

IN THE FIFTEENTH JUDICIAL CIRCUIT COURT  
IN AND FOR PALM BEACH COUNTY, FLORIDA

CASE NO. 83-308 CA (L) 01 B

RICHARD W. LOUDON and BETTY )  
J. LOUDON, his wife, )

Plaintiffs, )

vs. )

THE PRUDENTIAL INSURANCE )  
COMPANY OF AMERICA, etc., )

Defendant. )

ORIGINAL

THE DEPOSITION OF LAWRENCE BURTON, M.D.,  
TAKEN AT THE INSTANCE OF THE DEFENDANT.

Freeport, Bahamas  
Thursday, July 21, 1983  
2:35 - 5:10 o'clock p.m.

APPEARANCES:

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I N D E X

WITNESS:

PAGE

LAWRENCE BURTON, M.D.

Direct Examination by Mr. Morrissey	3
Cross Examination by Mr. LaSorte	60
Redirect Examination by Mr. Morrissey	89
Recross Examination by Mr. LaSorte	101

EXHIBITS:

PAGE:

Plaintiff's Composite Exhibit 1	103
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1                   The deposition of LAWRENCE BURTON, M.D.,  
2       was taken before me, Kimberly L.P. Garn, Registered  
3       Professional Reporter and Notary Public, State of  
4       Florida at Large, at The Immunology Researching Centre,  
5       in Freeport, Grand Bahamas Island, Bahamas, beginning  
6       at the hour of 2:35 o'clock p.m. on Thursday, July 21,  
7       1983, pursuant to Notice in said cause for the taking  
8       of said deposition, which is attached to the Court File  
9       herein, at the instance of the Defendant in the  
10      above-entitled cause pending in the above-named Court.

11                   - - -

12      THEREUPON,

13                   LAWRENCE BURTON, M.D.,  
14      being by me first duly sworn to testify the whole truth  
15      as hereinafter certified, testified as follows:

16                   DIRECT EXAMINATION

17      BY MR. MORRISSEY:

18           Q       State your name, please.

19           A       Lawrence Burton.

20           Q       And your professional address?

21           A       Freeport, Grand Bahama Island.

22           Q       If I was addressing a letter who would I  
23      send it in care of?

24           A       Box F-2689.

25           Q       All right. You work at The Immunology

1 Researching Centre?

2 A Correct.

3 Q What is your occupation?

4 A Medical research.

5 Q How long have you been doing that?

6 A Since 1958.

7 Q What degree do you have?

8 A Ph.D., experimental zoology. New York  
9 University Grad School Arts and Science.

10 Q When did you graduate from NYU?

11 A Degree was conferred January, 1955.

12 Q What were you doing between 1955 and 1958?

13 A Two-and-a-half years at Cal-Tech on the  
14 faculty, and then a year on the faculty in NYU Grad  
15 School.

16 Q Was that in zoology?

17 A All right. Zoology/biology.

18 Q Biology.

19 Okay. Where did you begin doing medical  
20 research in 1958?

21 A St. Vincent's Hospital, New York City.

22 Q What was the nature of your research?

23 A Well, I was an Associate in Pathology, an  
24 Associate in Oncology. I was also doing research in  
25 carcinogenesis in mice and human.



1 Q Did you say human?

2 A And human. Never treated a patient in my  
3 life.

4 Q This was all from a research standpoint?

5 A All research.

6 Q When you say that you're an Associate with  
7 Pathology, what do you mean by that?

8 A Yes. We used to see what happened after  
9 the orthod~~o~~x doctors had cured their patients and did  
10 the autopsies on them and found out how they had  
11 butchered their patients. But they died orthodoxly.  
12 You've got to say that's good.

13 Q What do you mean when you say that you're  
14 an Associate Pathologist? You were just performing  
15 autopsies?

16 A No. Studying -- well, observing autopsies,  
17 studying the pathological slides.

18 Q Okay.

19 A I was not an M.D. and didn't have the right  
20 to cut up any cadavers.

21 Q When you say you were an Associate in  
22 Oncology what do you mean by that?

23 A Well, we were studying causative effects of  
24 cancer and Hodgkin's, lymphoma, lung cancer in both man  
25 and mouse.

1 Q How long were you at St. Vincent's?

2 A From March, 1958 to December, 1973.

3 Q Okay. You associated with any other  
4 hospitals or any other research centers?

5 A No.

6 Q What did you do in December of 1973?

7 A A laboratory had been set up on Long Island  
8 called Immunology Research Foundation. Great Neck,  
9 Long Island.

10 Q That's a predecessor of this clinic?

11 A They're not associated.

12 Q It's not in existence any longer, is it?

13 A The Foundation is, but I'm not part of it.

14 Q All right, sir. Who was in charge of the  
15 IRF in Long Island during your time there?

16 A Robert Widom, W-i-d-o-m.

17 Q What was your position at the IRF?

18 A Research Director.

19 Q What was the nature of the research you  
20 were doing there?

21 A The beginning of the therapy.

22 Q This therapy here?

23 A The use of serum proteins extracted from  
24 healthy individuals in the treatment of cancer patients  
25 and mice.

1 Q The research was extracting proteins from  
2 humans and using them on mice, is that what you said?

3 A That was part of it.

4 Q What else was there to it?

5 A A group of six doctors were treating  
6 patients with it.

7 Q Who were they?

8 A Will not give you their names.

9 Q You will not give me the names?

10 A Will not give you the names. We don't need  
11 any witch hunts on these doctors. That was one of the  
12 reasons I came here.

13 Q Why do you feel it would be a witch hunt?

14 A Well, they already had a witch hunt in  
15 Connecticut on a doctor who recommended a patient to  
16 come here.

17 Q Who's that?

18 A Roseman Clark (phonetic), her husband is  
19 the last remaining member of the Avon family, trustee  
20 of Memorial Sloan Kettering, chief trustee New York  
21 Hospital, chief trustee of the Old Greenwich Hospital,  
22 and his wife was given seven to fourteen months. Wife  
23 is still alive. No symptoms. The doctor who  
24 recommended she look into this, Jack John Thurston  
25 Badey (phonetic), was put on a trial in Connecticut for

1 recommending a woman of such stature' to quackery. Even  
2 though they now come out with the statement in each  
3 three hospitals, and checked up every six months,  
4 Mrs. Clark, you're a miracle. You should have been  
5 dead in 1978. That quack in the Bahamas has something  
6 for you, only for you and you better stick with it.

7 For that, the doctor then in Connecticut  
8 had to spend fifty-five thousand dollars to defend  
9 himself. And I do not intend jeopardizing the other six  
10 doctors.

11 Q So we have Dr. John Thurston Badey who was  
12 a Connecticut doctor?

13 A That's right.

14 Q And he recommended a woman named --

15 A He recommended to a woman that she seek  
16 other alternatives. One of the alternatives was this.

17 Q Okay.

18 A For that, he was defended by Louie Nizer's  
19 (phonetic) firm. And Louie Nizer said, "I have never  
20 seen American justice fall to such a debasing  
21 character."

22 MR. MORRISSEY: Move to strike.

23 THE WITNESS: The reason being, his  
24 accusers were his judges. What a thing.  
25 Kangaroo court.

1 MR. MORRISSEY: Move to strike.

2 BY MR. MORRISSEY:

3 Q You said that three hospitals they  
4 mentioned this woman was a miracle?

5 A That's right.

6 Q What three hospitals were those?

7 A Sloan Kettering Memorial Hospital, New York  
8 Hospital, Old Greenwich Hospital.

9 Q All right. How long did you continue to  
10 research at the IRF?

11 A We left there -- well, let's put it this  
12 way, the second week of 1977.

13 Q That's when you came down here?

14 A And we came here. We came here March 17th,  
15 1977.

16 Q During the time that you did research at  
17 the IRF did you publish any articles concerning your  
18 research there in any of the scientific/medical  
19 journals?

20 A No, but I did get six patents.

21 Q You have six patents?

22 A Six patents. No patents pending. All  
23 approved.

24 Q When were they approved?

25 A I really -- I don't -- I don't keep the

1 dates.

2 Q All right. Do you know if that was since  
3 you came down here or --

4 A Some in New York. Some here.

5 Q Does that involve the serum that you  
6 administer?

7 A The extraction.

8 Q Have you submitted any articles for  
9 publication?

10 A I have not and will not.

11 Q Why is that?

12 A I've been blackballed. Any articles from  
13 me coming to the major journals are to be rejected with  
14 snide remarks. And if you want to go into that, call  
15 60 Minutes, the producer, and he'll give you the data  
16 on that.

17 Q Have you submitted any articles?

18 A I don't intend to. Why should I?

19 Q So then you really don't know whether  
20 they'd be rejected or not, do you?

21 A Huh! From 1964 till '73 about eight papers  
22 went in. The work is very good, and the last one was,  
23 the work is acceptable but proteins could be stinkweeds  
24 or roses. And I'll tell you, don't insult if you then  
25 intend.

1 Now, I've been asked to publish since, and  
2 my answer to the American scientific community is, go  
3 to hell.

4 Q Who asked you to publish?

5 A Let's see. Who asked me to publish? The  
6 American Cancer Society, The National Cancer Institute  
7 and diverse journals, for which I take their papers and  
8 I file them in the rectangular file.

9 Q / All right.

10 A There's no law that dictates you must  
11 publish your findings.

12 Q I understand that. From 1964 to 1973 did  
13 you have eight articles published or did you submit  
14 eight articles?

15 A We submitted them.

16 Q All right. And they were not published?

17 A Well, one was published finally in the  
18 Argentine Journal of Pathology. That's how far it  
19 reached.

20 Q Do you know when that was?

21 A '64 or '65.

22 The last one was rejected by Proc. Soc.  
23 (phonetic).

24 Q Who was that?

25 A Proc. Soc., the proceedings for the Society



1 of Experimental Biology and Medicine, 1972. A long  
2 case history by the Cancer Research. They have the  
3 annual meetings. We sent in articles after articles.  
4 We wanted to present papers. By the way, I've  
5 presented papers there before. At first they took two  
6 abstracts, then took my title and then even the title  
7 didn't even fit.

8 We caught Dr. Schimkin (phonetic), former  
9 editor, maybe still, of Cancer Research, Sorke  
10 (phonetic) Institute, with the -- his hand in the  
11 cookie jar. Which he stated, this paper we're going to  
12 publish in 1967 is so important, my laboratory will  
13 repeat it first.

14 Well, that's the classic old, what would  
15 you say, plagiarism you can imagine. And by the way,  
16 call 60 Minutes and they got an admission from  
17 Dr. Schimkin that he did that. We got it back and did  
18 not publish the paper.

19 MR. MORRISSEY: Move to strike.

20 BY MR. MORRISSEY:

21 Q How did you come to meet Dr. Weinberg?

22 A I don't think that's pertinent.

23 Q Excuse me?

24 A He came to me and asked to work, but I  
25 don't really know if that's pertinent, how I met him.



1 I could have met him in a toilet or I could have met  
2 him in a bar or I could have met him in the laboratory.

3 MR. LaSORTE: Could we go off the record  
4 for a minute?

5 MR. MORRISSEY: Sure.

6 (Discussion off the record.)

7 BY MR. MORRISSEY:

8 Q I take it you don't remember when you first  
9 met Dr. Weinberg?

10 A Truthfully, no.

11 Q Okay. Now, did you met Dr. Weinberg when  
12 you were still in New York?

13 A He came to the laboratory in Long Island,  
14 stayed there for months observing the patients and what  
15 we were doing. And then stated that he was retiring to  
16 Freeport. He knew we were going to build somewhere,  
17 could he be a part of it. He was impressed enough.

18 Q What is his function in your clinic here?

19 A Originally he was one of the therapists,  
20 but he's now gotten older and we cannot put him out to  
21 -- you just don't fire him. So he now assesses  
22 patients when they come. Has nothing to do with the  
23 therapy any more.

