wasn't in the records I was given.

19 QAnd you believe it was below the standard of practice because  
20 the diagnosis was improper, didn't you?

21 ACorrect.

22 QOkay. But you said that the maintenance of the records were  
23 in the standard of care.

1 AFor the records I saw, I thought they were, yeah.

2 QAnd then you said that the doctor should have not treated her  
3 with chelation therapy; is that correct?

4 AThat's correct.

5 QNow, Doctor, as I understand it, you basically believe that  
6 the standard of care for treating any cancer are the three  
7 modalities that you use and unless that is used any other  
8 experimental drugs has to be in a controlled environment  
9 like at Duke or Chapel Hill or someplace like that; is  
10 that correct?

11 AIt doesn't have to be Duke or UNC. It has to be in a controlled  
12 clinical trial. Now, I don't do them in my office because  
13 my office is too small, but there's lots of private  
14 practices that have clinical trials. Certainly in  
15 Charlotte there's one.

16 QThere's a Dr. White in Charlotte that does that?

17 AI'm not sure which -- Richard White?

18 QI believe you said there was a Dr. White that --

19 AOh, well, I'm -- yeah, there's a Richard White in Charlotte.

20 QHave you read that the doctors at CM Hospital at Charlotte,  
21 I keep forgetting the name -- Carolina Memorial Hospital --  
22 AYes.

23 Q-- is now treating people with microwaves for tumors?

1 AOh, sure. We've been doing it at UNC and Duke, yeah, but those  
2 are only trials.

3 QBeen doing it how long?

4 AI don't know, sir. I don't do it, but I know that they do  
5 it --

6 QHow about --

7 A-- radio frequency \_\_\_\_.

8 QI'm sorry. How about with radio waves? Are you familiar with  
9 any of those procedures?

10 AWhat do you mean radio? You mean, opposed to radiation?

11 QYes, radio waves.

12 ANo, I'm not.

13 QHave you read anything about that the Harvard people says it's  
14 the most innovative thing to --

15 AOnce again, that's not approved therapy and it's going on under  
16 a trial. It's not --

17 QWell, I'm asking what you know.

18 AWhat I've read in the newspaper, that's all I know. It's not --  
19 it's not an FDA approved treatment. It may be some day.

20 QYeah. Do you agree that CA 125 is -- is a measure of cancer  
21 cell growth?

22 AIIt's a very -- it can be, but it can also grow with  
23 endometriosis. We use it when somebody has been diagnosed



1 with ovarian cancer and it might respond to treatment.  
2 QWhat's your understanding that -- what's the highest level  
3 of CA 125 that you've seen?  
4 AOh, I'm going to say over 10,000.  
5 QAnd what's the -- what's the formula for what it's supposed  
6 to be?  
7 AIt's supposed to be under 20, depending on the lab they use,  
8 but supposed to be under 30.  
9 QOkay. And -- and I take it from that that you looked at Patient  
10 D and saw that her labs went from 10,000 down to about  
11 6200? Do you remember reading that?  
12 ANo, I don't remember reading it.  
13 QSo you never saw that?  
14 AWell, I looked at these six, seven months ago. I don't remember  
15 it.  
16 QI understand. But if that were to occur, would that be an  
17 improvement?  
18 ANot necessarily. The tumor mercury can fluctuate and you can  
19 see tumor mercurys go down and CAT scans get worse is why  
20 we don't rely entirely on tumor markers. We monitor them  
21 so we put them through so many CT scans. We always follow  
22 them up with CAT scan to be certain that the tumor marker  
23 reflects what's actually going on.

1 QFinally, you have said that in your review of the records,  
2 you can see no place that Dr. Buttar had done harm to his  
3 patients.

4 AWell, not -- yeah, he's done harm. He's scheduled them in  
5 his office 40 hours a week and took thousands of dollars  
6 from dying patients for no good reason.

7 QWell, and today you said that the treatment did not provide  
8 a risk --

9 AI don't -- I don't -- well, first of all, I don't know what  
10 provides risks because these things haven't been put  
11 through clinical trials. I don't think it looks  
12 dangerous.

13 QHang on just one minute. Let's go if you would please, sir,  
14 to 77 -- no, I'm sorry, 119. Okay?

15 PRESIDENT RHYNE: Where is it on 119?

16 MS. GODFREY: In his deposition. Tab 51 to our --

17 WITNESS: Well, where's the deposition one?

18 MR. JIMISON: 15 in the thin notebook.

19 MR. KNOX: I got it.

20 AWhich page?

21 Q(By Mr. Knox) 119, line 21.

22 AOkay.

23 QWhat about physically? Do you see any evidence that they were

1           physically harmed by Dr. Buttar's treatment and what did  
2           you say?

3    AI said:  No, but, you know, I wasn't there to examine them  
4           or talk to them.  And the people doing the  documentation  
5           were the people giving the bogus treatments, so I doubt  
6           they are going to write things down that are going to make  
7           them look bad.

8    QLet's go down to the next line.  So there's nothing in your  
9           review that shows any visible harm whether they occurred  
10          or not, you don't know?

11   AThat's right.

12   QAnd I believe you said today at your earlier testimony that  
13          you didn't find any risks of the alternative treatment  
14          that he was giving these patients?

15   ANot that I'm aware of.

16   MR. KNOX:  Okay.  That's all.

17   PRESIDENT RHYNE:  Before we do -- before we redirect, let's  
18          take a break.

19   MR. JIMISON:  Oh, sure.

20   PRESIDENT RHYNE:  I think everybody would like to take  
21          say a ten-minute break and we'll convene back and 4:10  
22          and then we can continue.

23   MR. KNOX:  We might can see if he doesn't have any

1 questions --

2 MR. JIMISON: No. I have questions.

3 PRESIDENT RHYNE: Let's just take a break.

4 \_\_\_\_\_  
5 (4:00 P.M. - 4:20 P.M. RECESS)

6 \_\_\_\_\_  
7 PRESIDENT RHYNE: Okay. Are you -- thank you very much

8 on that.

9 Mr. Jimison, are you ready to go ahead and resume with  
10 redirect at this time?

11 MR. JIMISON: Sure.

12 **REDIRECT EXAMINATION BY MR. JIMISON:**

13 QDr. Peterson, I want to try to go through this very quickly.

14 I know we've gone very long.

15 AExactly.

16 QAnd the therapies that Dr. Buttar provided, the hydrogen  
17 peroxide, the ozone, are any of those therapies indicated  
18 to boost their immune system?

19 ANo.

20 QAre you aware of any clinical trials that show they have an  
21 effect on boosting the immune system?

22 ANo.

23 MR. KNOX: Objection, asked and answered earlier.

1           PRESIDENT RHYNE:  The objection is sustained.

2   Q(By Mr. Jimison)  Well, I just -- if it actually was truly  
3           asked -- you know, answered earlier about how clinical  
4           trials have an effect of boosting the immune system, I  
5           think I might have asked about cancer.  But the answer  
6           is you're not aware of any --

7   A.No.

8   QThat was your previous answer.

9           And the -- the therapies that were being offered, did you  
10          see from your review of the records whether the patients  
11          indicated that they were consenting to any research?

12   A.No.

13   QAny -- that they were consenting to experimental therapies?

14   A.No.

15   MR. KNOX:  Objection, been --

16   MR. JIMISON:  No, this was a different witness.

17   MR. KNOX:  May I just make an objection.  Give me a chance  
18          to say something.  He asked all the questions about  
19          experimental and -- and whether the patients were placed  
20          in experimental on direct.

21   MR. JIMISON:  I think these are different questions and --  
22          and I think the objections are actually more long than  
23          the questions are, so if I could just keep going.

1 PRESIDENT RHYNE: Go ahead. I think as I recall without  
2 looking at the transcript, it was about cancer and not  
3 about the immune system.

4 MR. KNOX: Okay. I'm sorry.

5 Q(By Mr. Jimison) The -- the -- is there anything in the records  
6 that show that these patients were part of -- of an  
7 experiment or research that were being supplied by an  
8 Institutional Review Board?

9 ANo.

10 QIs cancer just a symptom of a faulty immune system?

11 ANo.

12 QIf you were to hear the phrase "cancer is just a symptom",  
13 what would you take that to mean?

14 ANonsense.

15 MR. JIMISON: Okay. I have no other questions.

16 PRESIDENT RHYNE: Ms. Godfrey and Mr. Knox, do you want  
17 to redirect?

18 MR. KNOX: No, ma'am. We're through.

19 PRESIDENT RHYNE: Okay. Any Board Members have any  
20 questions?

21 **EXAMINATION BY THE PANEL MEMBERS:**

22 DR. McCULLOCH: Now at this point, Dr. Peterson, would  
23 you -- would you agree that in each of these patients,

1 traditional therapy, as you would describe chemotherapy,  
2 etcetera, had failed these patients?

3 WITNESS: Yes.

4 DR. McCULLOCH: Is it your opinion that there was any  
5 physical harm done to these patients by this other  
6 treatment at this point?

7 WITNESS: Other than 40 hours sitting in a chair, no.

8 DR. McCULLOCH: Right.

9 WITNESS: No.

10 DR. McCULLOCH: But I guess the point I'm trying to get  
11 to, would there have been any -- would they have been  
12 improved at all by staying in traditional therapy?

13 WITNESS: No.

14 DR. McCULLOCH: Okay. Thank you.

15 DR. WALKER: Are you aware of any toxicities from EDTA  
16 or from hydrogen peroxide that maybe you read in the  
17 newspaper or from any other sources?

18 WITNESS: Not hydrogen peroxide. The only problem with  
19 EDTA and I don't know how far you want me to push it, but  
20 it does, in fact, pull lead and heavy metals out of your  
21 system similar to -- (inaudible).

22 I mean for instance, we now prescribe -- (inaudible) --  
23 to prevent prostate cancer and put prostate cancer patients

1 on, so I really don't know what you are saying when you  
2 just start pulling out the metals.

3 I mean, you are supposed to have heavy metals. I mean,  
4 you're supposed to have copper and lead in your system.

5 I mean, you're not supposed to deplete them. I mean,  
6 iron deficient -- iron is a heavy metal and iron deficiency  
7 -- (inaudible), so I don't know that it's necessarily safe  
8 to deplete it.

9 PRESIDENT RHYNE: Any other questions? Thank you very  
10 much, Dr. Peterson.

11 MR. KNOX: Unless you ask one, I won't.

12 WITNESS: Okay.

13 MR. JIMISON: Thank you.

14 WITNESS: Thank you.

15 MR. JIMISON: That concludes the Board's case, Dr. Rhyne.

16 PRESIDENT RHYNE: Thank you, Mr. Jimison.

17 Mr. Knox or Ms. Godfrey, do you have any evidence that  
18 you wish to present on behalf of Dr. Buttar?

19 MS. GODFREY: We do. We need to ask the Board about your  
20 timetables. We were originally told that Mr. Jimison  
21 would be finished by about 2:00 of the afternoon of the  
22 first day and we've run over about two and a half hours.

23



1 We have doctors that are supposed to be here first thing  
2 tomorrow morning to testify as expert witnesses and then  
3 we have one doctor who is testifying via videotape as an  
4 expert witness. Her videotaped deposition is an hour and  
5 24 minutes. What we would like to do is get her in today,  
6 but we realize that would take the Board about until 6:00.  
7 PRESIDENT RHYNE: That -- that'll be fine.  
8 MS. GODFREY: Is that okay with you?  
9 PRESIDENT RHYNE: That is okay.  
10 MS. GODFREY: That would be -- now is the best time for  
11 us to sit and watch a video, I think.  
12 PRESIDENT RHYNE: Okay. Just -- just for my information,  
13 so we'll have her and then how many witnesses do you  
14 anticipate tomorrow?  
15 MS. GODFREY: We have --  
16 MR. KNOX: Let me ask you, what time are you going to start  
17 in the morning? We have one by phone at 8:30.  
18 PRESIDENT RHYNE: Well, it depends on what you tell me  
19 because we can start at 7:30 or earlier. It depends --  
20 MR. KNOX: Well --  
21 MS. GODFREY: We make -- we're doctors, we make rounds  
22 at 7:00 or 6:30, so.  
23 MR. KNOX: We have Dr. Wilson and Dr. Biddle and then of

1 course we'll have Dr. Buttar and Jane Garcia. We have --  
2 on video we have Dixon Hewitt. We hope to have a telephone  
3 conference and -- and we have another party. And one of  
4 the people is Michelle Reid who worked with Dr. Buttar  
5 and Ms. Kennedy testified about.

6 MS. GODFREY: We have some videos of patient -- patients  
7 of Dr. Buttar's that I think altogether take about a couple  
8 of hours, but we can work them in tomorrow.

9 MR. KNOX: We will have a full day.

10 PRESIDENT RHYNE: So we'll have a full day -- well, I  
11 will -- we will be happy to start at what time you would  
12 like, 7:30, 7:00, whatever.

13 MS. GODFREY: Whatever time you want to start.

14 PRESIDENT RHYNE: How long do you think it will take you  
15 to get through your --

16 MR. KNOX: I don't know, but I would, like you, want to  
17 get back and so the earlier the better for me because I  
18 go about 6:30 every morning, they think I'm a doctor, so.

19 PRESIDENT RHYNE: That's fine. How about -- does anybody  
20 have any conflict. Barbie, do you have any problems  
21 starting say at 7:00? We'll start at 7:00 sharp.

22 COURT REPORTER: I'm at your pleasure.

23 MR. KNOX: Maybe 7:30. I mean, I'll do whatever you say,

1 but --

2 MS. GODFREY: 7:00 a.m.

3 PRESIDENT RHYNE: Let's start at 7:00.

4 MS. GODFREY: We can play videos.

5 MR. KNOX: That's fine. We'll put videos on if we don't

6 have the doctors.

7 DR. WALKER: Oh, but you can't put the videos on and go

8 to sleep now.

9 MS. GODFREY: No. Actually -- actually, our docs will

10 be here because I believe they're coming in tonight and

11 they'll spending the night, so they would be more than

12 happy to get -- get in and out, I'll bet.

13 PRESIDENT RHYNE: Okay. So we'll start at 7:00 then.

14 MR. KNOX: Okay.

15 PRESIDENT RHYNE: Okay. You want to proceed then?

16 MR. KNOX: Your Honor, we're calling Dr. Ripoll by video

17 conferencing. This is his deposition and we have agreed

18 that she can be sworn by the court reporter in Charlotte

19 and the transcript would be used at this hearing. Correct?

20 MS. GODFREY: And her CV is in our exhibits at -- at 31,

21 I believe. And I think the only other exhibit that we

22 used in her video deposition was Dr. Peterson's notes that

23 I think they're already familiar with and I think that's

1 Exhibit 8.

2 Didn't we use that? Oh, you weren't there, okay.

3 I think those are the two, but I do identify them by number  
4 during the video deposition, so if you'll just grab our  
5 book, then --

6 PRESIDENT RHYNE: Okay.

7 MS. GODFREY: -- that's the easiest way.

8 PRESIDENT RHYNE: Okay. Do you need help with -- are you  
9 ready?

10 MS. GODFREY: We're ready, I guess.

11 The transcript of this deposition is also in your exhibit  
12 book at Number 48.

13 PRESIDENT RHYNE: I'm sorry, number 40?

14 MS. GODFREY: 48.

15 PRESIDENT RHYNE: Thank you.

16 -----

17 (WHEREUPON, THE VIDEOTAPE DEPOSITION  
18 OF EMILIA RIPOLL, M.D. TAKEN ON APRIL 21, 2008,  
19 WAS PLAYED AND IS HEREBY ATTACHED  
20 IN ITS ENTIRETY AS EXHIBIT 48)

21 -----

22 PRESIDENT RHYNE: Can somebody turn on the lights? Okay.

23 Do you have anything more to add? Are you ready to --

1 MR. KNOX: I have a gentleman here who can testify and  
2 it might take ten minutes or so.

3 PRESIDENT RHYNE: Okay.

4 MR. KNOX: Let's go get Mr. Hewitt.

5 \_\_\_\_\_

6 WHEREUPON,

7 RICHARD DIXON HEWITT,  
8 being first duly sworn,  
9 was examined and testified  
10 as follows:

11 \_\_\_\_\_

12 **DIRECT EXAMINATION BY MR. KNOX:**

13 QWould you tell the Panel your name please, sir?

14 ARichard Dixon Hewitt.

15 QAnd, Mr. Hewitt, where do you live?

16 AAnderson, South Carolina.

17 QAnd who lives with you?

18 AMy wife, Deana, three children, a boy, boy, girl; 12, 10 and  
19 5.

20 QOkay. And what do you do?

21 AI'm a human resources director for Clareton Mills, a towel  
22 manufacturer in Delta in South Carolina.

23 QAnd how long have you been with them?

1 AAabout 17 years.

2 QAnd is your wife employed outside the home?

3 AShe is. She is a physical therapist.

4 QNow, you've had the occasion to take one of your children up  
5 to see Dr. Buttar, correct?

6 AThat's correct.

7 QAnd what's that child's name?

8 AHunter.

9 QAnd how old is Hunter?

10 AHe will be 13 next month.

11 QAnd tell the Board just a little bit about Hunter and how he  
12 did prior to going to see Dr. Buttar.

13 AAat the age of two and a half, three, Hunter was diagnosed and  
14 given a label of autism. And we bounced around from  
15 physician to physician, doctor to doctor, and he -- like  
16 I say, he's about 13, next month, and he's -- he's come  
17 along way.

18 He -- you know, he was taken out of preschool because he  
19 was not verbal and -- and -- and would strike out and would  
20 possibly create a danger to himself and others, so you  
21 know now he's, at times, in a regular education classroom,  
22 so.

23 QYeah. Was he diagnosed by a family doctor -- a family practice

1 doctor that he was autistic?

2 AHe was. He was diagnosed by our family pediatrician, Dr. Keith  
3 Hart.

4 QAnd did he have certain lead toxicity tests before he went  
5 to see Dr. Buttar?

6 ANo, sir.

7 QAnd went you went up to see Dr. Buttar, did you see Dr. Buttar?

8 AI saw -- my wife and I, our original appointment was with Dr.  
9 Buttar.

10 QOkay. And tell this Panel what kind of doctor he was and how  
11 much time he spent with you?

12 ADr. Buttar in the first visit spent, I'm guessing, an hour  
13 to an hour and a half that first visit.

14 QOkay. And did he explain to you whether or not he could cure  
15 autism or whether he could help Hunter or what did he tell  
16 you?

17 ADr. Buttar felt like there was -- there was a possibility --  
18 a very strong possibility Hunter -- Hunter had a toxicity  
19 issue and if that was the issue, that there was some help  
20 for him. And he outlined his treatment plan, what that  
21 would consist of. There was not any guarantee made.  
22 He did feel as though that if the toxicity wasn't even  
23 an issue, he felt very strongly we could help him. And

1 so it made sense to -- all of our research and -- and it  
2 made sense for us to try that treatment and therapy.

3 QAnd I'm trying to move along. Will you explain the policy  
4 of payments, whether insurance may or may not apply and  
5 the method of payment for the treatments?

6 AWe just paid for it. There was no guarantee of insurance  
7 assistance and we just, you know, put it on a credit card  
8 and hoped it would work out in the end, you know, with  
9 the -- you know, we paid on a cash basis.

10 And we knew -- again, I knew what I was getting into before  
11 I even walked in the door. I had called and -- and spoken  
12 with his staff on, okay, well, if we did this, what is  
13 it going to cost? If we did this, what's it going to cost?

14 And so, I mean, I knew that going in.

15 QAre you satisfied now that Dr. Buttar's treatment of Hunter  
16 has been beneficial --

17 MR. JIMISON: Objection, leading. It's leading.

18 MR. KNOX: I know. It's 6:30, I'm sorry.

19 QAll right. Tell me -- go ahead and tell us -- explain to the  
20 Panel what your observation is.

21 AMy current observation is -- is Hunter has got a long way to  
22 go, but he's -- he's come so very far. It's -- his --  
23 his -- his toxicity was an issue. It was his amounts were



1 grotesque. It was just -- it was toxic.  
2 And so, you know, we cleaned him up, began the hyperbaric  
3 oxygen therapy and -- and he can do things. He has a  
4 quality of life now that before, there's no question he  
5 wouldn't have had. You know, when you get -- when you  
6 receive a phone call from your physician, physical  
7 education teachers that hasn't seen him over the course  
8 of the summer and he tells you what's --

9 MR. JIMISON: Objection --

10 A-- what's going on --

11 MR. JIMISON: -- that's hearsay.

12 PRESIDENT RHYNE: I couldn't --

13 MR. JIMISON: That's what -- what the teacher said.

14 AI received --

15 MR. JIMISON: Objection as to what the teacher may have  
16 said.

17 AI received a phone call from the teacher.

18 PRESIDENT RHYNE: Go ahead and proceed.

19 AAnd the teacher asks what's going on with Hunter. I mean,  
20 he's -- he's -- his fine motor skills, gross motor skill  
21 is remarkably different and better, what's -- I mean,  
22 what's going on. That tells you all you need to know as  
23 far as how far he's come and whether he's benefited from

1 the treatments.

2 And my observation is I'm an ecstatic parent because the  
3 quality of life my son -- I see for my son versus what  
4 he had is not parallel.

5 QOkay. How many drugs was he on at the time he came to Dr.  
6 Buttar?

7 AFive -- at the time he walked in the door, he was on five  
8 medications. It might -- at one point in time it was seven  
9 and started out at one, but when he walked in the door  
10 he was on five medications.

11 QAnd how about now?

12 AHe's not. He's -- he's on vitamins and minerals and --  
13 that's -- that's what he's on.

14 MR. KNOX: All right.

15 PRESIDENT RHYNE: Yeah. Mr. Jimison, do you want to  
16 cross-examine.

17 MR. JIMISON: No.

18 PRESIDENT RHYNE: Any Board Members?

19 **EXAMINATION BY THE PANEL MEMBERS:**

20 DR. McCULLOCH: You said your son was toxic and I'm happy  
21 for your -- for his improvement.

22 WITNESS: I mean, there's things you're going to hear  
23 about.

1 DR. McCULLOCH: You said he had toxic levels of something.  
2 WITNESS: Yes, sir. Mercury, lead, zinc.  
3 DR. McCULLOCH: And -- and those toxic levels were based  
4 on what?  
5 WITNESS: We did labs --  
6 DR. McCULLOCH: I guess my -- my question is, your  
7 description of him being toxic is based on which -- what  
8 was --  
9 WITNESS: What my understanding of -- of a high --  
10 abnormally high level was.  
11 DR. McCULLOCH: And where did you get that understanding?  
12 WITNESS: From my research, from the laboratory results --  
13 DR. McCULLOCH: And from Dr. Buttar's office?  
14 WITNESS: Yes, sir. There were three parts. The lab gave  
15 you results, Dr. Buttar gave you results and I came up  
16 with what I thought were my own results.  
17 DR. McCULLOCH: Thank you.  
18 PRESIDENT RHYNE: Were these blood, urine, hair samples  
19 or what, and from the same lab.  
20 WITNESS: Fecal, blood, urine. It was a lot of them.  
21 PRESIDENT RHYNE: Were the labs done in Dr. Buttar's  
22 office?  
23 WITNESS: No. No, independent labs.

1 DR. WALKER: Did you have any of your other children  
2 tested?

3 WITNESS: No, sir. None of them displayed symptoms or  
4 were characteristic of -- you know, gave us any reason  
5 for concern. We did hesitate as far as vaccination with  
6 our five year old knowing what we, you know, knew, but  
7 we still went through with it, so. But we haven't had  
8 any of them tested, no, sir.

9 DR. WALKER: Do you have any ideas from your research why  
10 one child might have had toxic levels for what is presumably  
11 environmental contamination and nobody else did?

12 WITNESS: Yes, sir, I do and that's kind of what Dr.  
13 Buttar -- some information that he gave me was that, you  
14 know, perhaps Hunter has some type of genetic problem to  
15 where he just can't rid himself of -- of the metals. And  
16 if this was the case, then it's building up in his system  
17 to mimic the characteristics, you know, described in  
18 autism.

19 DR. WALKER: You know, most insurance companies will pay  
20 for treatment of metal toxicity. Did you ever try to get  
21 reimbursement from the insurance company?

22 WITNESS: Oh, yes, sir, we did. And we did receive some,  
23 but it was -- I would be willing to bet 95 percent of it

1 was turned down.

2 DR. WALKER: Has your son -- I assume that at the beginning  
3 of this ordeal that you've been through that he went through  
4 the usual developmental testing that the psychologists  
5 do on kids who are having learning problems or other  
6 problems. Would that be true? I didn't mean to upset  
7 you. I realize that --

8 WITNESS: If you only knew, but, yes, sir, he --

9 DR. WALKER: Has he -- since he's improved to such a degree,  
10 have you had him retested to sort of see where -- where  
11 he's at right now?

12 WITNESS: Yes, sir. We -- we stay in touch and frequent  
13 a developmental pediatrician in Greenville, South Carolina  
14 and so, yes, sir.

15 DR. WALKER: Is it -- so he's -- he's come around in all  
16 those -- not only is he looking better to you, but he's  
17 looking better on the tests?

18 WITNESS: What tests are you referring to?

19 DR. WALKER: The -- the developmental tests, you know,  
20 where they -- they do the little studies. I don't know  
21 exactly what they might have done.

22 WITNESS: Yes, sir. I didn't know if you meant the  
23 specific lab tests or what have you.

1 He is -- he's got issues every day, but I'm of the opinion  
2 the mercury -- the levels did significant brain damage.

3 I mean, they're a nerve toxin, so he's got issues that  
4 we have not -- he has not been able to overcome, but a  
5 lot of them he has been.

6 DR. WALKER: Thank you.

7 WITNESS: Sure.

8 PRESIDENT RHYNE: Did you call your public health in your  
9 area with these toxins, family public health to make sure  
10 it was not a problem in the area? Was that done?

11 WITNESS: I did not make a phone call to any public health  
12 official. I sought information from public health  
13 officials, but I didn't call asking that type of -- or  
14 nothing, I mean.

15 PRESIDENT RHYNE: And you said that he got hyperbaric  
16 oxygen and what else did he get? Did he get any other  
17 treatment?

18 WITNESS: Yes, ma'am, he did. We received two summers  
19 worth. We spent a summer in a hotel in Dustin, Florida,  
20 two summers back to back, '05 and '06 and -- in which he  
21 received the hyperbaric oxygen treatments administered  
22 by Dr. Eddie Zandt in Dustin, Florida. As well as we also  
23 tried and explored umbilical cord blood stem cell in

1 Mexico. That proved to -- you know, there was no benefit  
2 to the stem cell, but the hyperbaric oxygen was just  
3 miraculous, just off the charts.

4 PRESIDENT RHYNE: Thank you, Mr. Hewitt.

5 MR. KNOX: May I -- excuse me, Your Honor.

6 **FURTHER DIRECT EXAMINATION BY MR. KNOX:**

7 QDid that include some chelation?

8 AHe did. The chelation was the first process. We couldn't  
9 get to the hyperbaric oxygen until we basically got him  
10 cleaned up.

11 PRESIDENT RHYNE: So he had chelation before he did  
12 hyperbaric?

13 WITNESS: That is correct.

14 PRESIDENT RHYNE: Thank you.

15 QIs his speech better?

16 AIt's -- yes, sir, it's -- and, yes, sometimes too much.

17 MR. KNOX: That's all I have.

18 **FURTHER EXAMINATION BY THE PANEL MEMBERS:**

19 DR. WALKER: Could I ask one more question?

20 WITNESS: Yes.

21 DR. WALKER: What are you doing now to keep him from  
22 re-accumulating more toxic metals?

23 WITNESS: That's a great question. He's on a maintenance

1 program as Dr. Buttar, you know, his staff have -- you  
2 know, have him in place and he will use the drops, you  
3 know, topically and just monitor him, so it's just  
4 basically a maintenance program.

5 PRESIDENT RHYNE: So excuse me, he's done chelation, drops  
6 and hyperbaric oxygen?

7 WITNESS: Yes, ma'am, and stem cell.

8 PRESIDENT RHYNE: And stem cell. Thank you.

9 **CROSS-EXAMINATION BY MR. JIMISON:**

10 QDoes the maintenance program continue on indefinitely?

11 A I guess it could. I would think that -- I don't -- there's  
12 no reason for me to believe that if it's a genetic problem  
13 it's just going to go away, so I guess we're prepared for  
14 it to go on indefinitely, but we haven't discussed, you  
15 know, is that going to indeed be the case.

16 QIs it once a month or once a week?

17 ANo, weekly.

18 QSo -- so once a week for maintenance to keep the metal --

19 ANo, we're able to do it at home.

20 QOkay.

21 AWe're able to do it at home.

22 QWith chelating agent that you get from Dr. Buttar?

23 AYes, sir.



1 **FURTHER EXAMINATION BY THE PANEL MEMBERS:**

2 DR. McCULLOCH: Mr. Hewitt, you mentioned you said you  
3 had your child evaluated by the developmental  
4 pediatrician.

5 WITNESS: Pediatrician, Dr. Nancy Powers.

6 DR. McCULLOCH: Is she an M.D.?

7 WITNESS: Yes, sir.

8 DR. McCULLOCH: He or she?

9 WITNESS: She.

10 DR. McCULLOCH: She. Is she aware of this other  
11 treatment?

12 WITNESS: She is aware of the chelation. She was not  
13 necessarily for it, but she didn't -- she -- she felt like  
14 there wasn't any harm if it was done properly, so she  
15 supported us doing it. She was -- I guess, she was very  
16 happy with the fact that she's the one that put him on  
17 the five medications and the fact that he was off the five  
18 medications through, you know, weaned him off and what  
19 have you, she thought that there would be some merit to  
20 trying, you know, the chelation process and supported that.

21  
22 She supported the hyperbaric oxygen treatment therapy.

23 She did not support the umbilical cord blood stem cell

1 therapy.

2 PRESIDENT RHYNE: Thank you, Mr. Hewitt. And we're all  
3 delighted your son is doing better.

4 WITNESS: Thank you very much.

5 PRESIDENT RHYNE: Is there anybody else you want to call  
6 that's from out of state? No?

7 MR. KNOX: No. To be honest with you, we were supposed  
8 to talk with Mr. Hewitt tonight and I've got some people  
9 I haven't had a chance to talk to who drove here, so if  
10 we start at 7:00 in the morning, I'll bet we'll be done  
11 and I appreciate that.

12 PRESIDENT RHYNE: Okay. All right. We'll adjourn until  
13 7:00 in the morning.

14 (WHEREUPON, THE HEARING WAS ADJOURNED  
15 ON APRIL 23, 2008 AT 6:14 P.M.  
16 TO BE RECONVENED ON APRIL 24, 2008 AT 7:00 A.M.)

17 PRESIDENT RHYNE: Good morning.

18 MS. GODFREY: Good morning.

19 MR. JIMISON: Good morning.

20 MR. KNOX: Good morning.

21 PRESIDENT RHYNE: We will resume in the case of Dr. Buttar.  
22 And I wanted to just remind everyone to turn off their  
23 cell phones and pagers. I see -- see you doing that that

1 made me think about it.

2 Ms. Godfrey and Mr. Knox, are you ready to proceed.

3 MR. KNOX: Dr. Rhyne, the first thing that we would offer  
4 is an Affidavit of Michelle Reed which she's on standby  
5 because Mr. Jimison has graciously agreed that we could  
6 just admit her affidavit to you. I think it's Exhibit  
7 42, but this is the signed copy of it. If I could hand  
8 up to you a copy of it.

9 PRESIDENT RHYNE: Please do. Thank you.

10 MR. KNOX: You're welcome.

11 DR. WALKER: Thank you.

12 MR. JIMISON: Dr. Rhyne, while we're doing some  
13 housekeeping, here's the signed Stipulation and the  
14 Pre-hearing Conference for your copy.

15 PRESIDENT RHYNE: Thank you. I would -- I'd like to take  
16 just a minute or so to look at this.

17 Okay.

18 MR. JIMISON: And, Dr. Rhyne, if I may, I spoke to Mr.  
19 Knox about this, I mean just one point about the affidavit.

20 You know, clearly, Ms. Reed is not here to be  
21 cross-examined and the Board is not able to ask questions  
22 of Ms. Reed. However, in the interest of moving things  
23 along, I agreed to just allow that affidavit to be

1 submitted.

2 PRESIDENT RHYNE: Okay.

3 MR. JIMISON: I just wanted to make that point.

4 MR. KNOX: And you may -- that was his -- and he's correct,  
5 you don't have the right to cross-examine, but she's on  
6 standby at her office to be called. I just thought we  
7 would expedite.

8 This affidavit is made in rebuttal to what Patient B's  
9 wife had said about her conversation about Dr. Buttar's  
10 practices and how he charged people and so forth and that's  
11 what the rebuttal is about. Thank you.

12 PRESIDENT RHYNE: Okay. Thank you. Mr. Knox and Ms.  
13 Godfrey, do you have any more evidence you wish to present?

14 MS. GODFREY: We would call Dr. John Wilson.

15 PRESIDENT RHYNE: Okay.

16 MR. KNOX: Pull that mike toward you a little bit, so they  
17 can hear you.

18  
19 WHEREUPON,

20 JOHN L. WILSON, JR., M.D.,

21 being first duly sworn,

22 was examined and testified

23 as follows:

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23

---

**DIRECT EXAMINATION BY MS. GODFREY:**

QCould you state your name for the record, please?

AMy name is John Layton Wilson, Jr.

QAnd, Dr. Wilson, where do you reside?

AI reside in Fairview, North Carolina.

QOkay. And is that near Asheville?

AIIt's a bedroom community.

QOkay. And do you have a copy of your CV there?

AI do not.

QThere is an exhibit book, I believe it's Exhibit 29, so that you could -- I know you know what's on your CV, but for the benefit of the Board and just for the benefit of being able to follow along. Is Exhibit 29 your CV?

AYes, ma'am.

QCould you tell the Board where you graduated from college?

AI graduated from college from the University of Minnesota at Duluth with a B.A. degree in zoology and chemistry.

QAnd after that did you go to medical school?

AI attended medical school. I was in a charter class at the University of Minnesota, Duluth, Minnesota which is a school that was developed by the legislature with the express purpose of educating rural family physicians.

1 I graduated from the University of Minnesota in Minneapolis  
2 in 1976.

3 QWith an M.D. degree?

4 AYes, ma'am.

5 QAnd then you pursued a residency in family practice?

6 AYes.

7 QAnd you completed that residency in what year?

8 AI completed one year of the residency and went into practice  
9 following that.

10 QOkay. And did you practice for a period of time in Minnesota?

11 AI practiced for a period of 14 years in a small town in  
12 Minnesota.

13 QAnd after that did you move to North Carolina?

14 AI moved to Asheville, North Carolina in 1991.

15 QAnd --

16 AAnd I've practiced there since.

17 QOkay. And you're licensed by the North Carolina Medical Board?

18 AYes, ma'am. And I'm also licensed in Minnesota.

19 QAside from your qualifications in family practice, do you also  
20 practice in integrative medicine?

21 AYes, ma'am.

22 QAnd could you explain to the Board what sparked your interest  
23 in integrative medicine and how many years you've been

1 practicing?

2 AWell, I think throughout my medical school and early practice  
3 years, I had an abiding interest in holistic medicine and  
4 looking at the whole person. And in the process of dealing  
5 with some of the health challenges in my own family, I  
6 developed a greater interest in trying to find alternate  
7 ways to get -- to help my own family improve their health.

8  
9 And when I applied -- and I traveled this country from  
10 coast to coast many times and have attended many hundreds  
11 of hours of meetings in learning other techniques. And  
12 when I started finding my own family members improved their  
13 health, I was able to learn that I had numerous patients  
14 who had similar problems and I started applying the same  
15 principles in their -- in my practice with them and they  
16 also improved.

17 QOkay.

18 AAnd that interest was really sparked probably in the mid 1980s  
19 in particular.

20 QOkay. So you've been -- been practicing integrative medicine  
21 for some 25 years or close to that?

22 AClose to that.

23 QOkay. And have you held any positions in society that promote

1 integrative medicine?

2 AYes, I have.

3 QWhat positions are those?

4 AI have served on the Board of Directors of three  
5 organizations -- four organizations in integrative  
6 medicine. The American Academy of Environmental  
7 Medicine, I served on their Board of Directors for perhaps  
8 10 years. I was on the Board of Directors of the formerly  
9 Great Lakes College of Clinical Medicine which changed  
10 its name to the International College of Integrative  
11 Medicine for several years. I have served on the Board  
12 of Directors of the North Carolina Integrative Medical  
13 Society and I'm currently a Board Member of the  
14 International Academy of Oral Medicine and Toxicology.  
15 I have served as past president of the American Academy  
16 of Environmental Medicine and the Great Lakes College  
17 Clinical Medicine. And I served for five and a half years  
18 as the National Director of Continuing Medical Education  
19 for the American Academy of Environmental Medicine.

20 QOkay. And could you explain to the Board --

21 MS. GODFREY: Well, first of all, let me tender Dr. Wilson  
22 as an expert in integrative medicine and family practice.

23 Any objections?



1 MR. JIMISON: No.

2 QNow --

3 (PANEL DISCUSSION BETWEEN  
4 PRESIDENT RHYNE AND DR. McCULLOCH)

5 MS. GODFREY: I'm sorry, did you have a question for me?

6 PRESIDENT RHYNE: Well, we can go over it now or in the  
7 question period.

8 MS. GODFREY: Okay.

9 PRESIDENT RHYNE: But we just don't see where he completed  
10 a residency of family practice or is board certified in  
11 family practice.

12 MS. GODFREY: Okay.

13 WITNESS: I did not complete a residency in family  
14 practice, but I have earned the status of a fellow of the  
15 American Academy of Family Physicians.

16 PRESIDENT RHYNE: But you have not been certified?

17 WITNESS: Not in family practice.

18 PRESIDENT RHYNE: Okay. So we -- so therefore that's our  
19 issue of accepting him as an authority in family practice.

20 MS. GODFREY: Okay.

21 Q(By Ms. Godfrey) Dr. Wilson, in your current practice, do  
22 you use both conventional and alternative therapies on  
23 your patients?

1 AYes, I do.

2 QDirecting your attention to some of the therapies that are  
3 used commonly as alternative therapies, are you familiar  
4 with -- are you familiar with treating patients for toxic  
5 conditions?

6 AYes, ma'am.

7 QAnd what can you tell the Board about your experience treating  
8 patients with toxic conditions as it relates to heavy  
9 metals?

10 AI have had extensive experience doing chelation therapy with  
11 patients and depurating toxic metal of the patients, our  
12 clinic has administered -- I'm quite certain over a quarter  
13 of a million intravenous EDTA chelation infusions over  
14 many years and I'm proud to say without adverse reaction  
15 or serious complication with any of them.

16 QAnd in seeking to eliminate heavy metals from your patients,  
17 what conditions do you treat with that therapy?

18 AI think an important distinction to make with -- with the  
19 approach of integrative medicine is that we're treating  
20 the patient more than we're treating the condition, per  
21 se. Toxic metals have a huge impact on many different  
22 body systems and in depurating the body burden of heavy  
23 metals from patients, many -- many aspects have improved,

1 anywhere from -- from malignance -- conditions with  
2 malignancy to chronic fatigue issues to just many different  
3 types of problems.

4 So it's really not -- I think it's very important to  
5 differentiate between integrative medicine and just  
6 conventional practices in that conventional medicine is  
7 more oriented toward identifying, you know, signs and  
8 symptoms and determining, based upon that, which  
9 treatments could be used.

10 And in much of conventional medicine is involving and  
11 treating symptoms the patients have in alleviating  
12 suffering which of course is completely admirable and  
13 desirable and we all do that.

14 But I think what we do in integrative medicine is a step  
15 beyond that is trying to look at what are the burdens on  
16 this person's biology by reducing or using the total load  
17 on people. It has been my observation and that of my  
18 colleagues that many conditions improve. And so by  
19 reducing that body burden through these chelations and  
20 removing heavy metals results in clinical improvement in  
21 a wide range of conditions.

22 QAre you familiar with nutritional therapies?

23 AYes, ma'am.

1 QCould you explain to the Board how they are used by integrative  
2 medicine doctors?

3 AWell, I think in the larger picture we see illness as a  
4 manifestation of overburden of different aspects of  
5 people's health. You know, I mean you look at -- go from  
6 trauma to pregnancy to infections, parasites to toxic  
7 substances to sensitivities, hypersensitivities, and  
8 allergies to essential factor deficits such as nutrients,  
9 micronutrients, macronutrients, and we look at the broad  
10 spectrum of those who need to address micronutrient  
11 deficiencies through both oral and intravenous therapy.

12 QAre you familiar with the treatment by -- that is abbreviated  
13 IRR?

14 AYes, ma'am.

15 QCan you tell the Board what that is and how you know that?

16 AIRR is a term coined by Dr. Harry Philbert. Dr. Philbert is  
17 a physician now in his eighties and he actually discovered  
18 this autonomic reflex back when he was in his twenties  
19 and he practices outside of New Orleans, Louisiana. And  
20 he coined the term infra -- infraspinatus respiratory  
21 reflex.

22 And at that -- back at that point in time, Dr. Philbert  
23 was and still is just a remarkable individual who has a

1           photographic memory of anatomy. I don't think there's  
2           a nerve or a vein, or a muscle origin or insertion that  
3           he doesn't know where it's at. He can picture it  
4           immediately.

5           But he -- because of his interest in anatomy, he started  
6           doing a lot of work in his twenties looking at trigger  
7           point therapy and he identified a autonomic nerve reflex  
8           in the belly of the infraspinatus muscle. He actually  
9           went to the -- to the lab, the veterinary lab, at the  
10          University of Louisiana and -- and would do experiments  
11          with dogs and also with rabbits and he would inject the  
12          infraspinatus muscle trigger points in these animals with  
13          local anesthetics.

14          He would actually -- what he actually -- one of his really  
15          interesting experiments is where he -- he injected an  
16          irritant solution, a dilute phenol solution into the --  
17          into the infraspinatus reflex region of dogs and the dogs  
18          went into congestive heart failure. And they actually --  
19          they just -- they actually died following that irritation  
20          of that nerve reflex and this was confirmed by -- by the  
21          veterinary pathologist.

22          He went back to the lab and did the same experiment again  
23          and after he had irritated that reflex, he actually

1 injected it with lidocaine and completely reversed the  
2 findings.

3 And he started doing it -- so patients who had asthma,  
4 for instance, he would treat that reflex and his asthma  
5 patients improved.

6 He actually showed this or kept good records over many  
7 years and treated over 4,000 asthmatic patients over many  
8 years and found that 80 percent of the patients with asthma  
9 would show improvement from the IRR injections and they  
10 would have -- it improved peak flow following the  
11 injections as compared to before.

12 And he also found that -- that half of those patients who  
13 responded were able to get off all of their asthmatic  
14 medications. And so he actually found that this injection  
15 helped a number of different conditions.

16 QNow, do you perform IRRs?

17 AI have performed IRRs since I spent three days training with  
18 Dr. Philbert perhaps 10 or 12 years ago.

19 QAnd what types of patients do you find this treatment helps?

20 AIRR therapy, as I mentioned, can be a tremendous benefit for --  
21 for asthma. I have found -- I actually think it's one  
22 of the best kept secrets in medicine. I think it's  
23 unfortunate that medical students are not taught this

1 technique. It's a dramatic and usually immediate benefit  
2 that patients ever -- incurred in the patient's improvement  
3 from that treatment.

4 I found it's also very useful for chronic pain conditions  
5 in the shoulder and the neck region.

6 And the theory is that, you know, we have sort of developed  
7 with this injection is that the -- that the autonomic --  
8 when trigger points occur in that muscle -- in the belly  
9 of the infraspinatus muscle, an autonomic hypervigilant  
10 state is set up that puts the paraspinal autonomies into  
11 a state of sympathetic hypervigilance. The injection  
12 relaxes that entire -- that entire region.

13 We've seen shoulder pain and neck pain substantially  
14 improve from these injections, algias of the upper  
15 extremities, for instance.

16 It can be helpful for patients who have malignancy,  
17 particularly if they have malignancies in the lungs and  
18 Dr. Philbert has done that with a number of his -- I don't  
19 know his statistics, per se, but many patients he's seen  
20 that had lung cancer have had a substantial improvement  
21 in their breathing following the treatment.

22 QAnd would the same be true with patients that were -- had other  
23 cancers that have metastasized to the lung?

1 AOf course.

2 QYou were asked to be an expert witness in this case, correct?

3 AThat's correct.

4 QAnd I sent you a great deal of material to review. Do you --

5 did you review the Medical Board charges in this case?

6 AI did.

7 QAnd did you review the opinion of Dr. John Peterson?

8 AYes, I did.

9 QOkay. The sheets that he -- he provided to the Medical Board,

10 correct?

11 AYes.

12 QAnd with regard to Patients A, B, C and D, did you review their

13 medical records from Dr. Buttar's office?

14 AI did.

15 QDid you also review their billing statements?

16 AI did.

17 QAnd did you review the Medical Board investigative file on

18 those patients?

19 AI did.

20 QOkay. Now, after review of all of that information, some,

21 I think, a thousand pages that was sent to you on a CD,

22 do you have an opinion within a reasonable degree of medical

23 certainty of whether or not Dr. Buttar's diagnosis and



1 treatment of Patient A was within the standard of care  
2 for a doctor practicing integrative medicine in North  
3 Carolina in 2006?

4 MR. JIMISON: Objection, just to note that it's an  
5 incorrect legal standard. I'll just note the objection.

6 Q(By Ms. Godfrey) You may answer the question, Doctor.

7 AI do have an opinion.

8 QAnd what is that opinion?

9 AI believe that Dr. Buttar's therapies and choice of therapies  
10 and treatments in these patients would fall within the  
11 usual framework of the types of treatments that integrative  
12 doctors that I know that have experience dealing with and  
13 treating that would indicate that was appropriate.

14 QOkay. And with regard to Patient A, did you review  
15 Dr. Peterson's critiques and opinions as they relate to  
16 Dr. Buttar's treatment of Patient A?

17 AYes, I did.

18 QAnd do you agree with Dr. Peterson?

19 AI do not.

20 QCould you tell the Board why?

21 AI believe one of the criticisms that has been levied against  
22 Dr. Buttar, really not just to Patient A, but all three  
23 of the cancer patients, is an unjust criticism and I think

1 highlights the different yardstick by which integrative  
2 medicine is judged as compared to conventional standard.

3  
4 The conventional standard for this patient -- for all three  
5 of these patients who had Stage IV terminal disease was  
6 to refer them to a hospice unit and let them be in the  
7 hospice unit until death.

8 Dr. Buttar was approached by all of these patients that  
9 were seeking these treatments and they -- they went into  
10 it with full knowledge, they knew what they wanted to get,  
11 they were fully informed about what the treatments would  
12 involve, what the costs would be and they chose to do that.

13  
14 I think to without -- physicians who have something to  
15 offer to patients to improve their quality of life, to  
16 withhold that from them, I think is not correct. I think  
17 his position is -- if that's the conventional standard  
18 is to -- is to basically relegate people to the morgue,  
19 I think it's the incorrect standard and I think the standard  
20 should be expanded to allow people the freedom to make  
21 those choices.

22 So that was my major argument with Dr. Peterson's opinion  
23 of Dr. Buttar's supposed violation of the conventional

1 standard.

2 The conventional therapies failed in all of these patients.

3  
4 And I just -- I'm not comfortable sitting in a position  
5 of being -- playing God with any patient. If they want  
6 to make -- they have a right to make informed choices,  
7 I think they should have -- they should be given that right.

8 QOkay. With regard to Dr. Peterson's opinion as it relates  
9 to Dr. Buttar's practice with these patients and his  
10 physician contact with the patients, did you see documented  
11 in the chart that Dr. Buttar was, in fact, -- or did you  
12 see any documentation in the chart as to whether or not  
13 Dr. Peterson's opinion could be supported?

14 AWell, I'm puzzled by -- by Dr. Peterson's comments about Dr.  
15 Buttar, number one, not using SOAP notes and the charts  
16 are full of SOAP notes and -- and that Dr. Buttar never  
17 saw the patients.

18 You know, Dr. Buttar performed all of the IRR injections,  
19 for instance, on these patients. And I don't know how  
20 one could read those charts and not come to the conclusion  
21 that Dr. Buttar was very much involved with the patient  
22 and the care of these patients.

23 QOkay. Basically you covered my questions as they relate to

1 Patients A, B and C. I originally asked you as to Patient  
2 A, but I think in your answers you went on and told us  
3 that you feel the same way about Patients B and C as regards  
4 to the standard of care.

5 I want to focus for just a minute on Patient D, the  
6 non-cancer patient. First of all, do you have an opinion  
7 to a reasonable degree of medical certainty as to whether  
8 or not Dr. Buttar's diagnosis and treatment of Patient  
9 D was within the standard of care for a doctor practicing  
10 integrative medicine in North Carolina in 2006?

11 AI believe it was.

12 QOkay. And do you -- can you explain why you hold that opinion?

13 AThe types of therapies that were brought to -- to her care,  
14 I don't have her -- her record in front of me or the summary  
15 but --

16 QOkay.

17 ASo I'd have to refresh my memory a bit with that specific case.

18  
19 But as with the other cases, as well, the kinds of therapies  
20 that were utilized are kinds of therapies that are  
21 typically to be used in integrative medicine when you would  
22 see a patient and approaching a patient from the standpoint  
23 of not what are -- what is your disease and which -- what

1 treatment are we going to use to specifically focus on  
2 your disease, but where -- but the kinds of treatments  
3 that we'll be looking at, what the body -- this person's  
4 body burden is and how can you reduce that.

5 You know, one point I'd like to make in that regard, you  
6 know, I think it was about four years ago that the  
7 environmental working group published a paper where they  
8 studied the cord blood of ten infants -- I don't know if  
9 any of you saw that paper -- but they identified in these  
10 infants that -- that there were over 200 toxic pollutants  
11 in the blood of these infants.

12 That's how people in our society start life and that number  
13 increases substantially as we go through -- as we go through  
14 life by simply the acts of eating, breathing, drinking  
15 and touching. We are living in a world full of pollutants  
16 and these things slowly and gradually and chronically  
17 accumulate in our system and the accumulation of the  
18 pollutants interferes with biologic function. If these  
19 pollutants are removed, biological function improves.

20 This is the basic premise of environmental medicine and  
21 of integrative medicine. That by reducing the burden of  
22 these, patient's physiology improves. Again, it's one  
23 of the numerous stressors on the human biology that, you

1 know, I had mentioned earlier in the list of things  
2 including micronutrient deficiencies, trauma, stress, all  
3 these things that we look at.  
4 And I think it's an important point to mention that, when  
5 you're -- when you're looking at somebody who comes in  
6 for the symptom of fatigue or if they come with a symptom --  
7 whatever their symptoms may be, however the body makes  
8 -- expresses an illness, there's an underlying reason.  
9 I think it's another very important differentiating point  
10 between conventional and alternative medicine.  
11 Conventional medicine is symptom focused and integrative  
12 medicine is really more looking at the bigger picture,  
13 you know, why do things happen the way they do in the body  
14 and how can we reduce the stressors on the body.  
15 And it has been the experience of those of us who have  
16 done this for many years, that many people improve their  
17 physiology functioning. Are we curing disease? I don't  
18 think so. I think we're lessening the body burden and  
19 we're allowing people a better chance to operate and  
20 function in life with the remaining burdens that they have.  
21 MS. GODFREY: I think that's all the questions I have.  
22 Marcus, do you have any.

23 **CROSS-EXAMINATION BY MR. JIMISON:**

1 QGood morning, Dr. Wilson. Thank you for coming in so early.  
2 AGood morning.  
3 QDr. Wilson, you don't have any special training in oncology,  
4 correct?  
5 AI do not.  
6 QYou've never done the residency or fellowship or anything like  
7 that in oncology?  
8 AI have not.  
9 QAnd you're not an expert in cancer, are you?  
10 ANot at all.  
11 QAnd yet you treat patients with cancer, don't you?  
12 AI treat patients and if they have -- if my patients develop  
13 cancer, I will do what I can to assist them with them fully  
14 understanding that I'm not an oncologist and that I insist  
15 actually that my patients be followed by an oncologist  
16 if I'm going to be continuing to provide any supportive  
17 therapy for them.  
18 QSo when patients come to you, you treat them and you hope their  
19 cancer gets better, correct?  
20 AOf course.  
21 QOkay. But you don't treat their cancer directly?  
22 ANo. I treat their underlying biology and hope that we'll see  
23 improvement in immune function from the treatments that

1 we can offer and the body can better cope with the  
2 malignancy, that their body has expressed -- expressed  
3 in their situation.

4 QAnd so you told patients up front that you're not an expert  
5 in cancer and you're not treating their cancer clinically?

6 AOf course.

7 QAnd so is it achromatic that a doctor should only treat diseases  
8 for which he has training to treat?

9 APlease restate that question.

10 QIt is sort of an acumen of truth that doctors should only treat  
11 those diseases for which he has training to treat?

12 AI think the doctor should treat patients in a manner in which  
13 they are -- are trained and for which they have knowledge.

14 QFor instance --

15 AAgain, another important concept in integrative medicine, I  
16 see, is on the marquis of the North Carolina Medical Board,  
17 the Primum Non Nocere, we take it very seriously, above  
18 all, do no harm.

19 QA doctor who's doing neurosurgery should probably be trained --  
20 be trained in neurosurgery before he does neurosurgery?

21 AI would hope.

22 QColorectal surgery, a doctor should be trained in that before  
23 he does that?



1 AI would hope so.

2 QAll right. Infectious disease or anesthesiology?

3 AOf course.

4 QAnd so if a doctor is treating cancer, he should probably be  
5 trained in oncology, correct?

6 AIf a doctor is treating cancer, a doctor should be trained  
7 in oncology.

8 But if a doctor is treating patients and not the cancer  
9 primarily, even providing support of care, I think they  
10 should be trained in those fields as well, in those areas.

11 QIsn't it true that Dr. Buttar advertised and said he treats  
12 cancer?

13 AI am not familiar with Dr. Buttar's advertisements.

14 QAll right. Isn't it true that he holds himself out as a doctor  
15 who treats cancer?

16 AI'm not sure what Dr. Buttar holds himself out as. He holds --  
17 to my knowledge, he holds himself out as an integrative  
18 doctor.

19 QAre you familiar with Dr. Buttar's seminar where he has a  
20 seminar called Innovative Protocols for Treating Chronic  
21 Disease, Cancer, Cardiovascular and Neurodegenerative  
22 Disease?

23 AI have seen that brochure.

1 QSo would this be an advertisement that he holds himself out  
2 as treating cancer?

3 AI think it would be an advertisement for -- for the integrative  
4 medicine that's presented in the seminar he's conducted.

5 QProtocols of treatment.

6 AWhatever the seminar is teaching. I have not taken that  
7 seminar.

8 QOkay. And cancer is a -- if you -- you weren't here for Dr.  
9 Peterson's testimony, correct?

10 AI was not.

11 QOkay. You had critiques of Dr. Peterson from his deposition,  
12 but you weren't here to listen to him testify?

13 AThat's correct.

14 QAnd he testified about the heterogenous characteristics of  
15 cancer. Is cancer a single disease or is it many diseases?

16 AI is it a single disease or what?

17 QIs it a single disease or is it many diseases?

18 AWhat's the adjective, I'm sorry?

19 QMany.

20 ACancer is an immune system dysfunction. Ultimately it boils  
21 down to that and it is -- it has many potential  
22 manifestations.

23 QSo cancer is a symptom of a bad immune system?

1 AYes. An immune system that is not functioning properly, if  
2 you want -- if that's how you term a bad immune system.

3 QSo under your understanding of cancer, it being a symptom of  
4 the immune system of a poor immune system, if the patient  
5 has brain cancer or liver cancer or lung cancer or ovarian  
6 cancer, cervical cancer, all those cancers can be treated  
7 with a single protocol?

8 AThat is not what I said.

9 QOkay. And on there -- are there therapies that can treat all  
10 different cancers no matter what type cancer it is?

11 AThere are many therapies that are used to provide immune support  
12 for patients.

13 QSo if you have a protocol that's just to increase the immune  
14 system, that can treat all cancers?

15 AIf you have a protocol that provides improvement of immune  
16 system communication, a patient who has cancer which is  
17 a manifestation of an impaired immune system  
18 communication, their situation would very likely improve.

19 QOkay. And you --

20 AA properly functioning immune system will not allow -- will  
21 not allow the cancer to develop.

22 QSo hydrogen peroxide therapy would be a treatment for cancer  
23 or the immune system?

1 AHydrogen peroxide therapy has been used for treating immune  
2 disregulations that manifest as malignancy to my  
3 knowledge.

4 I do not hold myself as an expert in hydrogen peroxide  
5 therapy. I do not do it my practice.

6 QAnd ozone therapy, would that be a treatment for the immune  
7 system?

8 AOzone therapy is another oxidated therapy that I have no  
9 familiarity with other than what I've learned in seminars  
10 that I've attended, but I've never utilized it in my  
11 practice so I cannot even comment on that therapy.

12 QAnd hyperbaric chambers, would that be a therapy for cancer?

13 AI'm familiar with that. Familiar with the use of hyperbaric  
14 therapy in treating patients who have cancer.

15 QAnd these IRR injections, is that a therapy for cancer?

16 APatients who have cancer that have metastatic cancer that  
17 doesn't -- or a primary that involves the lung and results  
18 in immune -- in respiratory function compromise will  
19 benefit from an IRR injection, very likely.

20 QAnd these -- these therapies that you testified and when Ms.  
21 Godfrey asked you that when you reviewed the charts, Dr.  
22 Buttar was within integrative medicine standard, yet,  
23 you're not familiar with these therapies and you don't

1 use them in your practice.

2 AI'm familiar with the therapies, but I don't use them in my  
3 practice and so I don't have patient experience with those  
4 therapies.

5 Again, I have served as National CME Director for -- for  
6 an American Medical Society and I have in that role have  
7 invited physicians into the academy to speak to -- on these  
8 issues. I've heard many presentations over the years and  
9 I think the -- in my opinion, these therapies have a lot --  
10 a lot of potential value.

11 QYou don't have any firsthand experience with them, though?

12 AI have very limited firsthand experience.

13 QDo you have some experience? I mean, is it zero or some?

14 AWell, years ago. Many years ago. I probably haven't done  
15 hydrogen peroxide therapy in my practice for 15 years.

16 QAnd why not?

17 AI't is a therapy that has risen -- risen above the radar screen  
18 for many physicians in this -- in this country for political  
19 reasons and the medical boards have -- have found it a  
20 fairly favorite target of therapy to attack physicians  
21 for and I'm not -- I can get along without those therapies  
22 in my practice and help patients within the scope that  
23 are not as high profiled or politically dangerous is the

1 word I used in my deposition, I believe.

2 QAnd have any of these therapies proven effective by any  
3 double-blind placebo-controlled studies?

4 AWhat are any of these therapies you are referring to on this?

5 QThe hydrogen peroxide, the ozone therapy, the hyperbaric  
6 chambers, fusion and minerals and vitamin C.

7 AWell, I don't have an encompassing view of all of the -- all  
8 of the studies that have been performed that are in  
9 voluminous literature volumes, so I really can't comment  
10 about that. I can say that I'm not familiar with the  
11 studies that are -- that are putting on with that regard.

12  
13 I will mention that the NIH is currently in the middle  
14 of a \$30 million clinical trial on a double-blind  
15 placebo-controlled trial for the use of EDTA chelation  
16 therapy for treating coronary artery disease and that trial  
17 is currently to be underway.

18 QThe thin notebook, if you could grab this thin notebook over  
19 here and turn to Tab 17. It's the Board's thin notebook,  
20 Tab 17. Okay. Do you recognize that entitled --

21 AYes, I do.

22 QAnd this is your deposition?

23 AYes, it is.

1 QIf you could turn to page 36, it's on page 4 in the top right-hand  
2 corner. If you go to page 36.

3 AOkay.

4 QYou indicated that a double-blind placebo-controlled trial  
5 is the gold standard in medicine, correct?

6 AThat is generally the -- has been for years, what's considered  
7 the gold trial -- the gold standard for evaluating  
8 pharmaceutical agents.

9 QSo drug therapies is the gold standard for determining whether  
10 drug therapies work or not?

11 ACorrect.

12 QSo we're not talking about double-blind placebo- controlled  
13 studies for surgery or, you know, bypass or some sort of  
14 surgical procedure, we're talking about drug therapy,  
15 correct?

16 AWell, it has been performed on surgical procedures through  
17 the, you know, double-blind studies have been done on  
18 surgical procedures, for instance.

19 QIt mostly is, in fact, the gold standard for drug therapies  
20 and development of drug therapies?

21 ACorrect.

22 QAnd -- and then on page 37, I asked you: Did any of these  
23 therapies, hydrogen peroxide, ozone, the miscellaneous

1 therapies that actually you were not familiar with, that  
2 you --

3 AI didn't say I'm not familiar with that.

4 QWell, let me just read the question down to line 16 on page  
5 37. But the therapies that you listed for Patient A, the  
6 hydrogen peroxide, the ozone, the miscellaneous therapies  
7 with all the initials that you were not familiar with,  
8 have any of those therapies been subject to what you call  
9 the gold standard of medicine which is a double-blind  
10 placebo-controlled study?

11 And your answer was --

12 AI am not aware that they have, but my lack of awareness does  
13 not necessarily mean that they haven't.

14 QAnd I went to page 38 and I asked you whether these therapies --  
15 and it says element, but I think I might have mispronounced  
16 the word "ailment". But I asked you if any of these  
17 therapies have been subjected to double-blind  
18 placebo-controlled studies for any other ailment except  
19 for cancer.

20 And your answer was the same, correct?

21 ACorrect.

22 QSo none of these therapies have been subjected to double-blind  
23 placebo-controlled studies to improve the immune system



1           either, correct, to your knowledge?

2   A To my knowledge. But I will also add that there are -- that  
3           the double-blind placebo-controlled model does not work  
4           as a waiver of evaluating all types of therapies that can  
5           be applied to human beings.

6           The therapy is not practical for a number of different  
7           reasons especially if you're looking more holistically  
8           at patients in terms of, you know, what's happening with  
9           them.

10          Now, I would like to add to that, that when we talked --  
11          the purpose of the double-blind placebo- controlled study,  
12          to the best of my knowledge, is to -- is to separate the,  
13          quote, unquote, real effects of a particular therapy  
14          against the placebo effects of the therapy and however  
15          you may define placebo effects.

16          Placebo effect seems to me as a -- ultimately as the healing  
17          power of the mind and it would seem to me if we could find  
18          ways of harnessing the healing power of the mind, we would  
19          be enhancing the quality of health as well.

20   Q So Dr. Buttar is basically just practicing placebo therapies?

21   A I didn't say that. What I said --

22   Q But --

23   A -- what I said is that the patient -- is the double-blind

1 placebo-controlled study is not the only model that can  
2 be used to study and evaluate the effectiveness of  
3 particular therapies.

4 Many -- many integrative therapies and this has been  
5 endorsed by the National Center for Complimentary  
6 Alternative Medicine, NIH, use the SF36, the Special Form  
7 36 which is basically a way of evaluating a patient's  
8 symptom -- you know, as groups of patients symptoms respond  
9 to different therapies.

10 There are -- there are other models by which -- by which  
11 therapies can be studied. I'm not aware of all of the  
12 different studies that have been done. There are millions  
13 of studies that have been put into literature and no single  
14 physician could possibly have the encompassing view of  
15 all of that.

16 QAnd going back to the placebo, did you review anything regarding  
17 Dr. Ripoll's testimony or her testimony yesterday?

18 AI reviewed her testimony. I was --

19 QAre you familiar with her?

20 AYes, ma'am -- yes, sir.

21 QAnd from your understanding what is the amount of hydrogen  
22 peroxide that Dr. Buttar would use to treat patients?

23 AIIt's a very small quantity. I mean, the standard therapy of

1 that, from my knowledge of hydrogen peroxide therapy, even  
2 though I'm not doing it in my practice, is a very little  
3 dose. It's 1 cc of 3 -- 1 cc of three and a half percent  
4 solution of hydrogen peroxide. That is added to 100 cc  
5 of -- (inaudible) -- and that is what's used.

6 QAnd when hydrogen peroxide hits the blood it immediately  
7 dissipates, correct, into -- into hydrogen peroxide and  
8 oxygen?

9 AI am not prepared to testify about the physiology of hydrogen  
10 peroxide. I think I've already stated that I don't hold  
11 myself as an expert in this field.

12 QThe -- well, let's go to something you know about family  
13 practice. When you get a cut on your hand and you run  
14 into your house and get the hydrogen peroxide out of the  
15 medicine cabinet and you pour the hydrogen peroxide on  
16 the cut, what normally happens?

17 AIt has a fizzy and bubbling effect.

18 QIt bubbles up and that's because it's being immediately --  
19 there's a chemical reaction as to basically transforming  
20 into just water, correct?

21 AAgain, I think I will -- I'll go back to my previous comments  
22 that I'm not holding myself as an expert in this piece.  
23 Hydrogen peroxide in dilute solutions that are used do

1 not -- does not cause a bubbling effect in the blood --  
2 in the blood stream.

3 I would quite concur with Dr. Ripoll's opinion of hydrogen  
4 peroxide that when normal cells encounter hydrogen  
5 peroxide, the catalasing enzyme that was present in normal  
6 cells can easily dissipate and eliminate it.

7 The hydrogen peroxide even in very dilute amounts that  
8 are used causes mischief with certain kinds of cells,  
9 infectious agents or, you know, viruses and bacteria and  
10 malignant cells will adversely be effected because they  
11 do not have the catalytic enzyme system to be able to  
12 destroy the hydroxolode free radicals.

13 QAre you familiar with the proceedings in the National Academy  
14 of Science?

15 AI reviewed it.

16 QDid you review the article about pharmacologic absorbic  
17 concentrations likely kills cancers cells? Did you review  
18 this article?

19 AI just saw this in the -- I never reviewed the article, I  
20 reviewed the abstract.

21 QWould you be familiar with any study from the abstract that --  
22 that no matter how much hydrogen peroxide you put into  
23 the blood it immediately transforms to water and oxygen?

1 AIt's been some weeks since I've read that and I don't have --  
2 I don't have a specific recollection of that. I think  
3 I established already that I'm not holding myself in any  
4 particular expert status of really evaluating this other  
5 than from what I had learned from reading this.

6 QSo from your understanding of reviewing the testimonies, when  
7 hydrogen peroxide, especially as a very, very low  
8 concentration that Dr. Buttar uses when it's infused into  
9 the blood system, which he's doing, he's infusing it into  
10 the blood stream, it is immediately turned into just  
11 basically nothing more than saline, correct?

12 MS. GODFREY: Objection. Objection. I mean, we've been  
13 over this about four times and it's sort of old and we  
14 object to --

15 QWell, let me -- let me ask it -- well, let me ask it this way,  
16 Dr. Wilson.

17 If it is immediately turned into saline and the hydrogen  
18 peroxide is not finding its way to the cancer cells,  
19 essentially all that's being done is that saline is being  
20 injected and, at most, all you can have is a placebo  
21 effect --

22 MS. GODFREY: Well, objection.

23 MR. JIMISON: That's a good question.

1 MS. GODFREY: He just -- he's just testified he's not an  
2 expert in hydrogen peroxide. He is an expert in other  
3 integrative therapies and in integrative medicine.

4 QBut I'm asking just from your experience as a doctor, if the  
5 hydrogen peroxide immediately goes into water and if that's  
6 all that's going into the body because it immediately  
7 catalases when it gets into the blood stream, at most,  
8 all you're hoping for is a placebo effect?

9 A I think you'll have better luck with this line of questioning  
10 with Dr. Biddle who I think has more knowledge about this  
11 field. I'm quite aware that the -- there are very many  
12 complex mechanisms that are in play when hydrogen peroxide  
13 is given and it effects the redox system in cells.

14 And I've heard this -- I heard this explained numerous  
15 times and I have not quite gotten my mind around all of  
16 the different intricacies of this, but it is not what you  
17 are trying to label it as which is a placebo effect.

18 I personally like the placebo effect. I'm interested in  
19 anything that could be used to help my patients heal and  
20 I will utilize the placebo effect if I can, but I'm unsure  
21 the interest of using it alone is something that's going  
22 to have a real biological effect.

23 PRESIDENT RHYNE: Mr. Jimison, I think you can move on.

1 MR. JIMISON: I will move on.

2 Q(By Mr. Jimison) With Patient D, did --

3 APatient which?

4 QD, the non-cancer patient. Is it true that Dr. Buttar never

5 saw this patient?

6 AThat's my understanding.

7 QNow, you're also a member of the North Carolina Integrative

8 Medical Society?

9 ACorrect.

10 QAnd Dr. Buttar is a member of that organization?

11 AYes.

12 QDr. Biddle --

13 AYes.

14 Q-- is a member of that organization.

15 In fact, all three of you know one another?

16 AYes.

17 QAnd you all go to conferences with one another?

18 AYes.

19 QYou're friends?

20 AYes.

21 MR. JIMISON: I have nothing further.

22 MS. GODFREY: I just have a few.

23 **REDIRECT EXAMINATION BY MS. GODFREY:**

1 QDr. Wilson, in your -- in your work with the North Carolina  
2 Integrative Medical Society, were you involved in the  
3 effort in 2003 to appear before the Legislature to change --

4 MR. JIMISON: Objection, relevancy.

5 MS. GODFREY: Well --

6 PRESIDENT RHYNE: No, go ahead.

7 MS. GODFREY: Can I finish the questions?

8 Q-- change the law in North Carolina as it relates to the Medical  
9 Board and the recognition of integrative medicine?

10 AI was.

11 QOkay. And was Dr. Buttar also involved in that effort?

12 AYes.

13 QAnd as a result of your efforts, was the law in North Carolina  
14 changed in 2003?

15 AYes, it did.

16 QAnd is one of the changes that -- that integrative medicine  
17 is now recognized in the General Statutes as a separate  
18 type of medicine --

19 MR. JIMISON: Objection, that's incorrect. That's way  
20 beyond the expertise of this witness. He's not an expert  
21 on law.

22 MS. GODFREY: Well, he was involved in the effort to change  
23 the law.



1 MR. JIMISON: But everybody -- there's lots of people that  
2 talk to the legislatures. I mean, the law speaks for  
3 itself. He's not an expert in the law.

4 PRESIDENT RHYNE: True. He's not held himself as an law  
5 expert.

6 MS. GODFREY: Okay.

7 Q(By Mr. Knox) Let me just phrase the question this way. As  
8 a result of your efforts and the efforts of Dr. Buttar,  
9 Dr. Wilson, was this definition of integrative medicine  
10 inserted into the Chapter 90 of the North Carolina General  
11 Statutes: Integrative medicine, a diagnostic or  
12 therapeutic treatment that may not be considered a  
13 conventionally accepted medical treatment and that a  
14 licensed physician in the physician's professional opinion  
15 believes may be of a potential benefit to the patient,  
16 so long as the treatment poses no greater risk of harm  
17 to the patient than the comparable conventional  
18 treatments.

19 Is that change in the law part of your efforts?

20 AYes. Yes, ma'am, it was. I think the purpose of the statute,  
21 but, yeah --

22 MR. JIMISON: Well, objection. The law speaks for itself.  
23 He's not qualified to talk about the purpose of the

1 statute.

2 AOur intention --

3 PRESIDENT RHYNE: No, no, no.

4 MR. JIMISON: No.

5 PRESIDENT RHYNE: No, I think -- you're not a legal expert  
6 or a legislative expert.

7 MS. GODFREY: Thank you, Dr. Wilson.

8 WITNESS: All right.

9 PRESIDENT RHYNE: Any Board Members?

10 DR. McCULLOCH: I have a couple.

11 PRESIDENT RHYNE: Oh, excuse me, I'm sorry. Did you --

12 MR. JIMISON: No, ma'am.

13 MS. GODFREY: Do you have any questions of Dr. Wilson?

14 MR. KNOX: Yes.

15 PRESIDENT RHYNE: Dr. McCulloch.

16 **EXAMINATION BY THE PANEL MEMBERS:**

17 DR. McCULLOCH: I'm just curious as far as your background.

18 You did not complete a family practice residency. You  
19 went to one year of internship, correct?

20 WITNESS: Well, one year of family practice residency.

21 DR. McCULLOCH: And so how did you become a fellow in family  
22 practice? I'm just curious about that process.

23 WITNESS: I completed all of the educational requirements

1 and there was a period of time before the residency required  
2 was -- requirement was imposed to achieve fellowship status  
3 and I got in before that deadline. I was accepted as a  
4 fellow before that deadline.

5 DR. McCULLOCH: So you were grandfathered in before it  
6 became an accepted --

7 WITNESS: Before it was part of -- no, it was accepted --  
8 it was accepted, but there was a grandfather period where  
9 those who had been in practice for a period of time that  
10 they could apply for it and receive fellowship status if  
11 they completed the educational requirements and I got in  
12 under that deadline. I think a year after I got my  
13 fellowship, a full completion of the family practice  
14 residency was required.

15 DR. McCULLOCH: All right. You're a diplomat of the  
16 International Board of Environmental Medicine?

17 WITNESS: Yes.

18 DR. McCULLOCH: How did you become that?

19 WITNESS: By having taken extensive course work in  
20 environmental medicine and having passed both written and  
21 oral examinations.

22 DR. McCULLOCH: So there was an examination for that?

23 WITNESS: Yes.

1 DR. McCULLOCH: Same thing for clinical metal toxicology?

2 WITNESS: Yes.

3 DR. McCULLOCH: And the same thing for neural therapy.  
4 These are just things I'm not familiar with and I wanted  
5 to clear that up a little bit.

6 Why do you not use hydrogen peroxide therapy? You  
7 mentioned the political climate.

8 WITNESS: Well, that is -- that is the reason why because  
9 I think it is -- it is a therapy that does have a lot of  
10 promise and it can be beneficial. Many years ago when  
11 I did use it or when I did use it, to some limited extent,  
12 I was quite impressed by the effectiveness that it had  
13 for instance treating acute influenza. It could very,  
14 very rapidly improve that patient's influenza status and  
15 for acute viral infections.

16 DR. McCULLOCH: But it's, I guess, not worth it as far  
17 as you're concerned given the risks in your traditional  
18 practice?

19 WITNESS: Right.

20 DR. McCULLOCH: Do you have an opinion as to why that's  
21 a target?

22 WITNESS: I think it's a target because it's -- I mean,  
23 there are different things that are selected as targets

1 from -- from medical boards across the country and that  
2 just happens to be one that has risen to a level of awareness  
3 among a number of different staffs for medical boards.

4 DR. McCULLOCH: So you basically don't --

5 WITNESS: I think -- I personally think it's based on bias,  
6 is what I think it's based on. I think bias exists in  
7 all human endeavors including legislators and including  
8 physicians --

9 DR. McCULLOCH: Medical boards.

10 WITNESS: -- including boards, of course, you know. It's  
11 part of being human.

12 DR. McCULLOCH: All right.

13 WITNESS: And I'd like to also say that I'm sympathetic  
14 to the plight of people who serve on medical boards. I  
15 think it's a very difficult thing and whenever you're  
16 standing in judgment of others, it's just -- it's a tough  
17 thing because you know you're trying to balance reasonable  
18 fairness against protecting the public's interest and I  
19 appreciate that.

20 DR. McCULLOCH: Thank you. You mentioned studies and you  
21 mentioned some studies that are ongoing about EDTA, the  
22 treatment for coronary artery disease. It seems to me  
23 that you're willing to put the cart before the horse.

1 We're using lots of therapies and there are not studies  
2 to support those therapies, these --

3 WITNESS: Well, I think there are a lot of studies. I  
4 know that -- you know, that there have been over 45,000  
5 studies that have been published. You're looking at the  
6 utility of EDTA chelation therapy for -- for doing -- for  
7 treating cardiovascular disease, but there are studies  
8 from foreign journals, there's studies from other places  
9 that many of them are not of the United States that have  
10 shown the efficacy of that therapy.

11 And I think -- you know, if you think of a study ultimately  
12 as treating a patient and -- and what is a study, but you  
13 know it's doctors from seeing the effects on large masses  
14 of people.

15 You know, I've had a lot of experience watching EDTA  
16 chelation therapy with patients and you know, my experience  
17 with it is that it's extremely safe and patients have  
18 benefited tremendously from it. You know, not everybody  
19 benefits, but not everybody benefits from any conventional  
20 therapy either.

21 DR. McCULLOCH: True. Would it be unfair for me to  
22 characterize the practice of integrative medicine as a  
23 willingness to use therapies that seem to have an effect,

1 but have not been proven in scientific endeavors?

2 WITNESS: I think I would add a caveat to that which says  
3 that it would say that would have to be very huge safety  
4 profile.

5 DR. McCULLOCH: So you agree with what I said, but adding --

6 WITNESS: I think that -- with that many integrative  
7 therapies are -- that are being explored today, the  
8 practices are going to be the therapies of the future.  
9 I really do believe that, but I think that that is -- that  
10 not everything is -- you know, it has -- you know, I think  
11 that when you're dealing with pharmaceutical agents, you  
12 know, the potential for harm is far greater than when you're  
13 talking about treating people with nutrients, for  
14 instance. The forgiveness factors in the body are  
15 tremendously more. And so I think that, you know, to say  
16 that I would soften the conclusion that -- that you're  
17 presenting in that regard because I think that the safety  
18 factor is number one with patients.

19 DR. McCULLOCH: Okay.

20 WITNESS: And in the case of all four of these patients,  
21 you know, none of them were harmed either, that I could  
22 determine.

23 DR. McCULLOCH: Last question. Would you feel that it

1 would be inappropriate to tell a patient that you can treat  
2 their cancer successfully?

3 WITNESS: I would think it inappropriate to tell a patient  
4 that.

5 DR. McCULLOCH: Thank you.

6 WITNESS: I have never said anything like that to any  
7 patient. As a matter of fact, I make no promises to  
8 anybody. I always approach my patients with the same sense  
9 of cautious optimism, you know, we can try these things  
10 if you're interested and I can tell you what the -- what  
11 I see are the pros and the cons and I think that, you know,  
12 any physician would want to be honest with patients, as  
13 a matter of fact.

14 DR. McCULLOCH: I'm sorry, I do have another question.  
15 Are you familiar with the integrative medicine program  
16 at Duke?

17 WITNESS: I have some familiarity with it.

18 DR. McCULLOCH: Do you consider that a --

19 WITNESS: Well, I'm aware that --

20 DR. McCULLOCH: -- a --

21 WITNESS: I'm aware that it -- that it exists. I don't  
22 have -- that's my extent of knowledge with it.

23 DR. McCULLOCH: Do you --



1 WITNESS: I heard some -- I heard some of the presenters  
2 speak at the state meetings.

3 DR. McCULLOCH: National Centers for Complimentary and  
4 Alternative Medicine, are you familiar with that?

5 WITNESS: I'm familiar with that, yes.

6 DR. McCULLOCH: Is that a legitimate organization?

7 WITNESS: Yes.

8 DR. McCULLOCH: How about Mark Micozzi, Executive Director  
9 of the College of Physicians of Philadelphia?

10 WITNESS: I have -- I've read some of his articles and --  
11 that I've seen in journals and I've heard his name.

12 DR. McCULLOCH: In a textbook perhaps, Fundamentals of  
13 Complimentary and Alternative Medicine?

14 WITNESS: I've heard of him.

15 DR. McCULLOCH: Okay. Do you consider those reasonable  
16 experts and authorities in integrative medicine?

17 WITNESS: Well, they're people who bring prominence to  
18 the field.

19 DR. McCULLOCH: If none of those organizations recognized  
20 hydrogen peroxide therapy, would you be surprised by that?

21 WITNESS: I'm not familiar with what position on that or  
22 what they published on it at all.

23 DR. McCULLOCH: All right.

1 WITNESS: I am not familiar.  
2 DR. McCULLOCH: Thank you.  
3 PRESIDENT RHYNE: Dr. Walker?  
4 DR. WALKER: Dr. Wilson, of the boards that you are a  
5 diplomat of, are any of those recognized by the American  
6 Board of Medical Specialties?  
7 WITNESS: Not at the current time, but I know that, you  
8 know, there are some efforts that that is being looked  
9 at to move in that direction.  
10 DR. WALKER: So, no?  
11 WITNESS: Not currently.  
12 DR. WALKER: Do you believe that when you are an expert  
13 when you're treating someone for metal toxicity, is there  
14 a preferred avenue, a more accurate avenue of determining  
15 that person's contamination between urine, blood and say  
16 tissue analysis?  
17 WITNESS: Well, I think that blood testing is not accurate  
18 for determining body burden. If you look at, you know,  
19 the half-life of mercury for instance and the blood is  
20 only three and a half days, but the half-life once mercury  
21 is partitioned into the nervous system, it can be up to  
22 or beyond 30 years.  
23 And I think tissue is ultimately the optimal way to study

1 it, but that's not practical, clinically, to be taking  
2 pieces of tissue to assay it.

3 So in the American Board of Clinical Metal Toxicology,  
4 their opinion is that the most effective way to determine  
5 body burden is to challenge the body with a chelating agent  
6 and -- and recover either the urine or the stool to measure  
7 how much has been deputed. Of course, depending on which  
8 chelating agent you're using, which -- which method of  
9 excretion of that agent is involved and which particular  
10 heavy metals you're targeting.

11 DR. WALKER: Thank you. When you reviewed the records  
12 of Patients A, B and C, you indicated in your answers to  
13 the questions today that you felt that a quality of life  
14 was an appropriate measure of how people respond to these  
15 therapies. In your review did you find any objective  
16 documentation of quality of life issues?

17 WITNESS: I did -- I cannot say that I saw that indicated  
18 in the records. I saw that there was laboratory  
19 improvements and when you look at the -- the life expectancy  
20 these people had when they first showed to Dr. Buttar's  
21 office in relative to how long they lived, I think they  
22 outlived the expectancy that would have been considered  
23 by the conventional doctors who basically have exhausted

1 their approach.

2 DR. WALKER: So --

3 WITNESS: I think they lived longer. I cannot see  
4 anything in the record that tells me about what their  
5 quality of life was.

6 DR. WALKER: Did I mishear you then when you indicated  
7 earlier that you didn't believe that laboratory studies  
8 were necessarily the best way to follow these patients?

9 WITNESS: That's one way. I didn't say it's necessarily  
10 the best, but there are laboratory parameters, for  
11 instance, in the patient who had the dramatic drop in --  
12 in CEA levels.

13 DR. WALKER: Do you have an opinion as an expert, why IRR,  
14 if it seems to be so effective in the treatment of asthma,  
15 has not been more widely adopted?

16 WITNESS: It's just not taught. It's not taught in any  
17 medical school. I mean, you know, why it's not taught  
18 in medical school, it's just not heard of. You know, there  
19 are things that fit into that category that have not --  
20 you know, the effective therapies that have just never  
21 been recognized.

22 DR. WALKER: As an expert in integrative medicine, would  
23 you not think it reasonable to be familiar with the

1 literature in your field if there were studies that were  
2 performed in a prospective randomized fashion looking at  
3 the very subjects that you -- or the very treatments that  
4 you use?

5 WITNESS: Well, I think I do have some familiarity with  
6 the studies that I -- that I come across in the therapies  
7 that I do use. As I mentioned with hydrogen peroxide since  
8 I'm not using it, I don't focus really attention on that  
9 field.

10 DR. WALKER: So in the areas -- in the treatments that  
11 you personally use, are there any randomized prospective  
12 studies indicating efficacy of these treatments?

13 WITNESS: Not that I have seen.

14 DR. WALKER: Okay. Thank you. Do you refer patients for  
15 oxygen therapy?

16 WITNESS: Oxygen, meaning oxygen therapy?

17 DR. WALKER: Oxidated hydrogen peroxide, ozone,  
18 hyperbaric oxygen, do you refer -- since you don't do those  
19 things yourself, do you refer your patients to other  
20 physicians who do perform those treatments?

21 WITNESS: I have referred patients for hyperbaric therapy,  
22 but -- when their situations are appropriate for that,  
23 but I haven't referred patients for other oxidated

1 therapies to my knowledge.

2 DR. WALKER: Thank you.

3 WITNESS: But -- but there's nobody around me that I'm  
4 aware of that really does those therapies and so I would  
5 tend to send them elsewhere for that would be imposing --  
6 putting a burden upon them from my region.

7 PRESIDENT RHYNE: Did -- I just want to clarify for my  
8 own information. You had talked just a few minutes ago  
9 when you were answering Dr. Walker's question about a CEA  
10 level dropping. Were you referring to the CA 125?

11 WITNESS: I'm sorry, that's right. I'm sorry, the CA 125.

12 PRESIDENT RHYNE: Okay. You told us that you're not an  
13 expert in oxidated therapies and you don't contend to be  
14 an expert in that. What -- what therapies do you see  
15 yourself as the expert in?

16 WITNESS: I think I know a lot about nutritional therapies  
17 and I know a lot about heavy metal toxicology.

18 PRESIDENT RHYNE: All right. So those are the two things  
19 that you would think that your expertise is in?

20 WITNESS: Yes.

21 PRESIDENT RHYNE: And have you had any -- ever had any  
22 problems with nutritional therapies, any overdoses of  
23 vitamins? Are you aware of vitamin toxicity?

1 WITNESS: I have, but I've never had problems with them  
2 in the many years I've been doing it.

3 PRESIDENT RHYNE: Okay. Do -- do you have any -- just  
4 looking at quality of life, do you have any objective  
5 measurements for quality of life? How do you measure that  
6 someone's life has improved?

7 WITNESS: I think that patients would make that decision  
8 about their quality of life.

9 PRESIDENT RHYNE: So it's a subjective thing?

10 WITNESS: Yes.

11 PRESIDENT RHYNE: Okay.

12 WITNESS: I think it is. Again, SF36 form has been one  
13 method that has been endorsed by the NCCA for instance  
14 to -- to try to evaluate that, but you know it's -- it  
15 is basically a subjective evaluation and trying to track  
16 that through changes through time to see that, I think  
17 it difficult to really put your finger on the quality of  
18 life on how you define it.

19 I'm sure there are doctors who looked at these things and  
20 studied them and come up with conclusions. I just -- I  
21 think for me as a practitioner, it's one on one and patients  
22 making those decisions themselves.

23 PRESIDENT RHYNE: Who administers the boards that you were

1 talking about because we had asked if they were affiliated  
2 with ABMS and you said no. Who is -- what's the actual  
3 organization that administers them?

4 WITNESS: Well, they're their own organization just like  
5 the ABFP is an independent organization, but they do have  
6 some affiliation with AAFP.

7 You know, the International Board of Environmental  
8 Medicine has an affiliation with the American Academy of  
9 Environmental Medicine only in the fact that they -- they --  
10 they exchange information about what's taught so -- so  
11 they know so they can meet certain -- and evaluate  
12 candidates and what kind of questions to ask with  
13 evaluating candidates for -- for board status, but I --  
14 but they're independently operated.

15 PRESIDENT RHYNE: Okay. Now, I was pondering the  
16 statement that you had made that there were over 200 toxic  
17 metabolites in the cord blood of newborns or of infants  
18 and so it just made me wonder a little if -- if indeed  
19 that's true, you know, it's a little -- it's a wonder that  
20 any -- any children ever make it out of infancy. And do  
21 you have any theories or explanations for --

22 WITNESS: I think it's just reflection of the toxic burden  
23 of our times. And, you know, we all have a biology that



1 was designed to be able to handle certain toxic loads and  
2 it's -- you know, you're familiar but I'm sure with the  
3 concept of the LD 50 in toxicology. You know, there's  
4 a lethal dose of the substance at which 50 percent of the  
5 population is death and the remaining 50 percent, some  
6 are severely affected and some are moderately affected  
7 and some are minimally affected and some are not affected  
8 at all by -- by the exposure of that toxin.

9 And the spectrum of tolerance fits in that same scope,  
10 you know, that the levels were not necessarily high in  
11 these individuals, but there are some individuals for whom  
12 that coming into life with that kind of a toxic burden  
13 is going to have its effect on them downstream because  
14 if that's what they accrued in their bodies in nine months  
15 exposure in the womb as they come into the world, they  
16 start getting exposed to things, it's going to affect their  
17 biology. Ultimately, it's not reasonable to think it  
18 can't.

19 Conventional toxicology has been for years very much  
20 interested in the concept of acute toxicologic exposure  
21 and adverse affects from that. You know, there's --  
22 there's only in recent years has there been an increasing  
23 awareness of the slow gradual, you know, insidious bio

1 accumulation of things through time and how they affect  
2 our biology.

3 And conventionally in medicine, we have not looked at that,  
4 you know. Like cancer for instance, you know, 90 -- the  
5 American Cancer Society admits that and they have for years  
6 -- that 90 percent of cancers are carcinogenic induced  
7 and environmental factors that impact our biology. It's  
8 where our genes collide with our -- with our environment.

9 And we -- we don't look at that in medicine, you know.

10  
11 In conventional medicine we basically identify, you know  
12 that you have this cancer and we treat it the same way.

13 You know, that if you have this kind of cancer and it  
14 evolved this way, this is the formula for it.

15 Integrative medicine is recognizing biochemical  
16 individuality and we're realizing that no two patients  
17 with the same disease are necessarily going to get the  
18 same treatment.

19 And I think that, you know, hopefully medicine will evolve  
20 to the point where we can be more knowledgeable about how  
21 to apply things individually to patients and understanding  
22 individual susceptibilities.

23 PRESIDENT RHYNE: So you're saying cancer treatments are

1 pretty standard for the different types of cancers?  
2 WITNESS: Well, that's my understanding from what I've  
3 seen of the patients who have cancer, you know, that they  
4 are this kind of formula driven.  
5 PRESIDENT RHYNE: Well, that's a little different from  
6 what Dr. Peterson told us yesterday --  
7 WITNESS: Well, I didn't hear his testimony.  
8 PRESIDENT RHYNE: Okay. All right. I have no further  
9 questions. Thank you very much for testifying.  
10 DR. WALKER: Dr. Rhyne, could I ask a question of Ms.  
11 Godfrey?  
12 PRESIDENT RHYNE: Uh-huh (yes).  
13 MS. GODFREY: Certainly.  
14 DR. WALKER: Would you mind we've -- we've heard both you  
15 and Mr. Jimison read the statute relating to integrative  
16 medicine.  
17 MS. GODFREY: Yes, Doctor.  
18 DR. WALKER: Would you bear with me, please, and read the  
19 entire paragraph relating to integrative medicine that  
20 you started reading?  
21 PRESIDENT RHYNE: We would like a copy of that. We want  
22 a copy --  
23 MS. GODFREY: Okay. And I will be more than happy to --

1 I would love to hand up, before I close today, a copy of  
2 the current version of Chapter 90. Because when I talked  
3 to you today at the end of the day, I'm going to highlight  
4 some portions of it and because I'm not -- I'm not in my  
5 office, I can't -- I don't have a copy machine, but I would  
6 love to make a copy of this or have Lynne make a copy --  
7 MR. JIMISON: We can make copies. We can make copies.  
8 MS. GODFREY: -- and hand it up to you.

9 PRESIDENT RHYNE: Okay. That would be great.

10 MS. GODFREY: Because I think you really do need --

11 DR. WALKER: Thank you very much.

12 PRESIDENT RHYNE: We would like to have that.

13 MS. GODFREY: Well, this is just a printout from the --

14 (DISCUSSION OFF RECORD)

15 MR. KNOX: May I proceed?

16 PRESIDENT RHYNE: Please do go ahead.

17 MR. KNOX: This is a deposition taken of Erlene Thomas  
18 with all the parties present.

19 PRESIDENT RHYNE: Okay. Can we go ahead and see that video  
20 deposition?

21 -----

22 (WHEREUPON, THE VIDEOTAPE DEPOSITION

23 OF ERLENE THOMAS TAKEN ON APRIL 10, 2008,

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23

WAS PLAYED AND IS ATTACHED  
IN ITS ENTIRETY AS EXHIBIT 43)

-----

PRESIDENT RHYNE: Okay. Are you ready?  
MS. GODFREY: I will hand up -- Mr. Mansfield was nice  
enough to copy this for us and for you, so these -- this  
is a copy of the statute that I'm talking about and we  
will be talking about further.

PRESIDENT RHYNE: Okay. Thank you. We'll come back to  
that. Thank you.

PRESIDENT RHYNE: Ms. Godfrey, ready to proceed?

MS. GODFREY: I am.

PRESIDENT RHYNE: Okay. Mr. Knox, do you have any more  
evidence that you wish to present?

MR. KNOX: Yes. We would call Ned Jarrett through video.

PRESIDENT RHYNE: Thank you.

-----

(WHEREUPON, THE VIDEOTAPE DEPOSITION  
OF NED M. JARRETT TAKEN ON APRIL 9, 2008,  
WAS PLAYED AND IS HEREBY ATTACHED  
IN ITS ENTIRETY AS EXHIBIT 45)

-----

(DISCUSSION OFF RECORD)

1 PRESIDENT RHYNE: Mr. Knox or Ms. Godfrey, you can proceed.

2 MS. GODFREY: Thank you, Dr. Rhyne. We would like to call  
3 Dr. Buttar.

4 PRESIDENT RHYNE: Is he the last witness or --

5 Ms. Godfrey: No, we have more witnesses after that, but  
6 what we wanted to do is to --

7 MR. JIMISON: Can I have five minutes to consult for just --  
8 can we just take a five minute break?

9 PRESIDENT RHYNE: Sure.

10 MR. JIMISON: Until --

11 PRESIDENT RHYNE: Until quarter of 10?

12 MR. JIMISON: Until quarter of 10.

13 PRESIDENT RHYNE: Okay.

14

15 (9:35 A.M. - 9:50 A.M. RECESS)

16

17 PRESIDENT RHYNE: We're back in session.

18

19 WHEREUPON,

20 RASHID ALI BUTTAR, D.O.,

21 being first duly sworn,

22 was examined and testified

23 as follows:

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23

---

MS. GODFREY: And just for the Boards' benefit, I'm going to be using quite a number of exhibits that are in our exhibit notebook and I'll refer to them by number, so --

PRESIDENT RHYNE: Okay.

MS. GODFREY: Just to get you keyed up there.

**DIRECT EXAMINATION BY MS. GODFREY:**

QCould you state your name for the record, please?

A Rashid Buttar.

QAnd, Dr. Buttar, are you licensed by the North Carolina Medical Board to practice medicine in the state of North Carolina?

A Yes, ma'am, I am.

QAnd how long have you been practicing medicine?

A I graduated from medical school in 1991, so that would be 17 years.

QOkay. Now, tell -- is Exhibit 1 that's before you, is that your curriculum vitae?

A It's an outdated one, but, yes, it is mine.

QOkay. What year was that current for?

A I believe it was current for '92 -- I'm sorry to 2005.

QOkay.

A I would have to go back and look at the schedule to verify that.

1 QOkay. But -- and I've got to stop saying okay or else we're  
2 going to be here all day.

3 (DISCUSSION OFF RECORD)

4 AActually, I could tell you this was last updated in 2006.

5 QOkay. And so it would be -- it would be current and correct  
6 for your training and your activities through 2006; is  
7 that correct?

8 AYes, ma'am.

9 QCould you tell the Board what medical training you -- you  
10 received?

11 AI did three years of postgraduate training in general surgery  
12 at Brooke Army Medical Center.

13 QI'm talking about for medical school.

14 AOh, I'm sorry, excuse me, ma'am. I went to medical school  
15 at the University of Osteopathic Medicine and Health  
16 Sciences School of Medicine and Surgery in Des Moines,  
17 Iowa.

18 QAnd did you receive a degree there?

19 AYes, ma'am, I did.

20 QAnd following that training, did you do an internship?

21 AYes, ma'am, I did.

22 QAnd where was that internship done?

23 AIt was done at Doctor's Hospital, Airline part of the University



1 of Texas Health Care System as a transitional cell -- a  
2 transitional year internship at University of Texas.

3 QAnd then you started a general surgery residency?

4 AYes, ma'am. But I was pulled for military. I spent a year  
5 in the Republic of South Korea and then I came back to  
6 residency as well.

7 QAnd did you complete that residency?

8 ANo, ma'am, I did not.

9 QTell -- tell the Medical Board why you -- you discontinued  
10 that residency?

11 AThere were a number of reasons. Brooke Army Medical Center  
12 general surgery program that year was rated in the top  
13 three programs in the country. It was a great program.  
14 I loved everything there.

15 I was trying to save a marriage that was failing and there  
16 were also other professional issues for me personally that  
17 I was going through because I wasn't sure if medicine was  
18 really the right profession for me because from what I  
19 had seen while being in medical school and being in full  
20 student rotations, internship and then a couple of years  
21 of postgraduate training, it didn't seem like we were  
22 really helping people who were -- it was palliative and  
23 I was actually thinking about possibly getting out of

1 medicine. But I still owed an obligation to the U.S.  
2 military, so.

3 QAnd so -- so after leaving that -- that residency, did you  
4 continue on with your military service?

5 AYes, ma'am. I was -- I took a leave of absence for one year  
6 to decide what I was going to do. My program chairman  
7 at the department of surgery was kind enough to tell me  
8 that he would hold my position open as long as I needed  
9 and I took a one year leave of absence.

10 QAnd what did you do during that leave of absence?

11 AUnfortunately, the military is not so kind, so they don't let  
12 you take a leave of absence. So I was -- since I had already  
13 done a hardship tour, they gave me my choice of duty station  
14 and I went to Fort Jackson, South Carolina and started  
15 working in the emergency medicine department there.

16 QAnd how long did you -- did you stay in emergency medicine?

17 AWell, I continued -- I served out the next three years of my  
18 obligation from my -- from my military scholarship  
19 obligation and became the chief of emergency medicine at  
20 Moncrief Army Community Hospital until I got out in 1996.

21 QAfter you got out of military, did you become licensed to  
22 practice in North Carolina?

23 AI was licensed to practice in North Carolina while I was still

1 in the military, ma'am.

2 QOkay. And -- and you became licensed to practice in North  
3 Carolina when?

4 AI believe it was in 1995 because I was moonlighting.

5 QAnd did you -- once you got out of the military -- decide to  
6 move to North Carolina?

7 AWell, my -- as I said, I was trying to save a failed marriage,  
8 that's the reason I took a leave of absence. My family  
9 is spread out all over the United States, but my now  
10 ex-wife's family was actually from the Charlotte and the  
11 West Jefferson area and so her whole family was  
12 concentrated in this area.

13 Because Fort Jackson was so close, that's the reason we  
14 picked Fort Jackson. It was either at Fayetteville at  
15 Fort Bragg or at Fort Jackson and I chose Fort Jackson  
16 because actually the driving distance, it was easier to  
17 get to Charlotte. And that was the reason I went ahead  
18 and got my license here was because I knew that I would  
19 eventually end up moving somewhere where my daughter, who  
20 was my only child at the time, would have family and so  
21 that's why I chose North Carolina and worked the emergency  
22 rooms.

23 QFollowing that or during that period, did you have any

1 particular training in integrative medicine?

2 AActually, not in integrative medicine. My training had been  
3 mostly conventional. It was all conventional surgical  
4 training. I did spend two months at M.D. Anderson as --  
5 in one of my postgraduate years and I can't remember which  
6 one it was. It was three years and also my -- my fourth  
7 year into medical school, I also spent -- did a one month  
8 rotation there. I did surgical oncology rotation at --  
9 at Baylor.

10 There were a number of others, all the various types of  
11 surgical even though it was for surgical residences, for  
12 instance there was time we spent on the urological and  
13 medical. There was some -- in my course of training, it  
14 was not just like, you know, one year at a time or anything  
15 like that.

16 QDid you do a fellowship at the Institute of Preventive Medicine?

17 AYes, ma'am, I did.

18 QExplain to the -- the Board Members what that was.

19 AThe training at -- in Denville that I received, it was a --  
20 it was actually about 14 months. Two months of it was --  
21 actually, I spent two months before the program actually  
22 started. It was not a full-time program. I spent from  
23 Fridays to Sundays at the Institute of Preventative

1 Medicine in Denville, New Jersey. This was part of the  
2 Capital University program that was in Washington, D.C.  
3 which was the only program that had a national recognition  
4 in complimentary and alternative medicine. It has no --  
5 it's no longer viable, but it was at that time and the --  
6 the fellowship in alternative medicine was actually just  
7 starting then. I think I was in the second class.

8 QNow, after you got out of the military, you went into private  
9 practice; is that correct? Or after you finished with  
10 emergency medicine.

11 AWell --

12 QWhen did you go into private practice?

13 AI left the military in 1996 at the age of 29 and I wasn't sure  
14 if I was going to continue with medicine or not. But I  
15 had over 10,000 documented hours in emergency medicine  
16 and I was eligible for the American -- through the American  
17 Association of Physician Specialists for board  
18 certification in emergency medicine and I had to make a  
19 decision to tell the board I was going to sit for the exam  
20 or if I was going to leave medicine and go into law.  
21 My brother, my sister and my father are all attorneys.  
22 I come from six generations of attorneys, so I'm considered  
23 the black sheep in my family since I'm a doctor. So I

1 had to decide which way I was going to go.

2 But I was quite disenchanted with even emergency medicine  
3 people coming in at 2:00, 3:00 in the morning, same problem,  
4 how do you continue to contribute to their -- to their  
5 misery.

6 Asking the patient at 2:00 in the morning, have you talked  
7 to you regular doctor about this? Yes, I've been talking  
8 to my doctor about it for ten years and I still have ischemic  
9 neuropathy, I still have pain in my legs, I can't sleep.  
10 And I was beginning to not be able to look in the mirror  
11 and I was not proud of what I was doing. That was not  
12 why I became a physician. That was not what I signed on  
13 for.

14 The reason I wanted to do surgery was because I wanted  
15 to be able to see the problem, and look at it, spit on  
16 it, throw it on the ground and stomp on it and be done  
17 with it, but I kept on seeing, six months later, a year  
18 later it would pop back up, so obviously that was not the  
19 answer. I knew very early on I wasn't going to do internal  
20 medicine, that's for sure.

21 QSo -- so what direction did you decide to go in your medical  
22 practice?

23 AWell, I didn't really have much of a choice because the only

1 thing I really knew, I was 29 and I had a family that I  
2 had to support and I'd been moonlighting in the emergency  
3 rooms. I was making very good money, exceptional money,  
4 and so I just continued doing emergency medicine.

5 In the back of my mind, I thought maybe one day I'll save  
6 up enough money and maybe I'll open a practice where I  
7 can try to do something different.

8 I used to competitively body-build, natural bodybuilding  
9 and had a lot of nutrition and exercise components  
10 obviously and so I had an interest in that area.

11 I had given lectures on how people could do certain  
12 exercises for their health and their biomechanics and being  
13 an osteopathic physician I had some training in that  
14 anyway. And so I thought maybe one day I can do that and  
15 I don't have to do only conventional medicine.

16 QAnd did you open a private practice then? Yes or no.

17 AYes, ma'am, I did.

18 QOkay. And what -- what are -- what are the goals of the private  
19 practice that you -- when you opened it? What did you  
20 see yourself doing in medicine?

21 AWell, our motto is "making the change the world is waiting  
22 for" and that is -- at that time it wasn't formulated in  
23 those words, but I wanted to do something that I would

1 be able to look at myself in the mirror and be proud of  
2 who I was.

3 QAnd are you proud of yourself today?

4 AI'm very proud of myself now.

5 QAnd over the last eight or nine years since you've opened the  
6 private practice, have you become associated with any  
7 organizations that relate to alternative or integrative  
8 medicine?

9 AExtensive, yes, ma'am.

10 QOkay. Could you name some of those organizations?

11 AI'm the chairman of the American Board of Clinical Metal  
12 Toxicology that was founded in 1973. I'm the president  
13 of the North Carolina Integrative Medical Society that  
14 was founded in 2002, I believe. I have sat on various  
15 boards from the International College of Integrative  
16 Medicine.

17 I have presented at various conferences. I've sat in the  
18 CME committees for four different organizations. I  
19 have -- I'm on the currently on the board of the American  
20 Association for Health Freedom. I was one of the twelve  
21 member task force appointed by the U.S. Congress for the  
22 heavy metals in the United States. I can keep on going,  
23 but it --



1 QHave you been nominated for any awards for your practice of  
2 medicine?

3 AI was nominated for the National Institute of Health Directors  
4 Pioneer Award. As I understand it, it was the only  
5 bipartisan nomination.

6 QHave you testified before Congress on medical subjects?

7 AI have testified in front of the U.S. Congress and I've also  
8 testified in front of the North Carolina Legislature.

9 QAre you an oncologist?

10 AAbsolutely not, ma'am.

11 QDo you treat cancer patients with surgery, chemo or radiation?

12 ANo, ma'am, I do not.

13 QHave you been invited to lecture in conferences dealing with  
14 cancer or dealing with alternative therapies for cancer  
15 patients?

16 AI have lectured at -- I've been invited and I have talked with  
17 the NIH a number of times. I have been invited by the  
18 Central Disease Control and I met with them twice. I've  
19 presented at the American Cancer Society Conference, the  
20 8th Annual Breast Cancer Conference in Puerto Rico. At  
21 that time, I was the -- I was the only person that was  
22 in private practice. Since then I've received a  
23 university appointment.

1 I've lectured at the Frontiers -- Frontiers in Age  
2 Management and Cancer. I believe that's one that you  
3 have -- I've lectured in numerous conferences on dealing  
4 with patients that have compromised immune system and that  
5 are toxic and that are incapable of -- having an inadequate  
6 response in chronic disease and cancer happens to be one  
7 of them, yes.

8 QAnd we'll get to that in a minute about your philosophy of  
9 medicine --

10 AYes, ma'am.

11 Q-- and how you practice, but I want to get to some more of  
12 your credentials. Have you lectured at a conference given  
13 by the AC -- ACS?

14 AYes, ma'am, that's the American Cancer Society.

15 QYes. Okay, you mentioned that. In your 17 years of practice  
16 have you been the defendant in any malpractice cases?

17 ANever, ma'am.

18 QBefore this case, have you ever had a complaint before a medical  
19 board where you've been licensed to practice?

20 ABefore this, I've never -- if I have, I've never been aware  
21 of it, but --

22 QOkay. And have you been before this Medical Board before?  
23 Have you been called before the Medical Board before?

1 AYes, ma'am, I have.

2 MR. JIMISON: Well, objection, irrelevance. I don't  
3 think his prior history with the Medical Board is relevant  
4 to the present charges.

5 MS. GODFREY: Well, it --

6 MR. JIMISON: I mean, he's not charged with anything from  
7 any prior involvement with the Medical Board.

8 MS. GODFREY: Well, the relevance is, is that Dr. Buttar  
9 has been examined by this Medical Board before and -- and  
10 -- he is fully -- what this line of questioning is to show  
11 is that he has cooperated with the Medical Board and he  
12 has tried to work within the system and I think --

13 MR. JIMISON: She can ask that. I mean, without getting  
14 into confidential matters that --

15 MS. GODFREY: Well, it's not confidential if he's --

16 MR. JIMISON: -- are in violation --

17 MS. GODFREY: -- if he's testifying to it, it's his --  
18 it's his case.

19 MR. JIMISON: Dr. Rhyne, the -- as you know, as all the  
20 Board Members know, the doctor is not even entitled to  
21 his own confidential file until public charges goes out.

22 So the doctor cannot waive the confidentiality of his  
23 past public file -- or his past file, his confidential

1 file. If there's anything that's public in the past file,  
2 then you know that's public.

3 But, you know, for instance, doctors come in all the time  
4 and want to get a copy of their medical file for like a  
5 divorce proceeding or -- or a medical malpractice case  
6 and what we've always held consistently to every judge  
7 in the state is that the Board's past file, unless made  
8 public, is confidential and even the doctor cannot waive  
9 that confidentiality to his own file.

10 MS. GODFREY: We're not bringing the medical file into  
11 evidence. We're having Dr. Buttar testify about his  
12 experiences with the Board.

13 MR. JIMISON: But --

14 PRESIDENT RHYNE: You can testify about anything that's  
15 public.

16 MR. KNOX: Thank you.

17 PRESIDENT RHYNE: Anything that's not public has to be  
18 --

19 MS. GODFREY: Anything that's public?

20 PRESIDENT RHYNE: Uh-huh (yes).

21 Q (By Ms. Godfrey) Well, did you come here in -- were you called  
22 to the Board previously in 2003?

23 MR. JIMISON: Objection, that's not public. That's not

1 public information.  
2 PRESIDENT RHYNE: Only public information.  
3 MS. GODFREY: Okay.  
4 WITNESS: It was public, ma'am.  
5 Q(By Ms. Godfrey) Well, let me show you Buttar Exhibit 3.  
6 Would you turn to that please?  
7 PRESIDENT RHYNE: I'm sorry, will you say that again?  
8 MS. GODFREY: Exhibit 3.  
9 MR. JIMISON: That is a non-public letter.  
10 MS. GODFREY: It was --  
11 PRESIDENT RHYNE: Yeah.  
12 MS. GODFREY: -- it was a letter written to Dr. Buttar  
13 by -- by David Henderson.  
14 PRESIDENT RHYNE: That's -- that's -- that's a  
15 confidential letter.  
16 MS. GODFREY: Well --  
17 WITNESS: It's public.  
18 PRESIDENT RHYNE: It's not -- if it's not on our web site,  
19 it's a not a public document.  
20 MS. GODFREY: It was released to Dr. Buttar and Dr. Buttar  
21 has released it to us. I mean, Dr. Buttar made it public.  
22 MR. JIMISON: He can make it public; however, it's not  
23 a public record for purposes of this Medical Board and

1 he's not being charged with anything that happened in the  
2 past. The present charges don't deal with anything in  
3 the past.

4 MS. GODFREY: We're not talking about charges in the past.  
5 We're talking about his ability -- his cooperation with  
6 the Medical Board in the past.

7 MR. JIMISON: You can ask him that. I don't think you  
8 can --

9 MR. KNOX: Well, thank you.

10 MR. JIMISON: You can ask him if he's cooperated with the  
11 Medical Board in the past, but I don't think we can get  
12 into the substance of what the Medical Board did in the  
13 past.

14 PRESIDENT RHYNE: I agree.

15 Q(By Ms. Godfrey) Have you cooperated with the Medical Board  
16 in the past?

17 AYes, ma'am, I have fully cooperated with the Medical Board  
18 in the past.

19 QAnd did -- Buttar Exhibit 3, is that a letter that was written  
20 to you by David Henderson who's the executive director  
21 of the Medical Board?

22 MR. JIMISON: Objection.

23 AYes, ma'am, and the --

1 MR. JIMISON: This was a non-public letter. We're getting  
2 into --

3 WITNESS: Mr. Henderson had told me that my record is not  
4 available to me, but if the Board sends me anything it  
5 is no longer confidential. I specifically asked before  
6 I made this document public.

7 MR. JIMISON: I think we've dealt with this issue enough.

8 PRESIDENT RHYNE: Yeah.

9 MS. GODFREY: Okay.

10 PRESIDENT RHYNE: We've heard the objection.

11 MS. GODFREY: Okay. And are you sustaining the objection?

12 PRESIDENT RHYNE: I think the Board's position has always  
13 been that any -- our records that are sent to a physician  
14 that are not public, are not on the web site, are not public,  
15 they are private and they're not to be shared.

16 MS. GODFREY: All right.

17 Q(By Ms. Godfrey) Let me turn to Buttar Exhibit 4. And that's  
18 a letter written by you, Dr. Buttar, to Tom Mansfield.

19 AYes, ma'am.

20 QAnd it's dated March 11th, 2004.

21 AYes, ma'am.

22 QCan you tell the Board the occasion you had to write that letter?

23 AMr. Mansfield and I had exchanged some e-mails after our

1 testimony in front of the Legislature and one of the  
2 questions that I had was that one of the courses that we  
3 were teaching required physicians to be able to -- in order  
4 to become proficient in a procedure, they would need to  
5 be able to do that procedure just by watching it or being --  
6 having it demonstrated would not be sufficient and so I  
7 needed an opinion from Mr. Mansfield whether or not I could  
8 actually have these doctors do this procedure.

9 And Mr. Mansfield and I discussed this and he asked me  
10 to write him a letter explaining what exactly it was that  
11 we wanted. And his opinion was that since doctors are  
12 not considered -- as long as a doctor is doing it on --  
13 on each other and they had a medical license to practice  
14 in some state, as long as they were at my conference under  
15 my license, they could inject each other. They could not  
16 inject a patient or a staff member.

17 QAnd that was -- that was -- and why did you call Mr. Mansfield  
18 with that -- with that question?

19 ABecause at that time we were discussing the -- there were two  
20 reasons. One was because I had talked to Mr. Mansfield  
21 and Mr. Henderson about having a qualified integrative  
22 physician to review charts of integrative physicians  
23 because there seemed to be a preponderance of integrative



1 doctors being questioned by the Board compared to  
2 conventional doctors. And so I wanted to make sure that,  
3 one, the Medical Board was completely aware of what I was  
4 doing.

5 And, two, that the Medical Board had either given me an  
6 approval or the green light to allow me to teach these  
7 doctors adequately.

8 And I also did the same thing with the Board in South  
9 Carolina and they also approved it.

10 QNow, Dr. Buttar, what is your definition of integrative  
11 medicine?

12 AMy definition of integrative medicine is probably as varied  
13 as the types of therapies that could be construed as  
14 integrative. But to me integrative medicine is taking  
15 the best of what I have learned in conventional medicine  
16 and what I can possibly learn that may not be widely  
17 accepted in order to get the best patient result possible.

18 QAnd what is your philosophy of patient care?

19 AIt is a very serious obligation that I've taken on. I don't  
20 like taking an obligation unless I'm willing to be able  
21 to put 110 percent behind it.

22 And I know that when a patient comes to me, they've already  
23 gone on the average to 15 doctors before they come to me

1 and so I know that God is the only healer and I know that  
2 he's blessed me, that through his hand that I've been able  
3 to help some patients get better and I am very grateful  
4 for having to have that opportunity.

5 QExplain your approach to the treatment of patients who present  
6 to you with end-stage cancer.

7 AMy approach is very simple, ma'am. My approach is to find  
8 what caused the cancer in the first place and to alleviate  
9 that burden in the body. My belief system is that if you  
10 eliminate all toxicity, and that is the key, all toxicity  
11 effectively, unfortunately that is strange to us as humans  
12 that we haven't identified how to effectively remove all  
13 toxicity. But if you can remove all toxicities, then you  
14 have a much better chance of actually achieving a positive  
15 outcome. You may be able to then move on to somebody's  
16 immune system in optimizing the physiology, but the key  
17 is detoxification.

18 QAnd explain to the Board, in general, why you use chelation  
19 with end-stage cancer patients?

20 AWell, I don't use chelation for end-stage cancer patients any  
21 more than I use chelation for any other type of patient.

22 I use it to remove a burden and it just happens that most  
23 of these patients with end-stage cancer have a tremendous

1           burden.

2           In fact, the physiology of cancer patients seems to be  
3           very similar to that physiology of an autistic patient  
4           which is the reason that I was asked by them to come and  
5           testify on that issue.

6   QAnd --

7   AAnd if I can add something that may make it clearer, it's an  
8           inability to get rid of the burden.

9   QAnd, again, when you're addressing end-stage cancer patients,  
10           what do you feel the role of nutritional therapies are?

11   AIt's vital.  If you look at the cancer research, when you look  
12           at the epidemiological studies, it is quite evident that  
13           cancer or war against cancer that was declared by President  
14           Nixon in the late 1960s that we have miserably failed.  
15           We actually have a higher incidence of cancer and now cancer  
16           has become the new false death in the industrialized world.

17  
18           And with all the modern technology, if you can go to the  
19           moon, it would seem logical that we should be able to figure  
20           out what's causing cancer.

21           It appears that on the cellular level that there is an  
22           extreme deficit of nutrients.  When I say nutrients, I'm  
23           not talking about nutrient health, but cellular level

1 nutrients, things such as -- (inaudible) -- super oxide  
2 -- (inaudible) -- etcetera, etcetera. It seems to be the  
3 bottom co-factors that are necessary for these enzymatic  
4 reactions to act in a catalase form as they're supposed  
5 to be in a normal physiology. There seems to be a completed  
6 deficit on some of these patients. In fact, all cancer  
7 patients almost pathognomonically seem to have this  
8 micronutrient deficiency.

9 And what has been postulated which is something that I  
10 came with at the same time that a Greek physician had come  
11 up with, that I love trees and I noticed that the last  
12 thing that a tree does before it dies, it goes into a rapid  
13 state of reparation, it pollinates.

14 And it seems like that's what happens in cancer that at  
15 the last part, right before that area of the body gets  
16 so nutriently devoid, it goes into a self-preservation  
17 mode and starts to self-replicate the suppression of  
18 apoptosis which is characteristic of cancer, it becomes  
19 rampant, the under controlled cellular reparation, the  
20 obvious glucose metabolism, the anaerobic -- the anaerobic  
21 metabolism, there are many different common  
22 characteristics of cancer.

23 There's very -- there many different types of cancer, but

1           there's -- there are common characteristics and they all  
2           seem to be a response, a compensatory response to a  
3           deficiency on some micronutrient level, some microcellular  
4           level.

5   QCould you explain to the Board what role you see for oxidative  
6           therapies with end-stage cancer patients?

7   AThere are many postulates and hypothesis for how these various  
8           types of oxidated therapies work. Unfortunately, there's  
9           no profit for the pharmaceutical companies to do research  
10           to further postulate and elaborate as to what the actual  
11           mechanisms are, but there are a number of things.

12           Dr. Ripoll mentioned and I can further that, not only is  
13           it a catalyst, but it's a ferocity. There are various  
14           enzymes within the cells that in healthy cells that allow  
15           the body to deal with any type of oxidated stress.

16           However, fungi, yeast, various types of candidiases I guess  
17           would be the proper medical term to use, virus, some  
18           bacteria, heterogenic cells basically cells that have  
19           already had suppression of apoptosis that have  
20           uncontrolled cell reparation. They're various types of  
21           cells that actually do not have that compensatory mechanism  
22           intact.

23           So when you introduce an oxidated agent, what happens is

1 you can think of it as a burst of fire that comes to the  
2 scene, healthy cells can protect themselves, they pull  
3 the fire retardant over their cell membranes, if you will,  
4 for a lack of a better explanation, but these other cells  
5 that are the yeast, the viral, the bacterial cells, these  
6 abnormal cells that are mutagenic cells, they don't have  
7 that compensatory reaction, so they actually get hit with  
8 this burst of oxidation.

9 And we have seen sometimes, even within an hour of a person  
10 with say acute influenza what is a rapid change in their  
11 physical appearance and their ability to be functional.

12 It is completely done by this oxidated burst and the  
13 healthy cells are able to compensate and the unhealthy  
14 or un-normal cells that shouldn't be there for them not  
15 to be able to -- (inaudible).

16 QAnd I guess the last class of therapies that I want you to  
17 discuss with the Medical Board is the therapies that would  
18 somehow influence or boost the immune system.

19 AThere are various ways of doing that. There have actually  
20 been studies through using prayer to show that even prayer  
21 has actually increased the level of active killer cells,  
22 active killer cell activity -- (inaudible).