24 Q When you say therapy, do you mean the  
25 administration of the serum or --

1 A Or following the patient's or whatever.

2 Mr. Loudon was a bleeder and he didn't go  
3 to Dr. Weinberg when he was bleeding. He went to  
4 Dr. Clement.

5 Q I understand. Do you have some sort of  
6 screening procedure for applicants at your clinic?

7 A Well, we have first a physical part of  
8 Dr. Weinberg going over that their records are real  
9 that they bring over.

10 Q Okay.

11 A And occasionally we do get some fraudulent  
12 records sent by some society we won't name.

13 The other thing is we test their blood to  
14 see the state of their immune mechanism, whether  
15 there's a potential for augmenting their immune  
16 records.

17 Q How do you test the blood for the immune  
18 mechanism?

19 A Well, we test all the levels of tumor  
20 antibody, tumor complement, deblocking proteins called  
21 specifically an alpha 2 macroglobulin.

22 Q Why don't we go through that last part, how  
23 you test the immune mechanism.

24 A Well, the tumor antibody.

25 Q What is that?

1           A     It's an antibody to tumor. You want the  
2 technical part of it?

3           Q     Yes.

4           A     It's an alpha 2 macroglobulin that's  
5 associated with three immunoglobulins; IgG, IgM and  
6 IgA, with IgA being the predominant. And if you want  
7 to read about it, go get the papers on Mono-clonal  
8 antibody.

9           Q     Who published that?

10          A     Who published that? Gene Tech (phonetic).  
11 God, there's I don't know how many papers. It's a  
12 current rage in cancer therapy. One antibody to tumor.

13          Q     And after the tumor antibody you  
14 mentioned

15          A     Tumor complement. This is a breakdown  
16 product of C3 Complement known substance. There are  
17 fifteen or plus complements in your blood.

18          Q     Okay. Then you have a deblocking protein?

19          A     Deblocking protein which is an alpha 2  
20 macroglobulin. And you can get all the papers on that  
21 from

22          Q     How does that differ from tumor antibody?

23          A     Different alpha 2 macroglobulin.

24          Q     It's different chemical composition?

25          A     Well, what it means, alpha 2 means macro,

1 large globular round protein which on an electrical  
2 charge will move to the second two. They call it alpha  
3 2 instead of calling it two-two protein.

4 There probably are five to infinity alpha 2  
5 macroglobulins. It's just a class.

6 Q Okay. Do you do any significant specific  
7 research as to proteins or --

8 A Be a little more specific. What kind of  
9 proteins are you talking about?

10 Q That's what I was going to ask you.

11 A There's probably billions of proteins.

12 Q Well, do you try to get more specific in  
13 your analysis than just this alpha 2 class?

14 A Well, these are separated out by a  
15 technique which separates out these proteins.

16 Q And that technique is?

17 A It's published in the -- go look at the  
18 patent office. They're all there. There's no reason  
19 going through them.

20 Q What do you call the technique?

21 A What do I call the technique? Each one --  
22 isolation and standardization of each one of them.

23 Q Okay. Any other testing that goes on to  
24 the patient before you administer any of your therapy?


25 A We do some clinical chemistries which is

1 farmed out. We don't do that.

2 Q Okay. What tests are those?

3 A Like an SMA12.

4 Q What's that?

5 A Well, that's called a SMA12. Twelve   
6 different proteins. In the United States they have  
7 that. But it must contain alkaline phosphatase, lactic  
8 dehydrogenase, and your SGOT, transaminase. We also do  
9 a CBC with a differential on them.

10 Q Why those three particular proteins?

11 A The --

12 Q Well, you have the alkaline phosphatase.

13 A That tells your whole story about the  
14 patients.

15 Q What does the phosphate tell you?

16 A The alkaline phosphatase, whether they have  
17 bone or liver cancer involvement. LDH is lactic  
18 dehydrogenase, the non-specific for tissue destruction.  
19 SGOT is transaminase which will tell you whether the  
20 alkaline phosphatase is elevated due to bone metastasis  
21 or liver metastasis. You can get an elevated LDH if  
22 you get even a cut or any kind of tissue destruction.

23 Q If I had a cold or anything like that?

24 A A bad enough cold the LDH would probably go  
25 up. If you had hepatitis, all three of them would.



1 Q In evaluating the prospective patient then  
2 as far as his cancer is concerned, what is the  
3 significance of those three things?

4 A Well, we want to know what they're involved  
5 with beforehand. It's a base line. We do take x-rays  
6 of the patient, flatplates. Any kind of scans, we get  
7 the scans done in the United States.

8 Q That's in Miami?

9 A / Wherever the patient comes from.

10 Q Okay. Do you do any nutritional  
11 evaluation?

12 A No, sir. We do not push any diets.

13 Q Do you do any other testing for the immune  
14 system?

15 A For one thing, there is none.

16 Q How is it determined whether or not a  
17 patient will be admitted to care at your clinic?

18 A Well, now the computer really works that  
19 out, but it's based upon the original sample that came  
20 here with all different tests; which patient did well,  
21 which one did not do well based upon what our findings  
22 were before then. The original bunch we didn't know.

23 Q Okay.

24 A It's called trial and error.

25 Q Which ones didn't do well prior to their

1 treatment here?

2 A After they came here, we got the clinical  
3 chemistries, our tests, we got correlated with their  
4 patient history. Now, these did well in a certain  
5 group and these didn't do well. Well, then you try to  
6 eliminate those that match those that didn't do well.

7 Q Which kind don't do well?

8 A Well, the ones that are usually killed by  
9 orthodox medicine beforehand, if we can put that in a  
10 nice broad statement.

11 Q They're dead before they get here?

12 A Well, practically. They're anemic, needing  
13 blood. Anemic patients do not do well.

14 Q Okay. Any other kinds? Are there any  
15 particular kinds of cancers which don't treat well with  
16 your clinic?

17 A Well, some we haven't had too many. Some  
18 we've had quite a few.

19 Q Are there any particular cancers that you  
20 can think of that don't do well under your treatments,  
21 though?

22 A Well, based upon it's the nature of the  
23 beast, that is, a patient that has ascites fluid we  
24 test for proteins. If the patient throws the proteins  
25 into the abdomen or the chest, eventually some of them

1 do come out and we're trying to assess protein changes  
2 due to therapy. Now, if the proteins are derived from  
3 three weeks ago and been sitting in the abdomen and  
4 finally came out, it's not going to make our treatment  
5 very efficient. So we usually steer clear of those who  
6 have plural effusion or abdominal ascites.

7 MR. LaSORTE: What is that? Abdominal  
8 what?

9 THE WITNESS: Ascites, a-s-c-i-t-e-s.

10 BY MR. MORRISSEY:

11 Q The reason that those don't do well is that  
12 they don't absorb the protein?

13 A No. We can't tell when we see the proteins  
14 whether it's today's, yesterday's or four weeks ago.

15 Q Where are you obtaining these proteins?

16 A From their blood. We're testing their  
17 titres as we said originally daily.

18 Q Someone who did not have that condition, if  
19 you tested his blood daily what would you find with  
20 respect to the proteins?

21 A There would be changes.

22 Q There would be changes?

23 A Elevations, depressions.

24 Q That's on a daily basis?

25 A Minimum of a daily basis.



1 Q What is the significance of the change?

2 A Of a change?

3 Q Yes.

4 A Well, if the protein is used and the  
5 pre-albumin is the other one, which comes from dead  
6 cells, and there's eighteen papers by Jacobe  
7 (phonetic), Paris, this tells us whether tumor cells  
8 are dying, any cells are dying. Now, if this elevates  
9 and the patient's tumor is regressing, the correlation  
10 with animal is much easier. When this elevated we  
11 sacrificed the animal and then did pathology on the  
12 tumor. And if we found tremendous necrosis in the area,  
13 we achieved something. Now, you don't do that on  
14 patients so you then have to correlate.

15 Q Are there any other kinds of patients that  
16 don't treat well under your therapy?

17 A As I said before, those who have an immune  
18 mechanism that has been practically obliterated by the  
19 anti-immune effects of prior treatments.

20 There are some types of cancers that do not  
21 respond to chemotherapy which your company pays for  
22 very nicely, which is a chemotherapy for lung cancer,  
23 all different types.

24 Quote Dr. DeVita (phonetic), head of the  
25 N.C.I., our survival rate should be -- improvement rate

1        sixty percent if we discount the lung cancers that  
2        never responded to chemotherapy and it's only one  
3        percent, and yet all of the oncologists lay into  
4        chemotherapy. Question; why?

5                So if I seem angry, that's who I'm angry  
6        about. Stop killing people for experimental reasons.

7                MR. MORRISSEY: Move to strike the  
8        unresponsive portion.

9        BY MR. MORRISSEY:

10        Q        Who makes the ultimate decision as to  
11        whether or not a patient will be admitted to your  
12        clinic?

13        A        I do.

14        Q        You make that decision in each case?

15        A        Every case.

16        Q        Does Dr. Weinberg make a recommendation to  
17        you?

18        A        He makes a recommendation. Our other  
19        doctor, Dr. Pratt, she'll make a recommendation, too.

20        Q        What factors do you consider in making your  
21        decision?

22        A        I use the computer which as I said before  
23        has all the old ones in, and then I'll tell you what,  
24        after reading twenty odd thousand case histories and my  
25        memory is fairly good, I can remember which ones should

1 or should not.

2 We're not a money-oriented factory here,  
3 and the only way we exist is by getting results.

4 Q Okay.

5 A And might as well put it down, almost fifty  
6 percent of all patients that have come here have never  
7 paid one cent.

8 Q What kind of computer are you using?

9 A Hewlett-Packard System.

10 Q What model?

11 A Well, we'll have to give you the numbers.  
12 I don't remember now, but it's costs us, hardware and  
13 software, just under a half a million dollars.

14 Q You have the model number somewhere in your  
15 office I assume?

16 A Yes, it's on the machines.

17 Q You think we can get that some time  
18 tomorrow?

19 A When we're through you can go take a look.  
20 Hewlett-Packard would love it.

21 Q All right.

22 A One's a 9600 series, the old one. Can't  
23 remember the new one.

24 MR. LaSORTE: We'll get it.

25 THE WITNESS: We have two new ones.

1 BY MR. MORRISSEY:

2 Q Two new ones?

3 A '81/'82 vintage. Then what they put out in  
4 '83 which costs about triple. How far can you go?

5 Q Keep getting smaller, too?

6 A They're not small; they're big.

7 Q What is Dr. Clement's function here?

8 A Well, head M.D. in charge of the  
9 well-being, clinical status of the patients.

10 Q This clinic is not an overnight facility,  
11 is it? It's more of a walk-in arrangement?

12 A It's ambulatory.

13 Q Okay. A patient that is admitted to your  
14 clinic is going to get your treatment?

15 A Definitely. Otherwise what are they here  
16 for?

17 Q Right. How do you determine what treatment  
18 a particular patient is going to get?

19 A It's all a computerized system based upon  
20 their blood test.

21 Q Is this a blood test that we talked about  
22 earlier or --

23 A Yes.

24 Q -- is this another one?

25 This is involving the three components?



1           A       It involves those three components and the  
2       titre, that pre-albumin --

3           Q       Plus the alpha 2 antibody?

4           A       The alpha 2 macroglobulin, tumor antibody,  
5       the tumor complement and the pre-albumin which comes  
6       from dead tumor cells. This was originally evolved  
7       from testing on animals. Then after we tested that in  
8       the human we went back and tested the human formulas on  
9       the animals.

10          Q       This is still up in New York?

11          A       Here.

12          Q       Oh, here?

13          A       We still have almost four thousand animals  
14       back there and testing is still going on.

15          Q       Approximately how many patients come  
16       through here each day?

17          A       The patient load at the moment -- well,  
18       since January 1st has varied from a high of a hundred  
19       and twenty-six down to a low of seventy-eight daily.