23 But everything from oxidative therapy, we do whatever it

1 takes. We use oxidative therapies, we use various peptide  
2 analogs that's nutritional, whether it's oral, whether  
3 it's intravenous. We have used biofeedback. We have used  
4 meditation. We have used anything that I can possibly  
5 put my hands on to save my patient's life.

6 QAnd have you had empirical success with patients with cancer?

7 AAlmost all cancer -- almost all the patients that have come  
8 to me with cancer have failed conventional therapies and  
9 I would say that of all those patients that were all  
10 considered terminal, I probably have about 40 percent of  
11 them still alive today.

12 QAnd now is that a statistic that you advertise to patients?

13 AMa'am, I have not advertised in 11 years of practicing medicine.

14 I started advertising last summer because we were moving  
15 to a new location and my recurrent complaint by my patients  
16 is that I didn't know you were here, Dr. Buttar. Why won't  
17 you tell the world. I've had patients that lived a quarter  
18 of a mile down the street from me that drove by my office  
19 for ten years that were referred to me by a doctor in  
20 California.

21 QAnd -- and I guess when I said advertising, you took it as  
22 advertising to the -- in the media. What I was wondering  
23 is, do you tell your patients -- do you give them any kind

1 of statistics of success?

2 ANo, ma'am. I tell them that -- you know, to me it's anecdotal.

3 Sometimes doctors will say, well, this is some anecdotal  
4 response and to me, you know, it's a little strange that  
5 we say that because to that patient it's 100 percent of  
6 their experience is not anecdotal.

7 But I also know that I can't rely upon what happened to  
8 one person to be indicative of what happens with another  
9 person. So when my patients ask me what is your success  
10 rate, I tell them that my success rate whether it's 1 out  
11 of 1,000 or 10 out of 1,000 or 100 out of 1,000 is really  
12 irrelevant to their situation because I cannot predict  
13 what's going to happen. All I can tell them is that I  
14 will do my best, but I can't predict anything.

15 QNow, you heard Ms. Kenny testify yesterday, did you not?

16 AYes, ma'am, I did.

17 QYou heard her say that she was in a meeting with you the first  
18 time that her husband went to see you; is that --

19 AYes, ma'am.

20 Q-- correct?

21 AYes, ma'am.

22 QAnd you recall that she said that she heard you say that you  
23 have a 100 percent success rate with cancer patients?



1 AYes, ma'am, I did hear --

2 QDid you ever say that to Jeff Kenny or any other patient?

3 AI've never said that to any human being in my life.

4 QAnd, in fact, you believe that you've never met Stephanie Kenny  
5 before?

6 AI have never seen that lady. In fact, I didn't know who she  
7 was until she walked -- until she was asked to walk up  
8 here.

9 QAnd we'll get to more about that later with your -- when we  
10 go through Patient C.

11 AMA'am, may I make one comment?

12 QYes.

13 AIn medicine, what I was taught that any time anybody said 100  
14 percent, there's no such thing as always or never in  
15 medicine.

16 And I have told my patients and I've lectured on this and  
17 this has been publicly documented that I've told patients  
18 that if doctors say they've got 100 percent or even 90  
19 percent or even 80 percent, they are a liar, you need to  
20 move away from them.

21 QAnd is that just with regard to cancer or with regard to any  
22 kind of treatment for any kind of malady?

23 AWell, especially in the type of medicine I practice, I only

1 get treatment failures -- I only get patients that have  
2 failed everything.

3 I don't have patients that walk in and say, hey, I was  
4 thinking about doing this or that. I get patients that  
5 are coming there from all over the place. I have patients  
6 from other countries, 27 different countries.

7 We don't advertise it. They come because they've heard  
8 from word of mouth and they come because they've failed  
9 everything else.

10 So I can't tell them anything. If they've already failed,  
11 my chances are already less than 1 percent. But the fact  
12 that they get better, the only -- the only thing I  
13 contribute it to is that God has blessed me.

14 QNow, let's talk specifically about these patients that are  
15 the subject of the complaints --

16 AYes, ma'am.

17 Q-- Patient A.

18 AYes, ma'am.

19 QCould you just in general summarize for the Board your -- your  
20 analysis of Patient A's case?

21 AWell, Patient A was a 49-year-old. Do you want me to do my --  
22 my synopsis of the case or --

23 QOh, I want you to tell the Board what you recall about Patient

1           A.

2    Patient A was an end-stage cervical cancer patient who  
3           presented to me in late July of 2006. She was diagnosed  
4           in 2003. She had a history of a radical hysterectomy and  
5           bilateral salpingo-oophorectomy and node dissection  
6           sometime in 2003. Late 2003, she had -- if I remember  
7           right, she had one or two out of 14 nodes that were positive.

8  
9           By September of 2003, I believe she had completed about  
10          25 or 27 some radiation therapies. And after completion  
11          of the radiation, the patient had regular checkups for  
12          the next few months or was scheduled for checkups every  
13          six months.

14          I don't believe she went a full six months because in April  
15          she began having some pain. In 2004, I believe it was,  
16          she started having some pain on her right side and she  
17          ended up seeing a family physician. They had some scans  
18          done, some CAT scans and an ultrasound done and they found  
19          that she actually had a recurrence with metastatic disease  
20          to her lung and her liver. Her hepatic metastasis I  
21          believe was not as extensive as her lung metastasis was.

22  
23          She was referred to M.D. Anderson. She had chemotherapy

1           which included carboplatin treatments I believe she had  
2           it twice, it's all in the record. She completed her last  
3           treatment sometime in June of 2006.

4           Was seen in July of 2006 again by M.D. Anderson who noted  
5           that her liver enzymes were beginning to become elevated  
6           and they told her that she had basically failed everything  
7           and they referred her to hospice.

8           QCould you turn to Exhibit 11 in our -- in our book please?

9           AYes, ma'am.

10          QIs Exhibit 11 a medical note regarding Patient A as to her  
11          last visit at M.D. Anderson?

12          AYes, ma'am, it is.

13          QAnd is that part of the medical records that you reviewed to --  
14          to get that summary?

15          AYes, ma'am, it is.

16          QAnd does that reflect that as of July 13th, 2006 she was being  
17          denied further treatment at M.D. Anderson?

18          AYes, ma'am, it does.

19          QFollowing -- following her last visit to M.D. Anderson, did  
20          she then seek you out?

21          AYes, ma'am, she did.

22          QOkay. And do you know if you saw her the first time she came  
23          to the office?

1 AI saw her, but I saw her -- I stepped into the room. I did  
2 not do the office visit myself because our computer program  
3 for scheduling had been down and I remember that there  
4 was a out-of-country patient there that they were leaving  
5 the next day, so I went ahead and saw that patient and  
6 Jane saw Patient A and then I stepped in and talked with  
7 her and her husband briefly.

8 QDo you -- first of all, the person you referred to as Jane,  
9 who -- who is that?

10 AThat's Jane Garcia, she's my nurse practitioner.

11 QAll right. And how long has Ms. Garcia worked for you? We  
12 can turn to Exhibit 5 and that might refresh your  
13 recollection.

14 AIt's been years, I'm not sure, five maybe.

15 Exhibit 5, ma'am?

16 QYes. Is Exhibit 5 the collaborative practice agreement  
17 between you and -- and Ms. Garcia?

18 AYes, ma'am, but I think I started her -- I think she started  
19 before this.

20 QOkay. The earliest date on that is 2003. Is that --

21 AOh, 2003. I only saw a 2004.

22 QYeah.

23 AYeah, 2003 sounds right, about five years.

1 QOkay. And so -- so as of 2006 Ms. Garcia had been practicing  
2 with you for at least three or four years?

3 AYes. Yes, ma'am.

4 QOkay. And tell the Board about your working relationship with  
5 Ms. Garcia.

6 AWell, the joke is that I'm lucky she's not 20 years younger  
7 because I may be having an affair with her. That's how  
8 much time I spend with her.

9 I have a very, very good working relationship with Ms.  
10 Garcia. I interviewed -- I went through an extensive  
11 number of people before I found somebody that I trusted  
12 enough to take care of my patients with me to help me take  
13 care of my patients.

14 QAnd have you trained Ms. Garcia yourself?

15 AExtensively.

16 QAnd -- and describe the access Ms. Garcia has to you.

17 AWell, Ms. Garcia is -- has 24 hour access to me anywhere in  
18 the world at any time she needs.

19 Ms. Garcia also spends -- well, just this week the clinic  
20 closed at 5:30, she and I were in the clinic until about  
21 8:45.

22 We spend a lot of time together going over various things.

23 We have set once a week, I guess you would call it

1 mini-rounds where we review charts, but that's just what  
2 we have set aside time. Throughout the week, any time  
3 she needs me for anything.

4 She has become a very trusted member of my staff. The  
5 most trusted when it comes to clinical aspects. She is  
6 anal retentive. She constantly second guesses herself  
7 when she has shown to be very proficient and it's only  
8 because she's that anal retentive. She's a fantastic  
9 nurse practitioner and I would not -- I would not be --  
10 (becomes emotional) -- I would not be able to do everything  
11 that I need to do without Jane's help.

12 QDo you want a drink of water, Doctor?

13 AYes, ma'am.

14 QNow, let's -- let's go to Exhibit 6 in our -- in our book and  
15 again there's been redaction to that, but I'll represent  
16 to you that that is the set of consent forms that Patient  
17 A signed.

18 AI'm not sure what you mean by redaction.

19 QOh. The personal -- the identifying information has been  
20 removed --

21 AOh, I see.

22 Q-- for the privacy of Patient A, so her name is not on there,  
23 so it's -- you can't say -- I have to tell you what it

1 is. That's the only way in this -- it can work in a public  
2 hearing setting.

3 AYes, ma'am.

4 QAnd Exhibit 6, I will represent to you is a set of consent  
5 forms that was signed by Patient A.

6 AYes, ma'am.

7 QThe first one is just an intake form with information on it.  
8 The second page is the Consent for Treatment.

9 AYes, ma'am.

10 QDo you recognize that Consent for Treatment?

11 AYes, ma'am.

12 QAnd is that Consent for Treatment used with the patients  
13 consistently in your office?

14 AWith every patient that comes into our office.

15 QOkay. And if the patient has any questions about the consent  
16 forms, are there people that they can ask about that?

17 AAbsolutely. When the patient -- yes, ma'am.

18 QAnd this Consent for Treatment signed by Patient A refers to --  
19 to cancer, does it not?

20 ANo, ma'am. It refers to everything.

21 QOkay. Well, why don't you read it for the Board.

22 AI authorize the medical and nursing staff at Advance Concepts  
23 in Medicine and Dr. Buttar to perform diagnostic tests



1 and administer treatment plans for allergy, immune  
2 disorders, nutritional disorders, cancer, autism and  
3 public chronic medical conditions.

4 I fully recognize that the treatments I will receive may  
5 include nutrient, herbal, oxidative, functional,  
6 integrative, alternative, preventive and/or conventional  
7 therapies.

8 I also understand that: 1) the safety and efficacy of many  
9 such therapies has not been established with controlled  
10 studies; 2) specifically no claim to cure cancer with these  
11 therapies has been made to me; 3) Dr. Buttar will not be  
12 providing hospitalized care or emergency care for me from  
13 this clinic; and, 4) the therapies I receive will  
14 compliment the care I receive from my primary care  
15 physician and will not replace them.

16 QAnd tell -- tell the Board why you word your Consent for  
17 Treatment that way.

18 ABecause, again, I come from six generations of attorneys and  
19 my consent form that my father and my sister came up with  
20 would have taken a couple of weeks to go through, so we  
21 took the highlights and put this together.

22 And they told me that in our litigious society and  
23 especially with the limelight that doctors like I am that

1 are successful in certain modalities of treatment where  
2 those other people may not be, it would be better for me  
3 to have a consent form such as this and we basically kind  
4 of condensed it down to this one before we treat them.

5 QWell, and is this consent form consistent with the way you  
6 represent yourself to your patients?

7 AYes, ma'am. But there's another consent form before we start  
8 actual treatment. This is just before I ever see them  
9 or my nurse practitioner sees them. This is just before  
10 we even sit down to talk to them. And they're given this  
11 consent form, we sit down and talk with them and then they  
12 have to sign it afterwards.

13 Before we -- there's another consent form before treatment.

14 QAll right. And you're talking about the IV consent form?

15 AYes, ma'am.

16 QOkay. The third page of Exhibit 6 is the Financial Policy.

17 AYes, ma'am.

18 QAnd I think we've been over that and what it says. Is that  
19 presented to each patient before -- before treatment?

20 AYes, ma'am. And we have designated staff members that that  
21 is their responsibility and it has to be checked off by  
22 a second person to make sure that they have been -- had  
23 adequate explanation of this policy.

1 QNow, during the period of time that you treated Patient A,  
2 did you have -- and let's turn if we can to Exhibit 7 in  
3 the book.

4 During the period of time that you treated Patient A, did  
5 you have occasion to refer her to Dr. John Clements at  
6 Carolina Digestive Health Associates?

7 AAbsolutely.

8 QAnd tell the Board why you did that.

9 AWell, when she presented to me she -- it was obvious that nobody  
10 had addressed her issues of jaundice. We had -- she  
11 wasn't -- she didn't -- her course of progression made  
12 me feel that she may have some type of a biliary outlet  
13 obstruction and I wasn't sure what was going on. I called  
14 Dr. Clements and he was kind enough to get her in right  
15 away to see what was going on.

16 I don't -- he and I talked about possibly during a ERCP  
17 on her. I don't know whether he did, I can't remember.

18 But basically there was no biliary obstruction that he  
19 could -- that he could see.

20 QOkay. And just in general in treating your patients do you  
21 utilize other medical providers in treating your patients?

22 AIn all these patients you can see consultations with other  
23 doctors, oncologists and such.

1 QAnd in what circumstances would you particularly refer to a  
2 patient to an outside doctor?

3 AWhen I need help getting -- supporting what we're doing for  
4 the patient.

5 QLet's turn to Exhibit 8.

6 AYes, ma'am.

7 QExhibit 8 is the pages of the expert review sheet that Dr.  
8 Peterson filled out for the Medical Board.

9 AYes, ma'am.

10 QHave you had an occasion to review that?

11 AYes, ma'am.

12 QNow, I will tell you that -- I'm trying to see which order  
13 these are in. I think Patient A is the second review sheet  
14 in this sequence. I should have put them in correct order.  
15 But the 49-year-old female with cervical cancer.

16 AYes, ma'am.

17 QDo you see that one?

18 AYes, ma'am.

19 QOkay. And what I'd like to do now is go to the second page  
20 of that expert review sheet.

21 AYes, ma'am.

22 QAnd ask you to address the comments that Dr. Peterson made  
23 with -- with regard to your care and treatment of this

1 patient. The first comment I'd like you to address is  
2 Dr. Peterson's opinion that your treatment was below the  
3 standard of practice or care. Can you give a reaction  
4 to that, please?

5 AI've never done anything standard in my life and I'm not going  
6 to practice a standard when it's -- to me, it's not  
7 standard. I have a patient that comes to me and they want  
8 me to help them and I'm going to do everything I possibly  
9 can to help them.

10 Below standard of practice. Well, that's his opinion.  
11 I chose to only do one thing and that's practice above  
12 the standard.

13 QAnd -- and why do you believe you practiced above the standard  
14 with this patient?

15 AWell, because we had subjective and objective improvements  
16 through her short course of therapy.

17 QOkay. What were some of those improvements?

18 AOn -- do you want me to specifically give the dates and --  
19 and --

20 QWell, just tell us what the nature of the improvements are.

21 AWell, she had liver functions that were progressively  
22 increasing and we started her therapy and her liver  
23 functions came down between July 31st and August the 3rd

1 and she was able to sustain that improvement for about  
2 two weeks and then the liver functions started going back  
3 up.

4 She had -- she was anemic when she came to us and she had  
5 a consistent improvement in her hemoglobin and her  
6 hematocrit. In fact, her hematocrit was back up to normal  
7 within three weeks of therapy.

8 She was able to reduce her pain medication. In fact,  
9 eliminate her pain medication for about 12 days, 10 to  
10 12 days, if I recall correctly.

11 Her nausea had improved. She was able to ambulate. She  
12 had a better sense of -- she had a better sense of balance  
13 and her ambulation improved.

14 She did start after about 12 to 14 days start showing the  
15 liver function increasing and was also followed by -- she  
16 became icteric and she was -- had mild jaundice and that's  
17 when I got Dr. Clements involved to see if there was any  
18 type of massive -- mass effect versus a direct obstruction  
19 of her biliary tree.

20 QOkay. Now, Dr. Peterson's next comment is that he states the  
21 patient chart does not follow the problem oriented medical  
22 record methods of SOAP. So can you give your reaction  
23 to that, please.

1 AWell, I'm not sure which charts he was looking at because I  
2 can give you the specific dates in the chart, one, two,  
3 three, four, five, six, seven, at least eight entries where  
4 the SOAP note was used.

5 I use a SOAP note the same way learned how to use it at  
6 M.D. Anderson. We don't label the plan as a plan, we use --  
7 we label it as AP, assessment plan, and where the  
8 assessments only go through where you write it as an  
9 impression. So we have subject, objective, impression  
10 and assessment of the plan, but that's -- that's how I  
11 learned it in my training and it's the same way that  
12 everybody else uses it, but it's right there in the chart.

13 QAnd turn if you will to Exhibit 9.

14 AYes, ma'am.

15 QAnd I'll represent to you that those are the progress notes  
16 and treatment plan for Patient A.

17 AYes, ma'am.

18 QNow, the first two pages are the initial note; is that right?

19 AYes, ma'am. This is her first time.

20 QOkay. And who took the history?

21 AJane did.

22 QOkay. And did you review that?

23 AYes, ma'am.

1 QAnd are the notes that were made mostly made by Jane in here?

2 AIn this whole chart or just --

3 QIn this -- in this section.

4 AIn these two sheets?

5 QYes.

6 AYes. Jane -- Jane made these notes.

7 QOkay. And did you then review and countersign them?

8 AI reviewed the notes with her the same day actually, that's  
9 when I stepped in with the patient.

10 QOkay. And then as the treatment progressed, did you  
11 continually review the notes that were made?

12 AThe ones that I wasn't in there with her, I reviewed and  
13 co-signed; otherwise I did the notes myself or I did review  
14 them myself or whatever.

15 QOkay. And does the chart show your co-signature on that?

16 AYes, ma'am, after the slash.

17 QAnd let's go back to Dr. Peterson's comments. His next comment  
18 is the standard of care was to refer -- to refer this patient  
19 for hospice -- to hospice for palliation. Could you give  
20 your reaction to that?

21 AShe was already referred to hospice. I'm not -- she came to  
22 me from hospice, so I'm not sure why I would send a patient  
23 that came from hospice back to hospice if she was already



1 referred to hospice.

2 QOkay. And what did you note -- and I'll turn your attention  
3 to the progress notes. What did you note about this  
4 patient's desires to go to hospice as opposed to continuing  
5 treatment with you?

6 AIn -- well, I know that the family was very adamant. I know  
7 that they were -- they had already done their homework.

8 They had already checked out certain things and  
9 unfortunately sometimes the things that they were relying  
10 on may not be as reliable, but they had a lot of information.

11 They were well versed.

12 They knew that they were out of options on the conventional  
13 side. I asked them if they had talked with their  
14 oncologist -- (inaudible) -- providing clinical trials  
15 and they said that they had no -- they had no other options  
16 and that that's why they came to us.

17 QAnd what did you --

18 AI'm sorry --

19 QWhat did you observe yourself about this patient's desires  
20 as far as -- herself as far as continuing treatment?

21 AWell, I remember that when it became clear to us that she was  
22 failing our supportive therapies and her immune system  
23 was not responding or if it was responding, it was a little

1 too late because she was already in multi-organ system  
2 failure. I had -- she was actually in the IV suite, she  
3 was getting an IV and I asked Robin my nurse -- and the  
4 only reason I know it's Robin is because when you work  
5 at the office and you find out who it was because I couldn't  
6 remember who it was.

7 When one of my nursing staff members went to get her from  
8 the IV suite to bring her into the exam room, she refused.

9 She did not want to come to the exam room. And I was  
10 in the exam room, the daughter was in the exam room and  
11 I asked Robin, what's going on.

12 And Robin said, Dr. Buttar, she doesn't want to come in  
13 here.

14 And Marie, her daughter, went out and came back in in tears  
15 and she said, Dr. Buttar, she doesn't want to come in here  
16 because she thinks that you're going to stop her treatment  
17 and she cannot handle that. She will not stop treatment.

18  
19 And then I had this discussion that's documented on August  
20 14th with her daughter at that time.

21 QAnd is that documented in Exhibit 9 at page C7?

22 AC7A, yes, ma'am.

23 QC7A?

1 AYes, ma'am.

2 QOkay. And, again, whose writing is that?

3 AIt's mine, ma'am.

4 QOkay. And what did you document at that time?

5 ADo you want me to read the note?

6 QSure.

7 AI discussed with daughter the issue of evaluation with Dr.

8 Clements showing no external biliary obstruction,

9 deteriorating LFT, with increasing alkaline phos. and

10 bilirubin indication of progression of tumor and

11 increasing need of narcotics to control pain, further

12 indication of progression of disease. However,

13 hemoglobin and hematocrit actually improving.

14 Daughter states mom wishes to continue treatment and the

15 daughter nor myself wish to take hope away from that

16 patient -- from the patient. Daughter states her mother

17 is adamant about continuing treatment.

18 Abdominal ultrasound, enumerable hepatic lesions

19 consistent with extensive metastatic disease with no extra

20 biliary obstruction.

21 And I've got her lab values documented there and what we

22 were going to continue doing.

23 QOkay. And in this patient what was the influence as far as --

1 as -- well, let me withdraw that and try to restate it  
2 another way.

3 In this patient why did you continue treatment?

4 AWell, one was because I have -- I'll try to be succinct with  
5 this, but I'll --

6 QPlease do.

7 AWell, I've taken a lot of fire in service to my country to  
8 ensure freedom and I do not see why that freedom that I  
9 have potentially given my life for that I come back home  
10 and that my patients don't have that freedom to make a  
11 choice they want or I don't have the freedom to try to  
12 help them if I think that I can possibly help them.

13 QAnd at this point, had you given up hope?

14 AWell, I never give up hope, but I could see the writing on  
15 the wall. At this point, her detoxication and her immune  
16 colliquation was not the issue. She was already in organ  
17 failure. And unfortunately once you're in organ failure,  
18 there's nothing that could be done because now you've got  
19 the organs that necessary to up regulate if you want to  
20 detox by somebody they've already failed, so there's no  
21 way to get rid of the toxicity.

22 Just to make sure, I mean, I called Dr. -- one of the  
23 oncologists that I work with who is in my opinion probably

1 the leading oncologist in the country and talked with him  
2 too and discussed the case. I don't know whether it's  
3 documented in here or not, but I did. I remember talking  
4 to him.

5 QTurn to the next page.

6 AYes, ma'am.

7 QPage 70.

8 AYes, ma'am.

9 QWhat does that document?

10 AThat's discussed with Dr. Holbert in details -- in detail.

11 And basically I was --

12 QAnd who is Dr. Holbert, just --

13 AHe's a hematologist oncologist and he -- as I understand it,  
14 he's got board certified in nine specialties, but I'm not  
15 sure if that is correct.

16 QAnd so you called to discuss this patient with Dr. Holbert?

17 AYes, ma'am, I did.

18 QAnd -- and based on your discussion with Dr. Holbert, did you  
19 believe you could still continue the -- there was some  
20 chance you could help him?

21 ADr. Holbert and I were of the same conclusion. He said you're  
22 doing everything you can for Patient A and keep on going.

23 QOkay.

1 AI mean, basically he told me that, you know, if she's already  
2 been turned away by everybody else, what are you going  
3 to do, dump her in the street. That was pretty much the  
4 words that he used.

5 QOkay. And -- and, again, this note, the 15th of August was  
6 how long between that note and death at this point?

7 AI believe the patient was -- it was -- it was the same week,  
8 I believe.

9 QThe last criticism by Dr. Peterson on this patient is no  
10 physician contact documented. We just looked at a note  
11 that you wrote. Did you have physician contact with this  
12 patient?

13 AI had -- I made notes based on the chart. I don't know where  
14 they are here, but I know the dates that I saw the patient.

15 QOkay.

16 AI saw the patient on July 26th. I performed an  
17 intra-respiratory reflex on the patient. I'm the only  
18 who does that, so there was no way the patient could have  
19 received that treatment without having contact with me  
20 and the note is in the chart.

21 On August the 3rd, I performed IRRs on the patient. She  
22 was having problems with breathing and she had a documented  
23 improvement after the IRRs within about 25 seconds to a

1 minute, it's in the chart.

2 On August the 14th, I had a long visit with the patient.

3  
4 On August the 15th, I did IRRs on the patient. In addition,  
5 at least three separate detailed conversations with the  
6 patient and the daughter regarding the whole prognosis  
7 while Jane was in the office dictating while I was talking  
8 to the patient.

9 And pretty much with all my cancer patients I see them  
10 every day they're in the office. I just don't make a note  
11 perhaps, but I stop by and talk to them, see how they're  
12 doing, how they're appetite is. I may check for edema.

13 It's not a hard and fast rule because I may be tied up  
14 with other patients, but I see them virtually ever day.

15  
16 We only charge for an office visit when I sit down for  
17 an hour with them or an hour and a half, but, you know,  
18 five minutes, ten minutes, there's no -- there's no charge  
19 for it and sometimes it's not documented.

20 QNow, let's turn if we -- if we can to Patient B and I want  
21 to go back to Dr. Peterson's criticisms of your treatment  
22 of Patient B in Exhibit 8. That would be the next expert  
23 review worksheet starting with a 51-year-old, metastatic

1           ovarian cancer. Do you see that?

2   AYes, yes. Wait a second. Did you say it was the third one?

3           MR. KNOX: Yeah, the third one.

4   QYeah, third one right after Patient A.

5   AYes, ma'am.

6   QFirst of all before we address Dr. Peterson's comments, could  
7           you give us an overview of your treatment of Patient B?

8   AYes, ma'am. She was 51-year-old white female who presented  
9           April 29th. She was in Stage IV ovarian cancer referred  
10          to us by her primary care physician. Her initial diagnosis  
11          was in August of 2002 of having carcinoma of the ovary  
12          with staging done in 2002 and she was staged at 3C at that  
13          time. She went for a suboptimal bilateral  
14          salpingo-oophorectomy of the tumor could also be done.  
15          The patient's history included a total abdominal  
16          hysterectomy in July with the ovaries that had been left,  
17          but that was later resected.

18          After the diagnosis with the ovarian cancer she underwent  
19          chemotherapy with carboplatin and Taxol and until about  
20          April 2003. Her CA 125 continued to rise. I went from  
21          202 up to 715. The CAT scan showed persistent mixed radio  
22          dense masses on the bladder.

23          By June of 2003, cancer markers had risen to 1292. They



1 changed her chemo and changed her to weekly doses. I can't  
2 remember what the chemo was.

3 In August of '03, repeat CAT scans revealed that she now  
4 had lesions in her liver.

5 By September, chemotherapy was again changed. This time  
6 was to Doxil. All in all, she had 16 months of chemotherapy  
7 before she presented to us.

8 QAnd what was your treatment plan with this patient?

9 AOne of the things about this lady that I remember, she was --  
10 she was a very sweet lady. But she had -- she basically  
11 was referred to hospice when she came -- well, she was  
12 referred to hospice when she came to us, but she hadn't  
13 had any conventional treatments since December of the  
14 preceding year, so she hadn't had any treatments for about  
15 five months before coming to us.

16 And one of the things I wanted to do was get a CA 125 on  
17 her and her last CA 125 had been around 5,000. And she  
18 said, well, I had one done in December.

19 And I said, well, we need to do another one and she didn't  
20 want to do it because she didn't believe in -- one of my  
21 experiences is when patients have failed everything, they  
22 don't believe in anything that the doctor says.

23 So I just told her, I cannot do anything with you until

1 I get a baseline to see where CA 125 is. And we -- we  
2 obtained that before we initiated any treatment with her.  
3 QOkay. And before you initiated any treatment, what was her  
4 CA 125?

5 AWell, she came to us on April 29th, we -- I'm sorry, yes, I  
6 believe that was right, yes. We did a CA 125 on her which  
7 was done on -- CA 125 was done April the 15th. Actually,  
8 I guess she came to us before then, but we didn't start  
9 any treatments. The CA 125 was done, 10,000 -- it was  
10 10,000 -- 10,028.1.

11 QOkay. Turn if you will if this will help you to Exhibit 14.

12 AYes, ma'am.

13 QTurn if you and this will help you, to Exhibit 14.

14 AYes, ma'am.

15 QI will represent to you that Exhibit 14 are the blood work  
16 done for cancer work -- and I guess his brother --

17 AYes, ma'am.

18 Q-- just was a patient.

19 AYes, ma'am.

20 QAnd is there a chart in here that measures the progression  
21 as far as her CA 125?

22 AI believe there was one that she did herself or her -- her  
23 boyfriend did. It was -- it was referred to the letter,

1           it really wasn't a letter, but it was somewhere in here,  
2           I believe.

3   QIt's the last page.

4   AYes, ma'am, the last page.

5   QG27?

6   AYes, ma'am.

7   QAnd is that the chart that they presented to you --

8   AYes, ma'am.

9   Q-- with her progression on C 125 --

10   AYes, ma'am. We just --

11   Q-- CA 125?

12   AYes, ma'am. We just put it in the chart.

13   QAnd then is it also noted on that chart her -- her measures  
14           during treatment with you?

15   AYes, ma'am.

16   QWhat does it show?

17   AIt was 10,028 and after -- well, it's important to note that  
18           she really didn't initiate IV therapies until sometime  
19           in May and she was -- she was under -- she only had IV  
20           treatments for about three and a half weeks. And on June  
21           11th which was her last, I believe -- well, that was when  
22           we got the next CA 125, the CA 125 was down 6,219.

23   QOkay. And with regard to your treatment of this patient, turn

1           if you will to Exhibit -- Exhibit 12.  
2   AYes, ma'am.  
3   QAre these the same consent forms that we looked at earlier  
4           with regard to Patient A?  
5   AThere's -- yes, ma'am. They're slightly different because  
6           at that time the -- I mean, the wording is the same, it's  
7           just on the same piece of paper, the intake form instead  
8           of the other side.  
9   QOkay. And were these -- these consent forms, as far as Patient  
10          B, signed to your knowledge?  
11   AYes, ma'am, they were.  
12   QOkay.  
13   AIt's checked before we do any kind of treatment.  
14   QAnd with regard -- turn if you will to Exhibit 13.  
15   AYes, ma'am.  
16   QAnd I'll represent to you that Exhibit 13 is a set of progress  
17          note to this patient?  
18   AIt's --  
19   QOkay.  
20   AYes, ma'am.  
21   QAnd who saw the patient when she first came?  
22   ABoth of us did.  
23   QBoth of us who?

1 AJane Garcia and myself. Jane Sprite.  
2 QOkay. And -- and who -- who co-signed the note?  
3 AIt's mine.  
4 QOkay. And did you -- you yourself meet with this patient?  
5 AYeah. I was telling Jane what we were going to do. I'm talking  
6 to the patient and Jane was just writing everything down.  
7 QOkay. And then a physical exam was performed on this patient  
8 on May 11th?  
9 AYes, ma'am. Before we start IV treatments, we have to do our  
10 own exam.  
11 QAnd who performed the physical exam?  
12 AI did.  
13 QOkay.  
14 AI mean, we do an exam all the time, but this is a form --  
15 (inaudible) -- through the exam.  
16 QOkay. And are there more notes by you on the 11th of May?  
17 AYes, ma'am.  
18 QOkay. Summarize if you will the course of this patient with  
19 your clinic.  
20 AYou mean, how many times I saw her?  
21 QWell, not necessarily how many times you saw her, but what  
22 happened during the course of treatment.  
23 AWell, each time I would visit with her or we do the IRRs, she

1 was obviously responding to treatment, but the problem  
2 was that she was very non-compliant.

3 She was under the impression that if she came for the IVs,  
4 which she was very religious about doing, that she would  
5 get better and that's simply not the case. It's just one  
6 part of the treatment.

7 And so I kept on telling her she had to do -- she had to  
8 watch what she was eating. She would come in with those  
9 crackers and cheese that you pick up at gas stations that  
10 are laden with all sorts of preservatives and half the  
11 stuff is all synthetic and she was still putting that stuff  
12 in her body.

13 She wasn't doing the liver packs which -- and the coffee  
14 enemas that are necessary to help pull some of these body  
15 burdens and as a stringer she wasn't doing that stuff.

16 She wasn't -- she just overall wasn't doing what she was  
17 supposed to do.

18 She was under the impression that if she just did the IVs  
19 that she was going to get better.

20 QAnd as a result of her non-compliance, what -- what decision  
21 was made with regard to her further treatment by your  
22 practice?

23 AI told her that if she wasn't willing to do what was necessary

1 to get better, I was not going to watch her die.

2 QAnd -- and --

3 AI gave her the choice to see if she was going to change and  
4 she didn't and I had a conversation with Jane and then  
5 we had a conversation and we felt that it was best to  
6 discharge the patient from our practice.

7 QAnd -- and was that accomplished?

8 AThat was accomplished and it was -- she was referred back to  
9 her primary care physician.

10 QNow, with regard to -- going back to Exhibit 8 and the pages  
11 of Exhibit 8 that deal with this patient, can you tell  
12 us your response to Dr. Peterson's criticisms of your  
13 practice? The first one being she was treated by Dr.  
14 Buttar with alternative therapies without success.

15 AWell, he thinks that a drop of 4,000 in CA 125 after three  
16 weeks and three days of IVs is no success, then I guess  
17 he's entitled to his opinion.

18 QWhat about --

19 AI fought the -- (inaudible) -- part of it is -- for his freedom  
20 of choice as well, so.

21 QOkay. And his -- his assessment that your care was below the  
22 standard of practice?

23 AWell, Ms. Godfrey, I think you know what they say about

1 opinions, everybody has one.

2 QOkay. What about his reference to your failure to use SOAP  
3 notes?

4 AWell, it's documented. I'm not sure what he means by that  
5 because each one of these charts has SOAP notes. It was --  
6 if a person knows how to read English, then he can read  
7 the SOAP notes, but I don't know what -- how to comment.  
8 He obviously didn't read the notes -- or I'm not sure.

9 QAnother comment by Dr. Peterson is like the three prior  
10 patients, there's no evidence that Dr. Buttar or any  
11 physician at his clinic ever interviewed or examined  
12 Patient B.

13 AI've got my own exam in there. I've got notes in there. I  
14 can tell you exactly which days I saw her, what dates they  
15 were performed, it's all documented in the chart. The  
16 Medical Board has had this information since sometime in  
17 2006.

18 QDr. Peterson also stated she was treated with alternative  
19 therapies consisting of vitamins.

20 AYes, ma'am, she had --

21 QShe had vitamins, IRR injections --

22 AYes, ma'am.

23 Q-- all unproven. This is clearly not the standard of care.



1           What is your opinion of that statement?

2   AHe's right, it's not the standard of care, it's beyond the  
3       standard of care.

4   QAnd do you -- do you believe your therapies had the ability  
5       to help this patient?

6   AI believe that any therapy that eliminates a burden, a toxic  
7       burden in the body, is going to help the patient.

8       It's already been established now in the field of quantum  
9       physics where the quantum coherence field is being  
10      interrupted by some type of signal. And essentially what  
11      I'm trying to do is achieve zero point. Zero point being  
12      defined as maximal output with minimal expenditure.

13     To me, the human body is the most perfect piece of machinery  
14     because it's the only piece of machinery that I know of,  
15     the more you use it, the better it gets, but there's some  
16     reason that it's starts to deteriorate.

17     And the reason it's deteriorating is because of the level  
18     of toxicity that we are being exposed to on a constant  
19     level.

20     So any therapy that is going to remove that burden, whatever  
21     that burden is, will have a substantial improvement at  
22     helping the person's system. And if their system is  
23     up-regulated and their immune system is up-regulated, and

1           their detox, then obviously the patient is going to do  
2           better.

3   QDo you -- do you feel like during the time you treated this  
4           patient you had a good relationship with her. Well, what  
5           was the nature of your relationship with this patient?

6   AShe was a very sweet lady. I formed an attachment to her.  
7           I knew that she was going to not do well because she just  
8           wasn't listening. She wasn't becoming compliant.  
9           And her fiance was very supportive and actually was  
10           probably an instrumental part of her support system that  
11           tried to help encourage her, but he even told me that she  
12           just -- when she goes home, she doesn't do what you're  
13           asking her to do.

14   QNow, during the course of her treatment with you, did you  
15           receive a gift from Patient B and her fiance?

16   AYes, ma'am.

17   QAnd I can't part with this because we only have one copy of  
18           it, but could you -- could you tell the Board what this  
19           is? And it's designated as Exhibit 15.

20   AIt's --

21   QBut I couldn't get a copy of it.

22   AShe was an antique collector and she had gone out and tried  
23           to find an antique for me which I thought was very sweet.

1           It was -- it's a medical dictionary that's over 100 years  
2           old.

3       QOkay. And did she or -- or her fiance, I'm not sure which,  
4           inscribe something in that?

5       AYes, ma'am. Yes, ma'am. For Dr. Buttar from Alex and XXXXXX  
6           (Patient B), May 17th, 2004.

7       QAnd that was received by Patient B -- or -- okay, never mind  
8           that. Withdraw that question.

9       AShe gave it to me, yes, ma'am.

10      QShe gave it to you. I'll get it right.

11      AYes, ma'am.

12      QWhen Patient B left your care, was there a balance owing?

13      AI don't really know. I don't deal with that part of the  
14           practice, ma'am. I think there may have been, I'm not  
15           really sure.

16      QOkay. Do you know -- well, do you know if your practice ever  
17           collected from her estate?

18      AI know that there was -- I don't know whether she had a balance  
19           then. I don't know what the details were, but I know that  
20           nothing was pursued.

21           I didn't know when she passed on. She had been given --  
22           I believe she had been given just a couple of months to  
23           live, but she lived five -- five months or maybe six months.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23

And when she passed on, when she transitioned, there was no further effort from my staff because they know that if something like that happens, you know, we send a card.

And that's what we did, we sent a card. I don't know what else Libby does or --

QOkay. Now, with regard to Patient C --

AYes, ma'am.

Q-- could you describe your -- your overview of Patient C for us?

AIs it a he?

QYes.

AYeah, okay. I thought you said she, I'm sorry.

QIt's a he.

APatient -- the last patient we just discussed and this patient we're about to discuss, I've actually presented these as case studies in a couple of different conferences.

Patient C and I -- Patient C and my entire staff developed a very close relationship and I think that's just because of a function of time that he spent with us.

He was a patient with adrenal carcinoma initially diagnosed in 2003. Status post a cervical resection that was done in October with a left-sided nephrectomy, adrenalectomy

1 and splenectomy. He had extensive lymph node dissection  
2 done and he presented to me with a 59 pound weight loss  
3 after having had -- well, he presented with a 59 pound  
4 weight loss after his radiation therapy.

5 He had a history of a prior diagnosis of cancer. He had  
6 abdominal surgery done in October of 2002 with resection  
7 of his lower -- excuse me, of his sigmoid colon with greater  
8 than 4 centimeters removed. He had a colostomy and then  
9 a few months later had a colostomy take-down done.

10 Subsequent to that, he underwent 16 treatments of radiation  
11 and he was advised to have, I think, twice that many or  
12 close to that, I think 30 treatments or so, but he only  
13 underwent 16, maybe 18 because he couldn't tolerate it  
14 and he was becoming very sick and that's the period that  
15 he had that weight loss.

16 He was told by his oncologist that chemotherapy would not  
17 be an option and was reported to have less than six months  
18 to live. His 2004 -- February 13th, 2004 post-operative  
19 scan showed questionable lesions in multiple sites  
20 including new -- new lesions in the liver, lesions in the  
21 lungs.

22 He presented with Stage IV adrenal cancer to us in February  
23 of 2004.

1 QOkay. And what regimen did you prescribe for this patient?

2 AThe regimen that I prescribed was the same thing as the --  
3 you know, detoxifying his system that each one of the  
4 patients -- if there's one particular toxicity that we  
5 see that is different from somebody else's, then we deal  
6 with that on a different level.

7 But our fundamental approach is to reduce the -- reduce  
8 the heavy metal burden, to stimulate the immune system,  
9 to improve the nutritional components and get the weight  
10 back for this patient.

11 This particular patient's weight was a big issue because  
12 he was tachypneic and he was -- he was very close to --  
13 he was very close to demise when he came to us.

14 QNow, Exhibit 17 is a set of consent forms. Again, are -- and  
15 I'll represent to you that they were for Patient C.  
16 There's a third page to Exhibit 17 which is consent for  
17 chelation therapy.

18 AI'm sorry, ma'am, which -- where --

19 QExhibit 17.

20 AYes, ma'am.

21 QLook at the third page.

22 AYes, ma'am.

23 QOkay. Do you recognize that consent form?

1 AThat is an outdated consent form. We -- it's been updated  
2 since then, but, yes, this was the consent form at that  
3 time that we used.

4 QOkay. And it was -- and this I'll represent to you was signed  
5 by Patient C and was found in your chart.

6 AYes, ma'am.

7 QWhat are you informing them about there about chelation  
8 therapy?

9 ABasically, that -- by the prevailing standard of the  
10 double-blind placebo-control that -- do you want me to  
11 just read it or -- I mean, I --

12 QWell --

13 AI'm just basically telling them that there's no guarantee.  
14 This is what we observed. It's based upon guidelines from  
15 a couple of different national organizations, the American  
16 College for Advancement in Medicine, the American Board  
17 of Clinical Metal Toxicology, the American -- the Institute  
18 of Preventative Medicine and there's a number of other --  
19 this is the same information that actually when I helped  
20 with the TACT trial, the same information that we used  
21 for consent for in the TACT trial.

22 QThe TAC trial, what's that?

23 AA trial to assess chelation therapies, a \$30 million dollar

1 grant for that and I was an investigator for that -- for  
2 that trial.

3 QOkay. Now, specifically, that chelation therapy, I think  
4 there were some concerns from the Board Members as to  
5 possible dangers or bad effects from that. Can you explain  
6 to the Board how you do chelation therapy and how you try  
7 to prevent or monitor the patients so that they don't have  
8 adverse effects from it?

9 AYes, ma'am. EDTA, that means ethylenediaminetetraacetic  
10 acid. EDTA is one-third as toxic as over-the-counter  
11 aspirin. The problem with the chelator is not that the  
12 chelator is dangerous.

13 The definition of chelator is that whatever goes into the  
14 body must come out intact. The only difference is, that's  
15 it's bound to -- to a metal ion.

16 The issue of safety comes in with how a physician is going  
17 to administer this. For instance, a rapid IV bolus would  
18 be dangerous because it's going to defy the -- (inaudible)  
19 -- equation, it's going to cause a rapid physiological  
20 shift that is not warranted.

21 But a slow, steady infusion of the -- whatever the chemical  
22 is, whatever the chelator is, in this particular case we  
23 use diamine sulfuronic or diaminetetraacetic acid. If



1 done in the right way, it's completely safe.  
2 In fact, the issue that has been brought up and the few  
3 documentation -- excuse me, the few documented issues that  
4 have occurred has had nothing to do with the chelator,  
5 but rather the effect that the chelator had on the heavy  
6 metal burden.  
7 So what happens is that when you put in a chelator into  
8 the body, the chelator is going to bind to metals. If  
9 you put in a large dose of a chelator, initially it's going  
10 to bind to more metals. As it comes through the vacuoles  
11 of the renal parenchyma, the vacuoles can't handle the  
12 burden of metals.  
13 One -- one issue is that the -- there's been studies that  
14 have been shown on post -- on post-mortem biopsies of a  
15 patient's renal parenchyma showing a greater propensity  
16 of metals in the renal parenchyma. Actually, the American  
17 College of Cardiology published data that was done in Italy  
18 showing the patients that died of -- (inaudible) -- dilated  
19 cardiomyopathy had over 20 -- excuse me, yeah, over 22,000  
20 times a safe level of mercury within the myocardia compared  
21 to other tissues in the body. So there are certain tissues  
22 that are more prone to becoming susceptible and to becoming  
23 vectors if you will of holding these metals.

1 So in the -- in the renal parenchyma issue of the safety  
2 issue, what happens is one of the chelators going through  
3 the body and it's actually hitting the kidneys, the kidneys  
4 are used to seeing one part of mercury per million parts  
5 of urine, for instance, normally.

6 But EDTA would be used for lead, so let's use lead as an  
7 example. The kidneys would normally be seeing one part  
8 of lead per million parts urine. Now you're giving a  
9 chelator, so all of a sudden the kidneys are seeing 500  
10 parts of lead per million parts of urine.

11 That's a 50,000 percent increase in the load that the  
12 kidneys are used to seeing and load is what's going to  
13 cause an issue with the patient if the -- if the renal  
14 parenchyma can't handle -- if the -- (inaudible) --  
15 filtration can't handle the load.

16 Now, if done judiciously, there's absolutely no problem.

17 And we have infused well over 200,000 intravenous  
18 therapies in my office since 1997 when I opened my office,  
19 so the last 11 years. I have never yet seen a single  
20 complication. It just doesn't happen if the doctor knows  
21 what they're doing.

22 It's like saying that -- it's like saying that a car is  
23 good because it's a mode of transportation and a gun is

1 bad because it hurts people. But that car, if you put  
2 an alcoholic behind it, is going to kill somebody and that  
3 gun becomes very useful if somebody is breaking into your  
4 house.

5 So the issue is not the tool, but rather the user that's  
6 using the tool. If the physician is not competent, then  
7 of course you're going to have a problem. Just like with  
8 any medication if not given appropriately, you can have  
9 a problem.

10 QDo you -- are there certain labs you need to monitor when people  
11 are on --

12 AAbsolutely.

13 Q-- people are on chelation?

14 AAbsolutely.

15 QAnd what labs are those?

16 AThe most common ones -- one thing is always go for a very low  
17 dose challenging agent the first time because I don't know  
18 whether they will be an excreter or non- excreter and maybe  
19 we'll get into that, but that's -- that's a phenomena that's  
20 very crucial to this.

21 But if a person is an excreter, they're going to dump metals  
22 right away. This is -- this is depending on -- you know,  
23 what do I mean by excreter or non- excreter and I'll try

1 to summarize what I told the U.S. Congress.

2 But essentially some patients have a genetic  
3 predisposition for the inability to detoxify. They may  
4 have a methatechrohydrocholic (phonetic) enzyme  
5 deficiency. They may have a glutathione S transfer issue.

6 They may have a CUMT lesion. They may have some type  
7 of polymorphism. The gamuts out there, it's just -- they  
8 may have a methylation issue.

9 Whatever the case is, they're having a problem eliminating  
10 certain types of chemicals or substances out of their body  
11 that other people seem to be able to do without much problem  
12 or they're reducing -- they're eliminating less than what  
13 other people can -- can eliminate.

14 So what we have to do, is we have to first determine is  
15 this person going to be dumping metals readily or are they  
16 holding on to them.

17 For instance, the biochemistry of an autistic patient or  
18 a cancer patient seems to be a physiology that has an  
19 inability to excrete. So with those patients, we can be  
20 more aggressive because we know that they can't dump that  
21 stuff.

22 But with other people, you don't want to induce too much  
23 metal, so you have to go slow. You have to give them a

1 low dose and that's what we start with every patient just  
2 to see what the first load is.  
3 When you're doing that, you have to monitor renal function,  
4 that's the first thing, looking at BUN and creatinine and  
5 we do that. We have a standing order that every patient  
6 that's getting -- going through IV treatments, they must  
7 have a BUN and creatinine on record as well as a chemistry  
8 panel, baseline as well as every five treatments.  
9 If they have any history of renal impairment, we will  
10 actually then increase their frequency to every three weeks  
11 or two weeks.  
12 I've even had patients that have had a kidney transplant  
13 that we've done this with and they've been phenomenal with  
14 the results, but we monitor that patient every week because  
15 we want to make sure that we don't want to have any kind  
16 of complication from that aspect.  
17 We also do specific gravity urine. We also look at the  
18 heavy metal burden with the post-challenge test.  
19 Initially before we start any type of treatment with IVs,  
20 we also get our routine things such as 12 lead EKG.  
21 We do -- bone mass has been a big issue, some -- some  
22 non-educated criticisms of chelation therapy has been that  
23 it'll pull the calcium out of your bones which is absolutely

1 an untruth.

2 In fact, Rudolph and Madonna in Missouri have shown in  
3 a study that there was an increase of 32 percent of bone  
4 mass density in one year after a person underwent chelation  
5 therapy. And I can explain that if the Board wants me  
6 to explain it, but it's based upon parathyrodone (phonetic)  
7 and calcitonin balance. If you want me to, I can go into  
8 that.

9 But basically there's other tests that we do that we  
10 monitor, but basically the kidney function, the LFTs and  
11 urine specific gravity and then we do heavy metal  
12 challenges every 20 treatments to see what the burden is,  
13 whether it's going up or coming down. If it's going up,  
14 that means you are a non-excreter. If it's coming down,  
15 then obviously they're dumping the metals.

16 And there's other things that we do depending on what we  
17 have the patient -- you know, whether she's a patient to  
18 have.

19 QOkay. Thank you, Doctor. Turn if you will Exhibit 20.

20 AYes, ma'am.

21 QIs this documentation taken from this -- from -- I'll represent  
22 to you -- we'll do it that way. Is this documentation  
23 taken from Patient C's conventional medical treatment

1 records with regard to his treatment by his oncologist.  
2 AYes, ma'am.  
3 QAnd I think the second page of -- of Exhibit 20, L15 is the  
4 CAT scan that was -- that was done in February of '04.  
5 AYes, ma'am. That was done I think like -- if I remember right,  
6 that was just done shortly after -- within a couple of  
7 months afterwards.  
8 QAfter what?  
9 AAfter this diagnosis that he was given with no recurrence of  
10 disease.  
11 QRight.  
12 ARight.  
13 QRight. And then at that time though there was a recurrence?  
14 AYes, ma'am. He was -- he had nodules that were found in the  
15 lung, in the liver. He also had retroperitoneal  
16 adenopathy and there was some issue of left pelvic bone  
17 involvement, two small benign -- the two small benign  
18 presenting left pelvic bone -- as I mentioned are benign.  
19 QOkay. Let's turn back if we can to Exhibit 19.  
20 AYes, ma'am.  
21 QTell the Board, if you will, what that is with regard to Patient  
22 C.  
23 AThis test?

1 QYes.

2 AThis is a fundamental test that is crucial for my being able  
3 to follow a patient in seeing whether they're responding  
4 to my therapy or not.

5 QAnd what -- what -- what do those lab tests measure?

6 ANatural Killer Cell Activity. There have been multiple  
7 studies done to show that in patients with cancer or even  
8 AIDS or any other type of significant immunosuppressant --  
9 immunosuppression, excuse me, that the Natural Killer Cell  
10 Activities are significantly reduced.

11 In fact, the comment made by Dr. John Wilson is a completely  
12 true statement that if the immune system was intact,  
13 there's no way that cancer could manifest. The problem  
14 is if the immune system has had some type of burden that  
15 has compromised it and allowed for the cancer to become  
16 rampant.

17 Everybody, from the day they're born, we have cancer cells  
18 in our body and I'm sure the Board is aware of this. We  
19 have cells that are constantly going into -- into  
20 uncontrolled cellular proliferation and our body hasn't  
21 met apoptosis that basically allows us to have normal cells  
22 to commit suicide so that it doesn't affect the whole.  
23 This is a normal thing.



1 Natural Killer Cell Activity and some of these other things  
2 that -- that are part of this, the -- (inaudible) --  
3 response is actually showing how well their immune system  
4 is functioning and how well or how normal their cellular  
5 physiology is and that's what it's coming down to.

6 QAnd specifically with regard to Patient C --

7 AYes, ma'am.

8 Q-- when Dr. Peterson says that your treatment was below the  
9 standard of care, do you have any reaction to that with  
10 regard to the lab tests that we're looking at right now?

11 AAs far as remaining calm, there are three times we did the  
12 tests on this particular patient because he went through  
13 treatment more for well treatment than the other two  
14 because they only went through a short period of treatment.

15  
16 But when he came to us, his Natural Killer Cell Activity  
17 was 8.6 milliunits.

18 QAnd I don't mean to interrupt you, but just for the benefit  
19 of the Board, are you looking at a chart that is the last  
20 page of Exhibit 19?

21 AYes, ma'am. This is -- this is a sheet that I have that we  
22 put on all our patients so that we can document what we're  
23 doing so we can start seeing what the pattern is with our

1 cancer patients that are coming to us. We're obviously  
2 trying to -- most often in addressing this issue is one,  
3 immune modulation; and, two, detoxification for the toxic  
4 burden, we try to keep a concise method of documenting  
5 this information so that I can go back and refer to it  
6 quickly and see how they're developing. This is one of  
7 those sheets.

8 QAnd what does that sheet show with regard to Patient C?

9 AThe normal reference rate for lytic units for Natural Killer  
10 Cell levels is 20 to 50 lytic units. And when the patient  
11 presented to us, it was 8.6 lytic units with the Natural  
12 Killer Cell Activity per cell of 5.3.

13 So that I can perhaps explain this a little bit better.

14 Natural Killer Cell Activity would be how strong your  
15 army is. Natural Killer Cell Activity per cell would be  
16 how functional each individual soldier is. So if you have  
17 a high Natural Killer Cell level, but you have a low Natural  
18 Killer Cell Activity per cell, that would mean that you're  
19 Natural Killer levels are there, but the soldiers are  
20 apathetic and they're not really doing what they're  
21 supposed to be doing.

22 Versus if you have a Natural Killer Cell Activity that's  
23 say low, that means your army is small, but your Natural

1 Killer Cell Activity cell -- per cell being high would  
2 mean that each one of your soldiers is like a supersize  
3 soldier.

4 So a 5.1 would be -- on the Natural Killer Cell Activity  
5 per cell -- 5.1 would be the bare minimum for Natural Killer  
6 Cell to be considered functional and 10 would be the high  
7 end of normal.

8 When the patient came to us, his Natural Killer Cell  
9 Activity per cell was down to 5.3.

10 And I can look through the rest of it if that's what you  
11 want me to do or --

12 QOkay. Well, what significance is this to you as far as the  
13 efficacy of the treatments?

14 AWell, by the -- by the third time we did the test and actually  
15 this is the last one, right? One of the last ones we did  
16 which was in May, we had increased his Natural Killer Cell  
17 Activity to 20.8 bringing him into the normal range and  
18 we had taken his Natural Killer Cell Activity per cell  
19 and from his previous test which was the middle test, more  
20 than -- more than doubled that, so he was at 7.9.

21 His -- I can tell you all the specifics here. There were  
22 a number of things that were pertinent in this. his  
23 Natural Killer Cell Activity in 2.5 months went up 150

1 percent. Natural Killer Cell Activity went up more than --  
2 more than 100 percent. His NKHT3 plus cells -- we did  
3 that with competency -- and there's different levels of  
4 competency of these Natural Killer Cells. The NKHT3 plus  
5 immunocompetency cells increased from 15 percent to 19  
6 percent.

7 His lymphocytes increased from 6400 to 10,400, so his  
8 counts -- they were -- they were still normal, but they  
9 were increased without giving way to demargination or --  
10 (inaudible) -- like with infection or anything, but it's  
11 basically is an indirect measurement that his immune system  
12 was becoming more palliative.

13 His CD2 counts went up from 863 to 1,005. His CD3 increased  
14 from 849 to 1,034. His T helper cells CD4 went from 446  
15 to 612. His CDHT, the suppressors cells went from 381  
16 to 393. His CD19 and CD20 which are the B cells which  
17 are the ones that basically do the -- create the antibodies  
18 where the body went from 141 to 233. His CD15 and 56 went  
19 up from 163 to 262. His diapeptidal pepsase increased  
20 from 337 to 597. His cell cycle improved significantly  
21 before treatment and after treatment as is documented with  
22 the results. That's --

23 QSo --

1 AThat's what that showed.

2 QSo do you believe that the results show a positive impact from  
3 your treatments?

4 AThis person was told at this point that he could take a break  
5 from treatment and I was more concerned about another issue  
6 that was going on with him, but his immune system was coming  
7 up. I mean, I couldn't have asked for a better profile.

8 QOkay. And when you told him you wanted to take a break from  
9 treatment, what was his reaction?

10 AHe had a friend also -- I mean, renal cancer is very rare --  
11 but he had a friend also that had renal cancer and they  
12 had both planned in seeking treatment and his friend had  
13 gone to Europe to a place that I had actually suggested  
14 to Patient C also that I thought was a good place and his  
15 friend died at that time. And his friend's disease wasn't  
16 as extensive as his -- as Patient C's was and so he felt --  
17 I think he was scared and he felt that he needed to continue.

18 QAnd so did he continue then and for how long -- how many weeks  
19 of treatment?

20 AWell, I wanted him -- I wanted him to get out of this environment  
21 because there was another issue going on with him and I  
22 was pushing him to take a vacation, but he continued  
23 treatment and then followed up with my recommendation

1           sometime in June.

2   QOkay. And in June did he take a break from your treatment?

3   AWell, he -- it wasn't that I wanted him to take a break from  
4       my treatment, I wanted him to get out of his environment  
5       and I wanted him to find a place that he could continue  
6       getting maintenance.

7   QWhy did you want him to get out of his environment?

8   AThe most potent form of oxidative stress is stress which would  
9       mean that the most potent form of antioxidant therapy may  
10       be prayer, he was very stressed. He was under a tremendous  
11       amount of duress.

12       This man, when he was done with his treatments would not  
13       go home, he would stay in the clinic and sometimes wait  
14       until the last employee would leave.

15       On two separate occasions I walked into the exam room and  
16       there was screaming inside the exam room and I would walk  
17       in with some concern and he would turn to me and apologize  
18       and shut his phone.

19       There was just -- this was a very, very sweet man. He  
20       was in the process of writing a book and creating a web  
21       site to tell the world about what he was experiencing and  
22       how he was improving with our treatment, but he was under  
23       a lot of stress.

1 And my concern so much at that time was -- it was obvious  
2 his immune system was coming up. We had been debulking  
3 him from his toxic load and he was responding very well  
4 to treatment, but his face you can see he was -- he wasn't --  
5 I mean, he was gaining weight and his color was good, but  
6 you could see stress. You could see the frown on his --  
7 on his -- I mean, between his eyes. He was just stressed  
8 and he just did not want to go home.

9 And even when I told him that he was ready to stop treatment  
10 and just go on a maintenance program he said, no, I'm not  
11 ready. And he said, I like -- I like being here. And  
12 I said, this is a clinic. I mean, go to the park or, you  
13 know, go watch a movie or do something with your kids and  
14 he was actually doing things with his kids, but he just  
15 didn't want to go home. And --

16 QAnd so did a plan arise for him to leave the country?

17 AYes. I had actually discussed with him going to Dr. Tony Menez  
18 in Mexico who is a colleague of mine who's an oncologist  
19 who uses the same therapies that I do. And Dr. Menez  
20 basically couldn't take him because Dr. Menez was leaving  
21 on a missionary trip to South Africa. But Dr. Menez used  
22 to work at the Issles Clinic, I don't know how to pronounce  
23 that, but he recommended that that may be where Mr. XXXXX,

1           excuse me, where Patient C would perhaps want to go. And  
2           that happened to be the same place that he had looked at  
3           before, so he was very agreeable with that.

4   QGetting back to Dr. Peterson's criticisms and if you could  
5           just briefly react to EDTA chelation therapy has no benefit  
6           in treating cancer and bear in mind we have -- you discussed  
7           extensively why you believe it is.