20          Q       All right. And do each of these people  
21       need to have a blood test when they come in?

22          A       Yes, sir.

23          Q       Who extracts the blood?

24          A       Who takes the blood from them?

25          Q       Yes.

1 A Dr. Weinberg, the nurses, technicians.  
2 Always under a doctor's supervision.

3 Q Okay. And who does the testing on the  
4 blood?

5 A The technicians.

6 Q Technicians do? How many technicians do  
7 you have?

8 A Well, we've had a high of twelve. I think  
9 we have eight now.

10 Q All right. Do you know how long it takes  
11 to do each blood test?

12 A Well, we can run a series of twenty-four in  
13 approximately forty-five to fifty minutes.

14 Q All right. After the blood test is done  
15 what happens?

16 A The findings are put into the computer.  
17 Then the computer goes on from there and works out --

18 Q Who's programmed the computer?

19 A Programmed? My formulas. The programmer,  
20 I will not give you his name.

21 Q All right. And your reason for that?

22 A He is a resident in the United States and  
23 he doesn't need headaches.

24 Q He'll get a headache if he's programmed  
25 your computer?

1           A       No, sir. I'll tell you what. It's called  
2       safety first. At one time he was the head of  
3       Scientific -- Ph.D. of Scientific Programming for a  
4       very large medical school in the Washington, D.C. area.  
5       He would lose his job in ten minutes.

6           Q       Okay. I assume you're not going to tell me  
7       where he works then?

8           A       Of course not. Well, I'll tell you what.  
9       Would you?/

10          Q       I don't understand what your reasons are.

11          A       What the reasons are? That happens to be  
12       the American Cancer Society which does not happen to be  
13       very friendly to me which happen to be a gigantic  
14       octopus that has its tentacles in everything.

15          Q       Did this individual who has programmed your  
16       computer have to know what your formulas were to do  
17       that?

18          A       I have to surely give it to him.

19          Q       All right.

20          A       All in the software of the computers.

21          Q       Who has access to the computers here?

22          A       Myself.

23          Q       All right.

24          A       My daughter, the programmer.

25          Q       Dr. Clement does not have access then to

1 the --

2 A Not to the program. He's not interested in  
3 it.

4 Q And he doesn't know your formulas?

5 A No.

6 Q You're the only one other than this  
7 programmer who knows your formulas?

8 A Essentially, yes.

9 Q / All right. I assume if I asked you the  
10 sixty-four thousand dollar question: What are your  
11 formulas, you're going to say no, is that correct?

12 A You answered the question for me.

13 Q Well, what are your formulas?

14 A I'm not going to answer that.

15 Q All right. And your reasons for that are?

16 A Well, primarily they happen to be mine.

17 Q Aren't they patented?

18 A No.

19 Q Okay. What things are patented?

20 A The extraction procedures.

21 Q The extraction of the --

22 A Of proteins for therapy and the testing  
23 methods.

24 Q But the formulas that go back into the  
25 serum that are administered to patients is not



1 patented?

2 A That's all in the computer.

3 The answer to your sixty-four thousand  
4 dollar question is that when a programmer whispers to a  
5 Russian, IBM has a fit on their programmers. And why  
6 should I be different from IBM or Hewlett-Packard or  
7 what have you?

8 Q You're afraid of Russians taking this?

9 A I couldn't care less.

10 Q Okay. Have you applied for a patent on  
11 your formulas?

12 A No.

13 Q You have not applied?

14 A No.

15 Q Not thinking about doing it?

16 A It's still in the developmental stage.  
17 It's about ninety percent automatic now.

18 Q What's the other ten percent?

19 A Ten percent is to tell the computer to tell  
20 the patient frequency of augmentation as well as how --  
21 well, how the -- let me see. The frequency is the  
22 first part of the augmentations, and then how many  
23 augmentations per day. This has to be based upon their  
24 own reaction as well as other healthy patients who have  
25 reacted to similar doses of similar diagnoses.

1 Q What's the difference between the frequency  
2 of augmentations and the number of augmentations a day?

3 A Well, you can give -- it's like giving one  
4 shot of insulin at nine o'clock in the morning. That's  
5 an augmentation of the pancreatic -- the own patient's  
6 production of insulin. Now, if we give another one at  
7 eleven o'clock, that's another augmentation.

8 Q Okay.

9 A So that's how often and how frequent.

10 Q So they really are the same thing?

11 A No, they're not. You can have two  
12 augmentations at nine and ten o'clock in the morning or  
13 you can have one at nine and six at night. Or you can  
14 have one at nine, ten, eleven, twelve, one, two, three,  
15 four, five, six, and they're two different things.

16 Q If you say.

17 A Well, I can give you a dollar's worth in two  
18 augmentations; fifty cents now or fifty cents at night,  
19 or I can give you a dime's worth ten times. Still end  
20 up with the same amount.

21 Q But still the frequency --

22 A How often do you give it? Many  
23 augmentations or you give it in just two, three, four.  
24 They're two different things.

25 Q Frequency is the total amount?

1           A       You get a total -- it will determine how  
2 many augmentations and how to break it down in between.  
3 Do you do one? Some patients do fantastic on one  
4 augmentation. Others do better on the same amounts of  
5 each but split into two parts. Others do better when  
6 it's split into fifty parts. And only a computer can  
7 do that. The human mind hasn't got the capability.

8           Q       To do it as quickly?

9           A       / It still hasn't got the capability because  
10 this then has to check each time whether it's going to  
11 achieve what and what have you. Have to check the  
12 patient's file and other patient's file. You would  
13 take twenty-four hours to do one patient and may not  
14 even be able to do it.

15          Q       I don't have a formula.

16          A       Where a computer can do it in a split  
17 second.

18          Q       All right. After your computer spits out  
19 this information without going into specifics, what  
20 other general kinds of information does it give you  
21 other than the frequency and the number of times?

22          A       Dosage.

23          Q       Okay.

24          A       I'm dealing with three different proteins.  
25 If the patient produces antibody, that patient would

1 get the tumor complement which activates the antibody  
2 first. But if the patient is not producing much  
3 antibody, they would get the antibody first. If the  
4 patient has had a high tumor kill and his blocking  
5 protein elevated, you would first want to lower that in  
6 the blood so they would not get the deblocking protein  
7 first.

8 Q So it gives you the order?

9 A The order as well.

10 Q Does it give you the strength, the relative  
11 strength?

12 A Well, your dosage as well.

13 Q Okay. And what is being compared in order  
14 for the computer to generate numbers which show the  
15 order and the relative strength of these three factors?

16 A Well, primarily it was based upon what  
17 would the effects of this -- by the way, animals have  
18 the same substance, the success or lack of success in  
19 animals.

20 When we progressed from that in 1977, of  
21 course, we didn't have computers then. It was all on a  
22 lower level. We then worked what was similar effects  
23 on different cancer patients. Similar to what we had  
24 in the animals. Then after we had the computers, you  
25 now could compute with what are the effects in the

1 individual that gave the blood in comparison to his  
2 history as well as to the history, and the complete  
3 file of every patient that's ever been here, of a  
4 similar type of cancer.

5 Q So that the type of cancer that a person  
6 has may be a factor in determining --

7 A Yes, sir.

8 Q Okay. So if a person had some kind of lung  
9 cancer he might not get the same thing that somebody  
10 has with cancer of the esophagus or breast cancer?

11 A Yes, sir.

12 Q So if I understand you, your computer  
13 correlates all the patients who had say cancer of the  
14 esophagus?

15 A Correct.

16 Q All right. And from the blood tests that  
17 are done, it's going to generate numbers that show --

18 A What they were treated with, what was their  
19 blood test before the treatment, what was their blood  
20 test after the treatment, and we'll give you the  
21 efficiency of each one of them.

22 Q The blood test after the treatment, what is  
23 that designed to show?

24 A Well, if you give antibody and there is no  
25 elevation, you should find that you'll get an elevation

1 in the blocking protein which means that it's been  
2 successful in killing tumor and been utilized. Now, if  
3 there's a build-up in antibody, you will probably not  
4 see an elevation of the blocking protein because it was  
5 not efficient. Therefore, that was wrong and that is  
6 the time when the computer immediately shuts over to  
7 another patient who has a similar -- well, did we get  
8 into this problem before? How was it solved? Now this  
9 then modifies the dosage based upon that.

10 Q Okay.

11 A It's taken us five years to put this in.

12 Q So really the entire decision-making  
13 process is done in the computer?

14 A Correct.

15 Q Okay.

16 A Except for that last ten percent.

17 Q Frequency and --

18 A That has to go in. That's the last job.

19 Q It's not in the computer yet?

20 A No.

21 Q Who determines that?

22 A That's what I'm here for. \*

23 Q You're going to retire after you get that  
24 one in there then?

25 A No. I'll tell you what we've done. We've



1 expanded the colonies. We're going back because I  
2 happen to know there's six other immune proteins  
3 involved in this. They play a role, but not a major  
4 role and that's where the fault in the therapy is. Why  
5 we're not in the ninety percent improvement rate.

6 Q Okay. Will you tell me what those six are?

7 A Six are? One, there's another antibody in  
8 which -- similar to the other one, in which IgM is the  
9 predominant. It fluctuates in cancer patients. Why?  
10 Then the cancer patient produces another type of  
11 Complement C3 breakdown product which will not activate  
12 the tumor antibody.

13 Q Does it have a name?

14 A It's a breakdown product to Complement C3  
15 and it's not the tumor complement, but the cancer  
16 patient produces this. Why? They also produce another  
17 pre-albumin which is similar to the blocking protein,  
18 but it's only produced in the cancer patients. What is  
19 it there for?

20 Q Okay.

21 A Then the tumor -- well, then in mice alone  
22 produce another substance, a dialyzable substance,  
23 which can stimulate the production of tumor complement  
24 in normal mice. A few --

25 Q Stimulate tumor production?

1           A       Tumor complement. Tumor complement is only  
2 produced in a cancer patient.

3                   Now, we can probably stimulate the patients  
4 ahead of time with this, but how does it fit in? I  
5 don't know, but it's there.

6           Q       We've gone through four now.

7           A       Hard to figure out. Well, there's another  
8 -- there's two other alpha 2 macroglobulins that do  
9 vary in these cancer patients up and down.

10          Q       These alpha 2's have any specific name?

11          A       No.

12          Q       They have no specific names? They're just  
13 proteins?

14          A       These are proteins. And if you're asking  
15 me, why I haven't done it, how come they haven't  
16 identified the alpha 2 macroglobulin involved in alpha  
17 2 macroglobulin anemia? If they ever found out what it  
18 was, they could prevent the anemia. But this happened,  
19 I think, it took twenty to thirty years to identify  
20 what insulin is. So that it is not a short-term job to  
21 identify exactly what they are.

22          Q       You said a few minutes ago that the blood  
23 test afterwards will tell you whether or not there's  
24 been any success in fighting the tumor?

25          A       That's correct.



1 Q Okay. Now, if the tumor antibody element  
2 is elevated, what does that signify?

3 A It signifies that the patient's not using  
4 it. Somewhere it is blocked.

5 Q Okay. And would it also follow then that  
6 if a tumor antibody is elevated, that the deblocking  
7 protein is --

8 A Should be lower.

9 Q -- is low?

10 A Should be lower.

11 Q All right. And what about the Complement  
12 C3?

13 A Well, it's the same thing in each one of  
14 them. They're all interrelated. They can all elevate,  
15 all depress.

16 Q I don't understand what the Complement  
17 C3 --

18 A Tumor complement is the match that lights  
19 the gas which gives you the flame. It activates the  
20 antibody to kill tumor.

21 Q Complement is the match. What --

22 A Maybe like a match.

23 Q What is the gas?

24 A The gas to tumor antibody.

25 Q And what is the flame?

1           A       The flame? Well, now that you've asked  
2       that, would you define a flame for me? What is a  
3       flame? Utilization of energy. All right. How? I  
4       don't know. Nobody really knows.

5           Q       How does the deblocking protein come into  
6       this?

7           A       Deblocking is produced when a tumor cell  
8       dies. It's liberated, preventing further activation of  
9       the antibody by complement, which theoretically will  
10      give the liver enough time to get rid of the dead  
11      tissue proteins that have been liberated by the death  
12      of cells.

13          Q       All right. You have the death of the tumor  
14      cell liberating the deblocking protein --

15          A       No. Liberating the blocking protein.

16          Q       Oh, the blocking protein which stops the  
17      tumor complement from --

18          A       From activating the antibody.

19          Q       Don't you have a deblocking protein?

20          A       Well, if you have that sitting around we  
21      could stay the way they are in the U.S. and say there's  
22      a cocoon about that protects the tumor, or you could  
23      give them the alpha 2 macroglobulin which would remove  
24      the cocoon and let the antibody now be activated by  
25      the tumor complement and ending up in dead cells again.

1 Q I think my question is: If the tumor  
2 complement activates a tumor antibody, what does the  
3 deblocking protein do?

4 A Lowers the blocking protein.

5 Q Okay. Does that occur before or after the  
6 tumor cell has been destroyed?

7 A That's necessary after a tumor cell dies.

8 Q Okay. So you have tumor complement  
9 activating a tumor antibody?

10 A Correct.

11 Q Which somehow is going to kill this tumor  
12 cell?

13 A Yes.

14 Q Then you have a blocking protein which  
15 stops the tumor complement from operating?

16 A Correct.

17 Q So you need a deblocking protein to stop  
18 the blocking protein from operating?

19 A No. To lower the titre in the blood.

20 Q What in the blood?

21 A To lower the titre of the blocking protein  
22 in the blood.

23 MR. LaSORTE: T-i-t-r-e.

24 BY MR. MORRISSEY:

25 Q Okay. Have you been able to specifically

1 identify what tumor antibody is?

2 A I gave you the characteristics that I know.

3 Q And also with the tumor complement, you've  
4 given me that also?

5 A Total unknown.

6 Q Okay. And that holds true I guess for the  
7 blocking and deblocking proteins?

8 A That's correct.

9 Q / Okay. Once you've run your blood tests  
10 through the computer and you have your computer  
11 results, then what happens?

12 A Patients get treated.

13 Q Okay. How is that done?

14 A The computer calculates a dosage frequency,  
15 number of augmentations, how quickly, how often, with  
16 my help on the last couple of the last two.

17 Q That's what I was going to ask you. Okay.

18 A And then the technicians fill syringes out  
19 of standardized pathogen-free protein solutions.

20 Q Okay. Are they given the results of these  
21 computer tests then?

22 A The patients?

23 Q No. The technicians?

24 A They are merely given the dosages and how  
25 it's to be given. That's stamped out on a printer

1 outside.

2 Q How is the serum made?

3 A Get the patents and you can find out.

4 Q Not -- who makes it?

5 A Technicians.

6 Q Okay. How do they know how to make it?

7 A They've been given the flow sheets. The  
8 same flow sheets that are in the patents.

9 Q If I understand you, the computer will have  
10 a different formula for a particular patient?

11 A That's of using the proteins that have been  
12 isolated from normal blood. The computer computes the  
13 dose and then they fill the syringes based from the  
14 printout.

15 Q The formulas that you would not give me  
16 earlier, what do they relate to in this stage?

17 A Well, I think something like maybe one or  
18 two thousand formulas.

19 Q Okay.

20 A This hasn't arised. It just evolved from  
21 nothing.

22 Q I understand that.

23 I guess what I'm getting at is you have  
24 these one or two thousand formulas that you know that  
25 your technicians don't know.

1 A Why should they know?

2 Q I understand.

3 Now, they have to put together some serum,  
4 correct?

5 A They're told when -- the printout, it tells  
6 them to take a half a cc of bottle number one which has  
7 so much standardized material per cc.

8 Q Okay. You have a standard material?

9 A Standard and different concentrations.

10 Q Okay. Now, the one thousand or two  
11 thousand formulas that you have go into making what?

12 A Evaluating the patient's blood tests,  
13 correlating with their performer reactions with other  
14 patients of similar diagnosis in the production of what  
15 they should get, when and how and how often.

16 Q So it's a computer program?

17 A That's right. But the computer doesn't  
18 make the programs. I put the formula in and the  
19 programmer puts that into FORTRAN so that the computer  
20 will know what to do. And then after we put a new  
21 program in, we test it in the animals to make sure it's  
22 efficient. That there is no problem with it.

23 Q So your formula then is really how the  
24 computer correlates the numbers?

25 A Also what to do with the numbers.



1                   There's another program where it tells us  
2                   how the patient is doing, but that's still in the  
3                   experimental stage.

4                   Q       So when it gets to the technician then he  
5                   gets some kind of read-out that says he needs so much  
6                   of this stuff and so much of this stuff and so much of  
7                   this stuff?

8                   A       If you want, I'll give you a typical sheet.

9                   Q       / Sure.

10                  A       That's nothing.

11                  Q       But is that basically what it does?

12                  A       Yes.

13                  Q       And he puts it together from that? He has  
14                  the basic components?

15                  A       All isolated.

16                  Q       And the formulas that you're talking about,  
17                  the one thousand to two thousand, do not relate to how  
18                  to make the basic components?

19                  A       No.

20                  Q       Okay. How to make the basic components is  
21                  the stuff that you have patented?

22                  A       It's all patented.

23                  Q       All right.

24                  A       If we've made any improvements, that's not  
25                  in our patents.

1 Q Once the technicians have made up your  
2 serum, what is the next step?

3 A I standardize it.

4 Q Excuse me?

5 A I standardize it. I determine what's  
6 present in a cc or milliliter of this large batch.

7 Q Oh, they make a large batch?

8 A Oh, yes. They'll run through some thirty,  
9 forty liters of plasma before we have enough to go  
10 ahead. Each process takes from five to fifteen days to  
11 isolate.

12 Q How is it taken from this large batch and  
13 -- well, okay.

14 You're saying your standardized from the  
15 large batch to the particular patient?

16 A We standardize that so that we have -- no,  
17 once we have determined what is present in the large  
18 batch --

19 Q Right.

20 A -- it is then diluted down to standard  
21 utilizable concentrations for which when the printout  
22 comes, the technician will take if he needs five  
23 thousand units of antibody, he will take that out of  
24 say a ten thousand unit batch at a half a cc.

25 Q Okay. You move from the large batch to the

1 standardize, move to the smaller concentration trying  
2 to accommodate the read-out that that patient has?

3 A Correct.

4 Q Now, you have it down to the patient level.  
5 Then what happens?

6 A Then the patient is given the syringes and  
7 the patients treat themselves based upon instructions  
8 about which injection comes when at what time.

9 Q All right.

10 A And contrary to a ding-a-ling in Florida who  
11 said you need an M.D. degree to take an injection, and  
12 this is out of Broward County, well, if that's the  
13 case, what have all of these diabetics been doing all  
14 these years injecting themselves?

15 Q What doctor was that?

16 A I haven't got the slightest idea.

17 Q Okay.

18 A His name went into the toilet and you can't  
19 put mine on it. The man was devious, dishonest and  
20 what have you.

21 MR. LaSORTE: Motion to strike.

22 BY MR. MORRISSEY:

23 Q Now, so the patients that are I guess  
24 living in the community on a temporary basis while  
25 they're treating here come to your clinic on a daily

1 basis or --

2 A Daily basis. Sometimes two times a day.  
3 Some three times, four times a day.

4 MR. MORRISSEY: If you need to take a  
5 break or anything --

6 THE WITNESS: Yes, I'm going to have to  
7 take a break now. Now we've got patients.

8 MR. MORRISSEY: Can we continue this?

9 THE WITNESS: I'll be back in about  
10 fifteen or twenty minutes.

11 MR. MORRISSEY: Okay. That's fine. Any  
12 time you need to take a break feel free.

13 (Short recess taken at 3:35 o'clock p.m.)

14 (Thereupon, at 3:52 o'clock p.m. the  
15 foregoing deposition was resumed as follows:)

16 MR. MORRISSEY: What was the last question?

17 (Thereupon, the pending question and answer  
18 as stated by the witness was read back by the  
19 court reporter.)

20 BY MR. MORRISSEY:

21 Q When they come here do they obtain a serum  
22 that's been made for them?

23 A Well, either they do that or they give a  
24 tube of blood for us to determine what they should  
25 have.

1 Q Okay. Each day you're going to take the  
2 blood test anyway?

3 A Yes.

4 Q And you're going to take a before and after  
5 blood test?

6 A Right. Not always after.

7 Q Occasionally after?

8 A Sometimes.

9 Q To see what's going on?

10 A Yes.

11 Q All right. If I understand you, you  
12 testified a little while ago that they administered the  
13 shots themselves?

14 A Correct. They're taught by a nurse to do  
15 it.

16 Q What is the average treatment period for  
17 patients at your clinic?

18 A On an average six to eight weeks.

19 Q Six to eight weeks here? Then are they  
20 encouraged to continue treatment by themselves when  
21 they return home?

22 A When they go home.

23 Q How long do the home treatments last  
24 generally?

25 A Well, that's depending for a minimum of say

1 four weeks up to one year depending upon the state of  
2 the health of the patient.

3 Q Okay. And do they receive shipments of  
4 serum from you from the clinic?

5 A They take it themselves.

6 Q They have to come here and get it?

7 A Right.

8 Q Okay. And the people I see out in your  
9 waiting room with the little thermos jugs, they're here  
10 to pick up their serum?

11 A For the day, yes.

12 Q All right. And I assume when you take the  
13 occasional after treatment blood test that these blood  
14 tests are put back into the computer?

15 A Oh, sure.

16 Q And there might be some modification in the  
17 serum?

18 A Positively right. All patients are similar  
19 and they're all dissimilar.

20 Q Why don't you explain that.

21 A All patients -- all who have esophageal  
22 carcinoma are esophageals, but they happen to contain  
23 genes from their parents which are different from those  
24 patients. So they're similar yet different.

25 Q Okay. How are the differences accounted



1 for in your treatment?

2 A That's why we have a file on the patient.  
3 And after the first week or so the computer can detect  
4 when there are differences in them versus another  
5 patient.

6 Q Okay.

7 A Now, if a good patient -- a patient is new,  
8 comes in and -- well, I'll give you an example.

9 Mr. Estridge (phonetic), who I'm sure  
10 you'll be interested in, paid for by the United States  
11 Government out of the Nassau Embassy with procurement  
12 sheets out of Washington. I don't know who  
13 Mr. Estridge is, but he is a Mr. Loudon and he was not  
14 perking up. And the computer tacked it on Mr. Loudon  
15 who's lived too long according to the prognosis. So  
16 the computer modified out of Mr. Loudon, modified what  
17 track he should take and his therapy changed and  
18 immediately Mr. Estridge got better within a few day  
19 period. He was starting to -- well, he's a voice box  
20 patient to boot who now could breathe which he couldn't  
21 breathe before.

22 Q All right.

23 A So that he's an esophageal or overburned.  
24 Estridge is the name. Paid for by the U.S. Government,  
25 Nassau, Bahamas, in Bahamian money. They even made the

1 changeover in the money which was very good to us. It  
2 saved us a conversion fee.

3 Q Now, have you run across any patients who  
4 are so totally dissimilar to any others in your  
5 computer bank that the computer just couldn't figure  
6 out how to modify their treatments?

7 A Well, it couldn't modify it. It would then  
8 run out of the patient's own file. It took it back  
9 three years to the beginning.

10 Q And they couldn't find any way to modify  
11 it?

12 A They had to run out of their own file, and  
13 then it's up in the air whether this patient will or  
14 will not do well. Then make no predictions to them.

15 Q Okay. And to continue treatment with that  
16 kind of patient you would have to proceed on a  
17 trial-and-error basis?