8   A I wasn't treating this cancer with EDTA therapy.

9   QWhat were you treating with EDTA therapy?

10   A I was treating his -- his metal load which is in here somewhere.

11           I'm not sure --

12   QIt's not in that notebook, I think. No, it's in the patient  
13           regular notebook.

14   A Can I use it a minute?

15   Q Sure.

16   A Is it this one? I mean, I was treating his metal load is what  
17           I was treating, but, I mean, I can tell you the metals,  
18           but I don't remember offhand.

19           PRESIDENT RHYNE: I would like to see that.

20           WITNESS: Yes, ma'am. Is it the big one?

21           MS. GODFREY: Yeah, the big one.

22           PRESIDENT RHYNE: You can go ahead.

23           WITNESS: I'm sorry, ma'am.



1           PRESIDENT RHYNE:  You can go ahead if there's another  
2           question.  
3           MS. GODFREY:  Okay.  What I was going to try to do is just  
4           give him Patient C's chart.  How about -- yeah, it would  
5           be easier to do with this.  
6           MR. KNOX:  I'll tell you what --  
7           MS. GODFREY:  No, we can find out --  
8           PRESIDENT RHYNE:  I would like to see that.  
9           WITNESS:  I'll be able to find it faster.  
10          PRESIDENT RHYNE:  Okay.  
11          WITNESS:  Are all the labs together?  
12          AOkay.  I was treating him for a burden, an elevated burden  
13          of mercury and lead, as well as elevated levels of arsenic  
14          and tin.  Because he had been diagnosed with cancer, he  
15          was, by my definition, a non-excreter so his metal levels  
16          were -- I mean, he had the inability to excrete, but yet  
17          he was still excreting elevated levels.  
18          He had documented levels of arsenic, antimony, cadmium,  
19          lead, mercury, nickel, thallium, thorium, tin and  
20          tungsten, but the ones that were elevated were mercury  
21          and nickel.  As far as I'm concerned, any level in the  
22          body of these substances is not safe, but the ones that  
23          were considered elevated were mercury, nickel and arsenic.

1 QDr. Buttar, those results are from a urine test -- urine  
2 challenge test; is that fair?

3 AYes, ma'am, they are.

4 QAnd what lab performed that?

5 AThis particular one is performed by [REDACTED] which is  
6 a Medicare provider, certified with the American Board  
7 of Pathology approved laboratory.

8 QOkay. Do you own any interest in that lab?

9 AI wish I did.

10 QOkay. But you don't?

11 ANo, ma'am, I do not.

12 QOkay.

13 AAnd just as a side note, this urinary testing that Dr. Peterson  
14 said was bogus is done by Quest Diagnostics, it's done  
15 by LabCorp, is done by Nichols Laboratory which is all --  
16 all the big research that's done is done through Nichols.  
17 The Center for Disease Control uses it. In both my visits  
18 to the Center for Disease Control they do urine as well  
19 as blood, fecal and they actually -- the most accurate  
20 method is actually biopsy samples, but as Dr. Wilson  
21 mentioned, that's not conducive to the practice of medicine  
22 by doing multiple site biopsies. That's someone difficult  
23 to get a patient to consent to and obviously I'm being

1 a little facetious. But toenail clipping levels of  
2 mercury, that's been shown in multiple studies.  
3 In fact, the New England Journal of Medicine reported a  
4 study where they showed a direct correlation of mercury  
5 levels and myocardia infarction and -- (inaudible) --  
6 organic acid.  
7 But there are many labs that do this. Great Plains  
8 Laboratory, Geneva Labs, right here in North Carolina,  
9 there's numerous labs that do urinary metal profiles.  
10 Metametrics does this and they're all government -- and  
11 they are all Medicaid certified laboratories.  
12 QOkay. With regard to Dr. Peterson's other criticisms, he says  
13 that the labs that you've drawn have no clinical relevance  
14 such as urine toxic which you've just discussed.  
15 Stelocryte?  
16 ASteatocrit.  
17 QSteatocrit.  
18 AThat has nothing to do with metals. That's looking at the  
19 gastrointestinal system which a lot of these patients have  
20 problems that resulted in digestion of the nutrients in  
21 their -- you know, they think that it's normal to have  
22 a bowel movement every four days which is ridiculous and  
23 we have been able to establish a balance there.

1 QOkay. And so you believe those labs are necessary. What about  
2 labs?

3 AYeah, these are just -- he just pulled like some lab -- he  
4 just pulled some levels out of this complete diagnostic  
5 urinalysis that we do, but, yes, they're all -- they're  
6 all pertinent. I mean, if they're normal that's great,  
7 but many times they are not normal so we have to help the  
8 body get into a state of balance.

9 QNow, he says that the standard of care would be to treat with  
10 chemotherapy such as -- (inaudible) -- or enrollment in  
11 a clinical trial versus palliative -- (inaudible).

12 AI think that he's mistaken because from what I understand it --  
13 again, I'm not an oncologist, I don't know. I refer this  
14 to an oncologist. But I believe that chemo was not an  
15 option for him.

16 QAnd --

17 AHe had adrenal cancer which I think even -- I'm not sure, but  
18 I don't believe adrenal cancer is usually responsive, but  
19 I could be wrong, but --

20 QAnd, finally, if you'll turn to Exhibit 18 which is your --  
21 which is your progress notes for this patient, can you  
22 respond to Dr. Peterson's criticism that no physician  
23 contact was documented?

1 AOn June -- I'm sorry, excuse me, on February 16th, I conducted  
2 an exam myself and wrote a detailed note, a progress note,  
3 SOAP note.  
4 On March 24th, I conducted an exam and wrote a detailed  
5 note.  
6 On April 7th, I conducted an exam and wrote a detailed  
7 note.  
8 On April 7th, I also had a second -- a second note in there.  
9 On May 4th, I conducted an exam and did a note.  
10 On May 25th, I examined the patient and wrote a note.  
11 On June 9th, I did a progress note.  
12 On March 15th, I performed IRRs on the patient.  
13 On March 23rd, I performed IRRs on this patient.  
14 On March 30th, I performed IRRs on this patient.  
15 On April 6th, I performed IRRs on this treatment -- on  
16 this patient, excuse me.  
17 On April 14th, I performed IRRs on this patient.  
18 On April 20th, I performed IRRs to treat the patient.  
19 On April 27th, I performed IRRs on this patient.  
20 On April 28th, I performed IRRs on this patient.  
21 On May 4th, I performed IRRs on this patient.  
22 On May 11th, I performed IRRs on this patient.  
23 On May the 18th, I performed IRRs on this patient.

1 On May 25th, I performed IRRs on this patient.  
2 On June 1st, I performed IRRs on this patient.  
3 And on June 9th, I performed IRRs on this patient and it's  
4 all documented in the chart.  
5 And that does not include my post signatures and any notes  
6 that was done by anybody else.

7 QAnd the IRRs were, again, to relieve what?

8 AWell, Dr. Wilson gave a great history of IRRs, but what I have  
9 found it actually -- because the patients that have cancer,  
10 they are in a greater state of -- (inaudible) -- metabolism.

11  
12 And most of these patients are in respiratory distress  
13 and you document that a respiratory reserve is noted on  
14 pulse oximetry before and after treatment and there is  
15 an immediate, sometimes less than 30 second improvement  
16 in ventilation of these patients with -- with an  
17 improvement in respiratory reserve that sometimes exceeds  
18 200 percent with a pulse oximetry that generally goes up  
19 anywhere from 3 to 5 percentage points.

20 And these patients -- I mean, this is -- these patients  
21 literally want to get up and give you a hug and thank you.

22 I've seen patients with tears in their eyes because they  
23 can all of a sudden breathe better.

1 So I'm actually just trying to improve oxygenation.  
2 That's the reason I do hyperbaric, to improve oxygenation  
3 in these patients because cancer is anaerobic metabolite.

4 It is an -- (inaudible) -- anaerobic metabolite, so my  
5 goal is to increase that anaerobic metabolism in the system  
6 thereby using oxygen as beneficial.

7 First year of medical school we're taught that the -- in  
8 fact, I'm an ACLS instructor, ATLS instructor, I'm a PALS  
9 instructor and I've kept up with all these certifications  
10 as an instructor to continue to teach for the last 15 years.

11  
12 And the first line of drug -- in ACLS -- the first line  
13 of drug -- this is a question you always ask people, what  
14 is the first line of drugs. The answer is oxygen. So  
15 we use oxygen to help increase the airway state of the  
16 body.

17 QAnd in your observation of Patient C, did he -- did he object --  
18 physically get better under your care?

19 A I mean, it's documented throughout the note that his ambulation  
20 increased. I mean, the guy when he came had a hard time  
21 walking and was able to start walking, he was able to start  
22 playing the drums again. He was a drummer.

23 He ended up selling his business and started working on

1 these web sites. He was a programmer. In fact, on one  
2 specific occasion he had a gentleman that met him at the  
3 office while in his treatments to discuss doing some  
4 projects for this gentleman. He was able to start going  
5 to his kids' games.

6 He -- on one occasion when I asked him what he was still  
7 doing in the clinic -- it was like 5:30 and he was still  
8 there and his treatment had finished at 3:00. I had a talk  
9 with him because I thought he wasn't feeling well. He  
10 said, no, I feel great, I was just waiting for my kids'  
11 game to start and I'm going to meet him there.

12 And I said, why don't you just go home and he didn't respond,  
13 but he hugged me and thanked me and said, just the fact  
14 that I can go to my kids' games is something that I'll  
15 never -- never forget. And so that -- that was something  
16 that I remember because it's something that's just hard  
17 to forget.

18 QOkay. With regard to Patient C's conventional course, after  
19 he returned from Mexico there is a note and it's Exhibit  
20 21 that is a note from his oncologist. And I believe the  
21 date on that is August 10, 2004.

22 AAugust -- yes, ma'am.

23 QAnd was he under your care or was Patient C under your care



1 at that point?

2 AI didn't see Patient C after June. I know that he was still  
3 in touch with the office and there was, you know,  
4 communication, but I didn't see him coming in for -- as --  
5 I didn't see him come in to see me as, you know, no office  
6 visit or anything, so in August I did not see him. At  
7 least if I did, there was no note, but I don't -- because  
8 there would be a note.

9 QOkay.

10 AI think the last time he was seen in our office was before  
11 he left for Mexico.

12 QOkay. And as of August of 2004, he was beginning to have some  
13 edema in his distal extremities, is that correct?

14 AYes, ma'am, he did.

15 QAnd I think the -- he's also having problems talking.

16 AYes, ma'am. He -- he had some problems with breathing early  
17 on in his treatment course with us and that's one of the  
18 reasons that I did a little bit more IRRs than I normally  
19 would because he had such a benefit.

20 But before he left for Mexico there was nothing abnormal  
21 about his breathing. I mean, it was, you know,  
22 consistently responding to treatment and he was actually --  
23 we were proud of that -- he was -- the duration of how

1 much he felt improvement would last longer. Sometimes --  
2 the initial time, it may only last, you know, a day or  
3 so, but he was seeing longer residual.

4 QAnd as of -- as of August, does the note say that he's still  
5 receiving immune therapy from Mexico?

6 AYes, ma'am.

7 QAnd what's the recommendation of the oncologist with regard  
8 to that?

9 AContinue it.

10 QOkay.

11 AThis -- this patient's biggest issue was that he was under  
12 a lot of emotional and psychological duress.

13 QAnd then did you become aware that Patient C passed away?

14 AI did.

15 QAnd are you aware of the -- of -- I think we have his death  
16 certificate, if I'm not mistaken.

17 AYes, ma'am.

18 QIf we could look for that. Exhibit 33, if you'll turn to that.

19 AYes, ma'am.

20 QIs that a -- I'll represent to you that's a death certificate  
21 for Patient C.

22 AYes, ma'am.

23 QWhat are the listed causes of death?

1 AAtherosclerotic heart disease, adrenal cell carcinoma and  
2 pulmonary emboli.

3 QOkay.

4 AAAs I understand it, he presented with a pulmonary -- his  
5 symptomatology was acute pulmonary emboli.

6 QOkay. With regard to Patient D, I'm going to cover her with  
7 your -- with your nurse practitioner, Ms. Garcia in --

8 AYes, ma'am.

9 Q-- in detail. But you never saw Patient D; is that correct?

10 AI did not examine Patient D or see her.

11 QAnd is that a normal occurrence in your practice for a patient  
12 that presents with -- with metal toxicity issues?

13 AAbsolutely. It's -- I mean, she was not a compromised patient.

14 She had -- I mean, it was a very clear cut case. It would  
15 be like -- it's a very basic thing and Jane is more than  
16 qualified to handle something that was, you know, like  
17 that or even -- I mean, it was just -- I see the charts  
18 like I see all the patient's charts and I, you know,  
19 co-signed the notes and there was no issue when we went  
20 through -- I mean, I covered it in a regular weekly meetings  
21 that we have.

22 QOkay. And so you were aware and monitoring this patient's  
23 treatment?

1 AAbsolutely and everything was fine.

2 QOkay. In response to a question by Mr. Jimison in your  
3 deposition, were you asked to gather information about  
4 your office costs for providing certain IV treatments?

5 AYes, ma'am.

6 QAnd did you gather that information from your accounting  
7 records and from your accountant?

8 AIt was a tremendous burden, but, yes, we did, ma'am.

9 QOkay. And turn, if you will, to Exhibit 26.

10 AYes, ma'am.

11 QAnd, Dr. Buttar, is this a document that you yourself produced?

12 ANo, ma'am.

13 QOkay. How was it produced?

14 AWell, I helped format it because I do a lot of stuff in Excel,  
15 so I helped them format it because they couldn't get it  
16 in the right format. But it was done between my accountant  
17 and my financial officer in my office.

18 QOkay. And what -- what was the purpose of -- of collecting  
19 this information?

20 AI believe Mr. Jimison was saying that I was charging outrageous  
21 fees or something to that extent.

22 QOkay. And did he just ask you to provide cost information  
23 for five of your IV treatments that you do?

1 AActually, he asked for four. I must have misunderstood him  
2 because I've provided five. But I believe he only asked --  
3 because I don't think he asked for five but I put that  
4 in there, but I must have misunderstood him.

5 QOkay. And are all these IV treatments that were provided to  
6 the patients in this case?

7 AThese particular five, all those patients got -- (inaudible)  
8 -- I mean, everybody gets different depending on what their  
9 issue is, but for instance -- (inaudible) -- we would not  
10 do it, if somebody had a liver issue or something like  
11 that. But these five all -- all the patients in question --  
12 well, A through C, not D.

13 QOkay. And what does this show with regard to your -- well,  
14 first of all, I know we're looking at a period of time  
15 here from -- I think the first patient was in '04 and the  
16 last patient might have been in '06.

17 AYes, ma'am.

18 QWhat does this show with regard to how much money you were  
19 collecting for IV and can you explain that first as opposed  
20 to charging per IV?

21 AWell, we collect -- it was \$115 per IV, we collected in March  
22 2005. That was a question that was brought up sometime.  
23 I don't know if there's an adjustment on these patients'

1 charts. We were collecting \$115 per IV from 2000 to 2005.

2

3 From 2005 to 2007 our overhead had increased and we started  
4 charging -- I'm sorry, excuse me, we started increasing  
5 what we were collecting \$125 and after June 2007, we started  
6 collecting \$135.

7 QAnd does this then show -- for example, the first IV is EDTA,  
8 does it show all of your costs in providing that IV to  
9 the patient?

10 AYes, ma'am.

11 QOverhead, what does that include?

12 AIncludes everything from nursing staff, administrative staff,  
13 rent, electric, malpractice, CME, dealing with  
14 investigations of the Medical Board and costs of all these  
15 different things. I mean, it's just -- it's everything  
16 that it costs me to have my clinic functional so I can  
17 see patients.

18 QAnd then the other things listed there, are they direct --  
19 what are they?

20 AThose are the direct hard costs of what it costs us to do any  
21 of these particular IVs. That's -- the way our accountant  
22 has that, that's under cost of goods sold and the rest  
23 of it is under overhead which is all the other things.

1 QAnd -- and so are you able then to calculate what kind of profit  
2 you're making on the IVs that you're giving?

3 AWell, they were able to calculate, yes, ma'am.

4 QOkay. And is that shown in this exhibit?

5 AIt is.

6 QFor -- for which IVs?

7 AFor EDTA currently -- do you want me to read these?

8 QWell, you can. Currently for EDTA, what kind of profit are  
9 you making?

10 A\$1.78.

11 QPer IV?

12 APer IV.

13 QAnd how long does it take to provide EDTA IV to a patient?

14 AIt depends on the patient and what dose they're getting. It's  
15 usually giving one gram per hour, so their full dose of  
16 treatment, it will take two and a half to three hours.  
17 If it's an initial dose, .75 grams will take about 45  
18 minutes.

19 QAnd the next one is DMP -- DMPS.

20 AYes, ma'am.

21 QAnd what kind of profit are you currently making on a DMPS  
22 IV?

23 A\$7.68.

1 QAnd, again, is that -- how long does it take to administer  
2 one of those?

3 ADMPS is actually done over 20, 25 minute IV drip.

4 QGlutathione?

5 AGlutathione?

6 QThion, sorry.

7 AYes, ma'am. \$2.83.

8 QAnd how long does it take to administer one of those?

9 AThat can be done at a number of various methods. It can  
10 actually be done over a five-minute push, it could be done  
11 over an hour drip and it all depends on the status of the  
12 patients and what other things they are getting and also  
13 whether they've been, you know, there's other issues that  
14 we look at, but could be done, you know, a five-minute  
15 IV push which the nurse is there the whole time for the  
16 five-minute push or a drip over an hour and a half or so.

17 QOkay. And --

18 AIt's also depending upon dose.

19 QThe next one is hydrogen peroxide.

20 AYes, ma'am.

21 QAnd how much are you currently making off of hydrogen peroxide  
22 IV?

23 A\$7.22.



1 QAnd how long does it take to administer one of those?  
2 AHydrogen peroxide, about an hour and a half. Since we've been  
3 doing ozone, we don't do much hydrogen peroxide now, but  
4 when we do that, that's an hour and a half maybe.  
5 QOkay. And a vitamin C IV?  
6 AA vitamin C IV again, if it's 25 grams versus 100 grams it  
7 all depends how -- how much we're doing. We start the  
8 patient actually at 35 grams, they go up to 50 and they  
9 go 75. By the third IV they're at 75 and then I usually  
10 keep them there or we'll take them higher.  
11 QOkay. And how long does it take to administer a vitamin C  
12 IV?  
13 AAgain, it's based on the -- (inaudible) -- and based upon the  
14 problems with the patient, but it can take up to two hours.  
15 QAnd the profit per IV you're currently making on vitamin C?  
16 AI think this is actually wrong because it's -- each vial --  
17 it's \$9.41, but we don't charge anything more for your  
18 treatment.  
19 QOkay. Now, lastly, I'd like you to turn to Exhibit Number  
20 27 and tell the Board what that is.  
21 AThat's a sign that's in our front and it's also something that  
22 we have -- we used to have it in the front office in my  
23 old office. In the new office, it's just at the check-out

1 place and it's framed, setting up so all patients could  
2 see it when they're leaving when they pay.

3 QAnd is that something that you did -- well, why did you post  
4 that sign?

5 ABecause the Medical Board wanted to make sure that my patients  
6 knew that this was being done for profit the last time  
7 when they investigated me, whatever you want to call it.

8 QAnd -- and is that why the sign is then posted in your office?

9 AYes. Actually, this was -- this was -- this isn't actually  
10 the -- this says, last revised January 18th, but it was  
11 revised again after 2003, but this was actually -- I think  
12 after the second visit in -- maybe the first visit in 1999  
13 that the Medical Board had and we put this up.

14 And then in 2003, this last revised obviously isn't --  
15 isn't right because in 2003, we put this notice posted  
16 for all patients in order to be fully compliant with the  
17 policies of the North Carolina Medical Board.

18 QAnd did you play a role in the legislative effort of the North  
19 Carolina Society for Integrative Medicine --

20 AYes, ma'am.

21 Q-- lobbying the Legislature for a change in the Medical Board  
22 statutes?

23 AYes, ma'am, I was.

1 QExplain to the Board Members what role you played in that?

2 AI'm the president of the North Carolina Integrative Medical  
3 Society. We felt that integrative doctors were being  
4 singled out for the practice of medicine. We testified  
5 in front of the House. Our bill was 886, Due Process for  
6 Physicians -- for all physicians, not just integrative  
7 physicians, but every physician.

8 The House was 78 percent against us, 22 percent for us.

9 And after my testimony the vote went 116 to 6 in our favor.

10 It was presented to the Senate and it went 40 to 7 in  
11 our favor. 40 Senators voted for us, 7 against us. Of  
12 the 7 that voted against us, they represented all the  
13 doctors that were on the Medical Board of Dentists.

14 And it was interesting because it didn't make any sense  
15 why a doctor would be opposed to a bill called Due Process  
16 for Physicians. There were extensive meetings between  
17 Mr. Mansfield and myself and Mr. Henderson and the past  
18 president of the Medical Society, Dr. Kanof at the  
19 legislature. There were press releases done.

20 We -- we changed the law, actually, from what I understand  
21 the fastest law that's ever been changed in North Carolina.

22 And I was still under the impression that -- that the  
23 Medical Board is doing the best that they can and I'm not

1 so sure any more.

2 MS. GODFREY: I don't have anything further.

3 MR. JIMISON: I don't know if the Board wants to break  
4 for lunch.

5 PRESIDENT RHYNE: How long is your cross-exam going to  
6 take?

7 MR. JIMISON: Twenty to thirty minutes and I can't  
8 guarantee, but I think it would be about twenty, thirty  
9 minutes.

10 PRESIDENT RHYNE: Let's go ahead and take a break because  
11 some of the Board Members are indicating they need to take  
12 a break. So we'll -- we'll just go ahead and do lunch  
13 and then -- can you be back by 12:50? Does that not --

14 MS. GODFREY: 12:50?

15 PRESIDENT RHYNE: -- give you enough time?

16 MS. GODFREY: That's -- that's fine.

17 \_\_\_\_\_

18 (11:58 A.M. - 12:55 A.M. RECESS)

19 \_\_\_\_\_

20 PRESIDENT RHYNE: Okay. We'll go ahead and proceed then.

21 WITNESS: Yes, ma'am.

22 PRESIDENT RHYNE: You can have a seat, thank you, sir.

23 WITNESS: Okay.

1 PRESIDENT RHYNE: Mr. Jimison, I think that it's your time  
2 to cross-examine.

3 MR. JIMISON: Thank you.

4 **CROSS-EXAMINATION BY MR. JIMISON:**

5 QDr. Buttar, let's start off with some things that I think we  
6 can agree on. You have no medical training of oncology,  
7 correct?

8 AOther than what I did in my year in a residency, no, sir.

9 QBut you're not -- you didn't do a residency solely devoted  
10 to oncology --

11 AI did not.

12 Q-- or cancer?

13 ANo, I did not.

14 QYou're not board certified in oncology?

15 ANo.

16 QYou're not an oncology surgeon?

17 ANo.

18 QYou're not a radiation oncologist?

19 ANo.

20 QAlso, as to Patients A, B and C, but I think we can agree on  
21 this, they all came to your office with metastatic cancers,  
22 correct?

23 AThey came to me all with end-stage metastatic cancer, yes,

1           that's correct.

2   QAnd for each of these Patients A, B and C you -- you treated  
3           them with essentially with similar therapies, correct?

4   AWell, it's interesting that you brought this up because my --  
5           my goal of therapy is to debulk them and debulk them from  
6           their toxic load to stimulate their immune system.  
7           And the techniques that I have at my disposal with that  
8           I have so far learned are the same techniques whether --  
9           no matter what it is, whether it's a person's toxic and  
10          they've got cardiovascular disease or cancer, I'm using  
11          the same treatment to debulk the toxic load.

12   QI mean, we can agree that they all got hydrogen peroxide  
13          therapies?

14   AYes, they did.

15   QAnd we can agree that they all got ozone therapies?

16   AIn these three cases, I believe that's correct.

17   QWe can all agree that they all got some form of chelation?

18   AIn these three patients, that's correct.

19   QAnd we can agree that all of them got vitamin C?

20   AIn these three patients, that's correct.

21   QAnd they all got assorted minerals and vitamins?

22   AThat is correct.

23   QThey all got IRR injections?

1 AThese three patients, yes, they did.

2 QAnd they all got vitamin C?

3 AI believe in these three patients, yes, they did.

4 QOkay. And -- and everything I just listed from the hydrogen  
5 peroxide down to vitam C -- what about the glutathione,  
6 did they all get glutathione?

7 AI would have to look back at the chart, but I'm quite certain  
8 they all three got glutathione, yes.

9 QAnd maybe some got hyperbaric chambers, but not all got  
10 hyperbaric chambers but they could have got hyperbaric  
11 chambers down in South Florida?

12 AThat's correct, if I had it they would have definitely gotten  
13 it, yes.

14 QIf you had it. Now, each one of those things I mentioned,  
15 hydrogen peroxide, ozone, chelation, vitamin C, minerals,  
16 IRR, biofeedback, glutathione, hyperbaric chambers, none  
17 of those things have been shown to work for cancer in any  
18 clinical trial, correct?

19 AThere have been clinical trials that have been done on various  
20 modalities of treatment. If you're asking me in the United  
21 States, I'm not aware of anything that combines all those  
22 treatments together.

23 QSo Dr. Peterson would not have been incorrect saying that none

1 of these therapies are within prevailing treatment for  
2 cancer, correct?

3 AWell, if you look at the individual IVs for instance at the  
4 University of Kansas right now they're conducting trials  
5 of vitamin C.

6 The trials that Dr. Peterson was talking about versus what  
7 we're talking about, Dr. Peterson is talking about, those  
8 trials are to determine safety because you're giving a  
9 toxic substance. These treatments are not toxic, so  
10 there's nothing to determine as far as Phase I which is  
11 usually to determine toxicity and safety. There is no  
12 issue with toxicity or safety with any of these treatments.

13 QBut I'm just trying to stay on what we can agree with and I'm  
14 just trying to get -- you can answer yes or no and then  
15 explaining the answer and you can --

16 MR. KNOX: Objection. He says -- may I just speak. He  
17 doesn't have to answer yes or no.

18 PRESIDENT RHYNE: He can explain his answer.

19 MR. JIMISON: If it's possible. I'm just trying to see  
20 if there's areas of agreement.

21 PRESIDENT RHYNE: No. Go ahead.

22 Q(By Mr. Jimison) These hydrogen peroxide, ozone and  
23 chelation, vitamin C, minerals, IRR, glutathione,



1 hyperbaric chambers, those are not within the prevailing  
2 and acceptable medical practices for the treatment of  
3 cancer in this country, is it?

4 AThat is incorrect.

5 QWhy is that incorrect?

6 AThe American Cancer Centers right now or Cancer Centers of  
7 American use these modalities in their seven different  
8 hospitals throughout the United States that are using many  
9 of these modalities.

10 QFor cancer?

11 AYes, for cancer, that's why it's called the American Centers  
12 for -- I just said it, Cancer Centers for America. They're  
13 advertising all the time on TV. They use this in  
14 conjunction with other therapies, conventional therapies  
15 such as chemo, radiation, but they are giving these  
16 treatments that we just mentioned, yes.

17 QWhen Patient C went to -- I'm sorry, Patient A.

18 When Patient A went to M.D. Anderson which is a pretty  
19 progressive cancer center and you said you even got some  
20 training there.

21 AYes, absolutely.

22 QThey spoke about getting oxygen therapy after they basically  
23 said there's nothing more that we can do for you here,

1 correct?

2 AThat's correct.

3 QAnd -- and the doctor there said, well, there's not any  
4 legitimate clinical trials at all of these therapies being  
5 offered at M.D. Anderson, correct?

6 ADr. Garth Nicholson from M.D. Anderson has sent me patients,  
7 so I'm not sure what you're -- if that doctor didn't know,  
8 he didn't know. Is that what you're asking me?

9 QYeah. Mainly I'm just saying, is that a fair statement on  
10 his notes?

11 AFrom that note, yes, you're correct, that's what he said.

12 QAnd so M.D. Anderson according to this doctor with his knowledge  
13 of what was going on there, they weren't doing oxygen  
14 therapies?

15 AThat's correct.

16 QAnd you're familiar with the American Cancer Society, correct?

17 AAbsolutely.

18 QAnd they've recommended that oxygen therapy not be given to  
19 patients, correct, with cancer?

20 AI am not aware of that.

21 QIf you can turn to the thin notebook.

22 MS. GODFREY: Which notebook?

23 MR. JIMISON: The thin one, the Board's thin notebook.

1 MS. GODFREY: What exhibit?

2 MR. JIMISON: Number 19.

3 Q(By Mr. Jimison) I'm going to read you something at the bottom  
4 of that from -- from Memorial Sloan- Kettering Cancer  
5 Center.

6 AWhat page, I'm sorry?

7 QThe first page.

8 AYes.

9 QThe last sentence says: the American Cancer Society urges  
10 cancer patients not to seek treatment with hydrogen  
11 peroxide, ozone therapy or other hyperoxygenation  
12 therapies. Oxygen therapies should not be recommended.

13 AYou know, if you're going to ask me to make a statement --  
14 that statement -- line right above it, it says: because  
15 of the blood-borne viruses such as hepatitis C and HIV  
16 reported after treatment with contaminated  
17 autohemotherapy devices.

18 That's exactly what it says here. And obviously with any  
19 treatment that you do with contaminated autohemotherapy  
20 device, you are going to have a risk, so I would -- I would  
21 agree with the statement.

22 QWell, I read that statement correctly, correct?

23 AYou only read part of that statement. You took it out of

1 context.

2 QOkay, here at 21.

3 AI'm sorry, which page?

4 QThe first page.

5 ADoes it have page 22 on it? The first page is 19.

6 QExhibit 21. Exhibit 21, page 1.

7 AOh, sorry. Okay.

8 QAnd this is from the American Cancer Society.

9 AI do not believe it is.

10 Qwww.cancer.org?

11 AThat is not the American Cancer Society to the best of my  
12 knowledge.

13 QOkay. Well, let me just read the statement at the top under  
14 Overview from this document. It says: Available  
15 scientific evidence does not support claims that putting  
16 oxygen-releasing chemicals into a person's body, as  
17 described here, is effective in treating cancer.

18 MS. GODFREY: Well, unless the source can be identified,  
19 we're going to object to it being read into the record.

20 AYou could have read this -- I have no idea what it --

21 MR. KNOX: Wait a minute, Doctor. Wait until she gets  
22 through.

23 MS. GODFREY: Again, my objection is, Dr. Rhyne, that

1 unless the source can be identified and I believe under  
2 the Rules of Evidence in order to cross-examine somebody  
3 with a journal article you have to show first that they  
4 rely on that particular journal or publication and I don't  
5 think that foundation has been laid by Mr. Jimison's  
6 question.

7 MR. JIMISON: Actually, this may be a good point. I want  
8 to go fast, but I do want to make this point of law and  
9 I've got so many documents. I know the Board Members have  
10 the Motion in Limine, if you all could turn to that and --

11 MS. GODFREY: The Motion in Limine?

12 MR. JIMISON: Yeah, the Motion in Limine.

13 PRESIDENT RHYNE: We've got a lot.

14 MS. GODFREY: If you can move that up.

15 PRESIDENT RHYNE: This is the one I think, Ms. Godfrey --

16 MS. GODFREY: That I filed, yeah. And it has the rules  
17 of -- the hearsay exceptions attached. It's 803-18.

18 MR. JIMISON: It says: To the extent called upon to the  
19 attention of an expert witness upon cross-examination or  
20 relied upon by direct examination statements contained  
21 in published treatises, periodicals or pamphlets on the  
22 subject of history, medicine or other science of law are  
23 all established as reliable authority by the testimony

1 or admission of the witness or by other expert testimony  
2 or by judicial notice -- meaning that you folks can take  
3 judicial notice -- If admitted, the statements may be read  
4 into evidence, but not received as exhibits.

5 So all we're doing is reading it into evidence. You can  
6 take judicial notice of it, if you like. It's not  
7 contingent upon the witness. There's three different ways  
8 that it can be done. The witness can verify it, another  
9 expert witness can verify it, or you this Medical Board  
10 can take judicial notice of it.

11 MS. GODFREY: Well, unless the source is identified, how  
12 can they take judicial --

13 MR. JIMISON: Well --

14 MS. GODFREY: -- notice of it?

15 MR. JIMISON: I'll identify the source by the -- by the  
16 URL.

17 DR. McCULLOCH: Are we talking about Exhibit 19?

18 MR. JIMISON: Exhibit 21.

19 PRESIDENT RHYNE: No, I think you're talking about 21.

20 DR. McCULLOCH: He's talking about 21, I'm sorry.

21 MR. JIMISON: And that is from the -- at least at the bottom  
22 of the -- the bottom is from [www.cancer.org](http://www.cancer.org)?

23 MS. GODFREY: Right.

1 WITNESS: Ma'am, I'd like to make a comment on this  
2 document, if possible.  
3 MR. KNOX: Wait until --  
4 PRESIDENT RHYNE: Go ahead. Go ahead, sir.  
5 WITNESS: The reference at the back of this document, one  
6 of the references is an organization that is called --  
7 and this is on page 4, ma'am -- it is the, two, three,  
8 four, five, six, seventh reference down is an organization  
9 called quackwatch.org. They've already been found to have  
10 their references and their information that's been -- and  
11 presented in the courts of California and Wisconsin to  
12 be biased and unreliable. And so anything with a reference  
13 to that organization to me is fraudulent.  
14 Q(By Mr. Jimison) Are you familiar -- are you familiar with  
15 www.cancer.org as the American Cancer Society web site?  
16 ANo, I am not. The American Cancer Society's web site that  
17 I'm aware of is ACS.org.  
18 QWell, are you familiar with Duke or the UNC programs?  
19 AI am.  
20 QDo they have integrative programs?  
21 AThey do.  
22 QDo any of those programs use oxygenation therapy for cancer?  
23 ANo. They send those patients to me.

1 QDo you refer patients to Duke?  
2 AYes, I have.  
3 QOn the integrative programs?  
4 AActually, not only for the integrative programs. I'm not sure  
5 if it's with the integrative program or not, but I have  
6 had patients sent to me from Duke.  
7 QFor oxygen therapy?  
8 AYes.  
9 QAnd who are those oncologists?  
10 AThey're not oncologists. I didn't say they were oncologists.  
11 QWho will send you the patients then?  
12 AI would have to go back and pull those charts to find out the  
13 names of those doctors, but there have been two different  
14 doctors that have sent me patients from Duke.  
15 QSo I'm talking about -- you say you didn't know whether it  
16 was from the integrative medicine program?  
17 AI do not.  
18 QSo you don't have any knowledge that the integrative medicine  
19 program at Duke has ever sent you patients?  
20 AYou asked me if Duke has sent me patients. The answer is yes.  
21 QWhat I meant was that integrative program?  
22 AI'm not familiar whether any of those doctors had a position  
23 in the integrative department. The integrative



1 department doesn't have exclusive appointees. They  
2 usually serve on some -- in some specific division and  
3 they also have a physician on the integrative faculty.  
4 They have an interest in it from what I understand.

5 QAnd isn't it true that their curriculum does not include --  
6 does not include teaching oxidation therapy?

7 AI'm sorry, I'm not familiar with the curriculum.

8 QWhat about UNC, do you know of their curriculum?

9 AI've lectured. I've been invited to come and lecture at UNC  
10 Chapel Hill. I've had their medical students rotate  
11 through my office, but I'm not familiar with their  
12 curriculum.

13 QAre -- or have they -- do they teach oxidation therapy --

14 ALike I said, I'm not familiar with their curriculum.

15 QYou testified on direct examination that you've never done  
16 anything standard in your life, correct?

17 AWell, my goal has always been to be above the standard. I'm  
18 sure I failed sometimes and hit the standard.

19 QSo what is the standard for end-stage cancer as you understand  
20 it?

21 AI think that, Mr. Jimison -- and I'm not sure if I understand  
22 this question -- but I think every person is going to have  
23 a different definition of what their standard is. My

1 standard is can I look at the patient in the eye and can  
2 I look at myself in the mirror and that's what my standard  
3 is. If I can't, then I've done something short of doing  
4 the best that I can for my patient.

5 QOkay. You heard Dr. McCulloch ask a question earlier about  
6 the National -- I think it was the NCCAM. Are you familiar  
7 with that organization?

8 AThe National Council of Complimentary and Alternative  
9 Medicine. I'm not sure who Dr. McCall is. Oh, I'm sorry,  
10 Dr. McCulloch, that's right. I'm sorry. Sorry.

11 WITNESS: My apology, sir.

12 DR. McCULLOCH: It's not a problem.

13 Q(By Mr. Jimison) Have they taken the position on oxygen  
14 therapy, if you know?

15 AI had actually met with -- I met with the National Council  
16 for Complimentary and Alternative Medicine when the  
17 previous of -- HHS, he had set up an appointment for me  
18 to go meet and they actually -- during our meeting there  
19 was a discussion on what types of things that they are --  
20 what type of therapies and what type of treatments they  
21 openly promote.

22 And the assistant head of NCCAM at that time said that  
23 this is a very politically volatile time and they have

1 to be very conscious of which ways to make inroads. And  
2 anything that would be construed as being more than  
3 controversial, they would have to keep on the lower  
4 priority and use those types of modalities that have been  
5 more widely accepted to promote and get inroads with  
6 integrative medicine and complimentary and alternative  
7 medicine.

8 QSo they do not promote oxygen therapy?

9 AI am not familiar with what they do and do not promote because  
10 I do not use them as a reference, but that was what I was  
11 told during my last meeting at NCCAM.

12 QNow, we go -- let's go to Patient C's record.

13 APatient C?

14 AUh-huh (yes). Well, let me ask a question this way, are there  
15 other doctors in North Carolina practicing oxygen therapy  
16 for cancer patients by itself?

17 AI use oxygen therapy -- the correct name is oxidative therapies  
18 -- for various number of issues in the patient's body and  
19 those patients may present with symptoms of other diseases.  
20 They may have cardiovascular disease, they may have  
21 cancer. There are doctors that are using oxidative  
22 therapies in North Carolina besides myself, yes. For what  
23 purpose, I am uncertain.

1 QOkay. And so -- but to your knowledge you're the only one  
2 using it for patients with end-stage cancer?

3 AI'm not using it with patients with end-stage cancer. I'm  
4 using it to debulk their bodies. It just so happens that  
5 patients come to me that have end-stage cancer.

6 QOkay. So when Patient A, B and C presented to you, they didn't  
7 present to you for looking for you to help their cancer?

8 AThey came to me because they wanted to live.

9 QDid they look to you -- were they presenting because they wanted  
10 you to help them get rid of their cancer?

11 AThey came to me because they wanted to live. My patient, the  
12 one that you saw testify, I asked her did she have an issue,  
13 if she has cancer for the 50 years if she is still alive  
14 and she said no. But cancer is not what I'm going after.

15 QAre you familiar with the document Innovative Protocols for  
16 Treating Chronic Disease, Cancer, Cardiovascular and  
17 Neurodegenerative Disease?

18 AYes, I am.

19 QOkay. Just wanted to flip through it and see if that is  
20 familiar to you.

21 AYes, it is. It was an ACCME approved course that I give.

22 QOkay. Turn to page -- I believe it's --

23 MS. GODFREY: Do you have a copy of that for us?

1 MR. JIMISON: I don't, but I'll ask him if this is just  
2 a fair statement of his own materials.

3 Q(By Mr. Jimison) Who -- who made this up?

4 ASome marketing people.

5 QBut you read over it and approve it, correct?

6 AI think that my operations manager or somebody must have  
7 reviewed it. I've reviewed it, but probably not, you know,  
8 in a very detailed manner. I mean, I've gone through the  
9 content that's pertinent to the course, but the marketing  
10 stuff, I'm -- I really don't really look at it. I know  
11 there's nothing they are claiming from what I know.

12 QIs this a page with your sort of information? Could you read  
13 the first sentence?

14 MS. GODFREY: Well, Marcus, can -- can we just see that  
15 because you haven't --

16 MR. JIMISON: Yeah, well, before he reads it, you can show  
17 it to your counsel, if you want.

18 AYes, that -- that line said --

19 MR. KNOX: Did you hear what he said?

20 WITNESS: I'm sorry, sir, I did not.

21 MR. KNOX: Well, hand it over to me before --

22 WITNESS: Oh, I'm sorry, excuse me.

23 PRESIDENT RHYNE: Can you make copies --

1 MR. JIMISON: Yeah. I'm sorry.

2 PRESIDENT RHYNE: -- for us, also? Thank you.

3 MR. KNOX: I'm sorry.

4 MS. GODFREY: Yeah, we just wanted to see that exhibit,  
5 if that's okay.

6 WITNESS: Want me to give that back to you or --

7 Q(By Mr. Jimison) Well, if you could read the first sentence  
8 of the second paragraph.

9 ADr. Buttar practices in Charlotte, North Carolina where he's  
10 the Medical Director of Advanced Concepts in Medicine,  
11 a clinic specializing in the treatment of cancer, heart  
12 disease and other conditions -- chronic conditions in  
13 patients who have tried conventional treatments with a  
14 special emphasis on the relationship between metal  
15 toxicity and insidious disease process.

16 QOkay. So it says your clinic specializes in cancer, correct?

17 AAgain, Mr. Jimison, I will try to be as succinct as I can,  
18 but the World Health Organization in 1998 and 1999 stated  
19 that 8 out of 10 people in the industrialized world die  
20 of either cardiovascular disease or cancer. When you add  
21 neurodegenerative disease to it, it's 92 percent. It is  
22 92 percent of causes of all death which means homicide,  
23 suicide, all natural disasters, wars, all chronic disease

1 together 8 out of 10 people are dying of heart disease  
2 and cancer.

3 So the reason that says chronic disease, cancer,  
4 cardiovascular disease and neurodegenerative disease is  
5 because it represents 92 percent of causes of all death.

6 QIf you can turn to your -- the thin notebook that I think you  
7 might have in front of you.

8 AThis one?

9 QUh-huh (yes). To your deposition which is 12, I believe.

10 A12, yes, sir.

11 QIf you can turn to page -- I believe it's 51.

12 APage 51. Is that the -- is that the first number at the bottom  
13 or was it the -- I have the pages.

14 QNo, I'm sorry, do see the pages of four?

15 AYes.

16 QBeginning line 10, I asked you whether vitamin C is a treatment  
17 for cancer.

18 And then you said it is a treatment that we use for the  
19 immune system. Nothing that I'm doing is addressing  
20 cancer.

21 I asked you directly and then you answered the following.

22 What's your answer?

23 ABecause cancer is a symptom, so I'm not going to address it

1 directly, so I'm trying to direct it to the underlying  
2 immunosuppression and the issue of toxicity.

3 QSo when these patients come to you and they're coming to you  
4 because -- I mean, let's go -- Patients A, B and C came  
5 to you because they had been referred to hospice?

6 AThat's correct.

7 QAnd --

8 ABut I think actually that Patient C had not been -- he was  
9 not in hospice, A and B were in hospice.

10 QOkay. And what -- did you see them initially -- all initially?

11 AI saw all three initially, but I did not scribe the note.

12 In these three patients I saw them all initially, yes.

13 QWhat do you tell them?

14 AI don't really tell them much of anything, I'm listening to  
15 them most of the time because I get their history, what  
16 they've gone through, what they've been exposed to, what  
17 their, you know, history has been that led them to that  
18 point.

19 And it's usually pretty extensive because they've got  
20 charts, they've got scans, they've, you know, very thorough  
21 paperwork, they've got laboratory results, so it's pretty  
22 much mostly listening and collecting information and  
23 seeing what's pertinent.



1 QDo they ask you questions?

2 AGenerally speaking after we're done collecting the history,  
3 they may ask me some question, but most of them have already  
4 come seeking me out. They've done whatever research  
5 they've done. It's not that I have to convince them of  
6 anything.

7 QWhat kind of questions do they ask you?

8 AThey ask me questions -- I mean, they're varied. They ask  
9 me if they're going to feel nausea and vomiting when they're  
10 getting treatments. They ask me what are my chances.

11 QWhat do you tell them when they ask you that?

12 AI tell them I'm only a man, God is the only one who determines  
13 that.

14 QWould they ask if you -- if they -- if you can help them?

15 AIf they ask me if -- they ask me if I can help them, yes, I've  
16 been asked that.

17 QAnd what do you tell them?

18 AI tell them that I'm going to do my best, if I can.

19 QDo you say that you can help them?

20 ANo, I don't say I can do anything until I've made a determination  
21 after reviewing everything whether or not I can help them.

22 QAnd -- and you said they come with you with -- excuse me, with  
23 labs and scans and -- and all kinds of medical records?

1 AYes.

2 QAnd you review that?

3 AYes.

4 QAnd --

5 AI may not review it when I'm with the patient right there,  
6 but I review it, you know, later on at the end of the day  
7 or whatever.

8 QAnd I'm trying to understand why you review it because it seems  
9 as though despite what the records and scans may say,  
10 they're all still going to get the same treatments.

11 AWell, they're not getting the same treatments. If you look  
12 at the treatments you will see that the incidents of the  
13 treatments, the frequency of the treatments, the dosage  
14 of the treatments, even the -- even the constituents of  
15 the treatments.

16 For instance, Ms. -- Ms. -- well, Patient A received lipoic  
17 acid. That's how -- lipoic acid with selenium  
18 intravenously. That's the reason I was able to get her  
19 liver functioning again. That's documented with liver  
20 function tests over a week and a half period.

21 I can give you the exact numbers, but her -- but her LFTs --  
22 I'm going to find that chart, but I've got -- I've got  
23 the dates from -- from 7/31 to 8/03, in that four-day period

1 that she had drops in her liver functions tests based upon  
2 the lipoic acid, selenium intravenous drips that I give  
3 her.

4 But Patient B and Patient C did not receive that because  
5 they didn't have an issue with their liver.

6 Or for instance Patient C received IRRs more frequently  
7 because he had an actual perceivable deficit. He was  
8 actually experiencing shortness of breath, whereas Patient  
9 A and Patient B did not experience that. Patient A started  
10 experiencing it more towards the end.

11 So each one of these patients is getting treatment that's  
12 based upon them. We write orders -- you have the order  
13 sheets there, you can see how often orders are written  
14 and what things are different. We have a general protocol  
15 and then we adjust it based upon each patient.

16 QIs there a point where the cancer has spread so much that you  
17 will look at the scan and say I just can't do anything?

18 A Patient A is an example of that, yes.

19 QOkay. And tell me why, what happened there.

20 AAs I had previously said, the patient was now in organ failure.

21 When she came to me my goal was to up-regulate her liver  
22 if I could do that and it was successful for the first  
23 four, five, six days.

1 Her pain medicine levels -- excuse me, the level of pain  
2 she had was better and she didn't need as much narcotics  
3 and she was able to actually stop all of her narcotics  
4 for a period of five, six days, whatever it says in the  
5 chart.

6 And she had symptomatic reduction off abdominal  
7 distention, she had better energy, but then it started  
8 deteriorating again. That was correlated with her liver  
9 functions going up again.

10 So in that patient, it was obvious that she was already  
11 in organ failure. And if somebody is in organ failure,  
12 now the burden that is upon us as clinicians to try to  
13 help stimulate their immune system and to help detoxify  
14 their system becomes expedientially more difficult, if  
15 not impossible.

16 QAnd -- and with Patient C, the male patient.

17 APatient C.

18 QAt some point he came back with you and he went through all  
19 these protocols and -- and he showed you some scans,  
20 correct? He went through a radiation oncologist and  
21 brought back with him --

22 AYes, he did.

23 Q-- some scans?

1 AYes.

2 QAnd the result of that scan was to show that his cancer still  
3 spread?

4 AThis is -- are you talking about when he went to Mexico.

5 QNo, I'm talking about what he -- right before he stopped  
6 treatment.

7 AActually, that scan was done because I wanted the -- the doctors  
8 in Mexico to have a baseline of where he was. I did not --  
9 I did not review those test results with him because he  
10 had the CAT scan done and the day -- the last day I saw  
11 him, I said that the tests were due today or tomorrow.  
12 I don't remember. It was like -- it was coming up very  
13 soon, so I did not have an opportunity to go over those  
14 tests with him directly.

15 QSo let's -- well, I guess let's go back to things that we can  
16 agree on. Patient C began your protocol with hydrogen,  
17 ozone, just like the others?

18 AYes.

19 QAnd his cancer, nonetheless, still spread?

20 AYes.

21 QPatient A began your protocol and her cancer kept spreading?

22 APatient A, is that what you said?

23 QUh-huh (yes).

1 ANow, Patient A was, as I said, already in -- in organ failure.  
2 QAnd she -- she would die while she was basically there in  
3 Mecklenburg County in treatments from your office?  
4 AYes.  
5 QAnd Patient B, she began your protocols and her cancer still  
6 spread and she would later die in several months?  
7 AWell, all -- all these patients have been told they were going  
8 to die. Each one of these patients outlived their  
9 expectancy. Patient A was told that she was a week, two  
10 weeks, three weeks, I'm not -- I don't remember directly  
11 exactly what she told, but she was when she came to me  
12 looked -- I mean, she was completely cathectic. She was  
13 partially obtunded. She was in dire straits. In fact,  
14 my recollection is that we gave her nutrients right --  
15 right away because she was devoid.  
16 Patient B was told that he had -- if I remember correctly,  
17 Patient B was told that she had less than three months.  
18 She eventually succumbed to a cancer more than five months  
19 after she finished our treatment -- and she didn't even  
20 finish our treatment. She only had maybe three and a half  
21 of four weeks of IV treatments. She was the one that was  
22 discharged and so she outlived her expectancy with only  
23 partial treatment.

1           And Patient C was -- he -- that was his second round.  
2           He was the one that had the colostomy after the sigmoid  
3           resection. He had the nephrectomy, the splenectomy, the  
4           adrenalectomy. And when he came to me he had cancer that  
5           spread, as I read in the chart, had already metastasized  
6           to his liver and to his lungs.  
7           I don't remember offhand what they told him how long he  
8           had, but he's the patient that I remember that was under  
9           a severe amount of duress. And so I don't remember what  
10          his life expectancy was, but he died of a pulmonary emboli  
11          from what I understand.  
12         QAnd you said they were all told they were going to die, correct?  
13         AYes.  
14         QDid you tell them that?  
15         AI didn't need to tell them. Why would I reinforce what somebody  
16          else had said that they're going to die? We're all going  
17          to die, we just don't know how we're going to die.  
18         QWhy would you not tell them that?  
19         ABecause my job is not to play God. My job is to do my best  
20          to take care of my patients.  
21         QIf you have a bunch of scans and x-rays and -- and other medical  
22          information and you look at it and the patient has a very  
23          terminal illness, a very bad illness, would it be expected

1           that you tell the patient honestly what you think is going  
2           to happen to them?

3    AI think the best way for me to maybe explain this is by, if  
4           you will -- if the respective Members of the Board will  
5           indulge me, I will try to explain this in a way that may  
6           make you understand how I think. Is that all right?

7    QI mean --

8    AI'm going to try to answer your question.

9    Q-- if you could be responsive to the question --

10   AYes.

11   QYou know, if -- if it looks very dire from the medical record,  
12           the cancer has spread throughout the body, they're in organ  
13           failure --

14   AAbsolutely.

15   Q-- why not be honest with them?

16   AWell, they've already had honestly, that's not what they need  
17           at that point. They need reassurance at that point.  
18           But in my third postgraduate year in training and surgery,  
19           I was with my chief resident. At Brooke Army Medical  
20           Center we had a retired general with pancreatic cancer  
21           who had end-stage disease. He was in organ failure. And  
22           I sat there with -- with my chief resident who was  
23           explaining to this gentleman what was going to happen and



1 what we were going to try to do, how we were going to control  
2 his nausea.

3 And this retired general asked my chief resident, how much  
4 time do I have.

5 And my chief resident said, sir, I don't know how much  
6 time you have. I don't know how much I have. What we  
7 have to remember is that we are not the deciding factors.

8  
9 That night my chief resident drove home and was hit by  
10 a truck and he died. And he had just said that story less  
11 than five hours before he died.

12 So you see, I don't know when I'm going to be taken out,  
13 I don't know when you're going to be taken out, I don't  
14 know when anybody is going to be taken out, but I am not  
15 God and I refuse to tell a patient that they're going to  
16 die when every human being on this planet is going to die.

17 QI understand the -- you know, sort of the old saying that as  
18 soon as you're born, you start dying.

19 AThat's correct.

20 QAnd -- but some people have a better idea when they get a serious  
21 illness about when that time may come. So you refuse to  
22 tell them even though you have a very bad picture when  
23 they come in to you, but you are willing to treat them,

1 correct?

2 AWell, that would not be accurate because when they come to  
3 me, they're usually telling me that this is what my doctor  
4 told me, I have this much time left to live. I'm not sure  
5 why I would, as a physician, reiterate what they're already  
6 telling me.

7 In the case of Patient -- in the case of Patient A, when  
8 it became obvious that this patient -- that even what I  
9 was doing was not helping this patient, I had the discussion  
10 with the daughter. And -- and the patient wouldn't even  
11 come into the room because she didn't want to hear possibly  
12 what I was going to say.

13 I don't know if you've ever been in that situation, Mr.  
14 Jimison, but I have been in that situation more than once  
15 and I can tell you it is not an easy situation. And I  
16 can tell you that any person that is put in a situation  
17 like that, it is a difficult situation to deal with.

18 I cannot in good faith know that I have to face my creator  
19 one day and tell him that I made your decisions. So I --  
20 I've taken an oath to do no harm and I've taken an oath  
21 to do my best.

22 If I'm going to start telling patients that there's nothing  
23 that's going to be able to support your system, that you

1 need to go and die, then maybe Dr. Kevorkian is the right  
2 person because he, at least, puts them out of their misery.

3  
4 My point is very simple, I do what I can. Either I do  
5 that or I should alleviate their misery. We call it humane  
6 when you put a person -- or when we put a dog down, but  
7 we don't do that with humans. Why don't we do that with  
8 humans? Because we're trying to help them.

9 QDr. Buttar, if -- has there ever been an occasion where one  
10 of these end-stage cancer patients come to you and they  
11 bring you all their medical records and you review all  
12 their scans and you just look at it and you actually agree  
13 with their oncologist, there's nothing else to be done --

14 AWell, the patient that you saw, the Stage IV cancer patient  
15 with multiple metastatic sights to her skull, to her liver,  
16 her spleen, -- (inaudible), she was told that. She was  
17 given six months to live, that was five years ago. She's  
18 PET scan negative now.

19 So how can I make that decision? I -- I can't make that  
20 decision. I can only do one thing and that is do my best.

21 If my best is not good enough, then at least I know that  
22 I did my best, that's all I can do.

23 QAll I'm asking, again, I'm just trying to get a better response

1 to the question I'm asking.

2 MS. GODFREY: Well, objection to a better response.

3 MR. JIMISON: Well, it's not --

4 MS. GODFREY: I mean --

5 MR. JIMISON: -- a better -- an actual response. A  
6 response --

7 Q (By Mr. Jimison) Have you ever agreed --

8 MS. GODFREY: You might not be hearing what he wants to  
9 hear, but that --

10 Q But the question was, have you ever agreed with a doctor, that's  
11 all? I mean, an end-stage cancer patient comes in and  
12 presents to you, you look at their charts and you actually  
13 agree.

14 Has there ever been that occasion when you actually agreed  
15 with the oncologist that there's nothing that you could  
16 do and there's nothing that medicine can do for this  
17 patient?

18 A I think I've answered that, that I would be throwing that person  
19 out and they're not coming to me any more because they  
20 think that I'm going to do chemo or radiation or surgery  
21 on them.

22 They're coming to see if I can help them. I've had --  
23 I've had a patient that was brought to me with soft tissue

1 sarcoma who had lost over 100 pounds when he came to me  
2 and he was there because his family brought him to me.  
3 His family believed that I could help them.  
4 And while I was doing his physical, he was alone with me  
5 and he said -- he asked me a simple question. He said,  
6 can you help me?  
7 And I said, sir, I don't know.  
8 And he said, well, I know that it's important to my family  
9 because I'm ready to go, but whatever they want to do,  
10 let them do it.  
11 So what am I supposed to do, tell this man that no -- I  
12 mean, the family needed that -- that sense. I mean, it  
13 wasn't even by the patient, the patient himself had already  
14 resolved the fact. He told me, he said, I'm at peace with  
15 my maker, I'm welcoming my -- I don't -- I think his belief  
16 system was -- I think he's a Christian or I don't remember,  
17 but he was ready to go.  
18 But he asked me to do whatever the family wanted to do  
19 because he wanted them to feel that they had done everything  
20 in their power to save their father. So how am I to sit  
21 there and tell them that, no, I'm not going to do  
22 everything.  
23 PRESIDENT RHYNE: Mr. Jimison, I think -- well, he's

1 answered that question.

2 QLet's go to page 60 of your deposition. You said that you  
3 were on the cutting edge of medicine, correct?

4 AWell, I would like to think that.

5 QAnd why do you say that you are on the cutting edge?

6 ABecause more and more doctors are realizing that there's  
7 something wrong with the way that we've been taught. We've  
8 been taught -- we've been taught something that we thought  
9 was the right way, but after the Genome Project, it's become  
10 very clear and Dr. Peterson even testified to this, that  
11 there's more and more heterogenicity that they're finding  
12 and there's something that's wrong.

13 Because we usually think that the Genome Project that --  
14 that was portrayed to be the cure for all and that would  
15 give us all the information we needed for chronic disease  
16 -- would give us the information that we needed to find  
17 out which genes to turn on and which genes to turn off.

18  
19 However, we know that there's over 100,000 identified --  
20 identifiable proteins and yet there's only 21,000 genes  
21 in the Genome. In fact, the difference between the Genome  
22 and between a human and the -- (inaudible) -- is less than  
23 600 genes, so there must be something else that's going

1 on.

2 And Bruce Lipton in his work clearly show and he's  
3 extensively well published, he was in fact involved with  
4 the Genome Project and his own educational series now about  
5 the biology belief, talk about the fact that there is  
6 something that is a signal that causes the gene to create  
7 a protein one way or the other way. That is a toxic  
8 substance. Something that is -- causes a configuration  
9 change within the actual gene to elicit a different  
10 protein. So the same gene can actually define multiple  
11 proteins.

12 QWhy do you think you personally are on that cutting edge?

13 ABecause he verified and justified my entire 17 years -- or  
14 actually 11 years of clinical practice by his work in  
15 didactics that it is the signal. It is something that  
16 causes a disruption within our system. Each cell in the  
17 human body has over 100,000 reactions per second and  
18 there's over 50 trillion cells in the human body. This  
19 is the mechanism that's going on within our system.  
20 There's something that is introduced.

21 Why do you not have cancer, thank God you don't, and why  
22 does a person have cancer. What is the difference? And  
23 what makes one person have it and the other person not?

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23

My goal is to find out what turned that on and try to reinstate the state of the body back to the state before that cancer became obvious. We all have cancer in our bodies. Cancer cells are there constantly, but the apoptotic mechanisms are there to prevent the cancer from becoming fulminant and becoming rampant in our system. So what keeps my cancer cells in control and my cancer patient's cell, let them become out of control. That is what I'm trying to define. That is what I'm trying to identify. That is what I'm trying to resolve.

QLet me see if you still agree with this. When I asked you about why you call yourself on the cutting edge you said -- and this is on line 24, page 60: That's why it's called advanced medicine.

And I asked you what do you mean by that? And this is on top of page 61.

That's why I named my clinic it's the Center for Advanced Medicine because we believe we're practicing medicine 15 to 20 years ahead of it's time.