18 A Back to where it started.

19 Q How are the decisions made concerning the  
20 treatment of that kind of patient?

21 A There's a program in there for it, in the  
22 computer for it.

23 Q For trial and error?

24 A Well, trial-and-error basis. If they built  
25 up antibody, which means we're overdosing the antibody,

1       that may be the break. That's called enzyme kinetics,  
2       and let's not go into it. I'm sure you're not going to  
3       -- the jurors or yourself are not going to go into  
4       that. But in enzyme kinetics you'll have too much  
5       enzyme and then you'll get an enzyme substrate complex  
6       and you'll not get any breakdown of the product. So  
7       that in this case the computer will recognize that  
8       after two or three days and start to immediately cut  
9       back or evaluate the one that's needed. It's hard to  
10      change it on that. It doesn't mean the patient is  
11      hopeless, but we can't go on past performances.

12           Q       But this is still a computer program that  
13      will --

14           A       Yes, sir.

15           Q       -- engage in this sort of educated trial  
16      and error?

17           A       It's your terminology.

18           Q       All right. Do you keep records here of  
19      every patient who has applied for admission in your  
20      clinic?

21           A       Yes, sir.

22           Q       Even those who have been denied?

23           A       Yes, sir.

24           Q       Okay. Do you have brochures or written  
25      materials that you provide to patients when they first

1 arrive here?

2 A I think so.

3 Q Can I get some copies of those?

4 A You'll have to go over to the other  
5 building and see what's available.

6 Q All right.

7 A That's under the medical wing. That's not  
8 under my tutelage anymore.

9 Q That would be under Dr. Clement?

10 A That would be there or under the  
11 administrator.

12 Q Who's the administrator?

13 A Edward Granger.

14 Q And where are the records kept on all the  
15 applicants to the clinic?

16 A That would be kept over in the clinic.

17 Q What is this considered, the old clinic?

18 A Well, this is essentially the -- do you  
19 want to call it the treatment part? This eventually  
20 will be an adjunct to the other one next door to it.

21 Q Okay. Does the information given to  
22 patients when they first start treatment have anything  
23 pertaining to insurance coverage?

24 A Well, the only thing I know of myself at  
25 the moment is I tell them to sue the hell out of them,

1       okay?

2               Q       Okay. And do you tell them that right off  
3       the bat?

4               A       Well, in the course. I don't tell them on  
5       the first word. You're entitled to coverage.

6               Q       All right.

7               A       Now, some get paid without suing.

8               Q       Now, are the patients given any aid in  
9       acquiring information to use in bringing a lawsuit  
10      against their insurance company for payments? For  
11      example, names of other people who have done the same  
12      thing?

13              A       If they ask, I guess it's supplied.

14              Q       All right. Have patients ever been told  
15      that monies they give to the IRC are tax deductible in  
16      the United States?

17              A       Not by me.

18              Q       Do you know if by any of your --

19              A       Not that I know of.

20              Q       All right. And --

21              A       I'm not in the IRS, so I have no thing with  
22      them.

23                      If they would ask me, and some have, could  
24      I apply for it, go ahead and try. That's between you  
25      and the IRS.



1           Q     Have patients been given any information  
2     indicating that payments they made to the IRC were in  
3     the form of donations?

4           A     No, sir. We're not listed with the  
5     Internal Revenue.

6           Q     Are patients told when they come here --  
7     strike that.

8                     Are patients asked when they come here to  
9     apply or be evaluated as to whether or not they have  
10    any kind of health insurance?

11          A     Has no -- there is no question or any  
12    questionnaire on that.

13          Q     Okay. Is it indicated to patients in any  
14    manner that there have been problems with obtaining  
15    insurance coverage for treatments at this clinic?

16          A     If an individual patient calls and says,  
17    were there problems? Yes, there were problems. If  
18    they do not ask, they are not told.

19          Q     Do you have any independent recollection of  
20    Mr. Loudon?

21          A     Yes, I know him.

22          Q     Okay. When was the last time you spoke to  
23    Mr. Loudon?

24          A     The last time he was here.

25          Q     When was that? You can look at the records

1 if you want to.

2 A You're asking me my recollection? I'll be  
3 honest. I don't recollect.

4 Q All right. What kind of cancer did  
5 Mr. Loudon have when he first came here?

6 A It's in the record.

7 Q Okay.

8 A We did not diagnose it. He was diagnosed.

9 Q Right. He comes in with his medical  
10 records?

11 A That's correct. We treat no undiagnosed  
12 patients.

13 Q How long was Mr. Loudon treated here?

14 A Offhand, I couldn't tell you. It's in the  
15 record itself.

16 Q Okay. Was Mr. Loudon treated by the same  
17 procedures that you've described earlier --

18 A That's correct.

19 Q -- concerning the blood tests and computer  
20 printouts and all that?

21 A Exactly correct.

22 Q All right. Do you know if Mr. Loudon was  
23 provided any drugs or medicines other than the  
24 treatments you provided to him?

25 A Aside from this type, it would probably be

1 in the records and it's upon the discretion of  
2 competent physicians, licensed physicians.

3 Q Okay. That would be Dr. Clement in this  
4 case?

5 A Dr. Clement, Dr. Pratt.

6 Q Who's Dr. Pratt?

7 A That's a Bahamian M.D.

8 Q Does he work at your clinic?

9 A She does.

10 Q She does. I'm sorry.

11 Neither Dr. Clement nor Dr. Pratt have  
12 access to your computer?

13 A They've never expressed a desire. They're  
14 clinical physicians.

15 Q They don't know your formulas, do they?

16 A They've no need. They've never expressed a  
17 desire for it.

18 Q Did Mr. Loudon indicate how he found out  
19 about your clinic?

20 A I have no recollection. Probably from  
21 another **successful patient**. Word of mouth is usually  
22 the most **important**.

23 Q Do you **do** any kind of advertising in the  
24 United States?

25 A Well, if you'll define what kind of

1 advertising? Do you mean we take in a magazine? No,  
2 we don't advertise in that.

3 Q Okay. Do you do anything that disseminates  
4 information to the public?

5 A Well, when Lester Maddox (phonetic) came  
6 here, the television stations from Atlanta, Georgia,  
7 wanted a story and they put it on television.

8 Q We're not talking about ads. I want things  
9 that you've paid for.

10 A Paid advertisement? That we've paid to put  
11 in the television blips or newspaper, no.

12 Q Sent out brochures or mailings or anything  
13 like that?

14 A We don't even have a newsletter, but we're  
15 contemplating it being sent to former patients, present  
16 patients which will not include soliciting funds.

17 Q Have you all ever told a patient who is  
18 treating at your clinic that they should not come back  
19 for any more treatment?

20 A Yes, sir.

21 Q Under what circumstances have you done  
22 that?

23 A That we feel we cannot help them anymore.

24 Q And why do you feel that?

25 A I'm being honest.

1 Q If they're too severe? '

2 A There's too severe, there's too much tumor.

3 Patients have other complications which takes  
4 precedence over cancer.

5 Q Like what?

6 A Somebody whose kidneys are shut down,  
7 kidney problems.

8 Might as well put it in the record, no  
9 patient has ever been sent home for lack of funds.

10 Q Now, do you have any means of -- strike  
11 that.

12 Do you keep in contact with people that  
13 have treated with your clinic after they've gone back  
14 home and finished doing it?

15 A Well, they usually return again.

16 Q They usually return?

17 A Yes.

18 Q Why do they do that?

19 A Why? Because for another checkup.

20 Q Okay. After they stop treating with you do  
21 you keep track of them?

22 A Very few stop. Some may come back on a  
23 yearly basis, six-month basis, three-month basis. It's  
24 similar to there is no cure for cancer the same way  
25 there is no cure for diabetes. The diabetic takes



1 insulin most of the time for the rest of his life and  
2 we augment on a decreasing basis.

3 Well, the longest surviving patient --  
4 we'll start in April of '74. This patient I haven't  
5 seen now for three years, but I have spoken to her  
6 father. She's perfectly healthy and all. The  
7 cessation of treatment is usually the patient's own  
8 decision when they're healthy.

9 Q So your treatment is not something that  
10 they should have and then they won't need it anymore?

11 A Similar to a diabetic.

12 Q All right.

13 A They may not need as much or as frequent,  
14 but they're going to need it.

15 Q And what are the consequences if they don't  
16 continue with you?

17 A This is known as called Russian roulette.  
18 If there's no more tumor left and nobody knows how to  
19 tell that, they may get away with it. If they stop it,  
20 it may return. Similar to diabetics. Some diabetics  
21 or few do manage finally to get off insulin. Something  
22 changes in their physiological makeup.

23 MR. MORRISSEY: Do you want to go ahead and  
24 ask some questions?

25 MR. LaSORTE: Yes.

## CROSS EXAMINATION

BY MR. LaSORTE:

Q Doctor, I've got some questions for you, too. I'll be as brief as I can. I've got several areas I want to ask you about. Mine will take no more than probably half an hour, forty-five minutes.

A Go ahead.

Q Okay. I know that we went over this on your testimony by Mr. Morrissey, but for the benefit of the ladies and gentlemen of the jury, could you briefly just go over what the four different fashions of the blood are that you analyze and what role each of them plays?

A Maybe I can give you a result of an experiment done with two different groups.

Q Okay.

A One was at Down State Med, Dr. Saki (phonetic) in Down State Med in Brooklyn, New York. Jerry Finkle (phonetic) which was a pathology group from Stoneybrook Med. In which we have the large mammary breast tumor. We shot antibody. We took the hair off the tumors. Many mice. Took controlled mice, let them section them and we sectioned them. Three different groups were doing this; ours and the other two. We injected antibody by itself into some tumors,

1 tumor complement, the deblocking protein and the  
2 blocking protein individually. The results of that,  
3 macroscopically-microscopically with no effects. When  
4 we took the antibody and incubated with the tumor  
5 complement and shot it in and delineated with a black  
6 pen. The next day sacrificed the animals, we had  
7 necrosis wherever --

8 Q What is necrosis?

9 A Dead tumor cells. / Microscopically-  
10 macroscopically.

11 Q And that occurred by taking an animal that  
12 already had a tumor?

13 A Already had a spontaneous mammary  
14 adenocarcinoma. Breast cancer.

15 Q And injecting tumor antibody along with  
16 tumor complement?

17 A Together. When they're incubated together  
18 we had tumor cell death so that the two killed.

19 Now, if we added into that test tube the  
20 blocking protein coming from the dead cell --

21 Q What would happen?

22 A We shot that into tumors. We had no  
23 effect. They had their slides. We had our slides.  
24 All matched.

25 Q This would be in a situation where also

1 like the one you just related to me, tumor antibody and  
2 tumor complement were both injected?

3 A The control being those that did not have  
4 the -- those tubes that didn't have the blocking  
5 protein in it.

6 Q So when blocking protein was also  
7 present --

8 A When that was present, no tumor cell death.

9 Q Okay.

10 A When we then took the inactive preparation  
11 which was formed by putting antibody, tumor complement,  
12 the blocking protein, using that as a control, we added  
13 into other similar preparation the deblocking protein,  
14 the alpha 2 macroglobulin.

15 Q And what was the result of that?

16 A Incubated that and we had tumor cell death  
17 again. And there are the four substances.

18 Q Okay. Now --

19 A They have their slides on record by the  
20 way.

21 Q A person who has cancer, any type of  
22 cancer, will that blocking compound be present?

23 A To a greater or lesser degree. If the  
24 tumors are growing wildly, you will have very little of  
25 that blocking protein. If tumor -- now, we can go

1 back. The best way to do that is in the animals that  
2 have large solid tumor, we tested for -- again, we  
3 worked with the two other groups. We tested for the  
4 presence in the blood of the animals for the blocking  
5 protein, little or none. Sectioned the animals.  
6 Killed the animals and sectioned them and found little  
7 or no necrosis tumor cell death. This is all  
8 spontaneous by the way. In animals in which we found  
9 blocking protein in, depended upon the level. You had  
10 spontaneous necrosis from five to forty-five percent of  
11 the tumor. So there was a direct correlation through  
12 the presence of the blocking protein in the blood of  
13 the animal with the degree of tumor death in the  
14 animal.

15 Q I see. In other words, if there is no  
16 blocking protein present to begin with and you inject  
17 the tumor antibody and the tumor complement and you  
18 kill some cells?

19 A Kill some cells and then if it's -- now, in  
20 the animals in which we found no blocking protein, we  
21 would treat these animals. The next day we took blood  
22 on the animals, the animals are still alive, and if  
23 there was blocking protein left, it had now appeared  
24 and was significant. We sacrificed the animals and we  
25 found anywhere from forty-five to ninety percent of the

1 tumor dead.

2 Q So when there is tumor death because of the  
3 antibody and the complement working, the blocking  
4 protein is created?

5 A Will be shown.

6 Q And then what is the remedy for that? Do  
7 you inject an additional amount of deblocking protein?

8 A If we wanted this to go on, we would give  
9 the antibody and the complement again, but we would  
10 first give the deblocking protein to lower the titre of  
11 the blocking protein in the blood.

12 Q Now, the blocking protein keeps the  
13 antibody from killing the cells, correct?

14 A Correct, in one way or another.

15 Q Does the deblocking protein keep the  
16 blocking protein --

17 A Low.

18 Q -- from having that effect?

19 A Correct.

20 Q Okay. How do you determine on a -- strike  
21 that.

22 Is the relationship between these four  
23 fashions, what you monitor in a patient through their  
24 course of their treatment?

25 A Correct. I think I'll hire you.



1 Q Okay. On a daily basis how do you  
2 determine whether their blocking protein titre is going  
3 up or whether down or whatever?

4 A Well, by taking a sample of their blood.  
5 It's a micro sample. We use one-tenth of a milliliter  
6 of their plasma. And from that we can determine  
7 elevations or decreases.

8 Q Now, where does the relationship fit in  
9 with the laboratory mice that you inject and dissect to  
10 determine the presence of blocking compound? How does  
11 that fit in?

12 A Well, that was the original work to  
13 determine whether the blocking protein had any  
14 significant relationship to the percent of tumor cell  
15 there.

16 Q Are there ever any animals that are  
17 injected with the -- with any of the serum obtained  
18 from your patients to determine --

19 A No.

20 Q That was in the preliminary stages?

21 A That's correct. That goes back to 1966 or  
22 '67.

23 Q Now, these four fashions that we've just  
24 been discussing, only three of them would be injected  
25 into the patient, correct?

1 A Correct. No blocking protein.

2 Q Blocking protein is the bad guy, correct?

3 A Well, theoretically the bad guy. That's  
4 not as bad as you think.

5 Q Where do you obtain the other three fashions  
6 from?

7 A The tumor complement is derived from the  
8 blood of cancer patients.

9 Q Of the patient himself?

10 A Only a cancer patient will have tumor  
11 complement. As I told you originally, there's a signal  
12 that's elucidated from the tumor for the body to  
13 produce tumor complement. We could get the other two  
14 substances, the antibody as well as the alpha 2  
15 macroglobulin from the cancer patient, but they use it.  
16 Therefore, their titres are low. The normal individual  
17 makes this and essentially has usually a very hard  
18 titre.

19 Q The term titre, would that be the  
20 equivalent to the --

21 A Concentration per unit volume.

22 Q Okay. Where do you obtain the tumor  
23 antibody from? Isn't that produced by tumor  
24 complement?

25 A No. That's produced by normal individuals.

1 Q All right. So that is obtained through the  
2 body samples which you take from --

3 A We take from cancer patients.

4 Q Where do you obtain the deblocking  
5 complement?

6 A The deblocking, the alpha 2 macroglobulin,  
7 comes again from the non-cancer donor.

8 Q Okay. Is there anything that you use other  
9 than the three fashions we've already discussed that is  
10 actually injected into the patients?

11 A Injected into the patients?

12 Q Mm-hmm.

13 A Well, in terms of anti-tumor effects?

14 Q Mm-hmm.

15 A Well, as a rule, no. But we're not adverse  
16 when it's required. In the rare patients you use  
17 chemotherapy.

18 I spent fifteen years in Hodgkin's Disease  
19 Research Foundation in St. Vincent. Nitrogen mustard  
20 is very good to a patient, but this is never given to a  
21 patient without the patient being told what we suggest.  
22 The patient could refuse it and will go on, but this  
23 could shortcut.

24 Q Over the --

25 A And it's listed in the record that they

1 have been. It's been used.

2 Q Over the course of your maintenance of the  
3 Centre here in the Bahamas, have you had the ability to  
4 determine what your success rate is?

5 A Well, the original was, --

6 MR. MORRISSEY: Object to the form.

7 THE WITNESS: -- I would say about twenty  
8 percent. As of the moment

9 BY MR. LaSORTE:

10 Q By twenty percent what do you mean?

11 A How do we get that?

12 Q Mm-hmm.

13 A Well, I can't well give you the pet one.

14 We had a man by the name of Raper who is an  
15 adenocarcinoma of both lungs. Now, we took our x-rays  
16 here, but I'll tell you this, that's our x-rays you  
17 understand. So when the patient is home, he's referred  
18 back to his own doctor, if his doctor will cooperate,  
19 who took -- his radiologist took the pictures. And  
20 then merely stated that it couldn't be done. His lungs  
21 didn't clear due to those injections. It had to be the  
22 effects of radiation except that Mr. Raper never had  
23 radiation.

24 You test by clinical chemistries, by  
25 longevity, by scans, bone scans, CAT scans. We don't

1 use liver scans anymore. It's a decrepit outdated  
2 scan. And well-being, and a patient resuming his  
3 normal life.

4 All patients, by the way, have a tracking.  
5 Tracking. You know this.

6 There's a book called Cancer Biology. It  
7 has something almost two thousand pages into it in  
8 which it describes all of the cancers.

9 Now, most patients come with prognosis;  
10 three months, two months, six months.

11 Q And these would be prognosis --

12 A Not that we have given.

13 Q Right. Indicated by their orthodox --

14 A Their doctors that have been treating them.

15 Q -- doctors on the mainland?

16 A Now, when a patient significantly outlives  
17 the prognosis --

18 Q Would that be considered a success?

19 A That would be a success. The patient is  
20 still alive.

21 Q Are there any other types of --

22 A When a bone scan which was positive becomes  
23 negative.

24 Now, a doctor in Pennsylvania says to sun  
25 and fun. Eliminated this large lesion in Virginia



1 Early's skull. Which I found that kind of  
2 contradictory because the American Cancer in Florida  
3 says stay out of the sun. So if you want to get  
4 better, what's wrong with the sun over there and not  
5 here?

6 Q All right. I want to nail down if possible  
7 how we would be able to accurately assess whether your  
8 theory is, first of all, of any benefit to the  
9 patients, and, secondly, whether it is a substantial  
10 benefit to the patients?

11 MR. MORRISSEY: Object to the form.

12 THE WITNESS: We have four hundred plus  
13 patients that have significantly outlived their  
14 prognosis.

15 BY MR. LaSORTE:

16 Q Now, what percent would that be of the  
17 total amount of people that come here?

18 A We haven't accepted two thousand patients  
19 yet.

20 Now, keep in mind one important thing. The  
21 theory in '77 though using the same substance is not  
22 the one in '78 or '79 or '80 or '81 and '82.

23 Q Is this an ongoing refining process?

24 A This is not a theory project. It's an  
25 experimental project in which we are continually



1 changing. When and if we ever open up another adjunct  
2 such as Oklahoma, et cetera, they will get the last  
3 program up to date. There will be no further changing.

4 We have had significant effects in colon  
5 cases in which who have been pristine. Now, it's colon  
6 to liver, colon to this, colon to bladder/kidney, colon  
7 to paracolonial fat. You name it. Of these we are in  
8 the eighty to ninety percent improvement rate.

9 Q Now, what does that mean by improvement?

10 A Their lesions by scans are not there  
11 anymore. Their well-being and they have now resumed a  
12 normal life.

13 Q Regarding the particular type of cancer  
14 that Mr. Loudon suffers from, squamous cell cancer of  
15 the upper esophagus --

16 A We've had maybe over the years ten to a  
17 dozen. It's not a very popular number. So that we  
18 can't -- you know percent means per hundred. Well, on  
19 that. We have approximately I think four or five  
20 alive. The longest one, four-and-a-half years.

21 Q Now, are you personally familiar with  
22 Mr. Loudon and his condition when he came to you and  
23 his condition when he recently left?

24 A Mr. Loudon has outlived his prognosis.  
25 Mr. Loudon was an individual that was preparing to die.

1 Q Okay. When you originally met Mr. Loudon  
2 when he came to you to seek entry into this program,  
3 did you review his medical records from his orthodox  
4 doctor?

5 Yes.

6 Q What was their prognosis?

7 A Very poor. I mean, the exact prognosis you  
8 can get from the records. Don't ask me to pull it out.  
9 I haven't - for this interview I have not reread his  
10 records.

11 Q And that was a year-and-a-half ago roughly?

12 A Approximately.

13 He also was bleeding from the throat which  
14 couldn't be stopped in the States.

15 Q Internally?

16 A Yes. Well, bleeding from the area in the  
17 throat, the esophagus. That has popped up  
18 periodically. Usually it would mean a terminal state.  
19 We've been able to stop it each time.

20 Q Was there any way that you or anyone at the  
21 clinic was able to ascertain the size or the growth  
22 pattern of the cancer?

23 A Well, Dr. Clement examined him as best he  
24 could.

25 Q Originally?

1 A Originally or in follow-up data.

2 Q Would Dr. Clement be the one to talk to  
3 concerning that?

4 A To discuss his clinical part, yes, it would  
5 be with him.

6 Q What would Dr. Clement's relationship be  
7 with Mr. Loudon from a treating point of view?

8 MR. MORRISSEY: Object to the form.

9 THE WITNESS: He would see Mr. Loudon one,  
10 two, three, four times a week as necessary.

11 BY MR. LaSORTE:

12 Q And what does a treatment these several  
13 times a week constitute?

14 A It's not a treatment. He's merely  
15 examining him.

16 If Mr. Loudon needed a -- I'm just saying  
17 this on a theoretical basis. If he needed some  
18 treatment for the itch, jock itch, he would give it to  
19 him which is not related to his condition.

20 Q Right. I understand that.

21 A So that ancillary care as well as immediate  
22 care related to his cancer if he needed it.

23 Q The treatment which Mr. Loudon received  
24 here and continues to receive, is it ordered by a  
25 doctor?

1           A     It's ordered by Dr. Clement, Dr. Weinberg  
2 or Dr. Pratt.

3           Q     How procedurally does that take place for  
4 them to order this treatment?

5           A     Well, when we accept a patient, either  
6 multiple M.D. or physicians and myself or one physician  
7 and myself will say this patient based upon his  
8 findings -- well, Dr. Weinberg's findings, which is a  
9 review, let's go ahead and do it. Let's go ahead and  
10 treat.

11          Q     Did Dr. Weinberg recommend to you the  
12 admission of Mr. Loudon?

13          A     Yes.

14          Q     Has Dr. Weinberg had any contact with  
15 Mr. Loudon after the initial decision to admit?

16          A     Not on a regular basis.

17          Q     When the decision is made to admit a  
18 patient to this clinic, to this centre rather, is that  
19 a yes or no kind of question? In other words, are you  
20 saying we're going to admit him and give him the  
21 standard form of treatment or not admit him at all?

22          A     If that's it.

23          Q     Okay.

24          A     Well, we do in some cases, but it wasn't in  
25 his case. If a patient is that sick and the patient

1        says, well, I've had everything, I want you to try.  
2        Your chances are usually a billion to one. This  
3        patient is not charged and is treated on a weekly  
4        basis. If the patient improves up to the point where  
5        we think we can do something, then we will institute a  
6        charge.

7                Q        Okay.

8                A        Retaining the right to tell the patient,  
9        "Look, it's not going to work. Why are you wasting  
10       your time here as well as our time?"

11              Q        Now, did Mr. Loudon fall into that  
12       category?

13              A        No, sir.

14              Q        Regarding the roughly two thousand people I  
15       believe you said, is that accurate, about two thousand  
16       people have been treated here?