AThat is absolutely correct.

QAnd I keep going, I said -- now, if you go down to line 7, I'm basically trying to ask --



1 AIn the same -- in the same box?

2 QThe same box on page 61. I'm asking you: Do you know something  
3 that others don't. And I ask you and you say: That's  
4 exactly what I'm saying.  
5 And then I ask you: How do you come to this conclusion  
6 that you know more and others don't.  
7 So I'm asking you for the Board Members, why do you know  
8 things that others don't?

9 AWell, it's not that I know things that others don't, but I  
10 have become -- I've started seeing and observing certain  
11 things. The purest form of science is observation  
12 according to Hippocrates -- excuse me, according to  
13 Socrates, and that is what I do, I observe.  
14 The people that have come through our training program,  
15 people such as pediatric, a cardiologist, Dr. Philbert  
16 in California or the orthopaedic cancer surgeon from  
17 Harvard, or any of these doctors that have come through  
18 my course, they're coming not because I'm going to teach  
19 them something different about orthopaedics or  
20 cardiovascular disease because they know way more than  
21 I do. I've had four oncologists that have come through  
22 my training program. They know more about cancer than  
23 I'll ever know in my life.

1 But they're coming because they understand that what we're  
2 doing is causing a fundamental change in the physiology  
3 to start to allow the system to start operation again.  
4 All I'm doing -- I'm nothing more than a glorified garbage  
5 man. I'm pulling out things that are garbage inside the  
6 body, that's all I'm doing.

7 It is not rocket science. It is a simple thing. The key  
8 is, how effective are people at pulling out things that  
9 shouldn't be in the body, that's it.

10 QHow does hydrogen peroxide pull things out of the body?

11 AHydrogen peroxide is actually a secondary mechanism, not  
12 pulling stuff out of the body, but more stimulating the  
13 immune system.

14 QAnd ozone therapy, how is that --

15 AOzone is actually both. Actually, that's a great question.

16 Ozone has been shown in multiple studies -- I mean, some  
17 of those have been provided, and are phenomenal at pulling  
18 out persistent organic pollutants, the fluorinated  
19 hydrocarbons, the benzines, the -- (inaudible) -- the  
20 organophosphates.

21 My -- my last meeting with the Center for Disease Control,  
22 their number one -- the number one issue that I thought  
23 would be their number one concern, it ended up being

1 mercury, but it was based on alphabetical order and it  
2 was -- (inaudible) -- hydrocarbons.  
3 The only thing that has been -- the reason they call them  
4 POPS or persistent organic pollutants is because once they  
5 enter the body they can't be excreted.  
6 If you look at the liver and you look at COT polymorphisms,  
7 Phase I, Phase II, the conjugation of the pupil, --  
8 (inaudible) -- system into the liver, these chemicals  
9 cannot be processed through the liver. So what we do is,  
10 we try to, one, up-regulate the liver; and, two, we try  
11 to give the body something that can breakdown this  
12 persistent organic -- (inaudible) --so that they are no  
13 longer persistent.  
14 Ozone happens to be one of those therapies and this is  
15 well documented in the journal literature as well as --  
16 the journal literature is the most extensive. There's  
17 a couple of other pieces of literature.  
18 In fact, Baylor Oncology of Medicine in the 1960s and we  
19 provided those documents to my counsel. There are five  
20 different publications in -- in the Journal of Thoracic  
21 Surgery that was done by surgeons where they used ozone  
22 to show the change within the system. This was done in  
23 the 1960s. This was -- this was all stuff done at Baylor.

1 QFor the benefit of the Board Members and perhaps to benefit  
2 everybody in the room, I want to try to go as fast as  
3 possible. So -- and I want to use some of the exhibits  
4 and just want you to verify things and hopefully we can  
5 get done fairly quickly, but hopefully the exhibits won't  
6 be too bad.

7 Can you turn to Exhibit 8?

8 AIn the same book?

9 MS. GODFREY: In whose book?

10 MR. JIMISON: My book.

11 AEight in the thin book.

12 QEight.

13 AI'm there.

14 QOkay. Patient C, he was treated --

15 ASir, Patient -- Exhibit 8 is my CV.

16 QI know, but I just wanted to get you to --

17 AOh, I'm sorry, excuse me.

18 Q-- the exhibit when I ask the questions.

19 AI'm sorry.

20 QTo your knowledge or memory, you have the medical records in  
21 front of you, was Patient C treated essentially from April  
22 26th to June 11th of '04?

23 MS. GODFREY: The patient, which one?

1 WITNESS: Patient C.  
2 MR. JIMISON: Patient C.  
3 AThe gentleman.  
4 QFrom the end of April to sort of early, mid June?  
5 AI believe so. I believe that's correct.  
6 QIn 2004?  
7 AUh-huh (yes).  
8 QOkay. And Patient B was essentially around the same time,  
9 correct?  
10 APatient B was -- yeah, essentially, yeah. Patient -- Patient  
11 C actually came earlier, though.  
12 QOkay. But sort of around April to June --  
13 AYes.  
14 Q-- 2004?  
15 AYes.  
16 QAnd they were getting treatments five days a week, 40 hours  
17 a week in your office during that time?  
18 AYou know, I would have to go back. I think it was four days  
19 a week because Fridays -- we were only open certain days  
20 when we had cancer patients that were scheduled. But it  
21 wasn't a regular thing on Fridays, it all depended.  
22 QAnd --  
23 ABut generally speaking, yes.

1 Q-- if you go to the part on Exhibit 8 --  
2 AExhibit 8?  
3 Q-- to your lecture schedule.  
4 AExhibit 8, you said?  
5 QUh-huh (yes). Which is page 4 of the exhibit, the first page  
6 of your lecture schedule. Turn to page 3, starting at  
7 number 29 you talked about this Congressional testimony.  
8 AYes.  
9 QYou were out of the office on May 6, 2004?  
10 AThat's correct.  
11 QAnd then you were out of the office on May 21st -- May 23rd,  
12 2004.  
13 AThat's correct. This is -- either May 6th wasn't a weekend,  
14 but the May 21st, 23rd, that was over a weekend.  
15 QAnd that was in Brazil?  
16 AThat was in Brazil.  
17 QAnd -- and then you were out of the office from May 28th to  
18 May 30th?  
19 AThat's correct. That was also a weekend.  
20 QAnd June 4th to June 6th?  
21 AThat was also a weekend, that's correct.  
22 QAnd June 18th, June 19th?  
23 AI have a lecture almost every weekend.

1 QAre you out of the office during weekdays?  
2 AI'm occasionally out of the office during the weekdays, yes.  
3 Generally speaking, it's only when it's something of  
4 urgency, otherwise my -- my lecture -- doctors don't come  
5 to conferences during weekdays, so it's usually on the  
6 weekends.  
7 I have flown from here to Veronia and been back in less  
8 than 60 hours. I've done this numerous times. And I have  
9 done this numerous times on my trip to Brazil. I was only  
10 on the ground in Brazil for maybe nine hours just to give  
11 my lecture. I give two lectures and then I left.  
12 That's -- that is -- that is accurate.  
13 QAnd June -- number 35, June 24th through June 28th?  
14 AYes.  
15 QAnd that was in Spain?  
16 AYes.  
17 QAnd let's look at some of the things you're actually lecturing  
18 on. Go to --  
19 ASame page?  
20 QLet's go to number 4 -- page 4 which will be page 7.  
21 AOkay.  
22 QNumber 46, The Treatment of Cancer --  
23 AUh-huh (yes).

1 QOkay.

2 A-- Using Immune Modulating Peptid Analogs, okay.

3 QThen the next page, on Page 49.

4 APage 49. You mean Number 49.

5 QI'm sorry, yes. Course Chairman, Innovative Protocol for  
6 Treating Chronic Disease, Cancer --

7 ACancer, Cardiovascular and Neurodegenerative Disease, all  
8 three of them.

9 QUh-huh (yes). And Number 52, the same course?

10 AYes. As I've said, it's debulking the toxic load and it's  
11 stimulating the immune system in all chronic diseases.

12 QAnd Number 59, same course?

13 AYes.

14 QAnd Number 67, the same course?

15 AYes.

16 QAnd Number 72, the same course?

17 ANumber what?

18 QNumber 72.

19 AYeah, that's why they're all highlighted. You'll notice  
20 they'll all bold for a specific reasons.

21 QAnd Number 62, if you go to Number 62.

22 ANumber 62?

23 QYou lectured on a topic called The Treatment of Cancer, a Five



1 Step Non-Traditional Medical Approach in the Treatment  
2 of Cancer.

3 AYes, that's what the lecture says.

4 QAnd you -- I mean, you were speaking during that time frame?

5 AYes.

6 QAnd that's the title you gave your lecture, correct?

7 AThat is correct, I did.

8 QAnd number -- the next Page 75, again, a course on Innovative  
9 Protocol for Treating Chronic Disease Cancer,  
10 Cardiovascular and Neurodegenerative?

11 AYes.

12 QAnd when people -- do doctors pay a fee to come to these courses?

13 ADo doctors -- I'm sorry?

14 QDo doctors pay a fee to come to these courses?

15 AAbsolutely.

16 QAnd how much is that fee?

17 A\$20,000.

18 QAnd where does that fee go to?

19 ATo the AMESPA Group.

20 QWho is the AMESPA Group?

21 AAAMESPA is an organization that is -- it stands for the Advanced  
22 Medical Education and Services Physician Association.

23 QAnd what's your connection with that?

1 AI founded it, I organized it and I've been paid \$4.35 for that  
2 organization since I accepted it in 2005 and the balance  
3 sheet shows it.

4 We also opened up a foundation -- a children's foundation  
5 for AMESPA where contributions are now being made for the  
6 treatment of children that have succumbed to chronic  
7 diseases such as cancer, autism, these type of chronic  
8 diseases.

9 And I resent any implication that you have of those funds --  
10 QJust answer the question.

11 AI'm just answering the question, but I --

12 QI didn't ask a question.

13 A-- I've gotten \$4.35 from that organization because I forgot  
14 my credit card one day for lunch.

15 QSo your 20,000 -- \$20,000 that doctors pay that doesn't go  
16 to you?

17 AThat does not go to me. You're welcome to inspect those --  
18 those documents and those -- where that money exists.

19 QLet's now go to --

20 AIn fact, I'll be happy to tell the Board where that money goes  
21 and for what purpose it is set aside, if Mr. Jimison would  
22 like to know.

23 QSure.

1 AThat money is set aside and has a balance of about \$300,000  
2 in that account and it is set aside to protect the interest  
3 and the rights of doctors to practice medicine freely.  
4 And it is -- has doctors from three different countries --  
5 I'm sorry, excuse me, four different countries. We have  
6 over 50 doctors that are part of that organization. And  
7 those funds have been set aside to help defend those doctors  
8 if they are brought up on charges of unethical conduct  
9 for practicing integrative medicine.

10 QWell, that's kind of interesting. Are the funds from that  
11 organization being used to help defend you in these  
12 proceedings?

13 AI haven't used it yet because I have enough funds myself, but  
14 I may.

15 QI'll withdraw the question. If you go to Exhibit -- it's for  
16 Patient C, I believe it's --

17 AI'm sorry, what?

18 Q-- Tab 2 in the Board's big notebook.

19 MS. GODFREY: Tab 2 in the Board's notebook.

20 AI'm sorry, you said Patient what?

21 QPatient C.

22 AAnd Tab 2? Is this the book? Like this one?

23 QOh, no.

1 AThis one? Tab 2?  
2 QYes. If you can look from page 153 all the way to, I think,  
3 it's 206.  
4 APage 153 to 206?  
5 QUh-huh (yes).  
6 AOkay.  
7 QWhat is that? Is that the biofeedback?  
8 AYes, it is. Yes, it is.  
9 QAnd essentially there are -- I guess if you do the math, 153  
10 subtracted by 206, about 53 entries?  
11 AIf that is what it is, I'm -- if you want to count them, but --  
12 QWell, that does sound about right?  
13 AThat's probably right, yes.  
14 QAnd each of those are biofeedbacks that you administered to  
15 Patient C was \$150, correct?  
16 AI think that's what is on the chart, but that's not what's  
17 collected.  
18 QDoes insurance pay for that?  
19 ASometimes they have in the past, but we don't deal with  
20 insurance companies any more, but they have in the past.  
21 QWhy don't you collect the \$150?  
22 AVery simply because with cancer patients, they have a  
23 tremendous financial burden and we try to extend to them

1 every courtesy we can. These treatments are only  
2 recommended for the three times to see if the patient feels  
3 a difference. If the patient feels a difference, then  
4 they usually request it.

5 So our standing order is -- I think it's either three  
6 treatments or -- yeah, it's three treatments or four  
7 treatments. We basically do one week of treatments and  
8 then it's up to the patient to decide if they want to  
9 continue.

10 And I don't -- I cannot recollect a single patient that  
11 has not requested to continue with that because it makes  
12 them feel that much better.

13 QOkay. And go to page 265.

14 A265.

15 MR. KNOX: 265 or 255?

16 MR. JIMISON: 265.

17 WITNESS: 265.

18 AOkay, I'm there.

19 QYou're seeing a lot of bills for -- for IV infusions?

20 AYes, I am.

21 QTherapeutic or diagnostic injections?

22 AYes.

23 QBiofeedback?

1 AYes.

2 QAnd coffee enemas?

3 AThat's a kit that the patient gets.

4 QOkay. Chocolate protein powder?

5 AYes.

6 QAnd the total charges after adjustments, are what?

7 AI'm not -- it's my -- my one is one straight sheet down, it  
8 has dates of service of 5/27, 5/28, 6/01, 6/2, so I'm not  
9 sure which -- where's the total you're talking about.

10 QOn this -- the check payment on 6/11 or 6/02. The check payment  
11 AFor \$1,409; is that right?

12 QUh-huh (yes).

13 AYeah.

14 QWould it be fair to say that most days Patient C paid close  
15 to over \$1,000 for his treatments?

16 AIt would be probably a safe assessment to -- probably that  
17 that would be accurate. I'm not sure whether that's  
18 exactly right, but my financial -- I have a financial person  
19 that deals with those issues, so I don't usually deal with  
20 them, but I would think that's probably fair.

21 QHow many patients on average do you see a day?

22 ANow, I don't quite understand the question because there's  
23 different types -- there's different things that we see,

1           so I may not have -- if you -- you need to clarify that.  
2   QHow many patients does your clinic usually see a day?  
3   AFor everything?  
4   QUh-huh (yes).  
5   AOh, goodness. Well, basically we -- we don't see any more  
6           than two new patients in a day. So on a busy day we may  
7           see -- now, are you talking about IVs for this type or  
8           the charge of \$1,000 a day?  
9   QNo, just -- just the number of patients your clinic sees a  
10           day?  
11   AIt can vary. I mean, some days we've only had four patients  
12           and some days we've had 40, so I really couldn't --  
13   QHow many cancer patients do you see -- are you presently  
14           treating?  
15   APresently I'm treating two cancer patients -- well, I'm --  
16           in the first -- the number of patients that I'm seeing  
17           right now in their first phase of their detoxification?  
18           Two that have cancer, but I have numerous patients that  
19           have already gone through all that process and they're --  
20           some of them are here today and some of them you saw, but  
21           they're not in my clinic every day.  
22           They may -- I may see them once every six months, I may  
23           see them once every year. Some of them I haven't seen

1 in a year and a half. I've got two -- two doctors that  
2 are patients of mine with cancer. I haven't seen -- I've  
3 got an appointment with one of them coming up, but I haven't  
4 seen him for a year and a half.

5 QThe -- you testified in direct testimony when Ms. Godfrey asked  
6 you about the 100 percent success rate that was spoken  
7 about by Patient C's wife. And you said that -- and correct  
8 me if I'm paraphrasing this wrong, that -- that you would  
9 never tell the patient about a success rate for treatments.

10 ANo. I said that I can't tell them what a success rate is because  
11 it's going to be irrelevant to them. I have said to --  
12 I've said to patients that I've got patients that have  
13 failed everything else and they're still alive today after  
14 they've gone through our type of therapy, but I've never  
15 quoted any type of percentage that I can remember.

16 QHave you ever quoted a percentage for any therapy?

17 AI've probably -- yeah, but I'd say for like IRRs, I'd say 95  
18 percent effective or maybe even -- I would probably say  
19 that's about the closest that you can get to an  
20 always-and-never thing because IRRs, if done --  
21 administered appropriately, they're absolutely  
22 phenomenal. I think it's -- I think it's a great, great  
23 therapy.



1 And the question one of the Board Members had asked, why  
2 do you think that -- that -- I think, Dr. Walker, you asked  
3 that question -- why hasn't that been more prevalent and  
4 I -- I can honestly say I believe it's because of the  
5 influence of pharmaceutical company. Dr. Philbert did  
6 an extensive writeup and published this in a journal of  
7 family practice.

8 It is absolutely the most phenomenal therapy that I've  
9 ever seen. It is inexpensive, it is quick, it is a rapid  
10 response onset of efficacy, yet it's not done. And every  
11 doctor that has come to my course has learned how to do  
12 it.

13 In fact, the North Carolina Medical Board, that is the  
14 reason that I talked with Mr. Mansfield about being able  
15 to get that permission to teach doctors how to do that  
16 treatment. And was very happy to have that response from  
17 Mr. Mansfield and I also got permission for South Carolina  
18 because that's literally the two states that we teach the  
19 course in. That's just because it's convenient for us  
20 to teach in those two states, but doctors come in from  
21 all over the world. And so I've been able to teach doctors  
22 that particular treatment.

23 That treatment I would say is 95 percent or more efficacy,

1 if done -- if done correctly.

2 QAnything else you said had a percent success rate?

3 AI know I've said that according to -- a 42 percent efficacy  
4 of antibodies before they release -- before the FDA  
5 releases it. I'm sure I've quoted some kind of  
6 percentages. I know that pancreatic cancer has a 2 percent  
7 survival, one year -- well, one year of survival is 2  
8 percent and two years survival is zero percent, so I may  
9 have said things like that. I honestly can't remember  
10 all the different things I may have said in the past.

11 QOkay. Going back to your pamphlet which we passed out, could  
12 you turn to page 3?

13 AI don't have a copy of that.

14 QAll right.

15 MS. GODFREY: Page 3. We still don't have a copy, right?

16 QLet me just hand to you my copy. Look at the one, two -- the  
17 third paragraph. Could you read the third bullet point  
18 on that page?

19 AEffective, yes. There's a 95 percent success rate with  
20 efficacy of allergies -- effectively resolve all allergies  
21 in patients easily without difficulty with 95 percent  
22 success rate of treatment.

23 But this isn't -- this isn't for patients, this is for

1 doctors.

2 QAll right. At some point and I'll try to do this within five  
3 minutes, the -- you sent out an e-mail, correct, to your  
4 patients after the Medical Board charges?

5 AI did.

6 QAnd that e-mail basically made reference to -- why did you  
7 send out that e-mail?

8 ABecause based upon what the Medical Board already knows about  
9 my practice and based upon nine visits and numerous chart  
10 reviews and everything else, I wanted my patients to be --  
11 my patients are very open with me and I'm very open to  
12 my patients, so I wanted them to know the false allegations  
13 against me by the North Carolina Medical Board and so I  
14 notified them.

15 I know that those egregious allegations against me were  
16 designed to undermine my character, a character  
17 assassination, and I wanted my patients to know the truth.

18  
19 In fact, my patients were calling me asking me what is  
20 this kind of garbage, what is happening, why are they doing  
21 this. And so I sent out the e-mail to make it easier for  
22 me to respond rather than an individual response to each  
23 person that was calling and talking.

1 QLet me hand you a copy of that e-mail and a copy to your counsel.

2 You said in that e-mail, second paragraph: I have seen  
3 the comments by two experts the North Carolina Medical  
4 Board retained to review our patient records. Their  
5 assessments have been invalidated point by point and we  
6 are looking forward to proving this case to be not only  
7 without merit at the upcoming hearing, but an example of  
8 how the various state medical boards are singling out  
9 doctors who don't prescribe one drug after another.

10 Already one of the two experts is now refusing to testify  
11 against us.

12 Is that correct?

13 AThat's what you notified us about. I only know what I was  
14 told by my counsel that you told them.

15 QOkay. And one of those two experts was an integrative medicine  
16 doctor?

17 MS. GODFREY: Objection.

18 MR. KNOX: Objection.

19 QIf you know.

20 AI don't know.

21 QOkay. And you talked about -- and if we can get the Medical  
22 Practice Act and I think we passed this all out.

23 AI just know that we have nine experts and you limited us to

1 three and you had these cases since 2006 and all you could  
2 find was the one person.

3 QI'm going to read to you -- you said you were involved with  
4 the law -- do you have another copy?

5 AMr. Jimison, I think you've already changed the law since we --  
6 since we changed it. The eternal price of freedom is  
7 constant vigilance and we failed or dropped the ball  
8 because we weren't constantly vigilant, so we know you've  
9 already changed it again.

10 QI want to read to you 90-14(a)(g).

11 AI don't have that document.

12 QI'll hand you that. You now have 90-14(a)(g), subparagraph  
13 (g).

14 ASubparagraph (g), I'm there.

15 QIt says: Prior to taking action against a licensee to practice  
16 integrative medicine for providing care not equivalent  
17 to his practice for the procedures or treatments  
18 administered, the Board shall consult the licensee to  
19 practice integrative medicine. Correct?

20 AThat's what it says, yes.

21 QAnd the expert that you referred to in the e-mail was the expert  
22 that practices integrative medicine that the Board  
23 consulted with, correct?

1 MR. KNOX: Well, objection. He said he didn't know. And  
2 the second thing is that person is not labeled a witness  
3 or in the procedure. At some point we must be involved  
4 --  
5 MR. JIMISON: I'm just saying -- I just want to establish  
6 through Dr. Buttar that the Board made the consultation  
7 prior to charges --  
8 MS. GODFREY: Well, I don't think Dr. Buttar has any  
9 personal knowledge of what the Board did --  
10 MR. JIMISON: Well, the Board --  
11 MS. GODFREY: -- in investigating his own case.  
12 MR. JIMISON: The personal knowledge is reflected from  
13 his e-mail.  
14 PRESIDENT RHYNE: Well, we don't have a copy of the e-mail,  
15 so we don't --  
16 MR. JIMISON: Okay. I understand.  
17 PRESIDENT RHYNE: What we heard you say, it wasn't clear.  
18 MR. JIMISON: Yeah. If I could just have a minute while  
19 Ms. Carpenter goes to copy those. I think it will take  
20 her a few seconds. If we could have a minute. And then  
21 this will be sort of the last few questions and then I'll  
22 be done.  
23 MR. KNOX: Well, I know I'm being -- we are running behind,

1 and I know you've done all you can, but this was supposed  
2 to take 20 minutes and it's hour.

3 PRESIDENT RHYNE: That's all right, we'll give you your  
4 time.

5 MR. KNOX: I know.

6 WITNESS: Ma'am, is it appropriate for me to stand up and  
7 stretch my legs?

8 PRESIDENT RHYNE: Please do.

9 WITNESS: I appreciate that, thank you.

10 DR. McCULLOCH: Mr. Knox?

11 MR. KNOX: Yes, sir.

12 DR. McCULLOCH: Are you claiming that running over is a  
13 one-sided event here today?

14 MR. KNOX: Well, I'm not sure who said what, but I haven't  
15 said anything today so I can be critical, do you understand?

16 I wasn't in either one of those.

17 Q(By Mr. Jimison) So you write in the first -- you actually  
18 write in the very first sentence of that second paragraph  
19 that you have seen the comments by the two experts the  
20 North Carolina Medical Board retained to review the patient  
21 records.

22 AYes.

23 QAnd so you actually saw the worksheets, the comments that they

1           wrote?

2    AI was given those to respond to them.

3    QOkay. And one was from a UNC neurologist?

4    AYes. There's a -- yes, that's correct.

5    QA Dr. Mann?

6    AI believe that's -- that's correct. I'm not sure if it's the  
7           same Dr. Mann that I know, but I was told it was not, but --

8    QOkay. And the -- and that review was not favorable to you,  
9           was it not?

10   MR. KNOX: Well, objection.

11   MS. GODFREY: Well, objection.

12   AI think that's the reason you didn't bring it in because it  
13           was.

14   QIt was favorable to you?

15   AWell, obviously that's why one -- I mean, it said that --

16   MR. KNOX: Wait a minute. I'm sorry, Doctor. I mean,  
17           the reason we objected is that person has been discarded  
18           by the Board as a potential witness, so we never did a  
19           deposition and now to say that doctor was not favorable  
20           or was favorable to you is grossly unfair.

21   MR. JIMISON: Okay. Well, let me just -- let me -- let  
22           me withdraw that --

23   MR. KNOX: May I ask --



1 MR. JIMISON: I'll just withdraw the question. I'll just  
2 withdraw the question.

3 MR. KNOX: Thank you.

4 Q(By Mr. Jimison) The -- the law that we're talking about  
5 90-14(a)(g) that you said you were part of, it just says,  
6 the Board shall consult --

7 MR. KNOX: Well, object to what the law says. That's not  
8 a question. He's examined this witness and he does not --

9 MS. GODFREY: That's a --

10 MR. KNOX: I mean, what he's trying to do is prove  
11 indirectly what he failed to show on direct and it's too  
12 late.

13 MR. JIMISON: That'll be all.

14 MR. KNOX: Thank you, sir. You can step down.

15 PRESIDENT RHYNE: Well, wait a minute.

16 MR. KNOX: I'm sorry, I thought -- he said that was all.

17 PRESIDENT RHYNE: That's all on his part.

18 MR. KNOX: Okay.

19 WITNESS: This is all of his part right here.

20 PRESIDENT RHYNE: Yeah. did you want to redirect  
21 anything?

22 MS. GODFREY: No. I think the Board is the best redirect.

23 PRESIDENT RHYNE: Okay. Did Mr. Jimison recross? Okay.

1 Now, we'll go to the Board Members.

2 Dr. McCulloch?

3 DR. McCULLOCH: Oh, sure.

4 **EXAMINATION BY THE PANEL MEMBERS:**

5 DR. McCULLOCH: Not surprising through a lengthy testimony  
6 you might say some things are -- are perhaps contradictory,  
7 but -- and I don't want to pick -- pick on necessarily,  
8 but there is one point that bothers me. You said that  
9 -- you said, I treat cancer by treating the cause.

10 WITNESS: Yes, sir.

11 DR. McCULLOCH: And then you said, we don't know the cause  
12 of cancer.

13 WITNESS: We don't know the full cause of cancer, sir,  
14 but we know that there's a --

15 DR. McCULLOCH: We should be able to find the cause of  
16 cancer.

17 WITNESS: Yes, sir.

18 DR. McCULLOCH: And this gets to my problem that I have  
19 that we've been alluding to all along, is this total lack,  
20 apparently to me, of studies of scientific knowledge that  
21 isn't -- that there's no basis for what you're doing, in  
22 my opinion. And -- and perhaps that's my shortcoming.

23 One of the things that we are concerned about and we know

1 talking about the law, we -- we are aware that the law  
2 recognizes in traditional medicines, a lack of full  
3 understanding of what you do.

4 WITNESS: Yes, sir.

5 DR. McCULLOCH: But the law also says that we want to make  
6 sure that you don't cause harm.

7 WITNESS: Yes, sir.

8 DR. McCULLOCH: And in reading what appears to be  
9 reasonable literature from, for instance, Sloan-  
10 Kettering, talking about hydrogen peroxide therapy --

11 WITNESS: Yes, sir.

12 DR. McCULLOCH: -- it's dangerous stuff.

13 WITNESS: Sir, it was also considered inappropriate and  
14 dangerous -- well, I don't want to get to -- or, you know,  
15 washing your hands is considered to be ridiculous, but  
16 I won't get into that. If I -- if I may answer your question  
17 about the -- about the causes because these documents  
18 have been provided and these are -- these are journal --  
19 these are well repudiated.

20 DR. McCULLOCH: I'd rather just -- I'd rather not go into  
21 that. I just wanted to point out what I consider a --

22 WITNESS: I may not --

23 DR. McCULLOCH: And the reason why I don't want to go into

1 that is because I know what you're going to say.  
2 WITNESS: Well, it's just basically --  
3 DR. McCULLOCH: It will be a long litany --  
4 WITNESS: No, sir, it'll --  
5 DR. McCULLOCH: -- of stuff that I don't understand.  
6 WITNESS: No, it'll be 30 seconds, sir, actually.  
7 DR. McCULLOCH: All right, go ahead.  
8 WITNESS: If you'll allow me to be to -- there's a cancer  
9 statistics 1998 that was put out by the National Cancer  
10 Institute. I believe we have the reference here and it's  
11 a 35 page document.  
12 And in that document, sir it talks about the causes of  
13 cancer and we have the slides that I've used actually in  
14 presentations to show this and it was concurred by -- with  
15 the head of the -- Dr. -- (inaudible) Vega -- the head  
16 of radiation oncology that 75 to 95 percent of all cancers  
17 according to the National -- National Cancer Institute  
18 are directly related to some form of a toxicity.  
19 So my question was -- I apologize if I didn't get this  
20 across, my goal is to try to address that toxicity that  
21 is with the cause. I don't know what all the causes are,  
22 but that's what I'm trying to address.  
23 DR. McCULLOCH: I understand that and you're addressing

1 that with a blanket treatment without any study, without  
2 any controls, without any knowledge of really what your  
3 results are.

4 WITNESS: I'm using the same method that was used to  
5 evaluate the coronary artery bypass graph, sir.

6 DR. McCULLOCH: In an EDTA treatment or what?

7 WITNESS: No, sir. To assess the efficacy of coronary  
8 artery bypass graph. There was no double-blind  
9 placebo-controlled randomized cross-over studies.

10 DR. McCULLOCH: Oh, okay, so it's all right.

11 WITNESS: Well, no, I'm not saying it's all right, sir.  
12 I'm just saying that I'm using the same thing based upon  
13 empiric evidence.

14 DR. McCULLOCH: All right. Just a technical point, you  
15 were talking about the overhead and you listed the overhead  
16 in your costs.

17 WITNESS: Yes, sir. Well, my -- my accountant and my  
18 financial manager did, yes, sir.

19 DR. McCULLOCH: How did you determine the overhead? That  
20 was the biggest part of your cost and the IV.

21 WITNESS: Yes, sir. It was -- it was based upon everything  
22 from payroll --

23 DR. McCULLOCH: Payroll, light bill, benefits, dah, dah,

1 dah, dah, dah --  
2 WITNESS: Yes, sir.  
3 DR. McCULLOCH: -- which is for -- for that period of  
4 time as it is --  
5 WITNESS: Yes, sir, as it went -- I'm sorry, say again.  
6 DR. McCULLOCH: For that period of time that the IVs were  
7 --  
8 WITNESS: No, sir, it's based upon total dollars coming  
9 in. In other words, our cost of overhead when you take  
10 the cost of goods sold and then you take total expenses  
11 and you take total gross revenue that's coming in, when  
12 you subtract it out, that's what the percentage came out  
13 to be and that was --  
14 DR. McCULLOCH: How did you come up with \$75 for an overhead  
15 for starting an IV?  
16 WITNESS: Sir, I did not do that. As I said, it was my  
17 accountant and my chief financial officer. I just --  
18 because I don't deal with the number aspect, but that's  
19 how they come up with it based upon what our rents are  
20 and, you know, our overhead costs.  
21 DR. McCULLOCH: Well, my guess is they probably looked  
22 at the -- it's a two-hour infusion, they're probably  
23 looking at your two-hour overhead. And my problem with

1 that is, that it's counting --  
2 WITNESS: I don't believe that's correct, sir, because  
3 my revenue --  
4 DR. McCULLOCH: I mean, that's assuming that your overhead  
5 is not taking care of anything else during that two-hour  
6 period of time. Your payroll for instance, you're taking  
7 care of other patients at the same time.  
8 WITNESS: Yes, sir, that is how it is reflected, that's  
9 right. It's not -- it was extrapolated out to be based  
10 upon -- as I understand it at least, it's based upon the  
11 total amount of revenue that's coming in, total amount  
12 of cost of goods subtracted and then what was left over  
13 and that amount from expenses versus what was profit and  
14 they -- it came out to be something like 78 percent was  
15 expenses and 22 percent was profit and then they calculated  
16 it out based on that. I don't know exactly, but I believe  
17 that's how they did it.  
18 DR. McCULLOCH: How do you determine how many days a week  
19 to treat somebody with hydrogen peroxide?  
20 WITNESS: Well, sir, the hydrogen peroxide has gotten a  
21 lot of attention --  
22 DR. McCULLOCH: Well, okay, EDTA or whatever.  
23 WITNESS: Well, hydrogen -- yeah, I was just going to say,

1 hydrogen peroxide is maybe done six times in that six-week  
2 period, but EDTA I generally only give a chelator once  
3 a week.

4 And the reason is, is because I don't want to deplete the  
5 essential minerals. In fact, that is the bigger concern,  
6 so I don't do it more than once a week.

7 I may on rare occasion -- I have had patients with very  
8 high levels who are tolerant of the treatments and I have  
9 gone more aggressively given two treatments in a week,  
10 but usually in between they get a mineral drip. I've maybe  
11 done that half a dozen times in -- in 11 years of doing  
12 this treatment, but generally speaking it's only once a  
13 week.

14 And also if we're giving -- (inaudible) -- sulfonic we  
15 won't do that but more often -- more often than once  
16 every two weeks.

17 DR. McCULLOCH: Okay. But these people are getting IVs?  
18 We heard testimony they would come in for eight hours  
19 a day, five days a week.

20 WITNESS: The people that -- that are getting the immune  
21 modulation and some of those things, yes, sir, they can  
22 -- it can extend out that long. But the typical person  
23 that comes in for an EDTA, it's one gram per hour --



1 DR. McCULLOCH: I want to talk about the five-day-a-week  
2 people.

3 WITNESS: Oh, the five-day-a-week people, yes, sir. Some  
4 of those -- some of those may be an hour, an hour and fifteen  
5 minutes, some of the IVs and some of them may end up --  
6 like EDTA for instance, if it's the full dose it's three  
7 hours.

8 DR. McCULLOCH: My question is, how -- how did you  
9 determine to do it five days a week as opposed to two days  
10 a week, as opposed to seven days a week.

11 WITNESS: Oh, I see what you're saying, sir. I actually  
12 started doing this when -- when we had the -- my first  
13 patients that came to me we actually did it only twice  
14 a week, but I didn't see it to be beneficial.

15 And based upon some of the work at some of the conferences  
16 that I attended where I learned how other doctors are doing  
17 it and their doses, some of these people would actually  
18 have patients in hospitals like in Mexico and the Dominican  
19 and Costa Rica and some places in Europe, they actually  
20 had these patients getting drips throughout a 24 hour  
21 period so the patients would actually be in the hospital,  
22 they do everything and that's how they were getting their  
23 treatments. So obviously frequency of therapy was --

1 was an important component.  
2 We actually increased it to three and we saw that there  
3 was some more benefit and then I went to four to see if  
4 there was more benefit. We were only open four days a  
5 week for a number of years, but because we needed to be  
6 open a fifth day for patients that were suffering from  
7 either neurodegenerative disease or, in this particular  
8 case, cancer, we needed to have that fifth day, so we did.

9  
10 And we've actually had -- some of my staff that have  
11 actually come in even on Saturdays to do treatments if  
12 we thought patients needed it. But generally speaking,  
13 a weekend, I try to give them a respite because it is --  
14 our patients don't have hair loss and nausea and all that,  
15 but it is taxing on their system and they need a day of  
16 recovery.

17 DR. McCULLOCH: That's all I have, thanks.

18 PRESIDENT RHYNE: Dr. Walker?

19 DR. WALKER: Dr. Buttar, do you provide any charity care?

20 WITNESS: Yes, sir. I've been blessed to be able to treat  
21 every child that's come to us with cancer without charging  
22 them anything.

23 DR. WALKER: How about adults?

1 WITNESS: No, sir. I -- if I was doing that, then I would  
2 actually be probably flipping hamburgers for a living  
3 because I wouldn't be able to afford to --

4 DR. WALKER: So you can't afford to treat one or two people  
5 a month that might be in dire need of your services, you  
6 couldn't absorb that?

7 WITNESS: No, sir, I couldn't. I have done that with  
8 children and I -- I give a lot more to charity than 10  
9 percent, so -- but I chose not to go and to take this type  
10 of risk that I'm sitting here before you that I'm being  
11 scrutinized for in doing charity work. It would not be,  
12 I think, a wise -- a wise decision on my part from a  
13 financial basis or business decision.

14 DR. WALKER: Now, you stated earlier and correct me if  
15 I'm wrong, we can refer back to the record --

16 WITNESS: Yes, sir.

17 DR. WALKER: -- when you were quoting cancer patient  
18 survival, you said that you believed that about 40 percent  
19 of the cancer patients that you've treated are still alive.

20 WITNESS: Sir, I think -- I think I may have said that  
21 and what I meant to say, that I -- I can say that 40 percent  
22 of my patients that I have treated have had cancer something  
23 in their life that are still alive. That's what I meant

1 to say.

2 DR. WALKER: Okay. Do you have any idea how many patients  
3 with Stage IV cancer when they presented with that to you  
4 with Stage IV cancer are still alive?

5 WITNESS: I would say probably -- well, let's see --

6 DR. WALKER: You can say, I don't know, if you don't know  
7 that.

8 WITNESS: Well, I can tell -- I can give you definitely  
9 a minimum, I can't you tell about the top number. We've  
10 got -- there's eight of them on the web site talking about  
11 their results and they're still alive and they all had  
12 Stage IV.

13 DR. WALKER: The one that we saw today on the testimony  
14 with breast cancer that had metastasized to her thoracic  
15 spine, her spleen and her skull --

16 WITNESS: Yes, sir.

17 DR. WALKER: -- stated that, you know, she was five years  
18 down the road and her most recent PET scan was unremarkable,  
19 had no evidence.

20 WITNESS: That's right, sir.

21 DR. WALKER: However, she was also receiving Somata and  
22 hormone therapy. Now, do you have any idea of how many  
23 of your patients are not receiving any other type of therapy

1           except your therapy who are still alive?

2           WITNESS:  Sir, those -- those other treatments that they  
3           were getting, she had already failed everything.  She had  
4           been told that she only had six months to live.  But all  
5           the other patients, I'm not familiar with all the different  
6           things, but I encourage my patients as you've seen in the  
7           consent forms that they must continue with whatever other  
8           therapies their primary care providers have recommended.

9  
10          That's one reason that I have a close working relationship  
11          with a number of oncologists and I can name those  
12          oncologists, if you would like.

13          DR. WALKER:  That's okay.  On that question let me just  
14          clarify one thing.

15          WITNESS:  Yes, sir.

16          DR. WALKER:  Obviously, if she's still being treated by  
17          an oncologist with two additional drugs that might  
18          appropriately be called some type of chemo therapy, she  
19          had not exhausted all therapy because she's still receiving  
20          and she's still agreeing to receive it.  Just a little  
21          correction there.

22          WITNESS:  Well, sir, she was told by her oncologist that  
23          they -- she had been refracted to chemotherapy and that

1 they were going to just treat her from a hormonal  
2 respective. That's what she was told. I'm just going  
3 by what the oncologist --

4 DR. WALKER: Okay. Well, we don't know what the  
5 oncologist really told her.

6 Have you ever heard of the concept, you don't treat the  
7 labs, we treat the patient?

8 WITNESS: Absolutely, sir.

9 DR. WALKER: And it seemed as though in many of these  
10 patients the definition of success was a diminution of  
11 various markers or an allegation of various immune markers.

12 Is that not what you said that the patient's liver  
13 functions were getting better, that the patient's zero  
14 marker was decreasing, that the various immunologic  
15 markers which you measured were also improving?

16 WITNESS: Yes, sir, I did say that and that is exactly  
17 what I'm doing for two reasons. One --

18 DR. WALKER: I'm -- I'm just asking you if this is what  
19 you said.

20 WITNESS: Yes, sir, that is what I said.

21 DR. WALKER: And -- and did not two of these three patients  
22 die within the next few months?

23 WITNESS: One within four months and one within just a

1 few days.

2 DR. WALKER: Right.

3 WITNESS: Well, actually, excuse me. The one with the  
4 LFTs within a few days, yes, sir.

5 DR. WALKER: Have you ever not treated a patient?

6 WITNESS: Sir --

7 DR. WALKER: I'm not asking for your philosophy, I'm just  
8 asking a simply question. Have you ever not treated a  
9 patient?

10 WITNESS: I have never not treated a patient, sir.

11 DR. WALKER: Thank you.

12 PRESIDENT RHYNE: Dr. Buttar, early on in your testimony  
13 you said you left the military in 1996 and you were doing  
14 ER work at the time and you said, I could have become  
15 certified by the American Organization of Physician  
16 Specialists. Did you ever get certified by them?

17 WITNESS: For emergency medicine, ma'am, no, I did not.  
18 I -- but the emergency rooms that I was working at took  
19 my experience with the military as sufficient and I wasn't  
20 sure if I was going to stay in medicine and that's one  
21 reason that I decided that I would not pursue that course  
22 --

23 PRESIDENT RHYNE: Okay.

1 WITNESS: -- that course of action.  
2 PRESIDENT RHYNE: I want to go back to the small notebook  
3 to Tab 21 and --  
4 WITNESS: Yes, ma'am.  
5 PRESIDENT RHYNE: We'll go back to page 4 of that.  
6 WITNESS: Page 4, ma'am?  
7 PRESIDENT RHYNE: Yes, sir.  
8 MR. KNOX: I'm sorry, what tab was that on page 4?  
9 PRESIDENT RHYNE: 21 of the thin notebook. You have  
10 stated several times that hydrogen peroxide and the oxygen  
11 therapy that you were doing was really quite safe. Are  
12 you aware of these studies here and I'll just read out  
13 a few, Hydrogen Peroxide, a source of Lethal Oxygen  
14 Embolism, Case Review -- Report and Review of the  
15 Literature in the American Journal Forensic Medical  
16 Oncology and we want to skip the one -- the quackery  
17 one that you talked about.  
18 WITNESS: Yes, ma'am.  
19 PRESIDENT RHYNE: Cerebral Infarction Immediately after  
20 Ingestion of Hydrogen Peroxide, FDA Warns Consumers  
21 Against Drinking Hydrogen Peroxide and then Hydrogen  
22 Peroxide Poisoning. Are you familiar with all those?  
23 WITNESS: Absolutely, ma'am. Most of my patients that



1           come in that are seeking this type of therapy have read  
2           many of these types of things about the recommendation  
3           on the Internet, which as I mentioned before are not  
4           reliable, and asking me their opinion and I tell them  
5           certainly not -- this is -- this is very unsafe.

6           The amount of hydrogen peroxide we're giving is the same  
7           amount of hydrogen peroxide that the macrophage within  
8           the system secretes. In fact, it's -- it's less than  
9           what the macrophage secrete when you take the whole system  
10          into account. This is how our own immune system works,  
11          so --

12         PRESIDENT RHYNE: And it looks -- this is copyrighted down  
13         at the bottom and it looks like it was copyrighted down  
14         there by the Cancer Society.

15         WITNESS: Yes, ma'am, it does appear to be that. The  
16         American Cancer Society web site that I've been to is  
17         www.acs.org, so I just saw that just now, but I did not  
18         see that before.

19         PRESIDENT RHYNE: Okay. Now, you stated several times  
20         that you thought prayer was very important and that prayer  
21         might change your Natural Killer Cell Activity and prayer  
22         definitely helps things.

23         How do you know with just looking at some of your patients

1 and the patient improvements that what we're seeing is  
2 improvement not during the prayer -- not due to prayer?

3 How do you factor that out with your other variables?

4 WITNESS: Well, ma'am, I -- that's a great question and  
5 I don't factor it out because I don't know. I think that  
6 if I sat there and prayed for my patients and didn't treat  
7 them, though, I don't think I would get the same response  
8 rate in stimulating their immune system and detoxifying  
9 them.

10 But I do believe that part of prayer is God as in all the  
11 religions say that God helps those who help themselves,  
12 so I put a little bit of prayer behind what I'm trying  
13 to do and -- and hope for the best response for the patient.

14  
15 But I -- I certainly am not going to not say the prayer  
16 because it could be -- it could be giving me an edge and  
17 I believe that even if it's an edge that I believe or the  
18 patient believes or either way. It's not that we hold  
19 hands and say prayer around our patients or anything like  
20 that, but I pray for my patients and -- and I know that  
21 my patients pray for me.

22 PRESIDENT RHYNE: Okay.

23 WITNESS: And part of that is also that I ask patients

1 to pray that -- that -- that I'm guided in whatever it  
2 is the best to help them get the optimum response. So  
3 it's not just a prayer with the patient but a prayer where  
4 -- the patient with me to make sure that I'm doing the  
5 best of my ability to help them.

6 PRESIDENT RHYNE: Okay. The next question I was going  
7 to ask you he already covered about that 40 percent of  
8 the cancer patients still alive today and you now say you  
9 misstated that.

10 WITNESS: Yes, ma'am. It's -- it's 40 percent of my  
11 patients have had cancer that are still alive today, yes,  
12 ma'am.

13 PRESIDENT RHYNE: Okay. Under --

14 WITNESS: Ma'am, that's -- that's just a rough estimate.  
15 I -- I -- you know, it could be a little bit more, it  
16 could be a little bit less. I'm just eye-balling it.

17 PRESIDENT RHYNE: Okay. That is fine. On your consent  
18 form, that generic consent form, you had people consent  
19 to functional treatments and I was just curious, what is  
20 a functional treatment?

21 WITNESS: A functional treatment would be something that  
22 is seeking to improve a physiological function. For  
23 instance, giving somebody -- what would be a good example?

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23

Giving somebody that has -- let's see, a function treatment would be somebody that has a gut abnormality as far as mobility is concerned and maybe they're not digesting or absorbing their food and giving them a high dose of glutathione orally which would help the function of the absorption of nutrients because that -- (inaudible) -- seems to be very high in glutathione or actually the same thing could be done -- could be said about glutathione.

Glutathione as you know is an abundant antioxidant within every cell, but it's primarily found with that -- (inaudible) -- site. So if I give somebody glutathione, my goal is to up-regulate their P450 and Phase I/Phase II.

PRESIDENT RHYNE: Right. And I understand once you say that and I know that we've all been taught these things about chemistry.

WITNESS: Yes, ma'am.

PRESIDENT RHYNE: But in terms of randomized clinical trials looking at that, I don't think that you're going to find any evidence to support that.

WITNESS: I would probably concur with you, ma'am. It's been used pretty extensively throughout the world.

1           Glutathiones are given, you know, in many different forms,  
2           but I'm not familiar with any of those studies you're  
3           talking.

4           Although I do believe that there is more study being done  
5           now in the area of functional medicine. The Institute  
6           of Functional Medicine in Gate Harbor, Washington state,  
7           they have a number of studies that are going on right now.

8           PRESIDENT RHYNE: Okay. And then I was just a little  
9           curious too about the patient -- it's under Tab 11 and  
10          I can't remember if she was the ovarian or the cervical  
11          cancer.

12          MS. GODFREY: In whose book?

13          PRESIDENT RHYNE: Your book. Your book.

14          WITNESS: And, ma'am, if I --

15          PRESIDENT RHYNE: Tab 11, your --

16          WITNESS: Tab 11, the big book?

17          PRESIDENT RHYNE: Yeah, the doctor's and Mr. Knox's book.

18                 You had stated in your testimony that her jaundice wasn't  
19                 addressed and yet his first sentence or the second sentence  
20                 talks about jaundice and her elevated liver functions.

21          WITNESS: Sorry, ma'am, I haven't gotten to that point  
22          yet.

23          PRESIDENT RHYNE: And I think that was --

1 MS. GODFREY: Tab 11.  
2 WITNESS: This is -- Dr. Freedman's e-mail that we're --  
3  
4 PRESIDENT RHYNE: Yes, sir.  
5 WITNESS: And what was the question, I'm sorry?  
6 PRESIDENT RHYNE: Well, I think it was more of an  
7 observation than a question. You had said that her liver  
8 -- you had said at one time her jaundice wasn't addressed  
9 at all and yet he talks about her elevated liver test.  
10 WITNESS: Yes, ma'am. What I meant to say was and I  
11 thought that's what I said, is that her jaundice wasn't  
12 addressed, meaning that they didn't do anything to see  
13 if there was a mass effect causing compression of the  
14 biliary system or was it an obstruction. There was nothing  
15 that was done to address whether or not there was something  
16 that could be done, if she could have had a stent put in  
17 to maybe possibly help her and that's why I sent her to  
18 Dr. Clements to address it.  
19 I didn't say that they didn't recognize it, I said they  
20 didn't do anything to address it. But, again, it's not  
21 -- it's not a criticism on their part, it was just --  
22 PRESIDENT RHYNE: Yeah. I was just -- because he -- he  
23 does say she has massive liver metastasis and that he didn't

1 think there was any further therapy, so --

2 WITNESS: Yes, ma'am.

3 PRESIDENT RHYNE: -- I'm just taking that, you know --

4  
5 WITNESS: Yes, ma'am, I understand.

6 PRESIDENT RHYNE: I'm not sure I understand that he didn't  
7 address it.

8 WITNESS: Ma'am, if I may make one comment regarding the  
9 question previous to that that you had asked me about the  
10 studies.

11 PRESIDENT RHYNE: Uh-huh (yes).

12 WITNESS: One of the problems is -- and I think that, you  
13 know, one thing that I've learned in the last 17 years  
14 as a doctor is that 99.9 percent of doctors that I've come  
15 across truly want to do the best for their patients.  
16 But we have been trained, after our formal training,  
17 primarily by drug reps that come into our office. In fact,  
18 that's the reason I don't let a drug rep come into my office  
19 is because the reason that they're -- the reason that all  
20 these new drugs are being developed is because they're  
21 trying to patent something to make money on these drugs.

22  
23 Things like glutathione or things like hydrogen peroxide

1 or EDTA that are either out of pattern or -- there's no  
2 way for anybody -- any pharmaceutical company to make  
3 money, they're not going to fund the randomized clinical  
4 trials.

5 It's -- I mean, the TAC trial took us, you know, 60 years.

6 I fact, EDTA was indicated therapy for cardiovascular  
7 disease within the Physician's Desk Reference. It's been  
8 -- there's a whole chapter in Meserley's Textbook of  
9 Cardiology dedicated to EDTA. But once bypass was  
10 introduced, suddenly EDTA at this period from the  
11 Physician's Desk Reference leaving an indication for the  
12 removal of atheroma to help to reduce the  
13 lymphoperoxidation that's found within the atheroma.

14 My point being again that a lot of this funding of  
15 double-blinded placebo-controlled trials or  
16 multi-centered trials is motivated by the pharmaceutical  
17 companies to make big dollars. And if there's no profit  
18 potential for it, they don't have any incentive to do so.

19  
20 So either my choice is to do something empirically based  
21 upon what my observations have been because my patients  
22 don't have another 20 years or 15 years or 30 years before  
23 these studies have been substantiated to show that, yes,



1 this is the better way.

2 So I have a choice that I have to make. Either it's, one,

3 I do the best that I can for my patient based upon the

4 empirical evidence making sure that I do no harm; or two,

5 to resort to the same model of medicine that was making

6 me question whether I really deserve this type of personal

7 agony that I was creating for myself by being in this

8 profession that I didn't feel like I was helping people.

9 PRESIDENT RHYNE: And there again there are plenty of

10 opportunities for research, there are plenty of recognized

11 trials. You can do IRBs. There are some private IRB

12 organizations.

13 WITNESS: Yes, ma'am. Before you --

14 PRESIDENT RHYNE: I think what our point is, is that we're

15 scientists.

16 WITNESS: Yes, ma'am.

17 PRESIDENT RHYNE: -- and we ought to prove something.

18 We don't like to just say that there's no inherent proof

19 that we don't -- impericism has it's place in some forms.

20 We like proof that something works.

21 WITNESS: I'm --

22 PRESIDENT RHYNE: And objective evidence is the best sign

23 of that.

1 WITNESS: Yes, ma'am. I am one of the TAC trial  
2 investigators and we participate in as much as we can  
3 whenever there's an opportunity to do so.

4 PRESIDENT RHYNE: Okay. Do you send -- do you send notes  
5 to referred doctors, cardiologists, oncologist? I hadn't  
6 seen in your charts and yet I've seen you have plenty of  
7 notes from cardiologists and oncologists where they --  
8 they've sent copies to their doctors. And as you and  
9 I both know that communication between physicians is very,  
10 very important and I can't tell from your notes that you've  
11 had any communication.

12 WITNESS: As you can see, ma'am, there's notes in there  
13 from other doctors back to us from like Dr. Clements and  
14 from some of the other doctors, Dr. Holbert and such.  
15 But usually --

16 PRESIDENT RHYNE: Right, but I didn't see yours going the  
17 other way?

18 WITNESS: Yes, ma'am. And that's because I usually pick  
19 up the phone and I call them and I talk to them and then  
20 on this document, talked with so and so, but I have not.  
21 This is -- it's a logistical issue and we're going to  
22 electronic medical records so that we can actually have  
23 more of -- more of method of how -- what the discussion

1 was with the doctor.  
2 But usually I'll talk to them on the phone and when I send  
3 the patient I'll take our stuff and make a copy and give  
4 it to the patient, so the doctor has everything rather  
5 than having one letter that I send to the doctor that's  
6 included in the chart. I have not done that in the past.  
7 PRESIDENT RHYNE: And do you document in your chart that  
8 you talked to the doctor?  
9 WITNESS: Yes, ma'am, it is documented in the chart.  
10 PRESIDENT RHYNE: Where was that at? I guess I'm just  
11 --  
12 WITNESS: And which -- which patient would you like for  
13 me to --  
14 PRESIDENT RHYNE: Well, any of them. I didn't see it on  
15 any of them.  
16 WITNESS: We can start with the first one, ma'am, if you  
17 would like and work our way down.  
18 PRESIDENT RHYNE: If you can just show me one, I would  
19 be happy.  
20 WITNESS: Sure. In Patient --  
21 MR. KNOX: A.  
22 WITNESS: -- Patient A, okay.  
23 MS. GODFREY: That's 9 in our notebook.

1           PRESIDENT RHYNE:  Tab  --  tab 9?  
2           WITNESS:  And there's  --  and often, ma'am, I will just  
3           ask one of my staffs to make the note while I'm talking  
4           to them, but on 8/8/06 on C5 that I  --  myself and my  
5           nurse practitioner or by the RN, discussed the patient  
6           and I called Dr. Clements and arranged for her to see him.  
7  
8           On 8/15 on page  --  it's C7B, discussed with Dr. Holbert  
9           in detail.  And I think these are the only two times for  
10          this patient that I sent them.  
11          PRESIDENT RHYNE:  You had mentioned Patient B that you  
12          discharged her from your practice.  
13          WITNESS:  Yes, ma'am, because -- yes, ma'am, I did.  
14          PRESIDENT RHYNE:  Did -- and how did you do that?  
15          WITNESS:  It's --  
16          PRESIDENT RHYNE:  Is there a letter or --  
17          WITNESS:  Yes -- well, there's a final note and then my  
18          nurse practitioner, Ms. Garcia, called Dr. Holbert and  
19          told her that we were discharging her from the patient  
20          -- from our -- as a patient.  And we sent -- I believe  
21          we sent her records to Dr. Holbert or --  
22          PRESIDENT RHYNE:  Did you arrange for care for her?  
23          WITNESS:  Oh, yes, ma'am, we didn't -- we didn't desert

1 her. Of course we -- you know, we can -- we have a policy  
2 that for 30 days unless there's something else going on,  
3 but for 30 days, ma'am, we'll still continue to help the  
4 patient as much as we possibly can, but we won't  
5 administered any more IV therapies or do any types of  
6 treatments, just if there's any type of -- you know, when  
7 the patient doesn't have any continuity care, but she was  
8 referred back to an -- from the last note from Ms. Garcia  
9 indicates that. I can show you that if you like.

10 PRESIDENT RHYNE: Okay. And do you sell vitamins from  
11 the office for people to take home? I know you give the  
12 vitamin infusions. Do you actually sell them in the office  
13 also?

14 WITNESS: Yes, ma'am, I do. Yes, ma'am. And that's where  
15 that letter that -- or the document from the North Carolina  
16 Medical Board that we got that --

17 PRESIDENT RHYNE: Okay.

18 WITNESS: -- that they have a choice in --

19 PRESIDENT RHYNE: Okay.

20 WITNESS: Yes, ma'am.

21 PRESIDENT RHYNE: Okay. That's all I have.

22 MR. JIMISON: I have nothing.

23 WITNESS: The biggest reason we do that, ma'am, is, one,

1 is for quality, but the biggest reason is for convenience  
2 because the patients can get it while they're there in  
3 our office. And usually the cost of what they're going  
4 to pay us is less than what they would have paid at an  
5 GNC. Or just like the protein powder, I think it's \$76,  
6 that's actually two pounds so that's four pounds and that's  
7 a coal filter whey isolate protein and the same protein  
8 or the same -- if you want to call it the same quality,  
9 it's not the same quality because it's not whey, it's not  
10 concentrated as the way I sell it -- whey isolate that  
11 we're using for the same four pounds it's over \$180 at  
12 GNC.

13 PRESIDENT RHYNE: Thank you.

14 WITNESS: Thank you.

15 PRESIDENT RHYNE: Dr. McCulloch?

16 DR. McCULLOCH: Just one more question.

17 WITNESS: Yes, sir.

18 DR. McCULLOCH: The first person that, I can't say her  
19 name, I can't remember.

20 PRESIDENT RHYNE: No.

21 WITNESS: One of the patients, sir, you're talking about?

22 DR. McCULLOCH: The wife of the patient --

23 WITNESS: Oh, yes, sir.

1 DR. McCULLOCH: -- with adrenal cancer.  
2 WITNESS: Yes, sir.  
3 DR. McCULLOCH: It's Kenny.  
4 WITNESS: Ms. Kenny.  
5 DR. McCULLOCH: Yeah, I knew it, I just didn't know if  
6 I could say it.  
7 She testified that you told them that you could treat his  
8 cancer with 100 percent success rate. And -- and I would  
9 just like to hear you respond to that. Why do you think  
10 she would have said that if --  
11 WITNESS: I can't tell you -- I'm sorry, sir, go ahead.  
12 DR. McCULLOCH: -- if you didn't say that?  
13 WITNESS: Sir, I've never seen that woman in my life.  
14 I've never seen that woman and I document in my chart,  
15 if I have a patient that there with a family member, I  
16 always document it. Any charts that you pull from me,  
17 if it's a patient from out of state, I put down what state  
18 or what country they're from and then I put down who  
19 accompanied them.  
20 And you'll notice in this chart, it doesn't say anything  
21 about any family member. And when I was asked if I had  
22 seen her, I said I've never seen and then I was told that  
23 she said seen me once. And I said, well, if she says that,

1 then so be it. I didn't have any reason to doubt her.  
2 However, I talked to four members of my staff that worked  
3 with me -- that worked for me at that time that still  
4 continue to work for me and all four of them have said  
5 that they've never seen her. She's never been to our  
6 clinic. If she has been to the clinic, I certainly did  
7 not see here. She certainly never sat in on the first  
8 consultation with XXX.

9 I had a very close relationship with Mr. Kenny. He was  
10 very difficult. A lot of our staff members when we found  
11 out what happened, but he never talked about his wife.  
12 We always talked about his kids. There was never a mention  
13 about his wife. All I know is that on a few occasion walked  
14 into the examine room screaming on the phone, he apologized  
15 to me and shut the phone and that's all I can tell you.

16 PRESIDENT RHYNE: Thank you.

17 WITNESS: Yes, ma'am.

18 PRESIDENT RHYNE: Board Members, do you have anything  
19 else? Thank you very much.

20 WITNESS: Thank you.

21 PRESIDENT RHYNE: Go ahead with your next witness.

22 MR. KNOX: This is the deposition of Mr. Hewitt.

23 (DISCUSSION OFF RECORD)



1 -----  
2 (WHEREUPON, THE VIDEOTAPE DEPOSITION  
3 OF WILLIAM JOHN HEWITT TAKEN ON APRIL 9, 2008  
4 WAS PLAYED AND IS HEREBY ATTACHED  
5 IN ITS ENTIRETY AS EXHIBIT 47)  
6 -----

7 PRESIDENT RHYNE: Mr. Knox or Ms. Godfrey, how many more  
8 witnesses do you have?

9 MR. KNOX: Well, we have one short tape and I mean it's  
10 --

11 MS. GODFREY: Twenty minutes.

12 MR. KNOX: -- it's 20 minutes. That one went a lot  
13 longer than thought. But, anyway, then we have two  
14 independent witnesses.

15 PRESIDENT RHYNE: Okay. And they're new -- it's new  
16 material because this tape was a lot of the same stuff  
17 that occurred.

18 MR. KNOX: Well, one of them is a cancer patient. I have  
19 a series of affidavits in your book -- our book. The one  
20 I particularly ask you to read, I want you to look at all  
21 of them, but look Dr. Lintala who is a gentleman who was  
22 supposed to be on-call for us to talk to him and I'm willing  
23 to go pass that, but if I could put those affidavits in.

1           PRESIDENT RHYNE: All right. Why don't we take about a  
2 ten-minute break and then we'll come back and watch that  
3 other video. Everybody is talking about they want to have  
4 a break. Dr. Buttar is walking around the room.

5           MR. KNOX: But before do that, if I -- if I may, just the  
6 gentleman that's on the -- he gave an affidavit and it  
7 is in your book and we offer that as evidence. It's number  
8 39, is a copy of that. I think it speaks pretty much to  
9 what he said, but I'd like to say she was the first one  
10 to be treated by him.

11          PRESIDENT RHYNE: Okay.

12          MR. JIMISON: Now, there is one way we could -- I mean,  
13 the next videotape is just 20 minutes long. I think there  
14 is a transcript of it and we could just have the transcript  
15 entered into evidence of that instead of watching the  
16 videotape.

17          MR. KNOX: That's not -- I will do anything to accommodate  
18 you, but we took -- we've already waived one deposition  
19 that we took and this is an important person --

20          MR. JIMISON: Well, watch the videotape. Okay.

21          PRESIDENT RHYNE: We'll watch the video.

22

23

---

(3:27 P.M. - 3:38 P.M. RECESS)

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23

PRESIDENT RHYNE: Please proceed, Mr. Knox?

MR. KNOX: The affidavit of Dr. Alan Lintala who I indicated earlier, it's in Exhibit 36 and he was scheduled to be a telephone witness and there's affidavits -- and we can give everybody copies of these.

There's an affidavit of Rosi Arrondo and Number 39, affidavit of Hewitt, that I just told you about. And there is an affidavit Anne Phelps. Yeah, they were here yesterday and so were the Hewitts. An affidavit of both Anne and Joe Phelps, 41 and 42.

PRESIDENT RHYNE: All right.

MR. KNOX: We gave you an executed copy of Michelle Reed that was supposed to have been on the phone this morning and that completes the affidavits.

And we mentioned this to you, the transcript -- the video transcript we did of Frances Allen because he was duplicative to Mr. Jarrett, I did not show that.

PRESIDENT RHYNE: Okay.

MR. KNOX: But that affidavit -- that transcript will be introduced and I'm trying to do all I can to save as much time as I can. We can give these to Madam Court Reporter.

MS. GODFREY: While we're -- while we're waiting on that,

1 Dr. Buttar also asked -- I'm sorry, I didn't mean to stand  
2 up.

3 PRESIDENT RHYNE: Go right ahead.

4 MS. GODFREY: It's kind of a habit.

5 Dr. Buttar also asked could I hand up some additional  
6 articles. I'll go ahead and hand them to Marcus. I  
7 believe one of them you have already, the -- the one from  
8 the proceedings of the National Academy of Science. I  
9 think you used it in Dr. Ripoll's deposition and this is  
10 the role of hydrogen peroxide and hydroradical formation  
11 killing early tumor cells in the body -- anticancer.

12 There's also some articles dealing with ozone relating  
13 to the 8th Annual Ozone World Congress in Zurich,  
14 Switzerland, ozone in medicine over your future  
15 directions, ozone therapy for tumor, oxygenation of pilot  
16 studies.

17 And some articles on oxygen hemostasis.

18 Lastly, an article published in Lung Cancer by the  
19 Department of Oncology at the Mayo Clinic, is voluntary  
20 vitamin and mineral supplementation associated with their  
21 outcome in non-small cell lung cancer patients. And Dr.  
22 Buttar would want to -- wants to submit these to the Board  
23 for their consideration.

1           PRESIDENT RHYNE: Thank you.

2           MR. JIMISON: And in that vein, I don't have the --

3           MS. GODFREY: And the New England Journal of Medicine  
4           abstract is in -- in our exhibits already, but I'll hand  
5           this up. And that had to do with hydrogen peroxide and  
6           the -- I'm losing my words -- it's -- it had to do with  
7           hydrogen peroxide in increasing the efficacy of  
8           chemotherapy.

9           PRESIDENT RHYNE: Thank you.

10          MR. JIMISON: In that -- Dr. Rhyne, in that same vein,  
11          just for housekeeping and the court reporter, if the Board  
12          can go ahead and introduce Exhibits 18, 19, 20 and 21,  
13          and I believe you have the copy of Dr. Buttar's e-mail  
14          which will be 25. We can go ahead -- if we can go ahead  
15          and put those into evidence as well.

16          PRESIDENT RHYNE: Okay. That's fine.

17          MS. GODFREY: There's one thing I would like to do and,  
18          again, for housekeeping purposes with the court reporter,  
19          if I could get our exhibit list -- where's our exhibit  
20          list?

21          MS. GEMZA: I've got it right here.

22          MS. GODFREY: I have a list in the front of our exhibit  
23          book and I do a little check off as how I try to keep track

1 of it. And you see my chart, it's in the table of contents?  
2 I would just like to check off with the court reporter  
3 the ones that I believe were received into evidence.  
4 MR. JIMISON: Well, it might be faster if you do the ones  
5 that are not admitted.  
6 MS. GODFREY: Well -- well, there might be -- let's tender  
7 these for the record. Exhibit --  
8 MR. JIMISON: Well --  
9 MS. GODFREY: Exhibit 1, which is the CV of Dr. Buttar.  
10 Exhibit 2, we --  
11 MR. JIMISON: We could do --  
12 MS. GODFREY: -- Nurse Garcia is yet to testify.  
13 MR. JIMISON: That's fine, you can go ahead.  
14 MS. GODFREY: Number 3 is the correspondence from David  
15 Henderson. Again --  
16 MR. JIMISON: There are only a few that I have an objection.  
17 Number 3 right now is the only one I have an objection  
18 to.  
19 MS. GODFREY: Okay. Number -- I will tender it for the  
20 record whether or not the Board decides to consider it  
21 or not is -- it is certainly up to you, but I will tender  
22 Number 3 for the record, correspondence from Mr. Henderson.  
23 PRESIDENT RHYNE: Okay.

1 MS. GODFREY: Number 4, correspondence to Thomas -- Thomas  
2 Mansfield.  
3 Number 5, Collaborative Practice Agreement.  
4 Number 6, Patient A Consent Forms.  
5 Number 7, a letter from John Clements.  
6 Number 8, review sheets from Dr. John Peterson.  
7 Number 9, progress notes for Patient A.  
8 Number 10, IRR sheets for Patient A.  
9 Number 11, it's a note from M.D. Anderson Cancer Center  
10 on Patient A.  
11 Number 12, Patient B Consent Forms.  
12 Number 13, progress notes on Patient B.  
13 Number 14, Patient B lab work.  
14 Number 15, a medical dictionary that Patient B gave to  
15 Dr. Buttar.  
16 Number 16, the estate file of Patient B.  
17 Number 17, the Consent Forms for Patient C.  
18 Number 18, the progress notes for Patient C.  
19 Number 19, the blood work on cancer for Patient C.  
20 Number 20, Patient C's medical records and prior CT scans.  
21  
22 Number 21, Patient C's past treatment record.  
23 Number 22, Patient D Consent Forms.

1 Number 23, Patient D's progress notes.  
2 Number 24, Patient D urine toxic metal labs.  
3 Number 25, Patient D's -- those actually will be covered  
4 in Nurse Garcia's testimony.  
5 Number 26, Costs of selected IVs.  
6 Number 27, sign from the waiting room.  
7 Number 28, we have a witness for that.  
8 Number 29, CV of John Wilson, M.D.  
9 (COURT REPORTER'S NOTE - Number 30 omitted)  
10 Number 31, CV of Emilia Ripoll, M.D.  
11 Number 32, e-mail from Patient E's mother.  
12 Number 33, Patient C's death certificate.  
13 Number 34, the abstract from the New England Journal of  
14 Medicine.  
15 Number 35, CV of John Peterson.  
16 I believe that Mr. Knox just moved into evidence the  
17 affidavits 36 through 42; is that right?  
18 PRESIDENT RHYNE: He did. He did.  
19 MS. GODFREY: Okay. And we have the transcripts of the  
20 patients 43 through 47 that testified on video deposition.  
21  
22 We have one yet to hear and that will be Number 44.  
23 Number 48, the transcript of Dr. Ripoll.



1 49, the subpoena to Stephanie Kenny.  
2 Number 50, let's see, let me -- we have not -- we have  
3 not referred Exhibit 50. It's the transcript of Patient  
4 D. I'm not sure we're going to --  
5 MR. JIMISON: I will be objecting to that. That's a  
6 patient who has not testified and that would be just a  
7 discovery deposition. There is -- that's just --  
8 discovery depositions are when counsel on the other side  
9 is to ask questions of the witness. There's just really  
10 no rules and she hasn't testified and so therefore there  
11 would be no cause for that exhibit.  
12 MS. GODFREY: I believe under Rules of Civil Procedure,  
13 we can read a party deponent's deposition into evidence.  
14 And Patient B is a complaining -- was one of the  
15 complaining witnesses in the case and I believe that makes  
16 her a party deponent.  
17 MR. JIMISON: She -- she's -- I'm sorry.  
18 MR. KNOX: I don't think that's --  
19 MR. JIMISON: She's not a party in --  
20 MR. KNOX: I think we've already agreed that that's --  
21 that she's no longer a party in the case.  
22 PRESIDENT RHYNE: Okay.  
23 MS. GODFREY: Okay. There were some transcripts -- some

1 other discovery transcripts that I think were just used  
2 as cross-examination. Exhibit 55 is one that I would just  
3 like to move into evidence. It is a summary exhibit and  
4 it was previously furnished to the Medical Board.

5 What we did and this came in quite late, but we did get  
6 a list of the medical charges for Patient B at Forsyth  
7 Regional Cancer Center. And I just -- what we did is go  
8 through and add up the total amount of charges that Patient  
9 B incurred before she went to Dr. Buttar and I move that  
10 into evidence.

11 Like I said, those records were subpoenaed by the Board,  
12 they -- and -- and we went through and added up and provided  
13 this to Mr. Jimison as a summary exhibit because quite  
14 frankly the medical bill was that thick. And so rather  
15 than put that into evidence, we -- we did it this way just  
16 as a point of reference to the amount that was spent in  
17 Patient B's cancer treatment prior to her coming to Dr.  
18 Buttar.

19 PRESIDENT RHYNE: That's fine. We'll accept those that  
20 we agreed on.

21 MR. JIMISON: And one last brief piece of housekeeping,  
22 because a lot of these documents have specific patient  
23 information and they're very voluminous to have to be

1 redacted, I would like to move that they be kept under  
2 seal and that if there's a public request for them, that  
3 we will make them public, but only after we inspect them  
4 and make sure all the redactions were complete. So I  
5 wanted to keep these from errors, you know, because  
6 sometimes you don't redact everything. It's just so many  
7 documents and so we can --

8 MS. GODFREY: We did our very best to redact everything  
9 in the exhibits that we presented.

10 MR. JIMISON: I can't guarantee that we got everything.  
11 I'm not sure they can guarantee they got everything, but  
12 just keep under seal --

13 PRESIDENT RHYNE: That's -- that's fine.

14 MS. GODFREY: Until when?

15 PRESIDENT RHYNE: Until --

16 MR. JIMISON: Until there's a public request. I mean,  
17 it's just a government -- if there's a public request for  
18 the exhibits, then we would provide the exhibits, you know,  
19 as part of the public request, but only at the time we've  
20 had the time to inspect the documents and make sure they  
21 were completely redacted.

22 MS. GODFREY: Okay.

23 COURT REPORTER: Now, I still have a question. I'm still

1 uncertain about Exhibit 3 and Exhibit 50. 50 I could take  
2 out of this book and give back to you; and Exhibit 3, I'm  
3 not sure of that.

4 MR. KNOX: Well, actually Exhibit 3 was the letter, right?

5 REPORTER: Right.

6 MR. JIMISON: The tendered letter, but that was the  
7 non-public letter.

8 PRESIDENT RHYNE: Yeah.

9 MR. KNOX: Well, it's tendered for the record, so you would  
10 want to keep a copy of it for the transcription even though  
11 she knew not to consider it.

12 MR. JIMISON: Yeah, I don't --

13 MR. KNOX: There's no other way to do it.

14 PRESIDENT RHYNE: I'm sorry, you're going to have to tell  
15 me what tendered means.

16 MR. KNOX: Well, we tendered a letter by one of the people  
17 with the Medical Board.

18 PRESIDENT RHYNE: Right, I know what --

19 MR. KNOX: Tender means we handed up to you and he objected  
20 to it and you said, well, I'm not going to let that in.

21 We want to put that in the record for subsequent hearings  
22 if there are any that -- and if it's right or wrong. It's  
23 not personal, but it's that we want to consider that.

1 MR. JIMISON: That's fine.  
2 MR. KNOX: It's showing prejudice if nothing else.  
3 MR. JIMISON: That's fine. We're fine with that.  
4 MR. KNOX: That's the short version of it.  
5 PRESIDENT RHYNE: Okay.  
6 MR. KNOX: We're not quite as authoritative --  
7 MR. JIMISON: And just one last thing, Dr. Rhyne. Mr.  
8 Mansfield will be co-counseling during rebuttal. If  
9 there's a rebuttal we're planning on calling Dr. Buttar  
10 back to the stand for a quick rebuttal and Mr. Mansfield  
11 will be doing the examination and I just want to give  
12 everybody a heads up so at least after their last witness  
13 we have at least one more witness which will be Dr. Buttar  
14 that we will call back in rebuttal.  
15 PRESIDENT RHYNE: Okay. And then I think 50 we just  
16 said -- we all decided would --  
17 MS. GODFREY: We all decided that 50 was not going to come  
18 in.  
19 PRESIDENT RHYNE: Yeah --  
20 MS. GODFREY: No, that's --  
21 PRESIDENT RHYNE: -- that's the one you agreed --  
22 MS. GODFREY: -- deposition of Patient D. Well, we're  
23 tender it for the record.

1 MR. KNOX: Yeah.

2 MS. GODFREY: Well, the record will note that it's not  
3 admitted into evidence and we'll tender it for the record.

4 MR. JIMISON: Fine.

5 PRESIDENT RHYNE: Thank you.

6 MR. KNOX: Okay.

7 PRESIDENT RHYNE: All right. I think we're ready to go  
8 and you had can call your next witness.

9 MR. KNOX: Okay, yeah. Nina Wall, will you come around  
10 please and be sworn?

11 \_\_\_\_\_  
12 WHEREUPON,

13 NINA NEWTON WALL,  
14 being first duly sworn,  
15 was examined and testified  
16 as follows:

17 \_\_\_\_\_  
18 **DIRECT EXAMINATION BY MR. KNOX:**

19 QWould you tell the Board your name, please?

20 AMy name is Nina Newton Wall.

21 QAnd where do you live?

22 AMooresville, North Carolina.

23 QAnd are you married?

1 AYes.

2 QWould you just tell them your educational background?

3 AI have a Bachelor of Science degree in Health Education and  
4 a music degree. I have been certified in chelation therapy  
5 and --

6 QAnd how long have you worked at Advanced Concepts with Dr.  
7 Buttar?

8 AFor more than eight years.

9 QOkay. And y'all were in Cornelius, correct?

10 AYes.

11 QAnd the office is now down in Huntersville?

12 AYes.

13 QOkay. And would you just tell them generally what your job  
14 is and what you do?

15 AWell, I'm employed as an IV tech. I also work in the  
16 biofeedback and hyperbarics. I do EKGs for mass density.  
17 A little bit of anything that needs to be done.

18 QAnd in the course of your work you are watching Dr. Buttar  
19 in is practice quite obviously?

20 AYes.

21 QAnd what is -- what is his demeanor with his patients and things  
22 of that nature?

23 AWell, he's one of the most -- most kind people I've ever met.

1 He's very concerned about his patients. He tries very  
2 hard to -- to make sure they understand where he stands  
3 on things and he wants very much for them to understand  
4 that he's there to help them help themselves -- help their  
5 body to help itself. He's very quick to let them know  
6 that he's not the Almighty.

7 QAnd are you trained in some type of therapy of things that  
8 you do practice there at the clinic?

9 AYes.

10 QAnd what training have you had?

11 AI have had extensive training in biofeedback, advanced classes  
12 in that. I'm certified in chelation therapy and have been  
13 since 1991 -- I think it's '91 and have gone through some  
14 hyperbaric training.

15 QOkay. Just briefly, do you know Patient A? If Patient A came  
16 to the clinic, did you get to see her?

17 AI'm sorry, I'm not sure who is --

18 QPatient A is a lady from --

19 MS. GODFREY: With cervical cancer.

20 Q-- cervical cancer, the daughter that she had testified to

21 --

22 AYes.

23 QAnd do you remember her daughter coming into the clinic?



1 AYes, I do.

2 QAnd in the course of their time that they spent there, was  
3 there any dissatisfaction ever expressed by anybody about  
4 the daughter's treatment?

5 ANo, not at all.

6 QWould you -- would you do some of the therapy on those patients?

7 AYes, I did.

8 QAnd can you just express one way or the other her either interest  
9 in continuing the therapy or not?

10 AThe daughter or the mother?

11 QLet's take the mother first and the daughter next.

12 AThe mother was very determined to do whatever was necessary  
13 to prolong her life and make it as viable and enjoyable  
14 for however long. The daughter stood by her for every  
15 step of that.

16 QNo complaints by the two of them, ever?

17 ANot to me.

18 QHow about Patient B, the lady that was there for several weeks  
19 that had the ovarian cancer?

20 AShe was a very quiet lady. She was just sweet and kind. I  
21 heard her talk a great deal about her -- her daughter or  
22 her son. I can't remember if it was the daughter or son,  
23 but it was some years ago. But she did talk about how

1 much she loved her children.

2 I don't remember her talking very much about a nephew who  
3 seemed to be really -- I mean, she may have, I just don't  
4 remember at this time.

5 QWere there any complaints about -- from her or her boyfriend  
6 about the treatment that you were all giving?

7 ANo, sir, not that I remember.

8 QPatient C, the only one you had to deal with. Patient C is  
9 the patient that had adrenal cancer, right?

10 AYes.

11 QNow, do you remember when he first came there as a patient?  
12 Did you meet him?

13 AYes.

14 QDo you remember whether or not his wife, the lady that was  
15 here who testified, was she present with him?

16 ANo, sir, not to my knowledge. I've never seen her come in.  
17 I'm sure we would --

18 QAnd so the times that she -- can you hear her? Sorry.

19 PRESIDENT RHYNE: I didn't hear the last sentence.

20 AI'm sorry. Not to my knowledge can I ever remember seeing  
21 her come in.

22 QSo you don't know whether she did or not, but you don't remember  
23 seeing her?

1 ANo, I do not.

2 QThe patient had what kind of relationship with the staff?

3 AHe had a very close relationship with us. There was many  
4 mornings that when we would drive up and lots of times  
5 I was the first person there and the last one to leave,  
6 he would be in the parking lot waiting -- waiting for  
7 somebody to be there. Granted, it was kind of nice because  
8 sometimes it was dark, so I was glad to have somebody there.

9  
10 I'd go, come on in and sit down, you know, we've got to  
11 everything going. He said, oh, that's all right. Can  
12 I just, you know, come back and talk and visit. He just  
13 wanted to visit. He just wanted -- very quickly we became  
14 more than just a doctor's office to him. We were his  
15 comfort zone. He didn't like to leave. Many times he  
16 would be through with treatments early in the afternoon,  
17 but he would wait and just walk out with us and leave.  
18 He was a musician, too.

19 QBy the way, he lived in Matthews. How far is Matthews from  
20 Cornelius?

21 AI guess it's about an hour.

22 QOkay. And have you ever been to Matthews down 485 to Cornelius?

23 ANo.

1 QIs there any way to go up 485 and go to Cornelius?  
2 ANot that I know.  
3 QOh, there's not. Well, actually 485 runs into Statesville  
4 Road and stops there, doesn't it?  
5 ACorrect.  
6 QOkay. The times that you spent with him going over his  
7 treatment did you feel like he was improving?  
8 AOh, absolutely. Absolutely.  
9 QWhat was your observations about the improvements, if any,  
10 you made? Go ahead.  
11 ADuring the time that he was there we saw him almost blossom.  
12 When he came in -- I can remember vividly him coming in  
13 and the reason I can remember this is because I quickly  
14 found out that he was musician and a drummer and I always  
15 wanted to play the drums. So we struck up this  
16 conversation, but --  
17 QAnd you play -- you play the piano, don't you?  
18 AI play the piano and organ, yes. And our conversations were  
19 so -- just good. He even wanted to teach me how to play  
20 drums, he wanted me to help him with some music that he  
21 was wanting to write, but he seemed so weak.  
22 And I remember making the comment to him that, well, you  
23 know, we're going to have to get you a little stronger

1 before we start trying to do all this, but it's good to  
2 make plans. It gives us another goal.

3 So, yes, he -- he started to thrive.

4 He brought in a piece of poetry that he had written and  
5 he said, here, read this and come up with some music for  
6 it.

7 And I said, okay. When you get to the point that you start  
8 teaching me to play drums, I'll write your music.

9 And he worked really hard that before long he was thriving  
10 and he would even bounce in the office and tell me about  
11 something that he had come up with music-wise or he would  
12 say, I feel okay today, but, yet, he still had -- some  
13 energy was not there.

14 QDid he write this Postcard from Heaven and give it to you?

15 AHe did. That was --

16 QThat's in --

17 AThat was the piece that he wanted me to write music to.

18 QIt's the last page of Exhibit 28.

19 So you had continuous contact with him. Now, toward the  
20 end of his treatment, do you know if there was any  
21 discussion about him going somewhere else for therapy?

22 AI was not personally involved with a great deal of that. He  
23 did say that he -- he liked being with us, he was comfortable

1 with us, felt safe with us; however, he respected whatever  
2 Dr. Buttar's recommendation was going to be.

3 QI show that there's a series of e-mails from apparently to  
4 you. What is -- if you would look at these and tell me  
5 if they're yours that you received and who they were  
6 received from.

7 MS. GODFREY: This is Exhibit 28, the first part of the  
8 exhibit notebook.

9 PRESIDENT RHYNE: Thank you.

10 AYes. These are e-mails that -- that he had written to me  
11 because when he -- actually, it was the last day that he  
12 was in our office before he left to go to Mexico for  
13 treatment, I was on vacation, so we didn't get to actually,  
14 you know, say good-bye and wish each other well.

15 But I was so concerned that he was in a foreign country  
16 by himself that I kept e-mailing him just to let him know  
17 that we were not just still there for him, but we were  
18 still part of the team.

19 QAnd did he always respond to you?

20 AYes.

21 QWas there anything negative that you recall that this patient  
22 said to you or any other employee that the treatment there  
23 was erroneous or there was a guarantee, or anything of

1           that nature?

2   ANever.

3   QNow, you know that a payment -- a check was stopped by his  
4       wife that he paid? Do you know that or not?

5   ANo, sir. I'm not involved in any facet of the money portions  
6       of the office.

7   QAnd you're satisfied that the time that he spent there not  
8       only helped him, but also he was happy with it; is that  
9       correct?

10   AYes.

11   QWere there times that he would be on the phone that you could  
12       hear somebody screaming at him?

13   AYes, there was.

14   QDo you know who it was?

15   AYes, sir, I do.

16   QWho --

17   AOn several occasions, I don't know how often.

18   QWho did he say it was?

19   AMany times he would be very upset and just slam the phone and  
20       say something about his wife.

21   QSo he was under distress with the cancers and marital stress,  
22       as far as you knew?

23   AYes.

1 MR. KNOX: All right. That's it.

2 **CROSS-EXAMINATION BY MR. JIMISON:**

3 QMs. Wall, do you know Patient C's wife?

4 ANo, sir, I do not.

5 QDo you have any idea whether she is a grieving mother or not?

6 ANo, I do not. I have no knowledge.

7 QAnd when Patient C passed away he left three children behind?

8 AI do know that.

9 QAll right. He left his wife?

10 ACertainly.

11 QAnd -- and you've never been a visitor to their household?

12 ANo.

13 MR. JIMISON: That's all I have.

14 PRESIDENT RHYNE: Do any Board Members have any questions  
15 of this witness? I have one.

16 **EXAMINATION BY THE PANEL MEMBERS:**

17 PRESIDENT RHYNE: You said that you're certified in  
18 chelation therapy. What did -- what did you do to obtain  
19 that certification?

20 WITNESS: There is an International Society of Chelation  
21 Therapy Technicians and I went through their course.

22 PRESIDENT RHYNE: All right. All right, thank you.

23 MR. KNOX: Let me ask one question.



1 **REDIRECT EXAMINATION BY MR. KNOX:**

2 QDid you go to the funeral -- did a number of some of the employees  
3 at the clinic go the funeral.

4 ANo, I did not. I was out of town.

5 QI'm sorry, I misread that. Thank you.

6 MR. KNOX: We have that other video ready and then we'll  
7 have one other witness.

8 PRESIDENT RHYNE: All right.

9 -----  
10 (WHEREUPON, THE VIDEOTAPE DEPOSITION  
11 OF ELLEN HINSHAW TAKEN ON APRIL 20, 2008  
12 WAS PLAYED AND IS HEREBY ATTACHED  
13 IN ITS ENTIRETY AS EXHIBIT 44  
14 -----

15 PRESIDENT RHYNE: We're ready to continue. Ms. Godfrey,  
16 do you have another witness?

17 MS. GODFREY: Yes, we have Jane Garcia. Ms. Garcia,  
18 please come be sworn.

19 -----  
20 WHEREUPON,

21 JANE GARCIA,

22 being first duly sworn,

23 was examined and testified

1 as follows:

2 \_\_\_\_\_  
3 **DIRECT EXAMINATION BY MS. GODFREY:**

4 QCould you state your name for the record, please?

5 AJane Garcia.

6 QAnd, Ms. Garcia, I'm going to be using the notebook that's  
7 to your left there, the big one there. And if you could  
8 turn to Exhibit 2 in that notebook, is that the copy of  
9 your CV?

10 AYes, it is.

11 QOkay. And are you -- where are you currently employed?

12 AOver at Advanced Concepts in Medicine with Dr. Buttar.

13 QHow long have you worked there?

14 ASince September of '03.

15 QAnd what is your training?

16 AMy training is -- from the very beginning?

17 QFrom -- from post-high school, yes.

18 AOkay. I'm a registered nurse. I attended the first associate  
19 degree program at Central Piedmont College at Charlotte  
20 Memorial Hospital in 1965 and 1967, so that that makes  
21 me an old nurse, so to speak.

22 And then I went to the University of North Carolina at  
23 Greensboro in 1979 and '80 because AGW gave a grant to

1           them for three one-year tracks in occupation -- for  
2           occupational nurse practitioners. At that time I worked  
3           for Burlington Industries when Burlington Industries was  
4           an important factor in textiles in the state of North  
5           Carolina. And there were probably like 120 occupational  
6           health nurses and I received a degree from this program.

7           QAnd did you obtain a degree in the nurse practitioner's program?

8           AYes, I did.

9           QAnd what is the nature of that degree?

10          AThe nature of the degree is occupational health. And when  
11          I sat for my certification there was no other  
12          certifications other than being a certified patient health  
13          nurse. For a practitioner, I saw for the national  
14          certification for nurse practitioners.

15          QAnd when did you sit for that certification?

16          A1981 and 1982 because at that time I transferred to Mississippi  
17          with Burlington Industries and it was a requirement in  
18          the state of Mississippi to be nationally certified. At  
19          that time it wasn't a requirement in North Carolina.

20          QAnd did you continue to work in the occupational health field?

21          AI did for a short time and then my former husband was in law  
22          school in Michigan and I went to Michigan and I worked  
23          with Ingham Otolaryngology.

1 QAnd how long did you work with the --  
2 AFor about a year. For about a year.  
3 QAnd that was from '82 to '83?  
4 AYes, it is.  
5 QAnd following -- following that --  
6 AFollowing that we moved to south Florida for my husband's law  
7 practice and I started to work for a medical management  
8 company that were emergency physicians. At that time,  
9 it was a private group and then it became a public group  
10 and then -- which was under the name Impotent Medical  
11 Management. And then we were sold and it became American  
12 Services Group. But during that time, I spent 20 years  
13 with that company, both private and public.  
14 QOkay. And during that 20 year period and I guess that's from  
15 1983 --  
16 A'83 --  
17 Q-- to -- to 2002?  
18 AYes.  
19 QWhat positions did you hold with the company -- with the medical  
20 management company?  
21 AOkay. Initially I worked as a nurse practitioner with a  
22 collaborative relationship, was hospital based  
23 internists.

1 At that time, I don't know if you remember there was an  
2 HMO in South Carolina which was called Gold Plus and it  
3 later became Humana. It was for -- I can't recall the  
4 first name, but then it became Humana. And at that time,  
5 that was a hospital where they referred all there patients  
6 from their HMO clinics. And our company had been hired  
7 to set up a group of nurse practitioners and hospital based  
8 internists to do the hospital folks inside that took care  
9 of their patients from the HMO.

10 QAnd then did you advance through the -- through the company  
11 until -- what was your position in 2000 -- in 1998 to 2001?

12 AI'll do that, but can I also add something there, that I forgot  
13 to add the first time?

14 QI was going to ask you about the -- that. I'm sorry.

15 AThe oncology.

16 QOkay, I'm sorry.

17 AYeah. During that time in the hospital, I worked as a -- in  
18 the hospital and we also worked with oncologists and they  
19 wanted to have an oncology nurse practitioner. Of course,  
20 I was not trained as an oncology nurse practitioner, but  
21 they had worked with me and they said we want to train  
22 you. So I went to the University of South Florida and  
23 took some courses in oncology and I worked with those

1 oncologists.

2 QAnd that was 1983 to 1987?

3 AYeah, '87, yes.

4 QThen did you advance through the company to --

5 AYes, I did.

6 Q-- okay, of an administrative position?

7 AYes. I became the manager of physician recruitment for the  
8 physicians.

9 QOkay. Now, during the period starting 1987 through the time  
10 that you left the medical management company, how did you  
11 maintain your clinical skills?

12 AWell, we also had the contract with the Broward County Sexual  
13 Assault Treatment Center. Prior to that, gynecologists  
14 were doing the rape exams and the nurse practitioners --  
15 we got that contract and we started doing the rape exams.  
16 And I kept very active in doing rape exams throughout  
17 that time.

18 QAnd -- and on estimate, how many hours a week would you work  
19 at --

20 AAt least eight hours. I always did at least eight hours to  
21 keep my certification.

22 And also during this time, I was director of nurses for  
23 a military services contract. That's the time there was

1 privatization with the military bases, primarily the Navy,  
2 to bring in outside physicians and groups to manage their  
3 emergency departments and their -- their clinics. And  
4 we set up an employee based certification that was required  
5 more for physicians and for -- well, initial blood work  
6 and that sort of thing and I oversaw that.

7 QAnd that was part of your clinical --

8 ARight. All of that work came into my office, yes.

9 QNow, in 2002 or 2003 did you leave south Florida?

10 AYes, I did.

11 QAnd where did you move to?

12 AI moved back here to North Carolina.

13 QAnd since 2003 where have you been employed?

14 AI've worked with Dr. Buttar.

15 QAnd what's been your position with Dr. Buttar?

16 AI've been a nurse practitioner.

17 QAnd as a nurse practitioner how did you become familiar with  
18 integrative medicine?

19 AEverything I know about integrative medicine, Dr. Buttar has  
20 taught me, except for one thing that I would say I did  
21 integrative medicine for myself.

22 When I became that age of maturity where people thought  
23 that you needed to be on hormones when you're going through

1           menopause and that sort of thing, I did not go the  
2           traditional route.  There was an integrative medicine book  
3           that I read and I treated myself at that regard by not  
4           doing that type of thing.  But everything else that I know  
5           of integrative medicine Dr. Buttar has taught me.

6    QAnd do you have with Dr. Buttar a Collaborative Practice  
7           Agreement?

8    AYes, I do.

9    QAnd I believe that's our Exhibit 5; is that correct?  That  
10           was identified in Dr. Buttar's testimony.

11   AYes, uh-huh (yes).

12   QAnd do you and Dr. Buttar update that Collaborative Practice  
13           Agreement on a yearly basis?

14   AWell, we review it and update it if it needs to be, yes.

15   QAnd what is the scope of practice that you have under your  
16           agreement with Dr. Buttar?

17   AWell, my scope of practice is really under the agreement of  
18           the North Carolina Board of Nursing and with the Medical  
19           Board as -- because I am certified as a nurse practitioner.

20   QOkay.

21   AHowever, in our practice, we treat heavy metal toxicity and  
22           I follow that protocol for adults and children.  I do not  
23           treat children for private care or well baby checks or



1 anything in that regard. The same as when I worked the  
2 otolaryngologist. He had had a family nurse practitioner  
3 who did not work out, but because he had not trained that  
4 person to look at the ear as a specialist would, but he  
5 did train me in that regard and I did see children and  
6 adolescence before he did surgery on them and then  
7 afterwards.

8 Because in nurse practitioner training I was taught if  
9 you don't know the answer, you don't -- (inaudible) --  
10 and if you work with a physician in a collaborative  
11 practice, you can be taught by that physician.

12 QAnd does your Collaborative Practice Agreement list the types  
13 of drugs and devices that you --

14 AYes.

15 Q-- can prescribe?

16 AYes.

17 QAnd do you -- do you in your practice with Dr. Buttar stay  
18 within those limits?

19 AYes. I do not prescribe controlled drugs. I could get a DEA,  
20 but I chose not to, so that is not in my scope of practice.

21 QDescribe your working relationship with Dr. Buttar.

22 AOkay. My working relationship with Dr. Buttar is this. When  
23 I work with a physician, I have to believe in what they're

1           doing.  And when I came to work with him, initially we  
2           had a love-hate relationship and that doesn't mean bad  
3           that it was a love-hate relationship in that regard.  
4           It was just that when he was in the room seeing a patient  
5           and we were on a schedule, you know, I tried to stay on  
6           schedule.  And one thing that I liked about our practice  
7           is I have been an administrator in a medical management  
8           company and even set up guidelines that our PAs and nurse  
9           practitioners and physicians in other clinics should see  
10          so many patients an hour.  
11          In our practice with Dr. Buttar, we schedule at least one  
12          hour for a patient visit and that to me is very good because  
13          we have the time to sit down and really listen to the  
14          patient.  I think a lot of times in healthcare we don't  
15          listen to patients.  We go in with an idea of a cookbook  
16          or whatever, they tell us one thing and then we write a  
17          prescription and that's what we do.  
18          Sometimes I would get aggravated with him if we have a  
19          patient and we're supposed to see another patient in an  
20          hour, we might be in there for two hours.  And that's what  
21          I meant because I'm a pretty rigid person and if I've got  
22          an appointment in hour, I make sure I see that.  
23          QDid you and Dr. Buttar work out that problem --

1 AYes, we did.

2 Q-- between you?

3 AYes, we did.

4 QAnd as you progressed in his practice, did you begin to see  
5 patients on your own --

6 AYes

7 Q-- and not just with Dr. Buttar?

8 AYes, yes.

9 QAnd is that the way you practice today?

10 AYes, yes.

11 QIn your experience with Dr. Buttar, does he review your charts  
12 on a regular basis?

13 AYes, he does and we have a weekly meeting that we review the  
14 patients that I have seen for that week. If I needed him  
15 for, you know, a consultation or if I was having a question  
16 or needed him with a patient, I could see him any of that  
17 time or call him.

18 But as my understanding as a nurse practitioner, that's  
19 why there were nurse practitioner programs that nurse  
20 practitioners and PAs are extenders of those physicians  
21 and the physician doesn't have to see the patient every  
22 time the nurse practitioner does or co-sign the chart every  
23 time the nurse practitioner sees a patient other than that

1 first six months when they're working with a new provider.

2 QAnd in your -- in your experience, is there any limit on the  
3 types of patients that you see or do you see all patients  
4 in the practice?

5 AI see all patients in the practice.

6 QAnd is there any patient that you don't intake?

7 ANo.

8 QAnd so you've worked both with cancer patients and other  
9 patients in --

10 AYes, yes.

11 QWell, I'm going to direct your attention to Patient A and ask  
12 you to turn to Exhibit 9 in the book. Did you do the intake  
13 on Patient A?

14 AYes, I did.

15 QAnd just -- we've been through the medical records. What I'd  
16 like you to do though is tell -- tell the Board your  
17 recollections of Patient A and what you understood about  
18 her situation on this patient when you first met her.

19 AWell, when the patient came initially she came with her daughter  
20 and her husband. And this -- this lady was 49 years old  
21 and her daughter is in her 20s. And you could tell they  
22 were a very close knit family and this was a horrible time  
23 for them. And they were a very concerned family and wanted

1 to do whatever they could do and I know that this lady  
2 had a strong will to live.

3 QAnd after you did the intake on -- on Patient A, did you consult  
4 with Dr. Buttar?

5 AYes, I did.

6 QAnd was a treatment plan developed for Patient A?

7 AYes.

8 QAnd did that involve some -- some testing?

9 AYes, it did.

10 QWhat kind of testing did Dr. Buttar order to develop a treatment  
11 plan on this patient?

12 AWell, normally when I see a new patient, we do the initial  
13 visit which is the consult to review their history and  
14 to ask them of any history or anything that they bring  
15 with them.

16 And then we go to develop a plan. Before we start  
17 treatment, there's initial blood work that we do. There  
18 is initial testing that we do to look at the GI tract --  
19 (inaudible) -- analysis. We do a physical and we do an  
20 EKG.

21 QAnd as a result of those tests, was a treatment plan determined  
22 for this patient?

23 AYes.

1 QAnd -- and what the treatment plan?

2 AOkay. We have an established treatment plan which is to help  
3 to build up the immune system in cancer patients.

4 QAnd is that implemented --

5 AAnd it's a guideline. It doesn't mean that this patient gets  
6 this -- this much. We have a treatment plan to detoxify  
7 the body and to treat the patient.

8 QAnd is that what was implemented with Patient A?

9 AYes.

10 QDid -- did you see Patient A on a regular basis?

11 AYes.

12 QAnd what did you notice about her problems?

13 AWell, initially when I saw her, I noted -- I think our initial  
14 visit, she did have some jaundice, okay. And for the first  
15 several weeks, she started feeling better because she had  
16 -- and I think it's in my notes that she had reduced her  
17 pain medication, but then she did have to increase it later  
18 on in her treatment.

19 But as she progressed and the fact that her jaundice  
20 continued and she started developing abdominal pressure  
21 and distension which we sent her to the gastroenterologist  
22 to evaluate her for any blockage. She -- she started going  
23 downhill.

1 QAnd was there -- was there a period of time when you and Dr.  
2 Buttar were concerned about her continuing treatment?  
3 AYes. I think it was after she had seen Dr. Clements, the  
4 gastroenterologist. And as a matter of fact, Dr. Buttar  
5 and I spoke with her about it. And I think that's  
6 documented in the charts, Dr. Buttar's note on 8/14.  
7 QOkay. That would be page C7?  
8 AYes.  
9 QAnd were you present --  
10 AC7A, yeah.  
11 QWere you present for that meeting as well?  
12 AYes, yes.  
13 QAnd what was discussed, if you recall?  
14 AWell, the results of the consultation with Dr. Clements, that  
15 she was not improving and -- but the daughter said that  
16 her mother did not want to give up hope and wanted to  
17 continue.  
18 QAnd what did you and Dr. Buttar do as a result of that request?  
19 AWe needed to do a treatment plan.  
20 QAnd then -- and this patient died a few days after that?  
21 AThat was the 14th. I believe it was that following weekend.  
22 QAnd did you continue to monitor her treatment?  
23 AYes.

1 QAnd -- and continue -- and did Dr. Buttar continue monitor  
2 her treatment?

3 AYes.

4 QOkay. With regard to Patient B, that's Exhibit 13, and whose  
5 notes are they, the first page, the intake sheet for this  
6 patient?

7 AThey're my notes.

8 QAnd tell us what you recall about Patient B.

9 AWell, she came in and I thought she was with her husband, but  
10 it was her fiancée because I always document who is in  
11 with the visit when we see the patient -- when I see the  
12 patient.

13 And she was coming to us I think from Rutherfordton, North  
14 Carolina, that area. And she had been treated -- yeah,  
15 she had surgery for ovarian cancer in August '02 and she  
16 was coming to be treated by us April of '04.

17 QAnd do you happen to know who referred her for treatment?

18 AHer family physician.

19 QAnd I believe we've discussed there was some -- some better  
20 results in her lab work. What did you notice about the  
21 patient as she -- as she started treatment?

22 AOkay. She was a slightly quiet lady. When you talked with  
23 her and went over the plan as far as what she should do,



1 as far as there's something -- some procedures we would  
2 like for them to do like the castor oil liver packs, they  
3 help detoxify the liver and -- and when I would see her  
4 I would always go over what we had recommended, to ask  
5 her of her compliance if she was doing that and she did  
6 not do that.

7 Also, based upon one lab test, the comprehensive diagnostic  
8 stool analysis would show she had -- (inaudible) -- and  
9 it was recommended the sensitivity of the bacteria for  
10 her to be treated with Cipro. And I had seen her and then  
11 the following office visit, I asked her if she was on it  
12 and she said she wasn't, she had not filled the  
13 prescription, but it is documented that that -- one of  
14 our staff was in the room with me that I had given her  
15 the prescription. So she was there, but she didn't always  
16 follow through with what we asked her to do. She was  
17 non-compliant.

18 QAnd did you discuss that -- that problem with Dr. Buttar?

19 AYes.

20 QAnd what was the -- was there a period of time when you all  
21 tried to work with her on the compliance?

22 AYes.

23 QOkay.

1 AAt each visit I would always go over everything that we  
2 recommended and stressed the importance of everything.  
3 QDid there come a point when you and Dr. Buttar determined that  
4 a change in plan needed to be made with regard to this  
5 patient?  
6 AYes, it was. Yes.  
7 QAnd what was that change?  
8 AThat she was discharged from the practice for noncompliance.  
9 QAnd when -- when that happened, did you document it in a note?  
10 AI didn't document it in a note. I documented it on the last  
11 visit or it really wasn't a visit, this was the day that  
12 she was discharged. I think that's -- that's the last  
13 note, it's C8.  
14 QC8?  
15 AUh-huh (yes).  
16 QOkay. And that note is on what date?  
17 AThat note is on -- I don't think I see a date on this, on my  
18 copy.  
19 QIt may have been taken off when the -- when the thing was  
20 redacted, I'm not sure.  
21 AYes, because here is the last -- second to the last paragraph  
22 of my note, date of the option to see this physician at  
23 Lake Norman Regional Medical Center or go back to her family

1 physician by Dr. Theresa Romzick. And she -- I had her --  
2 I wrote down her office number and she said she wanted  
3 to go back to her family physician.

4 And I called Dr. Romzick and discussed the patient with  
5 her and she was to see the doctor as soon as she could  
6 get to that office and I sent her latest blood work with  
7 her.

8 QAnd did -- did you continue to follow the patient until she  
9 as back under the care of Dr. Romzick?

10 AWell -- well, she was to see the physician that day.

11 QOkay. Oh, so that was the day --

12 ARight, right. Uh-huh (yes). My note says, patient to see  
13 physician as soon as we could get to the -- as she could  
14 get to the office, so that was that day, but this was in  
15 the morning, so she was going directly there.

16 QAll right. Now, with regard to -- now, on Patient C, that's  
17 Exhibit 18. Whose notes are in the -- on the intake for  
18 this patient?

19 ADr. Buttar's.

20 QAnd were you involved with this patient's care?

21 AYes, uh-huh (yes).

22 QAnd what do you recall about this patient?

23 AI thought he was a young man. I don't -- yeah, I see he was

1 a young man, 43 years old. He had a strong will to live  
2 and he was always very compliant. And I do not recall  
3 ever seeing anyone come with him to any of his office  
4 visits.

5 QTo your knowledge, did he leave the practice on good terms?

6 AYes.

7 QNow, with regard to Patient D, that's the non-cancer patient  
8 and I believe her office notes are at Exhibit 23.

9 AOkay.

10 QDid anyone besides you see this patient on -- as a prescriber  
11 of treatment?

12 ANo.

13 QAnd what did this patient come to the office with?

14 AWell, she came here for the -- came to our office for evaluation  
15 of heavy metal toxicity.

16 QAnd was that something that she reported to you in the first  
17 visit?

18 AYes.

19 QDid it appear she had had lab work done elsewhere?

20 AA previous challenge, is what we call that.

21 QOkay. But she came to be evaluated for heavy metal toxicity?

22 AShe -- she came to be evaluated for heavy metal toxicity and  
23 she had also had a history of constipation.

1 QOkay. Now, did you ever diagnose this patient with heavy metal  
2 constipation?

3 ANo, there is no such thing.

4 QAnd did you order a urine metal test that -- or I guess we've  
5 been calling it a challenge test.

6 AYes.

7 QAnd is that -- are those notes in -- or is that lab work in  
8 Exhibit 24?

9 AYeah. That was only ordered after she had had the physical  
10 and had her lab work, EKG and bone mass density because  
11 we don't order this until they've had their physical done.

12 QOkay. And then at the time -- once the results came back from  
13 the challenge test, what was determined as far as her heavy  
14 metal levels?

15 AWell, if you look at Exhibit 24 and you look at the test results,  
16 her levels of lead were 12 micrograms per gram of kilo --  
17 of creatinine and her mercury was 5.4. And the reference  
18 range for lead is 5 and for mercury it's 4. Nickel was  
19 14, the reference range is 12. And the reference range  
20 for tin is 10 and it was 9.8. She did have heavy metal  
21 toxicity.

22 QAnd based on those labs did you initiate some treatment for  
23 the --

1 AYes.

2 QAnd what treatment did you initiate?

3 ATo alternate IVs of EDTA specifically for lead and cadmium  
4 and DMPS for mercury and the other metals.

5 QAnd to your knowledge, was this a compliant patient?

6 AShe was compliant up to -- well, I saw her one additional time  
7 and let me get to that note.

8 QThe private sets would be in 23.

9 AOkay. I saw her initially 12/6 and then I saw her for a  
10 follow-up visit and at that visit is when we go over some  
11 of the tests like diagnostic and the previous challenge  
12 and she had had three IV treatments and at that point she  
13 had been compliant.

14 QAnd then at some point was this patient discharged from the  
15 practice?

16 AYes, she was.

17 QAnd what was the reason that this patient was discharged from  
18 the practice?

19 AWell, if you look at the progress notes, I saw her on January  
20 the 17th of '06 and then a month later she called telling  
21 us she was having problems and then further on the note  
22 she was upset because she had not seen Dr. Buttar.

23 And that was the first time I had any knowledge of it because

1 when we saw -- when I saw her on the 17th of January, her  
2 subjective reports to me was that she had noticed she had  
3 more energy and had less constipation, had been taking  
4 her supplements as prescribed, had lost two pounds and  
5 that was one of her goals, she wanted to lose weight.  
6 And the only thing she had not done is started our GI liver  
7 detox program that we had recommended.

8 QLook if you would at Exhibit 25.

9 AOkay.

10 QIs this -- and I'll represent to you that this is a letter  
11 written by Tasha Claridge to --

12 AYes.

13 QWhat is your memory about why Patient D left the practice?

14 AWell, later on I was told that she had tried to use -- she  
15 used a credit card to pay the payment and then tried to  
16 take the credit card back and that whole issue. I don't  
17 really get involved in that, so I don't keep up with those  
18 details.

19 QBut you were aware that she was --

20 AI was aware, yes.

21 Q-- she was discharged from the practice for -- for non-payment  
22 or for reversing the credit card charge?

23 AYes.

1 QJust tell the Board briefly in your own words what your  
2 observation is in general of the practice of Dr. Buttar  
3 in how he treats patients, how he interacts with patients.  
4 AI have worked with a lot of physicians over my span as a nurse  
5 and as a nurse practitioner. Dr. Buttar is very  
6 conscientious. He spends time with a patient. He has  
7 a tremendous gift. He's an intelligent man. He is a  
8 excellent teacher. His lectures are very good and his  
9 true gift is seeing patients.  
10 And he has a sense or an ability to look at the physiology  
11 of a patient -- not of a patient, but of a body and that's  
12 how our approach is to treating patients.  
13 When I started working with him, I worked with him for  
14 about a month because, you know, when you develop a  
15 collaborative relationship with a physician, part of it  
16 is to see if the physician wants to work with you, but  
17 part of it as a nurse practitioner is to see if you want  
18 to work with that physician as well.  
19 And I have a step-grandson who had been diagnosed with  
20 autism and I had never seen any treatment for heavy metal  
21 toxicity in children with autism. As a result of that,  
22 I had my step-grandson come and be treated by Dr. Buttar.  
23



1           Anyone who has ever gone through that or have any relatives  
2           that have had to deal with a child that is not what you  
3           thought that child was going to be or have developmental  
4           delays particularly after when that child did not have  
5           any up to a certain point of time, that's very traumatic  
6           for everyone.

7           And you have to have a lot of trust in an individual to  
8           look at treating a child from a non-traditional way when  
9           other people have said they might be mentally retarded  
10          or they have some severe developmental delays.

11          We treated my grandson, he has made a lot of progress.  
12          He also has treated my daughter just from a preventative  
13          perspective and has treated my mother. And as a result,  
14          my daughter had her first child and he's three months old  
15          today and he has not had any vaccines and he is starting  
16          his life being as clean as you possibly can be and not  
17          having anything to help compromise his immune system.

18          MS. GODFREY: That's all.

19          **CROSS-EXAMINATION BY MR. JIMISON:**

20          QThank you for coming, Ms. Garcia. Do you have your CV in front  
21           of you?

22          AYes.

23          QAnd isn't it true that you have no formal training in oncology

1 as a nurse practitioner?

2 AIn what regard do you call formal training?

3 QYou're not an oncologist nurse practitioner?

4 DR. WALKER: Microphone please.

5 MR. JIMISON: Oh, I'm sorry.

6 QYou're not an oncologist nurse practitioner, are you?

7 ANo. But I worked as an oncology nurse practitioner and I have  
8 training in oncology. I've never taken the certification  
9 as an oncology nurse practitioner.

10 QAnd under the rules of the Medical Board and the Nursing Board,  
11 a nurse practitioner can only practice within her  
12 certification?

13 AYes.

14 QAnd your certification is as an adult nurse practitioner,  
15 correct?

16 AYes.

17 QAnd there's actually a thing called a pediatric nurse  
18 practitioner, is there not?

19 AYes.

20 QAnd you're not certified as a pediatric nurse practitioner,  
21 are you?

22 ANo, I'm not a pediatric nurse practitioner?

23 QAnd during the two days you have been here, you heard the mother

1 of Patient D testify?

2 AYes.

3 QAnd that patient's mother basically consulted with you over  
4 the telephone, correct?

5 AYes.

6 QAbout her child that had autism?

7 AYes.

8 QAnd you sent her materials, transdermal chelation agents and --  
9 and self-testing kit to her initially, correct, your  
10 office?

11 AYes, our office did, yes.

12 QOkay. At no time did your office ever personally see that  
13 child, correct?

14 AYes, we did.

15 QPrior to sending those materials?

16 ANo.

17 QOkay. At some point, she came down later, like four months  
18 later, correct?

19 AYes.

20 QSo it would be fair to say that the materials were sent to  
21 her to start the treatment of chelation therapy and the  
22 self-testing prior to your office personally seeing the  
23 child?

1 AYes, but we take an intake form on any child that we -- any  
2 phone consult that we do.

3 QWell, under your view, it's good medical practice to begin  
4 treating a child for severe autism without first seeing  
5 the child?

6 AWe did the intake form. The parents fill out a detailed history  
7 on the intake form.

8 QSo it is good medical practice to do that?

9 AWe're not treating the child for autism, we're not treating  
10 autism, we're treating the heavy metal toxicology --  
11 toxicity. There happens to be a protocol for children.

12 QAnd with metal toxicity, it's okay to begin treatment of the  
13 child for metal toxicity without seeing the child first?

14 AWe always like to see the child, but because of the distance,  
15 we did not.

16 QYou could have just refused, could you not, to sent them  
17 materials until you saw the child?

18 AWell, at that time, there's been such a backlog for patients  
19 being seen that we did agree to do some phone consults.

20 QOkay. And sort of instruct the mother on how she could  
21 self-treat her child?

22 AWell, there are detailed instructions that are given.

23 QWhen Patient A -- when Patient A first met -- came in the office,

1 she didn't see Dr. Buttar, correct?  
2 APatient A?  
3 QPatient A.  
4 AI saw her initially.  
5 QBut Dr. Buttar was not there, correct?  
6 AA lot of times Dr. Buttar comes in when I'm seeing a patient  
7 and he's seeing another patient. We did discuss the plan.  
8 I did go over the plan with Dr. Buttar.  
9 QAnd if you could turn to -- in the big notebook.  
10 AOkay.  
11 QIt's the Medical Board's big notebook, I believe.  
12 AThis -- this --  
13 QYes.  
14 AOkay.  
15 QTab 4 and page 95.  
16 MS. GODFREY: That's not the Medical Board notebook.  
17 MR. JIMISON: I'm sorry.  
18 MS. GODFREY: I think it's not that notebook.  
19 WITNESS: This one?  
20 MR. JIMISON: No, that's not it.  
21 MS. GODFREY: It's right there behind her.  
22 MR. JIMISON: Oh, it's like on the chair.  
23 MS. GODFREY: Here, I have it.

1 WITNESS: Okay.

2 MR. JIMISON: There you go.

3 Q(By Mr. Jimison) On page 95, that's -- is that the initial  
4 visit?

5 AIs there a section or just by pages?

6 QTab 4 in that. Tab 4 and then you can see the page numbering  
7 at the bottom.

8 AAnd what page did you say?

9 Q95. And if we can flip over to 96. Okay. This is your note,  
10 correct?

11 AYes, it is.

12 QOkay. And that last line, you actually note that the husband  
13 is this person and the daughter is this person?

14 AYes, uh-huh (yes).

15 QOkay. And -- and --

16 AOh, yeah, the last line I wrote their names, so when I  
17 communicate with them I can call them by name.

18 QAnd you did a impression, that's kind of a quarter of the way  
19 up and your impression is metastatic cervical cancer,  
20 correct?

21 AYes. And that's metastasized.

22 QAnd there's a metastasized to liver and heart.

23 AUh-huh (yes).

1 QAssessment and plan, patient to let us know if wants to follow  
2 with -- is that cancer plan?

3 AYes.

4 QSo you had a conversation with Patient A and her family?

5 AYes, I did.

6 QAnd what did you say in that conversation with her?

7 AWell, they came to us looking for treatment to help her mother,  
8 okay.

9 QWith her cancer?

10 ABut that was her underlying issue was cancer, yes. And I  
11 explained to her what we do as far as cleaning up her immune  
12 system and her body to help make break the cancer itself.

13 QSo you didn't tell them you treat cancer, you just told them  
14 you treated the immune system?

15 AYes, that's our approach, yes. To detoxify the body and to  
16 build up the -- enhance the immune system.

17 QAnd -- and your note says, patient to let us know, wants to  
18 follow -- and this is your handwriting, correct?

19 AYes, it is.

20 Q-- with cancer plan?

21 APatient to let us know if wants to proceed with cancer plans,  
22 correct.

23 QIt doesn't say immune building plan, does it?

1 ANo, it doesn't.

2 QIt doesn't say heavy metal detoxification plan, does it?

3 AWell, that's part of it.

4 QIt says cancer plan.

5 AYes, it is written there.

6 MR. JIMISON: Thank you, ma'am.

7 **REDIRECT EXAMINATION BY MS. GODFREY:**

8 QJust a little follow-up. Ms. Garcia, with regard to Patient  
9 D that Mr. Jimison asked you about, was any -- were any  
10 medications sent to Patient D's parents prior to doing  
11 labs or getting labs?

12 AOn any patient we don't -- I'm sorry, we don't treat any patient  
13 prior to doing elementary lab work, standard lab which  
14 will be other tests. We don't do anything until we --  
15 because our rule in our office is to do no harm.

16 QSo when --

17 AAnd how can you treat someone if you don't do anything, do  
18 any preliminary testing and we can see where the body's  
19 problems are.

20 QAnd so -- I know you don't have the record in front of you,  
21 but to your recollection and to your way of practicing,  
22 were -- were labs done to determine what types of problems  
23 or manifests for Patient D?



1 AWell, the labs were done primarily to look and see what the  
2 child's kidney function is because she did not -- we would  
3 not start anything without knowing the kidney function,  
4 that's very important. Also to look at liver function  
5 studies and also to look a iron levels.

6 QAnd once those are determined the -- the treatment is sent  
7 to the parents, correct?

8 AYes.

9 QAnd what kind of treatment is it? What -- what's -- how is  
10 it administered?

11 ATransdermally. Transdermally is you put it on the skin and  
12 rub it in.

13 QAnd that's the only type of treatment that this patient was  
14 administered prior to coming to North Carolina?

15 AAlso recommended some minerals and vitamins and some --  
16 (inaudible).

17 QAnd then was -- when the patient -- when the appointment was  
18 made for her to come North Carolina to review all those  
19 things, did you -- did you have further lab work done?

20 AYes. The lab work and other tests is done on a regular basis.

21 QAnd when patients come from out-of-state, is there an effort  
22 made to try to -- to try to schedule with Dr. Buttar?

23 AIf they want to see Dr. Buttar, they do. And if they don't,

1 they see me and I try to bring Dr. Buttar in the room.

2 He always tries to come in to see the patient.

3 MS. GODFREY: That's all I have.

4 PRESIDENT RHYNE: Do you -- did you want to recross, Mr.  
5 Jimison?

6 MR. JIMISON: No, ma'am.

7 PRESIDENT RHYNE: Okay. Are there any Board questions?  
8 Go ahead.

9 **EXAMINATION BY THE PANEL MEMBERS:**

10 DR. McCULLOCH: Thanks for being here, Ms. Garcia.

11 WITNESS: You're welcome.

12 DR. McCULLOCH: I'm going to ask you perhaps a few  
13 questions that are difficult to answer. I don't think  
14 you're a bad person, they're just difficult questions and  
15 they may not be that hard. With respect to this  
16 transdermal --

17 WITNESS: COPS.

18 DR. McCULLOCH: -- are you aware of the efficacy of this  
19 treatment?

20 WITNESS: Yeah.

21 DR. McCULLOCH: It works?

22 WITNESS: It works.

23 DR. McCULLOCH: Studies?

1 WITNESS: I'm not aware of studies, but I see the result  
2 we see in patients.

3 DR. McCULLOCH: Now, did you send that treatment along  
4 with the test kit?

5 WITNESS: That's sent from our office.

6 DR. McCULLOCH: At the same time?

7 WITNESS: No.

8 DR. McCULLOCH: No?

9 WITNESS: No, it's not -- that's not sent until after the  
10 tests are done and we look at the tests and everything  
11 is okay. That's never sent out until we -- we know kidney  
12 function, iron levels, that sort of thing.