17              A        Under two thousand.

18              Q        Would it be over fifteen hundred?

19              A        Oh, yes. Somewhere between eighteen and two  
20       thousand.

21              Q        Okay. Within those eighteen hundred to two  
22       thousand people, would you characterize Mr. Loudon as  
23       being more seriously ill than half of them or not?

24                      MR. MORRISSEY: Object to the form.

25                      THE WITNESS: You're asking me for an

1 off-the-cuff value judgment.

2 MR. LaSORTE: If you can't answer that,  
3 that's fine.

4 THE WITNESS: That's a tough question.  
5 That encompasses -- well, cancer-wise he wasn't  
6 any worse, but that since he was bleeding, he was  
7 much worse.

8 BY MR. LaSORTE:

9 Q I see. There are several variables?

10 A There are other variables in that. If we  
11 didn't stop the bleeding, we would have for sure  
12 stopped his treatment immediately.

13 Q Are you aware of Mr. Loudon's condition  
14 either now or the last time you saw him which I believe  
15 was

16 A The last time he was here he was improved.  
17 was talking. Originally he couldn't talk.

18 Q Okay. By improved, what areas either  
19 physical or --

20 A For my part back there his immune mechanism  
21 is much better. I don't know how much water that  
22 holds.

23 Q Right. How can you determine --

24 A Well, the computer then --

25 Q -- through hard evidence that his immune



1 system is working better?

2 A We don't have to give him that many -- the  
3 computer doesn't predict that many augmentations over  
4 what he was taking.

5 Q Okay.

6 A We don't have to -- now, the tumor  
7 complement has a side effect. It stops bleeding. We  
8 don't have to inject him with tumor complement daily to  
9 stop bleeding.

10 Q Has his esophagus in fact stopped bleeding  
11 while under the care of the clinic?

12 MR. MORRISSEY: Object to the form.

13 THE WITNESS: Under the care here he  
14 has stopped bleeding every time he has come  
15 here. When he's been at home he may start to  
16 bleed again.

17 Mr. Loudon is also suffering probably  
18 from fibrosis.

19 BY MR. LaSORTE:

20 Q What is fibrosis?

21 A Well, connective tissue going in there that  
22 was induced by other therapists.

23 MR. MORRISSEY: I move to strike that.

24 BY MR. LaSORTE:

25 Q Are you providing him any treatment for his



1       fibrosis?

2               A       There is none. That's normal connective  
3       tissue. If you could knock that out, you'd take his  
4       muscles with it.

5               Q       What are the effects of fibrosis?

6               MR. MORRISSEY: Objection.

7               THE WITNESS: Well, eventually he'll get  
8       restriction, constriction of his esophagus.  
9       He will not be able to eat.

10              Initially he was going for dilations  
11       which we don't do here. We don't have the --  
12       now, that's one improvement. He doesn't go for  
13       that many dilations.

14       BY MR. LaSORTE:

15              Q       Dilations would be a procedure to open up  
16       the esophagus?

17              A       A procedure to open up the esophagus.

18              Q       Now, the treatment that Mr. Loudon has  
19       undergone here at the Centre has constituted, has it  
20       not, injections of various percentages of the  
21       fractions?

22              A       Different fractions of the different  
23       dosages of proteins.

24              Q       And the occasional withdrawal of blood from  
25       Mr. Loudon to check --

1 A Well, not occasional. Daily, sometimes  
2 twice, sometimes three times.

3 Q Okay. Is there anything else that is  
4 involved in the treatment?

5 A The treatment per se itself, no.

6 Q How do you monitor either the growth or  
7 diminishment of the cancer within his body?

8 A Well, getting away from -- well,  
9 Mr. Loudon's x-ray will show that. The flatplates.  
10 When he goes home, take a scan.

*Never  
should*

11 Q Okay.

12 A You also have these patients who tend  
13 towards cachexia. Wasting.

14 Q Could you spell cachexia for the court  
15 reporter?

16 A C-a-c-h-e-x-i-a. It's called wasting  
17 disease. This can occur with a large tumor present or a  
18 small tumor. With a limitation on the intake of food,  
19 Mr. Loudon should have wasted and lost weight.  
20 Mr. Loudon has not done this.

21 Q Why is that, if you know?

22 MR. MORRISSEY: Object to the form.

23 THE WITNESS: Well, because he can eat a  
24 little more and he's utilizing his nutrition.

25

1 BY MR. LaSORTE:

2 Q Was he having a problem eating when he  
3 first showed up at the clinic?

4 A Yes, sir. He hardly ate at all.

5 Q Okay.

6 A Well, well-being gave him an appetite which  
7 made him want to eat again.

8 Q Now, I'd like you to look, if you would, at  
9 what's -- this will be Plaintiff's Composite Exhibit.

10 MR. MORRISSEY: This is the bills?

11 MR. LaSORTE: Yes, all the bills.

12 MR. MORRISSEY: Okay.

13 MR. LaSORTE: To be marked at a later time.

14 BY MR. LaSORTE:

15 Q Could you just look through these briefly  
16 consisting of five stapled together sheets comprised of  
17 insurance claims followed by the Immunology Researching  
18 Centre, Ltd. medical reports I guess. Would that be a  
19 corret term for those? Statement of charges, is that  
20 more accurate?

21 A Well, the overall charge, yes.

22 Q Okay. Now, looking at the first within this  
23 Composite Exhibit signed by --

24 A Dr. Weinberg.

25 Q -- Dr. Weinberg with a total bill of

1       \$2,520, is that accurate?

2           A       That's correct.

3           Q       Okay. From looking at that statement of  
4 charges, when were these services rendered resulting in  
5 that bill?

6           A       Well, started on the 31st of March, 1982.

7           Q       Okay. And when did they end?

8           A       Well, on this sheet he finished at the 28th  
9 of April, '82.

10          Q       Okay. Now, looking just briefly at the  
11 description of the treatments and procedures which  
12 Mr. Loudon underwent during that time period, are they  
13 more or less the standard procedures that the patient  
14 goes through during their initial visits?

15          A       Yes, sir.

16          Q       Okay. The charge of \$2,520, is that the  
17 customary charge for those services?

18          A       That was the customary charge.

19          Q       Okay. Are there any other centers or  
20 clinics or hospitals anywhere in the world that you're  
21 aware of that provide a similar service?

22          A       No.

23          Q       Is this \$2,520 bill customary and  
24 reasonable within the field of IAT treatment?

25                   MR. MORRISEY: Objection. He's not

1 qualified to answer. You can go ahead and  
2 answer it for the record.

3 THE WITNESS: This is the standard  
4 charge.

5 BY MR. LaSORTE:

6 Q Customary charge?

7 A It's a customary charge.

8 Q In your opinion is it a reasonable charge?

9 MR. MCCRISSEY: Objection. He's not  
10 qualified.

11 THE WITNESS: For whatever my opinion is  
12 worth.

13 MR. LaSORTE: Yes or no?

14 THE WITNESS: Well, if he got better, it  
15 was worth it, okay?

16 MR. LaSORTE: Off the record just for a  
17 second.

18 (Discussion off the record.)

19 BY MR. LaSORTE:

20 Q Back on the record.

21 Dr. Burton, if you know, why is it that  
22 this procedure is not available in the United States?

23 A You're asking for a two-hour thesis at  
24 least.

25 Q Well, if you could sum it up for the ladies

1 and gentlemen of the jury in about a sentence or two  
2 I'd appreciate it.

3 A It's legal in two states of the United  
4 States.

5 Q Which are they?

6 A Florida and Oklahoma.

7 Q Is this --

8 A It's not approved by the Food and Drug.

9 Q Food and Drug Administration of the United  
10 States?

11 A Of the United States.

12 Q And what is the practical effect of not  
13 being approved by the FDA?

14 A Well, the FDA could have -- since I don't  
15 treat any patients, has no effect upon me whatsoever.  
16 They can't take the "P" from my Ph.D. and they can't  
17 accuse me of being a quack because that's stupidity on  
18 the part --

19 Q You're not a doctor? You're not a medical  
20 doctor?

21 A By definition a physician uses unorthodox  
22 practice.

23 Q Okay. Can a medical doctor in the United  
24 States prescribe this procedure and have it  
25 administered in the United States?

1           A       In the State of Oklahoma and probably in  
2 Florida.

3           Q       Okay. It has been legalized in the State  
4 of Florida?

5           A       Correct.

6           Q       Were you familiar with the effort on behalf  
7 of the Immunology Researching Centre to have it  
8 legalized in the State of Florida?

9           A       (Nods head.)

10           MR. MORRISSEY: Is that a yes?

11           THE WITNESS: Yes.

12           MR. MORRISSEY: She needs to take it down.

13 BY MR. LaSORTE:

14           Q       When was it legalized in the State of  
15 Florida?

16           A       1982 they overrode the veto.

17           Q       And that was pursuant to an act of Florida  
18 Legislature?

19           A       Yes.

20           Q       As a result of that enactment, have there  
21 been any steps taken to --

22           A       There are no steps taken and there will be  
23 none taken --

24           Q       -- to do -- you didn't let me finish my  
25 question.



1 A -- in the State of Florida.

2 Q None taken to -- .

3 A Introduce this therapy into Florida.

4 Q Why is that?

5 A Because the law is a bad law.

6 Q Why is that?

7 A Because they will then have a whole group  
8 select the patients. Quote, the head of HRS in  
9 Florida: "We won't only pick the dying" and I finished  
10 the sentence for them. "You'll pick the dead as  
11 patients." They will select the patients.

12 Mr. Loudon might have qualified since he  
13 was coming to the end.

14 Q Do you know what parameters they had set up  
15 to determine who would qualify?

16 A The two oncologists, my own feeling, would  
17 have ruled the roost.

18 Q What is an oncologist?

19 A An oncologist? That happens to be the  
20 sixty-four million dollar question. That is a title  
21 that has been **usurped by** the chemotherapists.

22 **By definition** an oncologist is one who  
23 studies cancer.

24 A chemotherapist is an oncolysis, one who  
25 tries to kill cancer. But they took the name.

1 Q Okay. What is the difference between an  
2 oncologist and a radiologist?

3 A Well, now they call themselves  
4 radiologists/oncologists, pediatrician/oncologists,  
5 hematologists/oncologists. It means money.

6 Q What is a radiologist?

7 A One who uses radiation for the diagnosis  
8 and/or treatment of different conditions.

9 Q That would encompass people who take x-rays  
10 as well as people who administer chemotherapy?

11 A Well, they don't take the x-rays. No, they  
12 don't administer chemotherapy.

13 Q Who administers chemotherapy?

14 A That's a chemotherapist.

15 Q What does an oncologist do?

16 A That's a good question. Besides making  
17 money, I have no idea.

18 MR. MORRISSEY: Object to the form.

19 THE WITNESS: They give drugs theoretically  
20 to cure cancers.

21 BY MR. LaSORTE:

22 Q To cure cancers or to control the symptoms  
23 of cancers?

24 A Oh, no, no. They cure. They're always  
25 talking cure-rate which we play a statistical game that

1 if you live five years from diagnosis, you're cured.  
2 If you die in one day after five years, you're a death  
3 rate, you're a mortality figure and a cure-rate. Same  
4 patient.

5 Q Okay. I believe you stated that upon  
6 Mr. Loudon's application for admission you did review  
7 the medical reports from the various orthodox doctors --

8 A Yes, sir.

9 Q -- that he had been to.

10 Are you aware of what steps had been taken  
11 by these orthodox doctors --

12 A It's all in the records, yes.

13 Q -- prior to his visit to you?

14 A He had had radiation and dilations. He had  
15 no chemotherapy.

16 Q Had he had anything else?

17 A That's -- no, that's all that was ever in  
18 his records.

19 Q Do you know on how many occasions he had  
20 had radiation therapy?

21 A According to our records here, one.

22 Q Do the records that you have --

23 A He had had surgery as well.

24 Q What surgery had he had?

25 A I think removing the original -- excise the

1        original tumor in February of '81.