13 DR. McCULLOCH: Okay.

14 WITNESS: Never.

15 DR. McCULLOCH: But this patient was sent the treatment  
16 without having been seen by anybody in your office; is  
17 that correct?

18 WITNESS: Yes.

19 DR. McCULLOCH: I recall -- I'm going to ask you this  
20 because you may know, somebody -- I think it might have  
21 been done a videotape, I think it was a videotaped  
22 deposition -- something about someone being instructed  
23 on how to give a vaccination to someone at home. Have

1 you ever done that?  
2 WITNESS: No.  
3 DR. McCULLOCH: I didn't make that up.  
4 MR. KNOX: I'm not sure.  
5 WITNESS: I don't give vaccinations. I wouldn't instruct  
6 on that.  
7 DR. McCULLOCH: I need some chelation.  
8 MR. KNOX: You'll have to talk to the doctor afterward.  
9 DR. McCULLOCH: All right. Now --  
10 WITNESS: But there are things we have to do beforehand.  
11 DR. McCULLOCH: Okay. What percentage of patients that  
12 come for treatment receive chelation therapy, roughly?  
13 WITNESS: I big portion of them.  
14 DR. McCULLOCH: A 100 percent?  
15 WITNESS: 98 maybe, but a big portion of our patients.  
16 DR. McCULLOCH: So every patient that comes to you --  
17 through your door has heavy metal toxicity?  
18 WITNESS: They're evaluated for that.  
19 DR. McCULLOCH: Every patient is treated for it, so  
20 everyone must have it?  
21 WITNESS: Well, I can't recall -- no, I have seen --  
22 DR. McCULLOCH: Virtually everybody?  
23 WITNESS: A lot of people do, yes.

1 DR. McCULLOCH: Have you been treated?

2 WITNESS: Yes, I have.

3 DR. McCULLOCH: I figured so. Does that seem unusual to  
4 you that 100 percent of the patients that come through  
5 your door would have a particular condition?

6 WITNESS: Well, when we look at what we are doing in our  
7 environment. What are we doing with toxic waste? What  
8 are we doing with pollutants? Where is that going? It  
9 goes in our water supply, it goes in foods we eat and what  
10 do we do, we ingest that.

11 DR. McCULLOCH: So it does not seem unusual?

12 WITNESS: It doesn't. It would have seemed unusual to  
13 me six years ago, but not today. I mean, my daughter is  
14 35 years old, we tested her. She had some not severe,  
15 but she's young, so she did that from a preventive  
16 perspective. I have high levels of lead. I made a joke  
17 out it after I got a speeding ticket, so they said you  
18 had a lead foot. I said, well, I guess I do. That's just  
19 a joke, but, yes.

20 I mean, if you think about it and what we've done in our  
21 environment, what do we do in our environment to make sure  
22 we detoxified it or to take care of ourselves? What do  
23 we do with processed foods?

1 DR. McCULLOCH: That's all I have.  
2 DR. WALKER: Ms. Garcia?  
3 WITNESS: Yes, sir.  
4 DR. WALKER: Let me follow-up on one point that Dr.  
5 McCulloch raised.  
6 WITNESS: Yes, sir.  
7 DR. WALKER: Do you know what the medical practice laws  
8 are in Michigan?  
9 WITNESS: No. I was a nurse practitioner and lived in  
10 Michigan at one time.  
11 DR. WALKER: Would you consider prescribing transdermal  
12 chelation therapy a form of medical practice?  
13 WITNESS: Yes, it could be. I've don't -- I haven't  
14 thought about it.  
15 DR. WALKER: Did -- did it occur to you that perhaps it  
16 would be wise to check the regulations in the state of  
17 Michigan before you started practicing medicine across  
18 state lines in a state that -- are you currently licensed  
19 in Michigan?  
20 WITNESS: No, I'm not, sir.  
21 DR. WALKER: Did that thought of -- is that -- is that  
22 a consideration when you all were taking telephone  
23 consults?

1 WITNESS: It hasn't been.  
2 DR. WALKER: Let me go over a few points of the medical  
3 records of the patients that you have helped take care  
4 of.  
5 WITNESS: Yes, sir.  
6 DR. WALKER: And I echo Dr. McCulloch's remarks, I don't  
7 mean to be argumentative, I'm just trying to sort of  
8 establish what's in the record versus what you said. And  
9 correct me if I misstate what you have said.  
10 WITNESS: Yes, sir.  
11 DR. WALKER: At one point you said that before your  
12 patients receive any treatment they have a history and  
13 physical and laboratories; is that correct?  
14 WITNESS: And an office visit for adults, yes sir.  
15 DR. WALKER: Well, and when you said that I was intrigued  
16 because when I read the notes on Patient A, Patient A came  
17 in, according to your notes, on July 20th and you went  
18 through the history and you had your discussions and then  
19 you started the patients on multiple supplements or  
20 substances. There was no physical exam done on that day  
21 according your note.  
22 WITNESS: Well, we start -- we give them the supplements,  
23 but they don't start them until after they've collected

1 the comprehensive diagnostic stool analysis and we do the  
2 physical on them.

3 DR. WALKER: Okay. Your second note was 7/24/06 and the  
4 top of the note was, here for physical slash BMD slash  
5 EKG, feels fine, okay.

6 And then when I read your note, you report on the effects  
7 of the supplements, you report labs, but there's no  
8 physical exam, though.

9 WITNESS: May I leaf through here?

10 DR. WALKER: Sure. You can look in --

11 WITNESS: At which book? I mean, I have --

12 DR. WALKER: -- in your -- Dr. Buttar's book, it's on --

13 WITNESS: Okay.

14 MS. GODFREY: I don't think you'll find it in our book.

15 You have to select --

16 DR. WALKER: Well, actually is this your book?

17 MS. GODFREY: Yes.

18 DR. WALKER: It's under Tab 9.

19 MS. GODFREY: Right, but the physical exam, I don't think  
20 is under Tab 9. I'm glad to hand that --

21 DR. WALKER: Well, are you stating that some of the  
22 physical exams were included and some are not?

23 MS. GODFREY: Well, I put the progress notes and I think



1 the physical exam is in a different section.  
2 DR. WALKER: Well, in reviewing the records, there were --  
3 there was one occasion of a physical exam by Dr. Buttar  
4 on your form and was very thorough. And then there were  
5 notes in your progress notes of physical exams later on,  
6 so I was --  
7 WITNESS: His visits --  
8 DR. WALKER: Pardon me?  
9 WITNESS: With all his visits --  
10 DR. WALKER: Correct, right.  
11 WITNESS: -- the exam, not as extensive because we did  
12 an exam.  
13 DR. WALKER: Right. So I guess is -- is what counsel is  
14 saying is that y'all gave us incomplete records there.  
15 MS. GODFREY: No. What I'm saying is that I -- that Mr.  
16 Jimison gave you a complete set of the records. I was  
17 trying to not duplicate what he was doing. And indeed  
18 in the records and this is D5A there is a physical exam  
19 of this patient.  
20 The problem and I apologize to the Board, Mr. Jimison and  
21 I, we coordinated ahead of time, but we did not. Of course,  
22 he didn't ask me about his exhibits and I didn't ask him  
23 about mine.

1 But in the -- in the complete record there is -- and I  
2 can't find it, I can't locate it for you in Mr. Jimison's,  
3 but I can show you a complete record that at B5A in our  
4 records, there is a physical exam on 7/24/06 of this  
5 patient.

6 DR. WALKER: Okay. So in other words, it wasn't real clear  
7 from what I reviewed.

8 MS. GODFREY: And I apologize for that, Dr. Walker.  
9 That -- that is definitely my fault.

10 MR. JIMISON: If you look to Tab 4 in the Medical Board's,  
11 the complete record I believe is page 92.

12 MS. GODFREY: Is it page 92?

13 DR. WALKER: You're exactly right and I apologize for  
14 bringing up an issue which was apparently not the case  
15 because of the record review I did.

16 WITNESS: That's okay. I knew there was a physical note,  
17 so just locating it.

18 DR. WALKER: Well, I have no other questions.

19 PRESIDENT RHYNE: I need -- and thank you, by the way,  
20 for being here, Ms. Garcia.

21 You said something and I just didn't hear all of it. You  
22 said that and it had to do with Patient B and you said  
23 the stool showed something and you gave them Cipro.

1 WITNESS: Dysbiotic flora.  
2 PRESIDENT RHYNE: Can you tell me what dysbiotic flora  
3 is?  
4 WITNESS: Dysbiotic is -- well, we explain it to patients  
5 that it's bad bacteria. It's bacteria that is not good  
6 bacteria that can create problems in the gut.  
7 PRESIDENT RHYNE: Can I see that lab test?  
8 WITNESS: Sure.  
9 PRESIDENT RHYNE: Because -- go ahead.  
10 WITNESS: And we've got tests that also gives you a  
11 sensitivity of what the bacteria is sensitive to and Cipro  
12 was for that -- one of those.  
13 PRESIDENT RHYNE: Yeah, I would just like to see that --  
14 WITNESS: Sure.  
15 PRESIDENT RHYNE: -- because generally even with, you  
16 know, with many infectious diarrheas, you don't even want  
17 to treat them with antibiotics, they're self limited.  
18 The more antibiotics you give, the more you're giving the  
19 antibiotics that --  
20 WITNESS: And at the same time we give them good  
21 antibiotics as well.  
22 PRESIDENT RHYNE: -- clear the good bacteria out of your  
23 gut.

1 WITNESS: Well, that's one reason sometimes they have  
2 dysbiotic flora is they don't have enough good bacteria --  
3 PRESIDENT RHYNE: Right.  
4 WITNESS: -- so we treat that as well. Let me find that.  
5 PRESIDENT RHYNE: And -- and then the antibiotics tend  
6 to make it worse and that is why --  
7 WITNESS: This is B, Patient B we're talking about?  
8 PRESIDENT RHYNE: Yeah. You had testified of Patient B.  
9 WITNESS: Yes, it's B.  
10 PRESIDENT RHYNE: Now, actually, I was looking in your  
11 book, I wasn't looking in the Medical Board book, so it  
12 may be --  
13 WITNESS: Is this our -- this is --  
14 MR. JIMISON: Yeah.  
15 PRESIDENT RHYNE: I'll tell you what, Dr. Walker will look  
16 for it while I go ahead.  
17 MR. JIMISON: I guess it's a little confusing.  
18 WITNESS: It's F1 in the resource I'm looking at.  
19 MR. JIMISON: That's your notebook --  
20 WITNESS: Okay.  
21 MS. GODFREY: Right. It's a non-redacted, but she can --  
22 MR. JIMISON: But just to clarify this entire issue, what  
23 was decided was the Medical Board book for Patients A

1 through D to be the medical records. Those are in the  
2 big thick book.  
3 DR. McCULLOCH: So we have those?  
4 MR. JIMISON: Yeah. And they're actually in alphabetical  
5 order unfortunately and not correlated, so Patient -- which  
6 one are you looking for?  
7 PRESIDENT RHYNE: It's Patient B.  
8 MR. JIMISON: Patient B would be Tab 3.  
9 PRESIDENT RHYNE: Tab 3, okay.  
10 DR. McCULLOCH: I'll look, too.  
11 MS. GODFREY: And the lab work which is in --  
12 PRESIDENT RHYNE: Oh, is that D, Patient --  
13 MS. GODFREY: Patient --  
14 MR. KNOX: D was four.  
15 MR. JIMISON: Yeah, they're in alphabetical order.  
16 MR. KNOX: Patient B was two.  
17 MR. JIMISON: By -- by their last name, they're in  
18 alphabetical order, so E is five.  
19 PRESIDENT RHYNE: I see something that shows parasites.  
20 WITNESS: It looks like this. Can you see that?  
21 PRESIDENT RHYNE: And what is it -- oh, it says started  
22 parasite protocol. What is parasite protocol?  
23 WITNESS: As reference to this or are you asking me another

1 question?

2 PRESIDENT RHYNE: Yeah. On one of the other things it  
3 said started parasite protocol and what is your parasite  
4 protocol?

5 WITNESS: All right. It is a number of things to treat  
6 parasites. I can't tell it to you by memory. We use in --  
7 don't use it on a regular basis, we have a treatment  
8 protocol for that.

9 PRESIDENT RHYNE: Even though this lab test for parasites,  
10 there's no parasites seen?

11 WITNESS: Well, that's based on the basis that there are  
12 parasites within cancerous tumors, within tumors and there  
13 is a Ph.D. --

14 PRESIDENT RHYNE: Well, wait, whoa, whoa, whoa. Where  
15 did you get that from?

16 WITNESS: There is -- I can't recall the Ph.D.'s name.  
17 I would have to ask Dr. Buttar to comment on that, if that's  
18 okay.

19 PRESIDENT RHYNE: Okay. So -- so in other words, you're  
20 using Cipro to treat bacteria in the stool --

21 WITNESS: The dysbiotic flora, the Cipro, yeah.

22 PRESIDENT RHYNE: Right. You would expect that's a normal  
23 finding of bacteria in the stool. Everybody's stool has

1 bacteria.

2 WITNESS: Well, yeah, but this is three plus. The  
3 imbalance is for commensurable bacteria. The beneficial  
4 flora is of course the good bacteria and you want that  
5 to be higher. You see she has no bifidobacteria.

6 PRESIDENT RHYNE: Right, but she has four plus E. coli  
7 and three plus bifidocater.

8 WITNESS: Yeah, and that's good.

9 PRESIDENT RHYNE: Yeah.

10 WITNESS: And then if you look the last page under  
11 sensitivities, bacteria susceptibilities.

12 PRESIDENT RHYNE: Right. I see that, but as you know there  
13 again it's generally not recommended that you give  
14 antibiotics, all you do is deplete the good bacteria out  
15 of the stool. Okay.

16 Let me go on and ask you just two other questions --

17 WITNESS: Certainly.

18 PRESIDENT RHYNE: -- and I'll be finished. What thing  
19 struck me -- has struck me today and that it seems like  
20 every patient -- this goes along with what they said, every  
21 patient we have got the challenge test has too much lead  
22 and too much mercury.

23 Isn't it a little strange to you that almost 100 percent

1 of patient -- the same patients have the same things to  
2 show up in their labs.

3 WITNESS: They don't have the same levels and they are  
4 elevated levels.

5 PRESIDENT RHYNE: Yeah. Does it make you think that  
6 that's what you get if you did that test that everybody  
7 will have those elevated levels?

8 WITNESS: No. It's a specialized test --

9 PRESIDENT RHYNE: It doesn't strike you as a little strange  
10 that a 100 percent of the patients have the same results?

11 WITNESS: No.

12 PRESIDENT RHYNE: Okay. And let me just go on then.  
13 Throughout the day also you have said that some people  
14 have gotten vaccines and that vaccines are helpful and  
15 they stimulate the immune system. And in the e-mails --  
16 I think we've heard that and certainly in this e-mail in  
17 your book, Patient B is saying he had two vaccines last  
18 weekend, one with salmonella and strep -- and strep  
19 bacteria.

20 MR. KNOX: That's an e-mail that he sent from Mexico where  
21 he was being treated back from this clinic where he was  
22 just telling what was happening to him in Mexico.

23 MS. GODFREY: Because that wasn't -- that wasn't --



1 MR. KNOX: I maybe didn't make it clear.  
2 PRESIDENT RHYNE: No, but Dr. Buttar had testified that  
3 he sent him down and he was glad he went to Mexico, that  
4 he had agreed with that treatment and had sent him down  
5 there.  
6 MR. KNOX: I'm certainly not going to argue with you about  
7 what the evidence was, that he felt he had stress and he  
8 recommended to go to Mexico because he thought -- he goes  
9 to Mexico and one of the treatment they got, he e-mails  
10 one of the -- Nina back and tells her how he's doing and  
11 in that it says vaccines, but I don't think Dr. Buttar  
12 would prescribe that.  
13 PRESIDENT RHYNE: Okay. Then -- then it's my  
14 misunderstanding. I understood Dr. Buttar to say he had  
15 actually agreed with the therapies down in Mexico and,  
16 in fact, had done some of the same therapies.  
17 DR. BUTTAR: Do you want me to answer that?  
18 PRESIDENT RHYNE: No, that's -- that's -- that's okay.  
19 MR. KNOX: I'm sorry.  
20 PRESIDENT RHYNE: Well, let's look again since they're  
21 talking about vaccines and you're saying something else  
22 about vaccines.  
23 MR. KNOX: Okay.

1           PRESIDENT RHYNE: I'll withdraw that question. I don't  
2           have anything else. Thank you.

3           **RE-CROSS EXAMINATION BY MR. JIMISON:**

4           Q I do have a question just based on -- I do believe from your  
5           direct testimony, Ms. Garcia, that a child had not gotten  
6           his vaccines, your step-grandson?

7           A My -- my grandson.

8           Q Do you advise children about getting -- or parents of children  
9           not getting vaccines?

10          A We made that decision for my grandson.

11          Q I mean, on other patients.

12          A That's a -- that is a personal decision.

13          MR. JIMISON: Okay.

14          **FURTHER EXAMINATION BY THE PANEL MEMBERS:**

15          PRESIDENT RHYNE: I have one other question. Have you  
16          read the North Carolina Medical Board's policy?

17          WITNESS: Yes, ma'am.

18          PRESIDENT RHYNE: Okay. Thank you. That's all I have.

19          WITNESS: Okay.

20          MS. GODFREY: Okay. Thank you.

21          MR. JIMISON: At this -- do you want to add anything else.

22          MS. GODFREY: Yes. As long as we're sure on the record  
23          that we have all the exhibits in that we listed, I think

1 we did -- I think we clarified that already and I think  
2 we said that there were some --  
3 MR. JIMISON: I think we've said that Number 3 and 50 was  
4 tendered, but not admitted.  
5 MS. GODFREY: Right. And of the ones on our list, Exhibit  
6 30 and 51 through 54 were not tendered.  
7 MR. JIMISON: Those are just deposition transcripts.  
8 MS. GODFREY: Those are deposition transcripts that were  
9 of witnesses that testified.  
10 PRESIDENT RHYNE: Okay. Are we ready for closing  
11 arguments? Is there any -- any other --  
12 MR. JIMISON: We're ready, however, we have one rebuttal  
13 witness --  
14 PRESIDENT RHYNE: Oh, okay.  
15 MR. JIMISON: -- and Mr. Mansfield we'll be calling.  
16 PRESIDENT RHYNE: Okay. Proceed.  
17 MR. MANSFIELD: Thank you, Madame President. In  
18 rebuttal, we would call Dr. Buttar back to the witness  
19 stand, please.  
20 MR. KNOX: Well, I don't want to be a technician, but the  
21 truth of the matter is, if you have another lawyer examine  
22 and then they go bring in another one who needs to be  
23 examiner now is just absolutely contrary to procedure.

1 MR. JIMISON: He's on the Medical Board staff in the legal  
2 department. I don't think there are two lawyers.

3 MR. KNOX: Well, sure.

4 MR. MANSFIELD: Madame President, actually I was just  
5 glancing through the rule, Mr. Knox mentioned that to me  
6 in the hall. I was glancing through the rule and it says  
7 that in cross-examining a witness for instance when Mr.  
8 Jimison was cross-examining Dr. Buttar earlier we could  
9 not take turns. It wouldn't be fair for Marcus to go until  
10 he got tired and let me take a look at Dr. Buttar, that's  
11 what the rule is about.

12 Dr. Buttar was testifying as -- as a direct testimony  
13 witness for his case called by Mr. Knox at that time and  
14 we are now calling him as a rebuttal witness and we're  
15 not going to take turns questioning.

16 I have about ten minutes worth of questions, I think at  
17 the outside, and I don't believe it's contrary to the rules.

18 MS. GODFREY: Well, and I will state as far as that goes  
19 as a rebuttal witness, the -- the testimony needs to be  
20 limited to matters that were brought up in our case, not --  
21 not new matters. I believe that is the rule.

22 MR. MANSFIELD: Correct. Madame President, I intend to  
23 ask him only about previous testimony in his case.

1 PRESIDENT RHYNE: Okay. Proceed. You've already been  
2 sworn in, Dr. Buttar --

3 DR. BUTTAR: Yes, ma'am.

4 PRESIDENT RHYNE: -- so you can have a seat.

5 DR. BUTTAR: Thank you, ma'am.

6  
7 WHEREUPON,

8 RASHID ALI BUTTAR, D.O.,  
9 having been previously sworn,  
10 was examined and testified  
11 as follows:

12  
13 **REBUTTAL EXAMINATION BY MR. MANSFIELD:**

14 QDr. Buttar.

15 AYes, sir.

16 MR. KNOX: The rules keep changing and I mean -- I'm --

17 QDr. Buttar, you testified previously today that you were  
18 involved in the passage of House Bill 886 at the North  
19 Carolina General Assembly, correct?

20 AYes, sir, I was.

21 QAnd that was in the year of 2003, correct?

22 AThat's correct.

23 QAnd I believe you testified earlier today that you testified

1 to the House Committee on Health; is that right?

2 AI don't remember saying which committee. I testified I  
3 wouldn't even know which committee it was. I was just  
4 -- wound up and pointed in the right direction.

5 QDo you remember whether it was in April of 2003 that you gave  
6 the testimony that you recall giving?

7 AI recall that the day was the same day that my past --I served  
8 with the 101st Air Assault Division was moving into Iraq  
9 and I remember it was that day. I don't remember what  
10 that day was, but I believe that would be around the right  
11 time at some time in April.

12 QThank you. And did you work with any legislators with regard  
13 to House Bill 886?

14 ADid I work with any legislators?

15 QWell, did you ever have a conversation with any legislator  
16 in the General Assembly about House Bill 886?

17 AOh, I spoke with quite a number of them.

18 QDid you -- other than testifying in a front of a group within  
19 a committee setting, did you ever have any other  
20 conversations with legislators?

21 AI don't remember meeting any legislators one on one.

22 QIf -- if I asked you whether you had ever met with Representative  
23 Thomas Wright in particular, would you remember him?

1 AThe name is --

2 MS. GODFREY: Well, objection.

3 MR. KNOX: Objection.

4 A-- not familiar to me, I have no --

5 MS. GODFREY: I mean, and -- and what's this got to do  
6 with what he testified to on -- in his -- in his original  
7 testimony?

8 MR. MANSFIELD: Madam President, he testified about  
9 participating in the process and I just have a few  
10 preliminary questions about what he did in the process  
11 and then I'll get to the point.

12 MR. KNOX: How can that be relevant to what's going on  
13 it with this today.

14 PRESIDENT RHYNE: He's the one that brought it up that  
15 he testified.

16 MR. MANSFIELD: He brought it up.

17 MR. KNOX: I understand, but then you wouldn't let us show  
18 that there was retribution as a result of it.

19 PRESIDENT RHYNE: I beg your pardon.

20 MR. MANSFIELD: Well, I don't have any questions -- well,  
21 I'm not -- my questions are limited to his testimony about  
22 his participation and his personal knowledge of what  
23 happened with the legislature.

1           PRESIDENT RHYNE:  Go ahead and proceed.  He's the one that  
2           brought it up when he testified.

3   Q (By Mr. Mansfield)  Did you ever make any suggestions to anyone  
4           involved in the process of House Bill 886 regarding  
5           concepts or particular language that you -- you thought  
6           should be added to the Medical Practice Act?

7   A Mr. Mansfield, all I remember is that you and Mr. Henderson  
8           came in and slouched in a chair to show intimidation with  
9           13 members of the Medical Board and the North Carolina  
10          Medical Society.

11          And you had no interest in talking to me after the public --  
12          the -- the public hearing -- excuse me, the press conference  
13          and then immediately you all wanted to talk to me.

14          I was also essentially threatened by the North Carolina  
15          Medical Society attorney who told me that, why don't you  
16          be a smart boy and not testify because, one, you know you're  
17          not going to change the law; and, two, you know it's only  
18          going to make it difficult for you to practice medicine  
19          in the state of North Carolina.

20          I also know that two weeks after I testified I was given --  
21          I was delivered a registered letter while I was talking  
22          to Mr. Henderson on the phone and that the --

23   MR. MANSFIELD:  Madame President, I apologize for



1 interrupting the witness, but my question is whether he  
2 made any suggestions to anybody about the concepts or  
3 language that should be added to the Medical Practice Act.

4 And this -- I apologize -- apologize that if this is by  
5 way of explanation of his suggestions or concepts --

6 PRESIDENT RHYNE: Just answer his question.

7 AI don't -- you're asking me a question, ma'am -- he's asking  
8 me a question that I can only tell him what I remember.

9 I remember having conversations with you sitting at a  
10 table with a number of other people.

11 QOkay.

12 AI remember that.

13 QThat's when you made suggestions to me about what ought to  
14 change in the Medical Practice Act?

15 AI remember you asking me that there were certain things that  
16 were being proposed that may not be fair because you gave  
17 me an example that if a doctor cuts off the wrong leg,  
18 it's not fair that he be -- he be allowed to practice for  
19 another six months without the ability of the Medical Board  
20 to intervene and I agreed with that and we changed that  
21 language. I remember that.

22 I cannot specifically remember what you just asked me  
23 because I don't remember that, but I do remember having

1           conversations with you one-on-one and among -- with a  
2           number of other members of the North Carolina Medical  
3           Society and the North Carolina Medical Board.

4    QOkay. Before you testified to the General Assembly about House  
5           Bill 886, did you read it?

6    AOf course, we read it. We came up with certain language --  
7           and when I say we, I'm talking about the members of the  
8           North Carolina Integrative Medical Society as well as our  
9           lobbyists and there were certain changes that were -- that  
10          were proposed and that were made and it went back and forth  
11          and it's like a Mexican bizarre with people negotiating,  
12          but that's --

13   QOkay. Thank -- thank you, that's precisely.

14          MR. MANSFIELD: Madame President, I'd like to ask the Court  
15          Reporter to mark a document as the next numbered exhibit  
16          for the Board.

17          MR. JIMISON: 26.

18          MR. MANSFIELD: Exhibit 26. Would you --

19          MS. GODFREY: Can we see a copy of what you're marking,  
20          please?

21          MR. MANSFIELD: Yes.

22          MR. KNOX: May we just have a chance to look at it?

23          MR. MANSFIELD: Sure, absolutely.

1 MR. JIMISON: You can keep that one, Dr. Buttar, and I'll  
2 hand it up to the Board Members.

3 MR. KNOX: Which section are you talking about?

4 MR. MANSFIELD: Have you had a chance to take a look, Mr.  
5 Knox and Ms. Godfrey?

6 MR. KNOX: Well, can you tell me which section? It's a  
7 pretty broad five-page document to review in 30 seconds.

8 QDr. Buttar --

9 MS. GODFREY: Excuse me, do you have the section that you  
10 want us to review?

11 MR. MANSFIELD: I have some questions for the witness  
12 actually, Madame President, if I might be permitted to --

13 PRESIDENT RHYNE: Proceed.

14 MR. MANSFIELD: -- whenever you're ready.

15 MR. KNOX: Again, we're going to object to the record to  
16 the relevance of this to about three cases.

17 PRESIDENT RHYNE: Go ahead.

18 Q(By Mr. Mansfield) Dr. Buttar, can you identify the document  
19 that's been marked and it's marked as Exhibit 26. Can  
20 you look at the first page of that and tell me what that  
21 is?

22 AI can only read to you what it says. I don't recognize it,  
23 I don't remember ever seeing anything like this, but it

1 says General Assembly of North Carolina, Session 20 --  
2 2003 House Draft, 70244, which was not the bill that we  
3 proposed.

4 QDo you see a short title for this bill?

5 AI do not. Where would that be?

6 QDid you testify previously today that you participated in the  
7 passage of a bill called Due Process for Physicians?

8 AYes.

9 QAnd do you see that phrase on the first page of this document?

10 AI don't. Where would I -- oh, I see a short title, yes, I'm  
11 sorry, yes.

12 QThank you. And -- and just to get back to where we were a  
13 minute ago, I asked you already whether you read this before  
14 you testified at the General Assembly and you said, yes,  
15 correct?

16 AI don't remember reading anything like this. We had a specific  
17 component that we had. It was one paragraph that had been  
18 submitted and that had been changed, but I don't remember  
19 ever seeing this whole thing, no.

20 QOkay. Well, then let me direct you to some particular language  
21 and ask you if you remember that language. It's on page  
22 3 of this document and you'll see that there are line  
23 numbers on this down the side.

1 AYes.

2 QAnd at line 34 there's some underlying language and I would  
3 ask you to read out loud that underlying language beginning  
4 at line 34 down to -- to the end of the page, please.

5 AFrom -- starting from line 34 you said?

6 QYes, sir. The standards of --

7 MS. GODFREY: Well --

8 MR. KNOX: Objection.

9 MS. GODFREY: We're going to object to this. I mean, he  
10 says he does not remember this particular document and  
11 I think it's unfair to have him -- to cross-examine him  
12 about it if he doesn't remember the document or remember --

13 WITNESS: I've never seen this document. I just remember  
14 one paragraph. It's about integrative medicine.

15 MR. MANSFIELD: Madame President, I'd like to direct him  
16 to some language and ask him if that compares to the  
17 paragraph that he was referring to.

18 PRESIDENT RHYNE: Proceed.

19 Q(By Mr. Mansfield) So it's for the purpose of some of your  
20 attorneys and some of the Board Members, if you could read  
21 that language and then -- but I can make my question two  
22 parts. I'm asking you if this is the language that you  
23 were talking about, the paragraph that you were interested

1 in?

2 AIt's beginning at 34 you said?

3 QYes, sir. The standards of practice in any specialty, yeah.

4 AMine says: Such license may appear personally and through  
5 counsel, may cross-examine the witness.

6 What page are we on? A number of the page.

7 QPage -- page 3, and by that I mean the numbered page 3.

8 AOh, the number of the page, I'm sorry.

9 QI'm sorry. It's a two-sided copy.

10 AGotcha.

11 QSo the lower right-hand corner will say page 3 and at line  
12 34 on the right-hand side there's some underlying language  
13 that begins with the standards of practice.

14 ARight. The standards of practice in any specialty, including  
15 complimentary treatments, shall be defined by specialists  
16 in that field. Continue?

17 QPlease.

18 AThe Board shall not annul, suspend, revoke the license of or  
19 deny a license to a -- to a person -- to -- to any person,  
20 harass, or initiate an investigation solely because of  
21 that person's practice of a therapy that is experimental,  
22 nontraditional, or that departs from acceptable and  
23 prevailing medical practices unless, by a preponderance

1 of the evidence, the Board can establish that the treatment  
2 has a safety risk of harm to the patient greater than the  
3 prevailing treatment or that the treatment is generally  
4 not effective -- as effective in comparison to the  
5 effective rates of other prevailing treatments.

6 QDr. Buttar, is that language the same or similar to the  
7 paragraph you were referring to before?

8 AYes, Mr. Mansfield, it is.

9 QOkay. Thank you.

10 Let me also direct your attention to the preceding page,  
11 page 2. In the lower left-hand corner of page 2 at line  
12 28, the underlying language and we can just give everybody  
13 a chance to read it. You can read it silently, if you  
14 like or you can read it out loud, and I would like to ask  
15 you again if this is some of the language in the paragraph  
16 that you were referring to that you wished to be added  
17 to the Medical Practice Act.

18 AIf this is the language, it certainly wasn't adhered to in  
19 my case this time, was it?

20 QWell, is that language similar to or the same as the paragraph  
21 you were referring to earlier?

22 AI actually don't remember this being part of it, but I think  
23 it's good it's in there.

1 QOkay. Then let me go back to your testimony to the General  
2 Assembly. Is it fair to say that when you testified you  
3 were testifying in support of the notions and the language  
4 you read on page 3 from line 34 and forward?

5 MR. KNOX: Object again to the relevance.

6 PRESIDENT RHYNE: Madame President, it was Dr. Buttar and  
7 his counsel who repeatedly said that the -- his conduct  
8 is to be judged by the standard that's reflected in this  
9 language.

10 WITNESS: Mr. Mansfield, if I may --

11 MR. MANSFIELD: Sure.

12 WITNESS: -- it also --

13 MR. KNOX: Objection. I don't want you do that, I'm  
14 objecting for the record, just for the record.

15 PRESIDENT RHYNE: Okay. Okay. Objections noted. Go  
16 ahead and proceed.

17 AIt says that the power of the Board to subpoena is limited  
18 to persons with knowledge related to a matter before the  
19 Board and yet of these four cases brought against me, three  
20 of them were all hearsay and yet it's in the Board and  
21 yet it was complaints against me of people that lied and  
22 said that they were there when they had never even been  
23 there. Three people, so I'm -- I'm sorry.



1 QNo, I'm sorry. I was just going to make sure I understood  
2 the language you're talking about. You're talking about  
3 the page 2 again at line 28, correct?

4 AYes, sir.

5 QOkay. Those most recent comments you made about that language?

6 AYes, sir.

7 QThank you. And so when you -- my question before was when  
8 you -- when Mr. Knox objected was when you testified for  
9 the General Assembly, isn't it true that you testified  
10 in support of the provisions on page 3 again at line 34?

11 AYes, sir, it is. It was for due process and I believe that  
12 was part of the due process.

13 QCertainly. And after you testified to the General Assembly  
14 about this language that you had seen then as previous --  
15 we've previously referred to as the paragraph similar or  
16 the same as this language, did you continue to follow the  
17 progress of House Bill 886 through the summer?

18 MR. KNOX: Objection to relevance. And I know you can  
19 go on, but I want to note this for the record, but go ahead.

20 AI think I mentioned, Mr. Mansfield, that the -- the internal  
21 price freedom is constant vigilance and I believe we  
22 dropped the ball on that one.

23 QWell, my question was, did you visit the General Assembly during

1 the summer?

2 AThat summer?

3 QYes, sir, 2003 after you testified about the bill.

4 AI -- I came to the Assembly twice, two days in a row both in  
5 April, both back to back and I never came to the Assembly  
6 again. I came on -- the day that I came was I think whatever  
7 date you said, that I had to come back the next day because  
8 I had -- I was supposedly invited, but they didn't hear  
9 me and then after my press conference one of the state  
10 representatives insisted that I be there and they adjourned  
11 at -- they stopped everything at 10:00 the following day  
12 and they heard my testimony, but I had never been -- I've  
13 never been back to the Legislature after that.

14 QYou testified previously that after you testified the bill  
15 passed the House.

16 AYes, sir.

17 QAnd did you have any occasion to review the bill or language  
18 in the bill at any point in time after it passed the House?

19 MR. KNOX: Objection, relevance.

20 AI am not certain that we did. Again, as I said, we were a  
21 little overwhelmed with the fact that we passed this bill  
22 so fast. We had a lobbyist that was looking at this.  
23 I know that it was changed when it went on and I think

1 the Senate voted on it sometime in December, but I was  
2 not there and I am not aware of what the wording was.  
3 I know the wording has changed since then, like last year  
4 or two years ago, but this original I'm not aware of what  
5 happened with that. I wasn't directly -- I'm the president  
6 of the society, but there were other doctors involved with  
7 it. There were lobbyists and other administrative people  
8 that were involved with it.

9 So the question you're asking, I'm sorry, but I don't --  
10 I can't -- I can't give you an exact time because I don't  
11 remember.

12 QI'm sorry, just so I'm clear, are you saying that you never  
13 again read a version of the bill after you read whatever  
14 you read in preparation for your testimony?

15 AWe submitted language that we wanted and it was --

16 MS. GODFREY: Objection.

17 A-- there was something that you had -- you guys wanted us to  
18 consider, I think because you guys knew that we had the  
19 ear of the Legislature at that point.

20 I even had Dr. Kanof call me at home to make sure I got  
21 home that night which was very interesting. There was  
22 all of a sudden a lot of interest in my well-being and  
23 I appreciate that.

1 And I just remember that the language that we had originally  
2 submitted and that the rest of the group that we had  
3 discussed with had been negotiated down to a certain  
4 amount, but what -- what happened with it subsequent to  
5 that date, I cannot remember.

6 I do know it was changed. There were some words that were  
7 taken in and out. There were some other doctors that were  
8 looking at it closer than I was, doctors that are here  
9 in Raleigh that I'm not and that's all I can tell you.  
10 But I'm -- I did not come up again after April whatever  
11 it was.

12 QOkay.

13 MR. MANSFIELD: Madame President, I'd like to ask the Court  
14 Reporter to mark another document as Exhibit 27. And,  
15 Marcus, I'm going to hand you two copies so Mr. Knox and  
16 Ms. Godfrey --

17 PRESIDENT RHYNE: Yeah. Mr. Mansfield, do you have copies  
18 for us.

19 MR. MANSFIELD: And I have copies also for you, Madame  
20 President.

21 PRESIDENT RHYNE: And you said this would be ten minutes.

22 MR. MANSFIELD: Oh, I'm sorry, this -- I'm really almost  
23 done.

1 Q(By Mr. Mansfield) I'll be very quick about this, Dr. Buttar.  
2 You're -- you're now looking at what's been marked Exhibit  
3 Number 27 and I would ask you to take a moment to look  
4 at that and tell me whether you have read the contents  
5 of this document previously and I'm particularly  
6 interested in page -- what's numbered page 2, so the back  
7 side of the first piece of paper. Have you ever read  
8 this -- this document or the language in Section 2 or  
9 Section 4 on page 2?  
10 MR. KNOX: Object to the relevance.  
11 AThe 90-2.1 where integrative medicine is defined, I'm familiar  
12 with that, yes, sir. And what was the next section, I'm  
13 sorry?  
14 QSection 4.  
15 AI -- I think that sounds familiar, yes.  
16 QOkay. Dr. Buttar, are you aware of whether the language --  
17 I'm sorry, I'm jumping back and forth from the documents.  
18 I'm now going to ask you a question about Exhibit 26.  
19 Are you --  
20 AIIs it the first one?  
21 QYes, sir. Do you still have a copy of that?  
22 AYes, sir, I do.  
23 QAnd I'm going to direct your attention back to page 3 again

1 beginning at line 34. Are you aware of whether that  
2 language that I had you read out loud a little earlier  
3 and that you said was the same or similar to your paragraph,  
4 are you aware whether that language was removed from the  
5 bill prior to the time it was passed into law?

6 MR. KNOX: Objection.

7 MS. GODFREY: Objection. And he says he's not been to  
8 the Legislature since April.

9 MR. MANSFIELD: Madame President, he doesn't have to go  
10 to the Legislature to be aware of whether the language  
11 was taken out. And he's testified as to continuing  
12 activities, monitoring -- he remained vigilant and if he --  
13 if he's not aware, that's fine, I'm just asking.

14 AWe were not vigilant, that's what I said. That was our fault.

15  
16 Could you -- I'm not quite sure what you're asking. Are  
17 you saying that line 34 on the first document on page 3 --

18 QYes.

19 A-- whether that's been taken out.

20 QThat language. My question was, that language that you  
21 supported in your testimony, are you aware of whether that  
22 language was removed from the bill such that by the time  
23 it passed into law as you described that that language

1 was no longer in the bill?

2 MR. KNOX: Objection.

3 AI was not aware that it had changed out significantly, but  
4 obviously it has. I know -- as I said before when you  
5 asked me, I knew that it had been changed.

6 MR. MANSFIELD: Madame President, I would like to offer  
7 into evidence Exhibits 26 and 27 and I don't have any more  
8 questions for Dr. Buttar although there may be some  
9 cross-examination.

10 PRESIDENT RHYNE: Do you want to cross-examine?

11 MS. GODFREY: Well, we're going to object to these being  
12 offered into evidence. I wasn't aware that we were going  
13 to be -- I think this is what they call legislative history  
14 and it's used by -- sometimes by courts to -- to look at  
15 the law as it -- as it evolved, but I don't think it's  
16 given a lot of weight because the law is what the final  
17 law is.

18 And I don't think that what the House did and what the  
19 Senate did and what language went in and out has a lot  
20 to do with what we're about today.

21 And I -- and, again, I know of no relevance of this to  
22 this proceeding that is under, as I understand it, the  
23 law as it was finally enacted. Your Honor, I'm sorry,

1 Dr. Rhyne, it's getting late. But -- but again, I'm just  
2 not seeing any relevance to -- oh, to -- to what we're  
3 about today which is what happened in Patients A, B, C  
4 and D and whether or not if the Board should take any action  
5 against Dr. Buttar based on his treatment of those  
6 patients.

7 That's what we're here about today, not about what happened  
8 in the Legislature.

9 MR. MANSFIELD: Madame President, if I may respond if Ms.  
10 Godfrey is through.

11 The standard for admission into evidence first -- first  
12 is that something must be relevant. It's -- this is  
13 relevant because I've asked Dr. Buttar about facts related  
14 to these documents and the questions I asked were based  
15 on his previous testimony in which he made statements  
16 including that he was involved in the process, that he  
17 testified to the Legislature, that he gave a press  
18 conference.

19 And he testified that to the effect of, and I'm not quoting,  
20 but to the effect of that the Medical Board was targeting  
21 him and other integrative physicians unfairly and that  
22 he was at the Legislature trying to change the Medical  
23 Practice Act in order to protect practitioners like himself



1 and including himself.

2 Also, in his -- his case, both in defending against our  
3 expert witness and in presenting their own expert  
4 witnesses, Dr. Buttar and his counsel repeatedly indicated  
5 that this Board must judge his conduct by the standard  
6 of an integrative medicine physician. And Dr. Buttar  
7 explains why that was so, because he went to the Legislature  
8 and worked to change the law.

9 So I've asked him questions about facts when I -- and I  
10 would modify my motion to say with regard to Exhibit 26,  
11 I would like to move into evidence the portion that --  
12 that if you wish to exclude some part of this document,  
13 I would move into evidence the portions that Dr. Buttar  
14 just testified about with regard to the language that he  
15 recognizes that were changes that he himself sought and  
16 testified about to the Legislature.

17 And with that explanation, I would again ask that Exhibits  
18 26 and 27 be admitted into evidence.

19 MR. KNOX: Again, we again object. Now, he said he's got  
20 a whole document and would like for you to decide which  
21 part you're going to accept in the last hour. They really  
22 have not introduced this until today at the closing. The  
23 exhibits should have been handed out earlier when we had

1 the conference when they were exchanged and it's not  
2 relevant to this case.

3 PRESIDENT RHYNE: Can I have the attorneys approach  
4 please?

5 MR. KNOX: Yeah.

6 **(BENCH CONFERENCE)**

7 PRESIDENT RHYNE: I think we need to -- we're going to  
8 take a ten minute break and we're going to start with  
9 closing arguments. In fact, do you want to make it five  
10 minutes, Mr. Knox?

11 MR. KNOX: Whatever you say, you're the -- you're the head  
12 doctor.

13 PRESIDENT RHYNE: Okay.

14

15 (6:03 P.M. - 6:10 P.M. RECESS)

16

17 PRESIDENT RHYNE: Okay. Mr. Knox or Ms. Godfrey, would  
18 you like to make a closing statement?

19 MS. GODFREY: I will.

20 PRESIDENT RHYNE: Please proceed.

21 **CLOSING STATEMENT BY MS. GODFREY:**

22 I want to tell you a couple of things I'm not going to  
23 talk about first of all. I'm not going to try to talk

1 to you about medical ethics. I -- I'm a lawyer, I have  
2 been trained as a lawyer. I'm not going to try to tell  
3 doctors how to interpret the medical ethics.

4 I'm also not going to give a jury speech. You all aren't  
5 a jury. You're the findings of fact that have specialized  
6 training in this arena. And while I want to convey to  
7 you that Dr. Buttar's case is, I think, very plain here.

8 I'm not going to strive to do anything like that because  
9 this is not the proper forum for that.

10 I do want to talk about this issue that Mr. Mansfield has  
11 brought before you and I brought before you about what  
12 is the standard of care because I think -- I think that's  
13 really what we're looking at here, whether or not Dr. Buttar  
14 violated the standard of care. And the question is, what  
15 is the standard of care?

16 There's a whole lot of law in that area in the medical  
17 malpractice field. And I will tell you having  
18 participated in some of those cases, that the standard  
19 of care is very specific in the law of North Carolina,  
20 in the case law of North Carolina. The standard of care  
21 is determined by a practitioners in the same or similar  
22 specialty.

23 And the reason for that in the medical malpractice arena

1 is because it would be grossly unfair to hold a general  
2 practitioner or family doctor with a doctor that practices  
3 with a broad range of patients and conditions to the same  
4 standards as a specialist. And that is what I argue to  
5 you the standard of care is in this case.

6 Now, I want to go back a little bit and talk about history.

7 Marcus -- Mr. Jimison handed up to you the George Guess  
8 case and that is the only case I know of that has come  
9 through to interpret anything about the Medical Practice  
10 Act.

11 For whatever reason, cases since then have not reached  
12 the appellate levels necessary to generate published  
13 opinions. They may have gone to a Superior Court judge,  
14 but Superior Court judge's opinions are not published and  
15 are not precedent. The only legal precedent in -- in this  
16 area is the George Guess case which ended up in the Supreme  
17 Court in the year 1990.

18 And Mr. Jimison has argued to you that this case is --  
19 that it stands for the fact that there is only one standard  
20 of care by which we judge medical providers and it's the  
21 same standard of care no matter what kind of doctor you  
22 are.

23 The facts of the Guess case are that Dr. Guess was a family

1 practitioner that also practiced, I guess, in the late  
2 eighties, homeopathic medicine. And the evidence was that  
3 he was the only homeopathic practitioner that was licensed  
4 by the Medical Board in North Carolina at that time. I  
5 don't know if it's true, but that's what the -- that's  
6 what the case says.

7 And because Dr. Guess was practicing homeopathic medicine  
8 that was not practiced by any other medical practitioners  
9 at that time, it was held that he practiced below the  
10 standard of care and for that reason his license was taken  
11 away.

12 It went back and forth through the courts and the issue --  
13 the burning issue was not, is there more than one standard  
14 of care. That wasn't even discussed.

15 What was discussed is whether or not the Medical Board  
16 in order to take Dr. Guess's license had to show harm.  
17 And the Medical Board made a specific finding that there  
18 was no harm to Dr. Guess's patients. They took his medical  
19 license anyway and in the earlier appeals to the Superior  
20 Court and the Court of Appeals, they reversed that  
21 decision. They said that we feel like you have to show  
22 harm.

23 And it got up to the Supreme Court and the Supreme Court

1 said, no, the Medical Board can take away a practitioner's  
2 license if they find it's below the standard of care whether  
3 or not any patient is harmed.

4 Now, that was a controversial decision and there was a  
5 very strong dissent and the dissent was written by Justice  
6 Frye. And in that dissent he argued very strenuously for  
7 the opposite position. That's what we lawyers do,  
8 there's -- there's always two sides to every case and even  
9 in the Supreme Court of this state, there's two sides to  
10 every case.

11 And Justice Frye said that clearly the public policy of  
12 the state was to protect patients. If Dr. Guess was --  
13 was the only homeopathic person -- practitioner in the  
14 state, there was nobody to compare him to any other  
15 homeopathic practitioner and so therefore on that basis  
16 hold that he was below the standard of care when no showing  
17 of patient harm was brought.

18 And he went on to say that the majority of the evidence  
19 of the legitimacy of homeopathy in other states and  
20 countries throughout the world as being irrelevant because  
21 homeopathy is not a currently accepted -- accepted and  
22 prevailing system of medical practice in North Carolina.  
23 This raises the legitimate question of how the acceptable

1 and prevailing practice can be improved in North Carolina,  
2 if we do not even consider what happens in other states,  
3 so Dr. -- Justice Frye raised the question.

4 And there was some change to the Medical Practice Act in  
5 2003 that at least attempted to address and answer this  
6 question.

7 First of all, I want to go through some specific changes  
8 that are in the final statute, not in the draft that you  
9 have, but in the final statute and which are the law of  
10 North Carolina.

11 As we stated, but I want to emphasize, in 90-1.13 a  
12 definition was added recognizing that integrative medicine  
13 was a diagnostic or therapeutic treatment that may not  
14 be considered a conventionally accepted medical treatment.

15 And a licensed physician in that position -- and that  
16 a licensed physician in the physician's professional  
17 opinion believes maybe a potential benefit to a patient,  
18 so long as the treatment poses no greater risk of harm  
19 to the patient than other comparable -- than the comparable  
20 conventional treatments. I'm sorry I'm having trouble  
21 reading this.

22 That was a change in the law that addresses the question  
23 of Dr. Guess's case, thirteen years later. And it

1 recognizes that there can be an integrative practice of  
2 medicine in North Carolina and you don't have to prove  
3 that every other doctor considers these practices, you  
4 know, or uses -- uses the practices in their practices  
5 or considers them, you know, opposites.

6 What is says is that you can depart from the conventionally  
7 accepted -- accepted medical treatment and still practice  
8 integrative medicine in the state of North Carolina.

9 That's critical here.

10 Now, we've also looked at the change in 90-14(a)(6) and  
11 90-14 is the disciplinary authority of the Board and those  
12 are the 13 or -- no, I'm sorry, 15 things -- I guess it's  
13 actually 16 because there are to 11(a), things that this --  
14 this Board can discipline a physician for.

15 And Dr. Buttar has been charged under two of these. It's  
16 subsection 6 which is unprofessional conduct and subset --  
17 subsection 12 which is exploitation of patients. So that  
18 is the law that you are considering in this case, whether  
19 or not he has violated either one of these provisions.

20 The definition is unprofessional conduct including, but  
21 not limited to, a departure from or failure to conform  
22 to the standards of a acceptable and prevailing medical  
23 practice or the ethics of the medical profession



1           irrespective of whether or not a patient is injured thereby  
2           or committing any act contrary to honesty, justice, good  
3           morals, whether the same is committed in the course of  
4           the physician's practice or otherwise, and whether or not  
5           committed in the state of North Carolina.

6           That sentence must be read in the context of the entire  
7           statute. And when the Legislature added the provision  
8           that recognized integrative law -- integrative medicine,  
9           it specifically defined integrative medicine as a  
10          departure from the conventionally accepted medical  
11          treatment.

12          What do you do? How do you -- how do you make those two  
13          statutes go together? I submit to you, Doctors, that what  
14          you have to do is import the law that's well established  
15          in the state of North Carolina in the medical malpractice  
16          arena that says when a physician is judged, he or she should  
17          be judged by people in their own field of practice.

18          And I have some more evidence that I think the Legislature  
19          meant that when they -- when they made this change to the  
20          law.

21          If you will look at 90-14.6(b), I believe that was a change  
22          that was made at the same time in 2003. This is a section  
23          that deals with the evidence admissible at this hearing.

1  
2 (b) says: Subject to the North Carolina Rules of Civil  
3 Procedure and Rules of Evidence in proceedings held  
4 pursuant to this article, the individual under  
5 investigation may call witnesses including medical  
6 practitioners licensed in the United States with training  
7 and experience in the same field of practice as the  
8 individual under investigation and familiar with the  
9 standard of care among members of the same healthcare  
10 profession in North Carolina.

11 The evidence to be considered by the Board that can be  
12 presented by these -- the practitioner under investigation  
13 is members in the same field of practice.

14 What we have presented to you today or today and yesterday  
15 is evidence from an integrative medicine doctor, Dr.  
16 Wilson, and an oncologist who also practices integrative  
17 medicine. They both testified that Dr. Buttar met the  
18 standard of care for a doctor practicing integrative  
19 medicine in the state of North Carolina in -- in the  
20 treatment of these patients.

21 The question is, is Dr. Buttar held to the standard of  
22 an oncologist when he is clearly not an oncologist or is  
23 Dr. Buttar held to the standard of care of a doctor

1 practicing integrative medicine?

2 And I argue very strenuously that the latter should apply  
3 based on the language -- on the clear language in the  
4 statute and the laws of North Carolina as it has defined  
5 the standard of care and based on fundamental fairness.  
6 Again, the whole idea of the standard of care is that we  
7 do not judge a family practitioner by the standards of  
8 a neurosurgeon by diagnosis or treatment or anything else.

9 And you can say they look at different conditions, but  
10 so many times doctors who are in more general fields, like  
11 you Dr. Rhyne, or an internist or a family practice doctor,  
12 see a wide variety of conditions. And should doctors in  
13 the more general fields like Dr. Buttar who is an  
14 integrative medicine be held to the same standard of care  
15 as a specialist. Is that fair? We believe not.

16 Finally, and I don't want to overlook this, another section  
17 was added that I need you to turn back -- and I hope you're  
18 following with me on the numbers, it's 90-14 again,  
19 subsection (g). That section was also added in 2003.  
20 Again, I think a lot in reaction to the Guess case.  
21 And that section says: Prior to taking action against  
22 any licensee who practices integrative medicine for  
23 providing care not in accordance with the standards of

1 practice with procedures or treatments administered, the  
2 Board shall consult with a licensee who practices  
3 integrative medicine.

4 Well, we brought that -- those people to you in this  
5 hearing. And what they have told you is that Dr. Buttar  
6 has met the standard of care.

7 Now, again, the Legislature has carved out and it's not  
8 put integrative medicine doctors in a -- in a special  
9 category, but again they did. Because I think in reactions  
10 to the Guess case saying that there's conventional medicine  
11 and then there is alternative medicine and that's clearly  
12 recognized here, the right to practice integrative  
13 medicine is clearly recognized here. We don't have, you  
14 know, Dr. Guess being run out of town because there were  
15 no other homeopaths by which to judge him.

16 The Legislature has mandated that you do recognize this  
17 and that -- and we say that the law should be interpreted  
18 that you judge Dr. Buttar by the standards of a doctor  
19 practicing integrative medicine.

20 Now, we brought you the testimony of Dr. Buttar himself  
21 to directly answer the criticism of Dr. Peterson and  
22 it's -- it's pretty fundamental here. For conventional  
23 medicine oncology, no more treatment was available for

1 these patients. They had all been refused treatment as  
2 many patients that Dr. Buttar treats.

3 And if you judge him by the conventional standards, he  
4 should turn every patient away. He couldn't practice  
5 alternative medicine. But he sees medicine differently  
6 from the conventional practice of medicine and sees  
7 alternative medicine, I'm sure, differently from the way  
8 you practice medicine. He believes in different therapies  
9 and different theories of disease.

10 And, again, no area of science has a monopoly on truth.

11 I mean, if there's any example of that, it's the debate  
12 about will the climate change in global warming. You can  
13 find just as many good science -- scientists on either  
14 side of that debate no matter which side you are for.  
15 Does that mean, you know, there's -- there's one side that  
16 should be prevalence over another? We don't know yet.  
17 And that's how science progresses because some people think  
18 that things should be done differently. Sometimes they're  
19 right, and sometimes they're wrong, but they have the right  
20 to disagree with the established belief. That's how  
21 science progresses.

22 And we say that Dr. Buttar has that right and we believe  
23 his patients have that right to get alternative treatments.

1           Again, I'm not going to rehash the medical evidence for  
2 you because you can see that yourself if you saw the many  
3 patients that he has helped and the various patients that  
4 believe in his treatment, believe they were helped by him.  
5 You met Dr. Buttar, he's not a snake oil salesman. He's  
6 not, as Justice Frye put it, this is not the case of a  
7 quack yelling in the public, but a dedicated physician  
8 seeking to find new ways to relieve human suffering.  
9 That's a quote from the Guess case and I think it's  
10 applicable here.

11          Dr. Buttar is a sincere, passionate individual who sees  
12 things I'm sure differently than you do in the practice  
13 of medicine. But the question is, are any of his patients  
14 harmed by his treatments? Are some of them helped? Well,  
15 you've seen evidence of that. You've heard it from him,  
16 you've seen it from the patients themselves.

17          And does he have the right and do his patients have the  
18 right to his treatment, his care? Even Dr. Peterson has  
19 to admit that in the four patient charts that he reviewed  
20 in the two hours that he reviewed them, that he could not  
21 see any physical harm to the patients.

22          The last thing I want to do is urge you to keep your decision  
23 here confined to the complaints that were before the Board,

1 Patients A, B, C and D.  
2 We've heard a lot about Patient E, that complaint is not  
3 part of these proceedings. Mr. Jimison opened the door  
4 with that by saying I want to show a pattern of practice  
5 here, but what I really think is that when he decided not  
6 to call Patient D, the complaining witness in Patient D --  
7 for whatever reason he decided not to call them, that he  
8 wanted some other evidence to put before the Board.  
9 But what you have to remember is the charges here have  
10 nothing to do with Patient E. We've had no opportunity  
11 to investigate any charges for Patient E and more  
12 importantly the complaint that's brought before you  
13 doesn't include Patient E in this case, that's for another  
14 day.  
15 And the question here is, in cases of Patient A, B and  
16 C, and to the extent that you want to consider Patient  
17 D, who I think really has sort of been abandoned by --  
18 by the Board, did Dr. Buttar meet the standards of care  
19 for an integrative medicine doctor practicing medicine  
20 in the state of North Carolina for the relative periods.  
21 Patient A, B and C were cancer patients who had been turned  
22 away by conventional medicine. They were not roped into  
23 Dr. Buttar's practice with any kind of advertising, he

1           tried to be honest with them, he told -- he never made  
2           any promises to them except that he would try to help them.

3           With what he has seen through -- treatments that he has  
4           seen empirical evidence that this practice and the practice  
5           of practitioners in the alternative medicine are  
6           successful with some patients.

7           With regard to Patient A, there was not one family member  
8           that was upset with Dr. Buttar. Not one family member.

9           Dr. Herman, the person who did file the complaint, while  
10          she may have been very well intentioned, I think she files  
11          her complaint based on her interpretation of what was going  
12          on through somebody else's mouth.

13          And what's amazing to me is, she had an employee with a  
14          mother who had been her patient, the patient was dying  
15          of cancer. She was hearing things that apparently  
16          disturbed her about the treatment of this patient and she  
17          did not even go to see her and she was home on the weekends.

18          She didn't go to see her, didn't go to see her family,  
19          didn't go to see -- go to check anything out firsthand.  
20          Patient A wanted to be treated even when Dr. Buttar and  
21          his nurse felt that this really wasn't going to help her.

22          Patient A wanted to continue treatment and it was their  
23          clinical judgment to honor her wishes. Just like Ripoll



1 said, when we're dying you don't have very many things  
2 you can control, but one of the things you can control  
3 is whether or not to be treated and how you're treated.

4 Is that wrong?

5 Again, no complaint from Patient A's family even -- you  
6 know, they've had two years there to look back and to think  
7 about it. Had to subpoena her daughter to be here. The  
8 daughter did not want to be involved.

9 Patient B, the complaint -- again, we heard Patient B had  
10 a daughter that she loved very much apparently according  
11 to the testimony. She was the sole heir of the estate.

12 As we hear it -- do we even see Patient B's daughter here  
13 complaining? Do we see anybody who is on the scene with  
14 Patient B complaining? No. The complaint comes from a  
15 nephew in Los Angeles who was not here at all when Patient  
16 B was being treated.

17 Did the Medical Board go out and find any firsthand  
18 witnesses that were over here when Patient B was being  
19 treated, the fiance we've heard so much about? No. It  
20 all comes in through somebody who through time and distance  
21 really didn't know, really didn't take time to investigate  
22 what was going on with that patient.

23 And, again, Patient B is a different case. It appears

1 that, you know, she really didn't want to do this treatment  
2 after a while and she withdrew from the treatment and that  
3 was fine. She was not a compliant patient and the practice  
4 released her. Nobody tried to rope her in for more therapy  
5 when she wasn't doing what Dr. Buttar said she needed to  
6 do.

7 Finally, Patient C, the complaint was by his wife, but  
8 we've heard a lot of testimony about the dynamics of that  
9 family situation. It's clear that Patient C's wife was  
10 not supportive at all of this treatment while every bit  
11 of evidence you have was that Patient C wanted to pursue  
12 this treatment and indeed other treatments -- other  
13 alternative treatments in Mexico.

14 Patient C, and all of these patients, were intelligent,  
15 informed, capable of making their own treatment decisions.

16 And it was his decision to continue on with Dr. Buttar's  
17 treatment and then to seek other treatment in an effort  
18 to do something to help his -- his disease.

19 Now, finally, you know, a lot has been said about safety  
20 and -- and efficacy. Again, where that comes into play  
21 is if you were to decide that Dr. Buttar practiced below  
22 the standard of care, then if you were to decide that his  
23 license should be taken, you would have to make a finding

1 that the treatments that he gave were either less -- well,  
2 let me -- let me get the statute and I'll read it to you  
3 because I'm not going to try to recall that by memory at  
4 20 minutes till 7.

5 Under 90-14 -- I'm sorry, (6) it says: The Board shall  
6 not revoke the license or deny a license to a person solely  
7 because that practice -- that -- or that person's practice  
8 of a therapy that is experimental, nontraditional, or that  
9 departs from the acceptable and prevailing medical  
10 practices unless by competent evidence, the Board can  
11 establish that the treatment has a safety risk that is  
12 greater than the prevailing treatment or that the treatment  
13 is generally not effective.

14 Okay. And I'm going to go over the issues with you that  
15 we say you should decide. They're not very different than  
16 Mr. Jimison's issues. But the way this works is, if you  
17 make a finding that Dr. Buttar has departed from the  
18 standard of practice and you recommend a disciplinary  
19 measure, if that disciplinary measure were to be a really  
20 -- a patient one, you would have to make a specific finding  
21 of one of these things.

22 Now, I want to ask, rhetorically, suppose Dr. Buttar's  
23 position and Dr. Peterson's positions were reversed and

1 Dr. Peterson as an oncologist were brought before you?  
2 Suppose you were the alternative medical board and Dr.  
3 Peterson who is a conventional practitioner were brought  
4 before you for treating patients with chemotherapy and  
5 that is different from alternative practices. Would Dr.  
6 Peterson's treatment pass this same test?  
7 Would Dr. Peterson's treatments, chemotherapy,  
8 conventional therapy for cancer patients pass the test  
9 that they are -- have the safety risk -- or that they do  
10 not have a safety risk greater than the -- than the  
11 alternative treatment. There's lots of toxic side effects  
12 to the risks to chemotherapy -- it is far more risky than  
13 anything Dr. Buttar is doing.  
14 What about efficacy? Conventional treatments for cancer  
15 were generally effective, there would be no need for  
16 alternative treatments. But the fact is, that's one area  
17 of medical practice that is just in its infancy. And do  
18 we shut off alternative treatments just because they're  
19 different? What we're here to do is seek doctors to treat  
20 and to help patients and, of course, to do no harm.  
21 Can we say at this stage of development of cancer treatments  
22 that conventional medicine offers to a patient a treatment  
23 that is so effective that there's no reason to go to

1 alternative therapies? I think not.

2 I think the General Assembly has specifically recognized  
3 that alternative medicine -- or that integrative medicine  
4 and the alternative medicine part of that should be  
5 recognized in the state of North Carolina by the North  
6 Carolina Medical Board and respected and be judged by the  
7 standards of a doctor practicing integrative medicine,  
8 not by the standards of an oncologist in these cases.

9 Thank you very much for your generous attention. You have  
10 been just amazing in your attention with all the -- all  
11 the medical records and the patients and the witnesses.

12 I thank you very much and so does Dr. Buttar. I know  
13 your decision will be well considered and I ask, as does  
14 Dr. Buttar, that your decision be in favor of him.

15 We have separate -- we have two sets of issues here for  
16 the Board to decide. The only difference between our  
17 issues and Mr. Jimison's issues are that we ask that you  
18 apply a standard of care for a doctor practicing  
19 integrative medicine in the standard of care question.  
20 The issues are attached to the pre-trial stipulation --  
21 pre-hearing stipulation that you all have.

22 Mr. Jimison's issues, I want to make sure I get this  
23 straight, are Exhibit F. Our issues are Exhibit G. They

1 are identical with the exception of the one change in the  
2 first issue.

3 We say the proper question for you to answer is, Did Dr.  
4 Buttar depart from or fail to conform with the standards  
5 of acceptable and prevailing medical practice for a  
6 physician practicing integrative medicine and commit --  
7 and commit unprofessional conduct within the meaning of  
8 the statute.

9 We say the answer to that question should be no.

10 Question 3 is, Did Dr. Buttar provide services to patients  
11 in a manner as to exploit the patient within the meaning  
12 of 90-14(a)(12).

13 And none of these patients were exploited. There's no  
14 evidence of it. We don't even think that's an issue that  
15 should take you very long. You know, they all were fairly  
16 informed of their rights, their abilities to pay or not  
17 pay. There's no exploitation there and we say that should  
18 be answered no.

19 Thank you.

20 PRESIDENT RHYNE: Thank you, Ms. Godfrey.

21 Mr. Jimison, would you like to make a closing statement?

22 MR. JIMISON: Yes, Madame President. And initially I'd  
23 like to hand up what's a Memorandum of Law. Some of the

1 other staff helped to prepare it while I was doing this.

2 And here's a copy to Ms. Godfrey and to the Members of  
3 the Board. I'll be referring to it in my closing remarks.

4 And thanks to Mr. Mansfield for helping us on that issue  
5 with this.

6 **CLOSING STATEMENT BY MR. JIMISON:**

7 I'd like to start off with a point of agreement with Ms.  
8 Godfrey. I do think the Board Members have been amazing  
9 in your attention to this, your patience, your endurance.

10 I know these are not easy things to sit through. And  
11 I know there's been a lot of back and forth and give and  
12 take, and some of it between counsel.

13 And I'd like to again share in agreement with Ms. Godfrey  
14 that -- and because you've not mentioned this, I think  
15 it was implied, the case is not about the lawyers. It's  
16 not about, you know, Ms. Godfrey, it's not about Mr. Knox  
17 or myself. It's about the facts and the evidence and the  
18 law. That's the only thing that matters here: the facts,  
19 the evidence and the law.

20 Some of it's not disputed in the facts. In fact, the court  
21 facts are not disputed at all. There are three patients --  
22 there were four patients charged and I think everyone is  
23 focusing in on the three cancer patients.

1 There are three patients who came in to Dr. Buttar's office  
2 with late stage metastatic cancer. The cancers are of  
3 different types: adrenal, ovarian and cervical. Some  
4 had spread to the liver and the lungs, these people were  
5 dying and they were going to die.

6 There was testimony solicited from this Board that no one --  
7 I don't think there was any patient that Dr. Buttar refused  
8 to treat even though they were at very late stages of their  
9 lives.

10 And the undisputed facts, I think really are shown, if  
11 you step aside instead of backwards is that he  
12 administered -- although they all came with different types  
13 of cancers, he administered a single one-size fits all  
14 therapy, oxygen therapy from hydrogen peroxide to ozone  
15 to hyperbaric chambers, chelation therapy.

16 And the Board Members solicited information -- elicited  
17 information from testimony that 100 percent or close to  
18 a 100 percent, virtually everyone comes in with some metal  
19 toxicity. And the Board pondered whether or not that made  
20 sense.

21 Dr. Peterson testified and I don't think there's any real  
22 disagreement there from listening to Ms. Godfrey's  
23 arguments, it only sounded as though she conceded that



1 these treatments were not within the standard of care of  
2 prevailing and acceptable practice of medicine for the  
3 treatment of cancer in North Carolina.

4 So the argument she made, and she spent most of the time  
5 on, was that this had to be judged by a different standard.

6 That's not the law. It's clearly not the law and I will  
7 turn to that now.

8 When Mr. Mansfield did his rebuttal evidence, he showed  
9 you two pieces of legislation. The first legislation  
10 which was your Exhibit 26 was a proposed bill that  
11 essentially would have said that in order for you -- and  
12 this is 90-14(a)(6) and this is Exhibit 26, page 3. And  
13 this was additional language added to 90-14(a)(6) which  
14 is the charge for which Dr. Buttar is facing today.

15 That in order to find that a doctor departed from  
16 acceptable -- from standards of acceptable and prevailing  
17 medical practice, you had to judge them by the standards  
18 of practice in any specialty, including complimentary  
19 treatment, shall be defined by specialists in that field.

20  
21 And then this is actually very important, too. The next  
22 sentence: The Board shall not -- and you see the underline  
23 -- annul, suspend, revoke the license or deny a license

1 to a person, harass, or initiate an investigation solely  
2 because that person's practice of a therapy that's  
3 experimental, nontraditional or departs from acceptable  
4 standards.

5 That language as was shown on the rebuttal testimony did  
6 not make it to the final version of the bill.

7 The law which has been handed up to and I'll read it from,  
8 you know, the big official book is the following:

9 Unprofessional conduct, including, but not limited to,  
10 departure from, or the failure to conform to, the standards  
11 of acceptable and prevailing medical practice, or the  
12 ethics of the medical profession, and I'll skip some of  
13 this -- well, let me just read it.

14 Unprofessional conduct includes, but not limited to,  
15 departure from, or the failure to conform to, the standards  
16 of acceptable and prevailing medical practice,  
17 irrespective of whether or not a patient is injured  
18 thereby, or the committing of any act contrary to honesty,  
19 justice, or good morals, whether the same is committed  
20 in the course of the physician's practice or otherwise,  
21 and whether committed within or without North Carolina.

22  
23 That law -- that sentence is the exact same law that the

1 Supreme Court upheld in the George Guess case. And we  
2 had an argument yesterday and I know it's been essentially  
3 four days crammed into two, but if I can remind the Board  
4 Members, the North Carolina Supreme Court said we conclude  
5 that the Legislature in enacting 90-14(a)(6) -- the very  
6 statute that is the basis of the charges that is before  
7 you today, and that was considered in this case -- the  
8 Supreme Court said that the Legislature in enacting this  
9 law reasonably believed that a general risk of danger to  
10 public is inherent in any practices -- and any is italicized  
11 and emphasized -- which failed to conform to the standards  
12 of acceptable and prevailing medical practice in North  
13 Carolina.

14 We further conclude that the legislative intent was to  
15 prohibit any practice departing from acceptable and  
16 prevailing medical standards without regard to whether  
17 the particular practice itself could be shown to endanger  
18 the public. Our conclusion is buttressed by the plain  
19 language of the statute which allows the Board to act  
20 against any -- and again they emphasize any -- departure  
21 from acceptable medical practice irrespective of whether  
22 or not a patient is injured thereby.

23 And by authorizing the Medical Board to prevent or punish

1 any -- and again it's emphasized -- medical practice  
2 departing from acceptable and prevailing standards,  
3 irrespective of whether a patient is injured thereby, the  
4 statute works as a regulation which tends to secure the  
5 public generally against the consequences of ignorance  
6 and incapacity as well as deception and fraud, even though  
7 it may not immediately have that direct fact in that  
8 particular case.

9 That was the law when Dr. Guess's case went to the North  
10 Carolina Supreme Court. Dr. Guess was a homeopathic  
11 physician who was practicing beyond the standard of care  
12 for the patients that he was treating, the Medical Board  
13 brought in doctors to say this was not within the standard  
14 of practice. He was saying no -- none of these doctors  
15 are homeopaths, I'm basically the only homeopath doctor  
16 in North Carolina, you have to judge me by homeopathic  
17 standards.

18 And the North Carolina Supreme Court specifically rejected  
19 that -- that interpretation. They specifically rejected  
20 that -- that law or that proposed meaning of the laws.

21 And then when the North Carolina General Assembly  
22 considered changing the law to include some information  
23 about integrative medicine and we had this bill that was

1 proposed which talks about you have to judge them by the  
2 standards of practice in any specialty, including  
3 complimentary treatment, shall be defined by specialists  
4 in that field, the General Assembly specifically rejected  
5 that and did not include it in the law.

6 And also when they added that whether the Board can do  
7 certain discipline against certain doctors if they depart,  
8 they only left in -- they only left in revocation.

9 So when the law was changed to include the next sentence:

10 The Board shall not revoke the license of or deny a license  
11 to a person solely because of that person's practice of  
12 a therapy that is experimental, nontraditional or it  
13 departs from acceptable -- or that departs from acceptable  
14 and prevailing medical practices unless by competent  
15 evidence the Board can establish that the treatment has  
16 a safety risk greater than the prevailing treatment or  
17 that the treatment is generally not effective, they --  
18 they kept that language in and they pinned it to -- they  
19 pinned it to only revocation.

20 And when they actually tried to expand the law to include  
21 other acts of discipline, they specifically refused to  
22 include other acts of discipline. They pinned it solely  
23 to revocation.

1 So in the event you find that Dr. Buttar departed from  
2 acceptable and prevailing medical practices for the  
3 treatment of cancer, and I think it's undisputed that he  
4 did, then the only time this law comes into effect -- the  
5 only time that this law becomes relevant is if the Board  
6 decides it wants to revoke Dr. Buttar's license.

7 And if the Board decides it wants to revoke Dr. Buttar's  
8 license, then and only then, are you required to make a  
9 finding of whether or not the safety risk was greater than  
10 the prevailing treatment or that it was generally  
11 ineffective.

12 I would submit that if you get to that point that you can  
13 actually make the finding that it was generally ineffective  
14 from Dr. Peterson's testimony. The only testimony that  
15 actually went by treatment to treatment, procedure by  
16 procedure, and asked what was the efficacy, the scientific  
17 research based, evidence based efficacies for all these  
18 treatments for cancer and his answer for each and every  
19 one of them was zero.

20 And -- and all the witnesses -- and not just to put it  
21 all on Dr. Peterson -- I think even from the other side  
22 that came to -- when it came to defending these treatments  
23 on the basis of evidence based, scientific research based

1 research regarding clinical trials showing the efficacies  
2 of these treatments to a person, even Dr. Buttar's own  
3 witnesses said there is none, said there is no -- no  
4 acceptable and prevailing recognized scientific evidence  
5 based research showing the efficacies of these treatments.  
6 And I believe the Board elicited testimony about how this  
7 was somewhat putting the cart before the horse, that he's  
8 doing these treatments without having any research, having  
9 had any scientific basis for doing it. He just thinks  
10 it may be good.

11 So I'd now like to return you to the other section of the  
12 statute where in 90-(a), the General Assembly again was  
13 asked to -- and this is on page 2, if you flip back to  
14 page 2 of Exhibit 26.

15 The General Assembly was asked to consider whether or not  
16 medical expert witnesses called by the Board including  
17 medical practitioners licensed in the United States must  
18 routinely and actively practice in the specialty that is  
19 under investigation by the Board.

20 And then it goes on to talk about each party must make  
21 certain disclosures. But the key part of that was the  
22 first sentence I read about the medical expert witnesses  
23 must routinely and actively practice in the specialty that

1 is under investigation by the Board.  
2 Again, they specifically rejected that language. They  
3 specifically rejected that language. And what they ended  
4 up with was 90-14(g) where it says: Prior to taking action  
5 against any licensee who practices integrative medicine  
6 for providing care not in accordance with the standards  
7 of practice for the procedures or treatments administered,  
8 the Board shall consult with a licensee who practices  
9 integrative medicine.

10 That has been done. There has been no argument from Dr.  
11 Buttar that there has been no consultation.

12 And it's interesting to note the choice of the word consult.

13 It does not say that the integrative medicine practitioner  
14 must testify in front of the Board. It does not say that  
15 the Medical Board must agree with the consultation. It  
16 just simply says that prior to issuing charges that you  
17 must consult with an integrative medicine practitioner.

18 And, again, there has not been any argument from the other  
19 side, nor could there be, that that has not been done  
20 because that has been done.

21 And if you look at the -- you know, 90-(a)(g) they used  
22 the word testify. So not only was that language about  
23 medical expert witnesses must be of the same specialty,



1 but they talked about testifying. And here not only did  
2 they not adopt that language, but when they included some  
3 additional language in 90-14(a)(g), they changed it to  
4 merely consult, which again has been done.

5 So I will circle back and go back to what I always like  
6 to do which is to find realms of agreement. Ms. Godfrey  
7 said, and the argument has been made, that you should only  
8 judge the case, this present case, on the law that exists  
9 on the books now. And the law on the books that exists  
10 now is the law that was applied in the Dr. Guess case.  
11 The only change that was made is that in order to revoke  
12 Dr. Buttar's license that you have make certain findings,  
13 they specifically rejected broadening that to include any  
14 other disciplinary action besides revocation and they  
15 put -- they specifically rejected any requirement that  
16 there be an integrative medicine doctor practice -- an  
17 integrative medicine doctor testify in any of these  
18 proceedings.

19 So the Board's case to me reflects essentially what the  
20 General Assembly was trying to say which is that if a  
21 medical practitioner -- and -- and I think this is actually  
22 revealing, if you look at 90-14(a)(6), the word integrative  
23 medicine does not appear in 90-14(a)(6). You cannot find

1 the word integrative medicine in 90-14(a)(6).  
2 And what the -- the medical -- the General Assembly was  
3 saying is that any practitioner cannot come into -- cannot  
4 come to North Carolina, start practicing medicine, start  
5 treating a whole -- you know, a whole slew of different  
6 illness, diseases and not do it in a way that's acceptable  
7 and follows prevailing medical standards and then escape  
8 any sort of regulation from this Board by attaching a name  
9 to it, call it integrative, call it nontraditional, call  
10 it experimental.  
11 So long as the practitioner has slapped a name to it, then  
12 this Medical Board cannot -- cannot regulate it. That  
13 would give medical practitioners free reign to do whatever  
14 they want without any regulations from this Board.  
15 In essence, it would nullify the need for a medical board  
16 at all. Because if you found a doctor departed from  
17 acceptable and prevailing standards in the treatment of  
18 certain patients for certain conditions, the doctor can  
19 then say, whoa, whoa, I'm -- you know, I'm this kind of  
20 practitioner.  
21 You can't look at me and before you -- and if you do look  
22 at me, you're going to have to find someone who calls  
23 themselves exactly what I call myself and they're going

1 to have to testify that what I'm doing has no effect and --  
2 and hurts people. Basically creating an impossible burden  
3 for you to take any action against any practitioner so  
4 long as he's just attached a label to what he did.  
5 And the North Carolina General Assembly, when it created  
6 -- this Board was created -- you were created to protect  
7 the public health. And if that was the case that anybody  
8 could just slap a label on what they're doing, then the  
9 public health is endangered and that's what the North  
10 Carolina General Assembly was -- I mean, the North Carolina  
11 Supreme Court was saying in the Guess case.  
12 So that is why the General Assembly rejected those  
13 provisions, because it just doesn't make sense. And that  
14 is not the law today. I mean, again, I circle back to  
15 the agreement I have with Ms. Godfrey, you should judge  
16 this on what the law is today.  
17 In other cases, I mean for instance, they say to make --  
18 they make an argument that, well, if different doctors  
19 of different specialties are doing certain things, then  
20 you should only judge them by the doctors -- the doctor  
21 who is accused of doing it wrong, but I know a doctor who  
22 does it like him.  
23 The Medical Board has historically never done that. In

1 the case of Dr. Talley, Dr. Talley was a family practice  
2 doctor out of Shelby who was practicing pain medication,  
3 chronic pain -- chronic pain treatments in using abundant  
4 Schedule II narcotics to treat chronic pain and was doing  
5 it in a way that was just completely unacceptable.  
6 The Board's expert witness in that case was Dr. Roth.  
7 Dr. Roth was a board certified research-based, I believe  
8 university-based anesthesiologist. And the reason we had  
9 a board certified university-based anesthesiologist  
10 review Dr. Talley's work and testify against him is because  
11 Dr. Talley was practicing chronic pain medicine.  
12 And if you're going to practice chronic pain medicine,  
13 you will be judged by the standards of practicing chronic  
14 pain medicine. If you're going to do surgery -- if you're  
15 a family practice doctor and you're going to operate on  
16 a patient, you know, assuming somehow you're able to get  
17 privileges in a hospital somewhere or do so in your office,  
18 you're going to be judged by the standard of that surgeon.  
19 And to do so, to judge them by some other standard saying  
20 you cannot judge this doctor for doing surgery unless you  
21 find another specialty in his practice, will endanger the  
22 public health. And that's why these interpretations --  
23 that's why these proposed laws were specifically and

1 out-of-hand rejected.

2 And I'd like to expound on this just a little bit more  
3 and I know the night -- the time of night is getting long,  
4 but it goes back to what the meaning of standards are.  
5 If standards are relegated to the subjective beliefs of  
6 individuals, then they no longer become standards, but  
7 that's not to mean that standards are rigid. They are  
8 subject to evolution and progress.

9 Modern medicine makes -- progresses all the time and it  
10 does so in way that is responsible. It does so through  
11 clinical trails, Phase I, Phase II, you know, institutional  
12 review boards, university settings. And the reason those  
13 protocols and safeguards are there, these standards are  
14 there, is because they protect the public.

15 When medicine has -- has strayed from those safeguards,  
16 then that is when medicine has been denigrated. And the  
17 denigrations of medicine in history are known by single  
18 words, Peskidy, Stonybrook. And the reason that we have  
19 these standards are because they are there to protect the  
20 individual.

21 And at this point, you know, I'm just trying to pause and  
22 say that, you know, it's been, you know, a long day. You  
23 know, it's been, you know, many depositions, many hours

1 of preparation and at times, you know, all of this gets  
2 funneled through one person and I feel, you know -- you  
3 know, humbled and awed and scared, frankly, by trying to  
4 sum up everything that all the resources of this Medical  
5 Board that gets put into these cases, that get investigated  
6 in these cases, and it gets funneled through essentially  
7 one person and that person is me and, you know, you just  
8 don't want to flub it up, so -- but -- you know, but I'll  
9 try not to.

10 But in this case what you end up finding is that the evidence  
11 is overwhelming. The only evidence you have in front of  
12 you, and again I go back to judge it by the facts which  
13 seem to be undisputed about the patients who came and saw  
14 Dr. Buttar and what they got, what therapies they got,  
15 the law which I've explained and -- and the evidence.

16 The only evidence you have about the standard of care for  
17 the treatment of these cancer patients came from Dr.  
18 Peterson. He looked at these therapies and he saw them  
19 having no benefit, no benefit whatsoever. He saw these --  
20 these therapies and said, this is not cancer therapies.

21 It's just not how you treat cancer. And that's the only  
22 evidence on the standard of care, the acceptable and  
23 prevailing medical practice in North Carolina. That's

1 the only thing you have in front of you.  
2 Dr. Buttar seems to be making the argument and they kept  
3 phrasing the question in front of their witnesses is that,  
4 well, is Dr. Buttar performing to the standard of care  
5 for an integrative medicine practitioner. Again, not to  
6 repeat myself, but that's the incorrect standard. These  
7 patients all have metastatic Stage IV advanced cancer.  
8 They were all dying and -- and Dr. Buttar was treating  
9 them for their cancer.  
10 Not a single person from their side, Dr. Buttar included,  
11 Dr. Ripoll from Colorado, Dr. Wilson who testified today,  
12 and Dr. Biddle who did not even testify today, not a single  
13 one testified that Dr. Buttar was within the acceptable  
14 and prevailing standard of medical practice for the  
15 treatment of late stage cancer patients. Not a single  
16 one.  
17 So the only evidence you have of the applicable standard  
18 of care, which these people came to Dr. Buttar for, the  
19 only evidence you have is from Dr. Peterson and your own  
20 expert opinion.  
21 That's the other thing about medical boards, you are  
22 doctors. You can apply your own -- your own sense of what  
23 the acceptable and prevailing standards of medicine are

1 to this case.

2 But to go back to Dr. Peterson, only Dr. Peterson -- not  
3 only did he say that the care was not within the standard  
4 of care, but he characterized it in very strong terms.  
5 And I really don't need to repeat those -- those terms  
6 here. And why did he use such strong language when --  
7 when he -- when he opined about this being outside the  
8 standard of care?

9 And the reason is, is because he's a scientist. He is  
10 an oncologist. He treats hundreds of patients a year.  
11 He sees the highs and lows of this horrible disease. He  
12 was on the faculty at UNC. He is board certified in  
13 oncology and hematology. He goes to several conferences  
14 a year. He subscribes to journals and he reads and he  
15 stays current.

16 And he went through every single one of those therapies  
17 and looked at them and said, not a single one was effective.

18  
19 And every witness on their side, again, testified that  
20 not only were these therapies not effective that's proven  
21 through clinical trials and research for cancer, but they  
22 were also not approved or shown to have any effect for  
23 boosting the immune system. And this whole notion of



1 boosting the immune system, there again sort of lies the  
2 heart of the issue in 90-14(a)(12).

3 When the curtain started getting pulled back on what we  
4 were seeing with Dr. Buttar, at some point it became, well,  
5 I'm not treating cancer any more. I'm just trying to boost  
6 the immune system, how the immune system has some effect,  
7 and that would drive the cancer away. And -- and that  
8 was sort of how he was sort of explaining his -- his  
9 treatments and -- and saying that the cancer was only a  
10 symptom of an impaired immune system.

11 And we heard that over the past two days and -- and --  
12 and what is interesting about it, and I won't go too long  
13 on this, is that -- let's look at the address -- let's  
14 look at the facts in the address. Dr. Buttar's clinic  
15 holds itself out as specializing in cancer treatment.  
16 He has a seminar that he -- that he goes to and he has  
17 the brochure which says Integrative Protocols for the  
18 Treatment of Cancer. His consent form which he makes a  
19 lot to do about talks about, in the consent form, he treats  
20 cancer.

21 When Ms. Garcia was on the stand and she talked about  
22 Patient A she wrote in her note, Patient A to -- to think  
23 about whether she will proceed with the cancer protocol.

1  
2 And if you go through all the other progress notes, you  
3 will see it mentions about the cancer protocol, the cancer  
4 protocol. Not the immunology protocol, not the immune  
5 system protocol, but the cancer protocol. And this is  
6 where we sort of get this -- this sort of -- this sort  
7 of thing about 90-14(a)(12) about providing services in  
8 the manner that exploits the patients.

9 These patients are coming to Dr. Buttar in their darkest  
10 hours. They're dying, they're going to die and -- and  
11 they're -- they're signing all kinds of paperwork and  
12 they're willing to give over a lot of money, \$1,000 a day,  
13 you know, several days a week, tens of thousands of dollars,  
14 when it's all said and done. They're not doing that  
15 because their immune -- to get their immune system up.  
16 They're doing that because they think he can help them  
17 with their cancer.

18 The patients testified about the fact that he could help  
19 them with their cancer. Ms. Garcia's note talks about  
20 the cancer protocols. No one is going to give over ten  
21 thousand -- tens of thousands of dollars on a bet that  
22 the immune system is going to be boosted and that their  
23 cancer is there and somehow going to go away from that.

1 He's being -- the patients who testified by video, they  
2 searched for him on the Internet, they have cancer, they  
3 find him. His -- like I said, his -- his literature that  
4 goes out, he specializes in cancer. And there's a -- I  
5 mean, even though they talk about how educated these  
6 patients are and how -- and how informed they are, no matter  
7 how smart you are, no matter how informed you are, if you're  
8 in late stage cancer, there's a power differential.  
9 There's a power differential between a patient and her  
10 loved ones or his loved ones, you know, dealing with cancer  
11 and then sitting down in front of a doctor with your Medical  
12 Board license hanging on the wall and him telling you that  
13 he can do something, he can help you with your cancer.  
14 That has a -- that has a persuasive influential effect  
15 on patients that no matter how informed the patients are,  
16 no matter how educated they are, you are just going to  
17 put your trust into that.  
18 And in exchange -- and in defense of that from your side,  
19 what we got essentially were, you know, these therapies  
20 are administered in such a way and -- and that when --  
21 and when these therapies are administered, there's  
22 accusations that the -- that the Medical Board is -- you  
23 know, the medical boards are out to do this, the

1 pharmaceutical companies are out to do this, the patients  
2 are unhappy about paying their bills and -- and there's  
3 marital strife and -- and that a doctor, Dr. Herman, you  
4 know, didn't go see the patient while she was dying.

5 Who -- who can tell Dr. Herman that what she did was wrong?

6 Her -- her employee was sitting -- who she works with,  
7 her mother is dying of cancer, she's going to get therapies  
8 that Dr. Herman felt were so outside of the mainstream  
9 that she felt motivated to complain to the Medical Board  
10 and she's mocked. She's mocked for not visiting her  
11 daughter -- or her daughter's mother.

12 Patients are mocked because, you know, there was marital  
13 strife or that they just don't want to pay bills. And  
14 when I think about these sort of defenses, these sort of  
15 responses, you know, it's reminiscent of, you know,  
16 Macbeth's famous soliloquy that Shakespeare wrote that  
17 life is just sound and fury and signifies nothing. These  
18 defenses, these -- these responses is just nothing but  
19 sound and fury and it signifies nothing.

20 What it does signify is that there is -- somewhere there  
21 is -- there is a loved one that's going to Dr. Buttar's  
22 office, they're dying, and they would be looking for any  
23 glimmer of hope.

1 And Dr. Buttar is more than willing to give them that  
2 glimmer of hope, but it's all false hope and they will  
3 be set up to IVs, getting eight hours a day of treatment,  
4 five days a week, paying him tens of thousands of dollars,  
5 and the whole time there's a North Carolina medical license  
6 on his wall.

7 And if this is allowed to continued, if this is allowed  
8 to go on, that is your stamp of approval. His medical  
9 license is your stamp of approval. So if this goes on,  
10 then anyone can come into North Carolina and take this  
11 Dr. Buttar case because it will then become legal precedent  
12 and say, I can do whatever I want, follow no standards,  
13 so long as I put a label on it there's nothing this Medical  
14 Board can do.

15 That is not the facts, that's the law and that's not the  
16 evidence. It is nothing but sound and fury and it's time  
17 to stand up to that sound and fury and if you do, there's  
18 nothing untoward that will happen. This is the time to  
19 stand up for science-based, evidence-based medicine. And  
20 if you do so, there will not -- nothing -- not only will  
21 nothing untoward happen to this Board, it will be this  
22 Board's finest hour.

23 I ask you to look at the two issues and Exhibit F which

1 is my issue that says: Did Dr. Buttar depart from or fail  
2 to conform to the standards of acceptable and prevailing  
3 medical practice.

4 The evidence, the facts, the law clearly says he does --  
5 he did. That has to be answered yes.

6 As to whether he exploited patients in a manner under  
7 90-14(a)(12), I just remind you of that power differential.

8 These patients were in their darkest hours. So I will  
9 respectfully submit that the Board answer the  
10 interrogatories yes and that we proceed to Phase II.

11 Thank you.

12 PRESIDENT RHYNE: Thank you. The Board will now go into  
13 closed session to consider the evidence and then we'll  
14 announce the decision.

15 MR. KNOX: Madame Chairman, I would like to except two  
16 things. One is the placing of the -- of the Board in the  
17 position of saying that you have put your stamp of approval  
18 on or take it off, that's all -- that you're supposed to  
19 argue to a jury or to you.

20 And to the extent that he supplemented the record by saying  
21 who had reviewed certain data. I would take exception  
22 to those two and that's all I have to say.

23 PRESIDENT RHYNE: Okay. I want to make sure I have a copy

1 of the pre-hearing agreement.

2 MR. JIMISON: Okay. I'll give you mine, Dr. Rhyne.

3 MS. GODFREY: I have a copy here if you need it.

4 PRESIDENT RHYNE: Okay. Let me get you --

5 MS. GODFREY: I'll get another one.

6 PRESIDENT RHYNE: I've got so many sheets of paper to go  
7 through them --

8 MS. GODFREY: I understand your problem.

9 -----

10 (WHEREUPON, THE PANEL RECESSED INTO

11 EXECUTIVE SESSION AT 7:18 P.M.

12 AND RECONVENED AT 7:58 P.M.

13 -----

14 PRESIDENT RHYNE: Our concern is with questions five and  
15 six. Is that a Phase II and do we have to go into Phase  
16 II or do we answer those now?

17 MR. JIMISON: I would recommend going into Phase II.

18 PRESIDENT RHYNE: Okay.

19 MS. GODFREY: And what --

20 DR. McCULLOCH: And we have different questions, yeah.

21 MS. GODFREY: -- what is meant by Phase II? I don't  
22 know --

23 MR. MANSFIELD: Well, that's --

1           PRESIDENT RHYNE: That was our --

2           MR. MANSFIELD: The parallel in a civil case would be,

3           this is the negligent -- you know, the equivalent of a

4           negligence, but it's not negligence, but it's equivalent

5           of a negligence phase. And they they come back again and

6           answer the questions, did misconduct occur. If the answer

7           is yes, then and only then, it's Phase II which is the

8           appropriate discipline phase.

9           MS. GODFREY: Well, is there more evidence given?

10          MR. MANSFIELD: You can -- you are permitted to -- and

11          the way we do it is you can present more witnesses,

12          documents, evidence in support of your argument about what

13          you think the discipline ought to be.

14          MR. KNOX: To the full Board you're talking about?

15          MR. MANSFIELD: No, to this panel.

16          MS. GODFREY: This panel. We're still in this --

17          MR. MANSFIELD: This panel is going to make a

18          recommendation as to the initial questions of misconduct --

19          PRESIDENT RHYNE: Right.

20          MR. MANSFIELD: -- and the appropriate punishment.

21          PRESIDENT RHYNE: And the way I understand it and you

22          correct me if I'm wrong, is that we can do that tonight

23          or we can do it another time. And I guess part of my



1 question about that is, do you guys want to do it tonight  
2 at this time or if you were going to do that and present  
3 more evidence, you have --

4 MS. GODFREY: Well, I don't think --

5 PRESIDENT RHYNE: -- more evidence, no more evidence.  
6 We have a court reporter we're looking at and we're prepared  
7 to stay.

8 COURT REPORTER: I am here at your pleasure.

9 MR. JIMISON: I was just going to make an argument about --  
10 I just want to make an argument and not present evidence.

11 I'm not going to put a time limit on it, but it was not  
12 going to be long.

13 PRESIDENT RHYNE: Yes, sir. Do you -- do you think --  
14 could each side do it in ten minutes?

15 MR. KNOX: No.

16 MS. GODFREY: No. I mean, understand, Dr. Rhyne, the  
17 procedures here are not something that, you know, we deal  
18 with every day. And the -- you know, if you're saying  
19 that we're going to consider more evidence, I mean, we  
20 would consider more evidence on the issue of penalty.  
21 I don't see how we can possibly be prepared to address  
22 that, you know, at this point.

23 We -- we put on our case with regard to, you know, to the

1 charges, but I mean the issue of penalty is -- is something  
2 that, you know, we're going to have a chance to submit  
3 additional evidence. And -- and that may be, you know,  
4 in the form of -- I know there's disciplinary guidelines  
5 that we would need to look at, as you would need to look  
6 at and -- and maybe even some of the cases we've reported,  
7 so.

8 MR. MANSFIELD: Madame President, I think the Board should  
9 be fair. Every time we conduct one of these hearings,  
10 the Board should be fair and I would suggest that you use  
11 that as your guide to make a decision about this.

12 On the other hand, I would advocate for pressing ahead  
13 and finishing this case for several reasons. And I don't  
14 have the pre-hearing stipulation in front of me, but I  
15 believe that the penalty issues are in your issues, that's  
16 the pre-hearing agreement that we embarked on this hearing  
17 with, including the penalty phase issues.

18 And we have, you know, and what we normally do as -- as  
19 Madame President knows, is we forge ahead because folks  
20 come prepared to try the case and the parallel and in civil  
21 court is you come to prepared to try on liability and  
22 damages at the same time.

23 So I certainly -- if you think it's unfair to Dr. Buttar

1 because his attorneys are not in a position to go forward,  
2 then you should make whatever decision you think is right.

3 On behalf of Marcus and me, I would advocate for going  
4 ahead and conducting Phase II, reminding the Board that  
5 this -- you know, you're a panel making a recommendation.

6  
7 The final decision in this case is already not going to  
8 occur until I would anticipate July and to -- to have to  
9 come back and do Phase II at another time and further delay  
10 the final decision in this case, seems like a poor use  
11 of judicial resources of the Board which the hearing time,  
12 as you know, is very limited.

13 MR. KNOX: May I be heard? This whole thing has been sort  
14 of like -- okay. If you could listen just a minute. We  
15 were told initially we would have a hearing before the  
16 Board. We were -- told them there was no way we could  
17 get ready -- I think we were notified --

18 MS. GODFREY: You mean, the charges?

19 MR. KNOX: Yes.

20 MS. GODFREY: In December.

21 MR. KNOX: -- in December and the hearing was supposed  
22 to have been in --

23 MS. GODFREY: February.

1 MR. KNOX: -- February. And I said, there's no way, I'm  
2 in trial in a lot of -- in a lot of cases. So then it  
3 was set to be heard today. And then we were told we would  
4 have a panel and then we were told that it couldn't be  
5 continued. Then we were told that it would be continued  
6 unless we took off some of our experts. So we talk about  
7 fairness and I appreciate what he said, I think he means  
8 it. I think in fairness to our client, he ought to have  
9 the opportunity -- I'm sorry for you to come back, but  
10 on the other hand, I have not consulted -- on the issues  
11 you've answered and I'm not asking you to tell me, but  
12 I think in fairness we ought not to be put in that position,  
13 not at this late hour.

14 MR. MANSFIELD: Well, if I may just address two points  
15 specifically that Mr. Knox mentioned. The charges that  
16 were issued in this case in December specified that this  
17 case would be heard either before a panel or the full Board,  
18 so notice was given from the get-go that it could be before  
19 a panel.

20 And unless Mr. Knox or Ms. Godfrey tells me I'm wrong,  
21 my belief is that there has been no request for a discussion  
22 about a continuance from this setting. I mean, I can  
23 perfectly well understand why they didn't try the case

1 in February based on the charges coming out in December.

2 But --

3 MR. KNOX: Well, I don't think you've been privy to that.

4 We did say to Marcus and Marcus said to me, I don't think  
5 there's a chance that the Board is going to put this off.

6 And I said, I don't know how in the world we can get ready  
7 and in that short of a period of time and we were told  
8 it's going to be tried. And then Marcus said, we will  
9 try it if you eliminate some of our experts which we did  
10 and I think you wanted me to move expeditious just as Marcus  
11 has tried to move expeditiously. But in fairness to our  
12 client, it was a big issue, quite obviously. That's all  
13 I have to say.

14 MR. JIMISON: You know, historically we can move straight  
15 to Phase II. And Dr. McCulloch and Dr. Rhyne, I think  
16 you have more experience than Dr. Walker. You know,  
17 historically we've always sort of moved to Phase II. And,  
18 again, my -- my -- my presentation would be mostly just  
19 what the discipline should be based on whatever here --  
20 what you say the issues were in three and -- and that could  
21 go very, very briefly.

22 The other point is that this is just a recommendation and  
23 if there's any more argument they want to make, that either

1 a -- the decision of the panel or the decision -- or the  
2 recommended sanction is something that's not warranted,  
3 they can do that in front of the full Board.

4 DR. WALKER: So what you're -- excuse me.

5 PRESIDENT RHYNE: Go right ahead.

6 DR. WALKER: So what you're saying is that if we render  
7 a Phase II decision that that would be the recommendation  
8 of the Panel to the full Board and Mr. Knox and Ms. Godfrey  
9 will have an opportunity to present to the full Board.

10 MS. GODFREY: No more evidence.

11 MR. MANSFIELD: Correct. Let me hasten to clarify that  
12 they would not be able to bring witnesses or additional  
13 documents at that time. They would need to do that in  
14 Phase II before this Panel. They would get to present  
15 arguments that the punishment was excessive or that the  
16 first decision was wrong to the quorum of the Board.

17 MR. JIMISON: However, typically the evidence and I will  
18 make an objection to this in front of the Board Panel --  
19 before the quorum of the Board is that's normally what  
20 the Board had done in similar cases in the past. I mean,  
21 the Board can always take judicial notice of what they  
22 did in similar cases in the past and that's typically the  
23 type of evidence the Board would receive.

1 So, again, I agree with Tom, whatever you, Dr. Rhyne, and  
2 the members of the Panel believe is fair. I'm not going  
3 to -- I don't know if I'm contradicting my boss, but I'm  
4 not going to jump up and down about it.

5 MR. KNOX: Dr. Walker, the only thing I can say, that  
6 assumes anything we might say or prepare could be  
7 appreciated or changed or modified now and so I do think  
8 that in fairness of the doctor, he ought to have a chance  
9 to do that. And I was -- I thought you made a  
10 recommendation to the -- to the full Board, but I didn't  
11 know you made a recommendation today. I'm sorry, I should  
12 have known. I've been down here on several occasions,  
13 but they are more casual appearing than the Panel.

14 PRESIDENT RHYNE: Can we go back into closed session --

15 MR. MANSFIELD: Sure, no problem.

16 PRESIDENT RHYNE: -- and we'll make a decision and then  
17 call you back --

18 MS. GODFREY: Okay.

19 PRESIDENT RHYNE: -- but thank you.

20 -----

21 (WHEREUPON, THE PANEL RECESSED INTO  
22 EXECUTIVE SESSION AT 8:08 P.M.  
23 AND RECONVENED AT 8:15 P.M.)





1 -- I mean, the Board.

2 PRESIDENT RHYNE: Would you like -- do you want to present  
3 other witnesses, exhibits or be heard on that?

4 MR. KNOX: I've indicated --

5 PRESIDENT RHYNE: Or to question anyone.

6 MR. KNOX: I'm not prepared to do so, so if you want to  
7 go ahead hear what they have to say --

8 MS. GODFREY: Well --

9 PRESIDENT RHYNE: Ms. Godfrey, would you like to present  
10 any witnesses, exhibits or otherwise be heard on the  
11 question of the penalty.

12 **CLOSING STATEMENT BY MS. GODFREY:**

13 Well, I think -- I think we would like to be heard. I  
14 think that the Board is now in the phase of considering  
15 the disciplinary guidelines and I think we ought to at  
16 least address that because it's very clear that some of  
17 them apply and some of them don't apply.

18 And so practicing below the minimum standard of care is  
19 the one charge.

20 And I must admit that in the disciplinary guidelines, I  
21 don't see any guidelines with respect to the second charge  
22 that specifically say with regard to exploitation of  
23 patients, so I'm not quite sure how to proceed with that.

1 But with regard to practicing below the minimum standard  
2 of care as published by the Board, the presumptive maximum  
3 is revocation of the license, presumptive minimum is stayed  
4 suspension of the license.

5 The aggravating factors that you can consider in deciding  
6 which of those or, I assume, any remedy in between are  
7 the prior disciplinary actions. There's been none.

8 Patient harm, none.

9 Dishonest or selfish motive, I don't think any dishonest  
10 or selfish motive was proven. I think all the evidence  
11 is that Dr. Buttar was doing what he thought was best for  
12 his patients.

13 Position of false evidence, false statement or other  
14 deceptive practices during the disciplinary process, no  
15 evidence of that.

16 Vulnerability of the victim, we would say that these were  
17 all competent adults and perfectly capable of making  
18 decisions on their own for their own medical treatment.

19  
20 There's no children involved in these charges. There's  
21 no incompetent people involved in these charges. These  
22 were all people that were in their right mind. They happen  
23 to be suffering from cancer, but they were still all in

1 their right minds and they could do -- make decisions on  
2 their own.

3 Refusal to admit wrongful nature of conduct. That's a  
4 tough one because as I argued to the Board, Dr. Buttar  
5 does not believe that his conduct was wrongful. And if  
6 that's held against him, I think that's completely unfair.

7 He has a different perspective of the practice of medicine  
8 than you three doctors and the prevailing medical practice,  
9 but I do -- I think it would be wrong to hold that against  
10 him in this case.

11 Pattern of misconduct, repeated -- (inaudible) -- of the  
12 same misconduct. I don't know what you found whether you  
13 found it based on one or all three and that's -- that's  
14 hard for me to say. I would say that if you found in --  
15 in less than all three cases, then, you know, you found  
16 a pattern. And, again, these are three individual cases  
17 that you ought to consider individually.

18 Patient A is not Patient B is not Patient C. And so whether  
19 or not he's found to be violating the standard of care  
20 in all three cases or one or whatever should be a factor.  
21 Multiple offenses, again, I don't know how that plays in  
22 here when we've got three separate patients. I don't know  
23 what the Board decided on.

1 So I would say there are no aggravating factors.  
2 The mitigating factors, again, sort of counterbalance  
3 absence of prior disciplinary record, no direct patient  
4 harm, absence of dishonest or selfish motive, full  
5 cooperation with the Board. I think that's been obviously  
6 displayed. There was no visible disability or inherent  
7 rehabilitation, again, I think that's in a different type  
8 of case.  
9 Remorse, again, I think it would be wrong to hold his  
10 validly and sincerely held beliefs against him.  
11 And remoteness of prior discipline, I'm not sure how that  
12 comes into play.  
13 I do think the mitigating factors would outweigh any  
14 aggravating factors in this case and we mitigate towards  
15 a lessor penalty than revocation.  
16 I'm not going to sit here and suggest to the Board any  
17 specific penalty. I think that the Board though would  
18 be wrong to give the maximum penalty in this case and I  
19 think that the mitigating factors do outweigh the  
20 aggravating factors and based on your own published  
21 guidelines that ought to be taken well into consideration  
22 in setting any discipline that you see -- that you give  
23 cases.

1 Do you have anything to add, Mr. Knox?

2 MR. KNOX: Well, I do not at this time.

3 PRESIDENT RHYNE: Thank you.

4 Mr. Jimison, would you like to present any witnesses,  
5 exhibits or otherwise be heard on the question of  
6 appropriate discipline?

7 **CLOSING STATEMENT BY MR. JIMISON:**

8 I do want to be heard. And you may have a copy of the --  
9 of the Medical Practice Act in front of you. Since the  
10 Board's Panel has found both issues, one and three, not  
11 only are the aggravating and mitigating factors relevant --  
12 and I'm sorry I don't have those in front of me.

13 If I may ask Ms. Godfrey if I can see her printed list.

14 MS. GODFREY: Only if you use my checks and balances.

15 MR. JIMISON: Okay.

16 MS. GODFREY: Do you want to argue the same ones.

17 MR. JIMISON: Not really so much those.

18 But what I really want to draw your attention to in  
19 90-14(a)(12) because you answered that question yes, is  
20 that upon the finding of exploitation the Board can order  
21 restitution to the individuals. And that's really going  
22 to be the -- you know, the bulk of my comments.

23 I believe that the Board should order restitution to the

1 three patients, A, B and C or their estates, in the amount  
2 that Dr. Buttar charged them. And that his license should  
3 be indefinitely suspended until such time that he reapply  
4 and that he not be -- that his application not be processed  
5 until such time as he has paid restitution to those three  
6 patients.

7 If you indefinitely suspend his license with the  
8 restitution, then you don't have to make the finding  
9 regarding did his care carry a greater safety risk or was  
10 generally ineffective because you're not revoking him.  
11 But if you do decide to revoke him, you can do one of two  
12 things. If you -- if you -- if you determine that  
13 revocation is in order, then I suggest you do one of the  
14 following two things.

15 One, you designate it for which charge.

16 If you revoke them for (a)(6), then you must make one of  
17 the two findings about whether or not it was a greater  
18 safety risk or was generally ineffective.

19 If you revoke them for (a)(12), then you don't have to  
20 make those findings. So I would -- I would ask you to --  
21 to, you know, give a sanction for each charge.

22 And, again, just to clarify because, you know, this is  
23 not something we do every day, so I'm sorry to repeat

1 myself. So if you revoke him for (a) (6), you must make  
2 the findings. If you do anything less than revocation  
3 (a) (6), you do not have to make the findings.

4 If you -- and also I suggest that you make a separate  
5 discipline for (a) (12) and that you order restitution to  
6 the victims.

7 I do believe with Ms. Godfrey's, you know, aggravated --  
8 recitation of the aggravating and mitigating factors.

9 One that I think we could absolutely agree on is there  
10 are no -- there are no prior disciplinary actions by Dr.  
11 Buttar.

12 Patient harm, I would submit to that the financial loss  
13 is the loss away from their -- from their family to arrange  
14 their affairs was a harm that should be considered.

15 Dishonest or selfish motive, clearly I think Dr. Buttar  
16 had a money interest in this case just from the evidence  
17 that was presented that, you know, patients were given  
18 an arbitrary protocol, one-size fits all, everybody seemed  
19 to be paying close to almost \$1,000 a day. I think you  
20 can reasonably infer from -- from that evidence that that --  
21 there was a dishonest and selfish motive.

22 I will say this -- about this and it's not like I'm trying  
23 to incur your favor with, you know, decide, but I'm not

1 Dr. Buttar, no one here is Dr. Buttar. We don't know.  
2 Motive and intent is one of the hardest things to prove  
3 in any litigation.  
4 However, you can draw reasonable inferences from the  
5 conduct. And I think it is a reasonable inference to draw  
6 from that conduct that there may have been selfish or --  
7 or a selfish motive.  
8 Vulnerability to victim, I think clearly they were  
9 vulnerable. They were desperate people -- you know, they  
10 were dealing with -- with a terminal prognosis and -- and  
11 one day we probably all will be in that situation. And,  
12 you know, and I can't imagine what it must feel like to  
13 be in that situation. You all see that in your practices.  
14 You all know better than me. So clearly you have much  
15 more experience than probably anyone in this room about  
16 whether there was vulnerability of the victim.  
17 Refusal to admit wrongful nature of the conduct, clearly  
18 that's -- that's here.  
19 Willful or reckless misconduct, again, intent is one of  
20 the hardest things to prove, but I think there's reasonable  
21 inferences to be drawn.  
22 There isn't really a pattern of misconduct. I think patter  
23 of misconduct probably -- well, I'm sorry, I have that



1 wrong.

2 I think there is a pattern of misconduct in the sense that  
3 there's multiple patients, he did this over a course of  
4 years.

5 Multiple offenses, I see as a prior disciplinary action.

6 Multiple offenses is that he's been in front of the Board  
7 many times in a public setting. I don't think that's  
8 established even though there are three patients, I kind  
9 of put that more on number 8 and number 9.

10 There are mitigating factors. I agree with Ms. Godfrey  
11 about the absence of a prior disciplinary record.

12 No direct patient harm, again, I think financial loss is  
13 a harm and time away from the family.

14 Absence of a dishonest or selfish motive, we talked about  
15 that.

16 Full cooperation with the Board, I will admit that, you  
17 know, this has been a case that has been prepared in --  
18 between essentially December and now and it has been  
19 difficult at times, but I will not say there has been --  
20 there has been non-cooperation -- I cannot say there's  
21 been no cooperation. I would agree to that mitigating  
22 factor exists.

23 Physical or mental disability or impairment, I don't think

1 Dr. Buttar has a physical or mental disability.  
2 Rehabilitation or remedial measures, I wish there was  
3 comments on that. I really hope that would it would be  
4 remedial or rehabilitation.  
5 Remorse, I -- you know, that only can be established by  
6 Dr. Buttar.  
7 So when you take all that into account, whether or not  
8 the aggravating factors outweigh the mitigating factors,  
9 I don't know.  
10 But what I do know is that the law allows restitution,  
11 you found that. And I think in order for there to be clear  
12 restitution, there should be an indefinite suspension of  
13 his license, that he not be able to reapply until  
14 restitution is made to the victims.  
15 I don't have that number in front of me. We can -- we  
16 can -- that can just, you know, tailored to -- to the amounts  
17 that the Patients A, B and C paid Dr. Buttar's office for  
18 their treatments. And that that be conditioned upon his  
19 ability to reapply for his license.

20 MR. KNOX: Can I just add a couple of things.

21 PRESIDENT RHYNE: Yes, sir.

22 **CLOSING STATEMENT BY MR. KNOX:**

23 Number one, the restitution, there's not much evidence

1 that anybody was ever sued or anybody collected from most  
2 of these folks. In particular, Patient C canceled payment  
3 on a check and all payments made up until then were made  
4 by consent of the individual and apparently he was happy  
5 with it.

6 I don't think Patient D actually sued him and it did not  
7 appear and as a result we filed counterclaim and you said  
8 we did not consider --

9 PRESIDENT RHYNE: We excluded Patient A.

10 MR. KNOX: Then if you go to Patient B, there's no one  
11 complaining about that. And Patient C apparently hasn't  
12 paid that bill yet. And so the restitution, it just is  
13 not there.

14 The second thing is the question about no harm. I think  
15 their expert -- and I want to tell you this and I've tried  
16 in a number of malpractice cases -- (inaudible) and the  
17 examination of the record and you have to understand if  
18 that's what you got, that's what you got and apparently  
19 you've not satisfied with all this being enough.

20 You have to weigh that when it comes to litigation and  
21 it's not to his credit for what he did. He spent two hours  
22 to go through multiple records and because he's never  
23 studied and didn't know anything about it. And so I think

1 you have to weigh that when it comes to litigation of how  
2 much credibility and how much time did he spend. He did  
3 say it was two hours. I don't have the section, he's got  
4 it.

5 And I wonder when it comes to exploitation with regards  
6 to the money, if you look at what it costs for that lady  
7 to go up to Forsyth Hospital compared to what this doctor  
8 is charging you look at the videotapes, what all the people  
9 said, he's well in the ballpark of reasonable charges.  
10 So I don't think you can just jump off and say, well, his  
11 fees were astronomical.

12 And -- and if you didn't have any efficacy. Oftentimes  
13 chemotherapy doesn't have any efficacy and they charge  
14 you \$187,000 for it. So don't know how you gaged to get  
15 the quantitative money on one side or the side that that's  
16 exploitation.

17 If it is, your fees could be jeopardy. Somebody could  
18 come and say, well, you know, an anesthesiologist in  
19 Wilmington charged X number of dollars and we charge Y,  
20 that's the freedom of the market. And so I urge you to  
21 consider that in the mitigation.

22 Anything else?

23 PRESIDENT RHYNE: All right. Thank you.

1 The Board will now retire to closed session to consider  
2 the evidence and the arguments of counsel and we'll  
3 announce the decision.

4 MR. KNOX: Dr. Buttar wants to know if he can something.

5  
6 MR. JIMISON: I don't object to Dr. Buttar making a  
7 statement before the Board.

8 PRESIDENT RHYNE: Go ahead, Dr. Buttar.

9  
10 **COMMENTS BY DR. BUTTAR:**

11 Dr. Rhyne, I'm not going to -- I'm not going to say much.

12 I'm just going to say that everything that's happened  
13 over here today and yesterday, I appreciate you extending  
14 the courtesy of coming in early and staying later. I  
15 understand that only you guys asked, but I certainly didn't  
16 ask for it.

17 But I can tell you that in 1999 when this fiasco started  
18 with me, I really thought that there was a reason for  
19 physicians to be physicians to help patients.

20 If people let government decide what foods they eat and  
21 what medicines they take, their bodies will soon be as  
22 sorry a state as the souls of those who live under tyranny.

23 That was said by Thomas Jefferson. And I can tell and

1 I can assure, I can assure you that I will do everything  
2 in my power to protect my patients.

3 I appreciate your time and I appreciate your consideration.

4 But I also know that this witch hunt has been going on  
5 for a while and I also know that as in all truth, it will  
6 sustain itself. Thank you, ma'am.

7 MR. KNOX: I'm through.

8 PRESIDENT RHYNE: Okay. We'll go on into closed session.

9 -----

10 (WHEREUPON, THE PANEL RECESSED INTO  
11 EXECUTIVE SESSION AT 8:34 P.M AND  
12 RECONVENED AT 8:45 P.M.  
13 -----

14 PRESIDENT RHYNE: This Board stands for public protection  
15 and not a witch hunt of doctors; and therefore, we think  
16 that we should be protecting the people of our state, so  
17 we're going to recommend the following to the full Board.

18  
19 That a summary (sic) suspension to be stayed immediately;  
20 And with three restrictions on your license, Dr. Buttar.

21  
22 One is that you cease the use of hydrogen peroxide.  
23 Number two, you do not treat any cancer patients whether

1 they had cancer in the past, or cancer currently, or they're  
2 diagnosed with cancer once you start treatment; and that  
3 you do not treat children less than 18 years of age.

4 This hearing is concluded.

5 MR. MANSFIELD: Madame President, may I ask a question  
6 that may --

7 MR. KNOX: I'm sorry, I didn't hear what you said on the  
8 first thing. You said something about --

9 PRESIDENT RHYNE: Yeah. I said, this Board stands for  
10 the public protection and not --

11 MR. KNOX: I understand that.

12 PRESIDENT RHYNE: -- and not a witch hunt of doctors.

13 MR. KNOX: You say they were suspended and for how long.

14 PRESIDENT RHYNE: Stayed immediately.

15 MS. GODFREY: Stayed immediately.

16 MR. MANSFIELD: Madame President, I think you said the  
17 word summary suspension, did you mean indefinite  
18 suspension?

19 PRESIDENT RHYNE: Indefinite, yes, sir. Indefinite  
20 suspension stayed.

21 MR. KNOX: It was stayed.

22 MS. GODFREY: No, it was stayed immediately.

23 PRESIDENT RHYNE: It was stayed immediately.

1 MS. GODFREY: Stayed. Well --  
2 DR. McCULLOCH: A stayed suspension.  
3 PRESIDENT RHYNE: A stayed suspension.  
4 MR. KNOX: I don't understand.  
5 MR. MANSFIELD: But if I'm right, just for the benefit  
6 of the folks here, they asked for clarification on the  
7 agreement, Madame President.  
8 Since your panel is making the recommendation,  
9 Dr. Buttar's license status will continue to be exactly  
10 the same as it was two days ago until such time that the  
11 quorum of the Board receives your recommendation and makes  
12 a final decision.  
13 PRESIDENT RHYNE: Right. This is our Panel decision --  
14 this is the Panel decision that will go to the full Board.  
15 MR. KNOX: Right.  
16 MR. MANSFIELD: Should the -- should the quorum of the  
17 Board adopt your recommendation, if they do that, then  
18 the effect of the order that will go into place at that  
19 time would be that as soon as the order is prepared and  
20 executed by the president and served on Dr. Buttar, then  
21 that discipline would become effective at that time pending  
22 any further appeals you might make.  
23 PRESIDENT RHYNE: Correct. All right.



1  
2  
3  
4  
5

MR. KNOX: Thank you.

PRESIDENT RHYNE: Thank you.

---

(WHEREUPON, THE HEARING WAS CONCLUDED AT 8:48 P.M.)

---

STATE OF NORTH CAROLINA

-714-

COUNTY OF WAKE

C E R T I F I C A T E

I, BARBARA H. LAXTON, a Verbatim Reporter and Notary Public, that on April 23 and April 24, 2008, the foregoing hearing of:

RASHID A. BUTTER, D.O.

was called before the NORTH CAROLINA MEDICAL BOARD and held at the time and place aforesaid, and that the record as set forth in the preceding pages is a true and correct transcript of said proceedings to the best of my ability and understanding; that I am not related to any of the parties to this action; that I am not interested in the outcome of this case; that I am not of counsel nor in the employ of any of the parties to this action.

IN WITNESS WHEREOF, I have hereto set my hand, this the 2nd day of June, 2008.

\_\_\_\_\_  
BARBARA H. LAXTON, Notary Public  
Notary Public Number: 19970730133

My Commission Expires 4/7/2012  
TRANS/STAT VERBATIM & VIDEO REPORTING  
Post Office Box 33288  
Raleigh, North Carolina 27636  
Telephone: 919/828-1895  
Facsimile: 919/834-1050