2            Q        Do the reports from the orthodox doctors  
3        Mr. Loudon had been to see prior to coming to see you  
4        indicate what their prognosis was?

5            A        Well, it's in their records. We'd have to  
6        go through, but it's recurrent tumor. It had come  
7        back. They no longer could excise it.

8            Q        Okay. What is a recurrent tumor?

9            A        Tumor that has returned to the site that  
10       were originally excised.

11          Q        Can it be -- I believe you said it could  
12       not be excised again?

13          A        Not according to the records. They would  
14       not attempt it.

15          Q        In Mr. Loudon's case?

16          A        It had enlarged to a point that it was no  
17       longer surgically manageable.

18          Q        And is that the physical state Mr. Loudon  
19       was in when he came to see you?

20          A        He had one radiation treatment which was  
21       palliative.

22          Q        What is palliative?

23          A        It means for pain. Ease the patient's mind  
24       that something is being done. And that was it.

25                MR. LaSORTE: Okay. Thank you. That's all

1 I have.

2 MR. MORRISSEY: I have a few.

3 REDIRECT EXAMINATION

4 BY MR. MORRISSEY:

5 Q Since Mr. Loudon's treatments have you seen  
6 any x-rays or bone scans of him?

7 A That would be seen by the medical  
8 department. Not me.

9 Q Okay. You haven't seen them?

10 A No. There's no reason for me to see it.

11 Q Okay. You mentioned something about a  
12 treatment that was used in New York. I'm not sure I  
13 quite caught the name. It was nitro --

14 A That's the oldest chemotherapeutic aid;  
15 nitrogen mustard.

16 Q Nitrogen mustard?

17 A That's mustard gas of World War I. The  
18 first alcoholating agent. Specifically treating for  
19 Hodgkin's disease. Not specific for Mr. Loudon.

20 Q This is the only facility in the world that  
21 provides Immuno-Augmentative Therapy?

22 A That's correct.

23 Q You have no intention of opening up a  
24 facility in Florida?

25 A Well, not in the near future. When we have

1 a track record in another state, we'll come back to the  
2 State of Florida. And if anything goes wrong, we'll  
3 then put the <sup>owners</sup> owners on the doctors who picked the  
4 patients. Why is it good there and not here?

5 Q You plan to open a clinic in Oklahoma?

6 A In the future. And in a few other states  
7 which I will not tell you at the moment. Why warn the  
8 enemy to provide the troops?

9 Q / Okay. Have you ever applied to the FDA for  
10 approval of your treatments?

11 A In 1974.

12 Q And what did they say?

13 A It was a gigantic stall in which -- and  
14 I've challenged them -- originally they said we never  
15 answered the questions. And I challenged them on the  
16 radio. I think one of the members rose to debate.  
17 They said we never answered a question and I blankly  
18 called them a liar.

19 Q Have you ever permitted any outside group  
20 of researchers or doctors to test your methodology?

21 A How would they test? We're the only place  
22 that has the computer. Have we allowed other doctors  
23 to come and see what's going on? All the time.

24 Q Couldn't you tell them what these four  
25 factors are?

1 A How are you going to get the computer  
2 programmed?

3 Q Couldn't they trial and error it?

4 A What?

5 Q Couldn't they trial and error it?

6 A Well, I hate to tell you this. We all are  
7 obnoxiously, what would you say, bent? For the simple  
8 reason, why should they start at the beginning when you  
9 already have made the steps?

10 Q Why won't you tell them what they are?

11 A They can read the patents. And I'll tell  
12 you a blanket statement.

13 Q They don't tell you the --

14 A How to make it. Go ahead and use it. And  
15 I'll give a blanket statement on the radio, television,  
16 what have you, we will not ask for any royalties. Go  
17 ahead and do it. We'll not ask for any patents and no  
18 patent infringements.

19 Q Now, you have a tumor antibody which is an  
20 alpha 2 macroglobulin?

21 A Yes, one component.

22 Q You have a deblocking protein --

23 A Oh, no, no. The tumor antibody, just for  
24 the record, is an alpha 2 macroglobulin that is  
25 associated intimately with three immunoglobulins; IgG,



1 IgM and IgA. These are immunoglobulins.

2 Q Immunoglobulins. All right.

3 A The predominant to be repetitive is IgA.  
4 These are known established fractions. We not only  
5 determined it, but we farmed it out to three other  
6 laboratories and they identified it for us.

7 Q Okay. What labs were they?

8 A In New York State, and I haven't got any  
9 recollection of their names now.

10 Q All right. Is there only one alpha 2  
11 macroglobulin associated with the IgA?

12 A To the best of my knowledge. But as I  
13 referred to you before, there could be millions, but  
14 each one has its own sedimentation rate and what have  
15 you.

16 Q So you've identified the sedimentation rate  
17 of this particular one?

18 A Of this particular one under the specifics  
19 of the extraction procedure.

20 Q And those are your patented procedures?

21 A That's right.

22 The reason, did you or didn't you ask, you  
23 may as well. You wanted discovery. Why did we patent  
24 it? Well, if they don't let you publish it, where  
25 can you get your entire publication on record? In the

1 patent office. Now, I had hoped they would reject the  
2 patents or leave them pending. Well, I think the  
3 longest one was three months. There was no pendings.  
4 They were immediate acceptance. So we have that on  
5 record now in terms of what we did, when we did it.

6 Q Now, this deblocking protein is also an  
7 alpha 2 macroglobulin?

8 A That's right, with a different  
9 sedimentation rate.

10 Q Okay.

11 A Fully described by Dilusio (phonetic) at  
12 Tulane. He calls it a recognition factor.

13 MR. LaSORTE: Is that a particular  
14 periodical that he discusses that in?

15 THE WITNESS: Oh, in repeated papers.

16 BY MR. MORRISSEY:

17 Q The blocking protein, is that a different  
18 kind of protein other than an alpha 2 macroglobulin?

19 A This is a pre-albumin.

20 Q Pre-albumin?

21 A Pre-albumin. There's sixteen to eighteen  
22 papers by Jacobe out of Paris. You can get the  
23 description from him.

24 Q I can't read French.

25 How many different kinds of pre-albumins are

1 there?

2 A I think only God knows that question.

3 Q Okay. More than one?

4 A Oh, numerous.

5 Q And does this particular one then, this  
6 blocking protein, have its own sedimentation value?

7 A Correct, under the technique when applied.  
8 That is in the patents as well.

9 Q All right. And that would -- I think tumor  
10 complement is taken from the cancer patient or a cancer  
11 patient?

12 A Comes from the cancer patient's blood.

13 Q Okay. Where does the blood come from that  
14 you use to get the other ingredients?

15 A Relatives and companions of the cancer  
16 patients who are cancer-free.

17 Q You ever buy any from any hospitals or --

18 A We used to.

19 Q You don't do that anymore?

20 A Well, John Elliott Blood Bank said that the  
21 FDA and the American Cancer Society had to approve of  
22 them sending overaged blood to a foreign country which  
23 happens to be a lot of hokum. So of course when we got  
24 a lawyer to challenge them on that, he did a double  
25 talk and double take and we told them we didn't really

1 care any longer.

2 Q Do you have a refrigeration unit to store  
3 the blood --

4 A Sure.

5 Q -- in the facility?

6 Is that in the new building or the other  
7 building?

8 A Right here.

9 Q It's in here?

10 A Minus seventy degrees centigrade. Don't  
11 put your hands on the wall, you won't get your hands  
12 out again.

13 Q If you were to open a clinic in Florida,  
14 would you be required to disclose your computer program  
15 in order to satisfy the --

16 A Nothing in the law.

17 Q You wouldn't have to do that?

18 A Not according to the law.

19 Q But they have a panel to approve patients  
20 for the experimental --

21 A Well, that was the reason why we didn't go  
22 to Florida. The patients would have gotten a bad deal  
23 out of it. I would have made a fortune, but we'd have  
24 been a party to a swindle.

25 Q Have you attempted to test your theory

1 using a controlled group as well?'

2 A I will not participate in a double-blind.

3 Q You will not do that?

4 A I will not.

5 Q And what is your reason for that?

6 A Reason for that? Well, I'll put it right  
7 back on you. If your son, if you had one, if you do  
8 have, had cancer, would you like me to treat him with  
9 something that I knew wouldn't work because so that we  
10 could prove the significance for another child?

11 And I asked that to one big time oncologist  
12 in Miami. And he said, "No. My son is going to get  
13 the best therapy in the world. And I wouldn't let him  
14 go under your protocol based on that."

15 To which I called him a hypocrite. For the  
16 other one, it's all right.

17 Q Who said that?

18 A Well, we'll skip the name.

19 Q You're not going to give me his name?

20 A I'm not going to give you the name because  
21 I know who it is. He said it to me. There was no  
22 witnesses there. He could say that I didn't say it.  
23 But the answer is; this means -- well, he did say to  
24 me, "You're a Ph.D. What do you give a damn whether  
25 the twenty-five controls die, but you'll finally prove

1 your thesis."

2 My answer is: Even though I don't shave  
3 anymore, I still have to look in the mirror, and I'm  
4 not going to get into an approved, quote,  
5 pseudoscientific experiment leading to death.

6 Q Why do you consider it a pseudoscientific  
7 experiment?

8 A Because it's pseudoscientific the way it's  
9 set up.

10 If the great scientists ever came out with  
11 the truth which said: Well, we will give them this  
12 standard therapy based upon scientific principle, if  
13 the control improves since they got the standard  
14 treatment, how can you evaluate the experiment since  
15 they both got better? It could be a mental thing. It  
16 could be a placebo effect. You have to give them  
17 knowingly something that will either kill them or not  
18 help them, and I'm not in the death business. We did  
19 the double-blind on animals and that's what the  
20 four-legged animal is for.

21 The other halfway getting out, we might as  
22 well finish it, is that they now pick their controls by  
23 computer so that they can live with themselves. They  
24 put fifty names in, fifty numbers, and ask the computer  
25 to pick out the twenty-five so they won't know how they



1       were picked.

2               If I were shaving, I would tend to slit my  
3       throat. You're a murderer. That is society's approved  
4       murderer. So I will not partake.

5       Q       Your sedimentation procedure, does that  
6       involve a centrifuge?

7       A       That's correct.

8       Q       How many centrifuges do you have at your  
9       facility?

10      A       Out there? One, two, three, four, five,  
11      six, seven, eight -- twelve.

12      Q       Okay. How long have you had that number?

13              MR. LaSORTE: If you know.

14              THE WITNESS: Since we're here. All  
15      right? I don't know.

16      BY MR. MORRISSEY:

17      Q       All right.

18      A       We've had more. I think we had more. We  
19      put one out to pasture. Even machines die.

20      Q       What training do your technicians have?

21      A       I trained them.

22      Q       You train them?

23      A       Mm-hmm. I don't want them to know  
24      something else. When I tell them to do step A, B, C, I  
25      don't want them doing A-prime or B sub-1.



1 Q All right. Who is Herschel K. Mitchell?

2 A Herschel K. Mitchell is a -- well, I don't  
3 know. A Professor of Biology at Cal-Tech.

4 Q Okay. Did you work on any research  
5 projects with Mr. Mitchell?

6 A He was my sponsor at Cal-Tech.

7 Q What research were you doing?

8 A Disulfuryl malonic acid (phonetic).

9 Q All right. Did Dr. Mithcell dissociate  
10 himself from the findings he --

11 A We dissociated ourselves with Dr. Mitchell.

12 Q You did that?

13 A Yes, sir. I'll meet him in court if he  
14 wants to argue the point.

15 Q What was the reason for that?

16 A Herschel K. Mitchell wanted to steal  
17 everything we had and we utterly refused to let him do  
18 it. And in being an egomaniac -- now, we were  
19 injecting disulfuryl malonic acid larvae with hand  
20 ground needles, so we had injection needles. The  
21 egomaniac said, "You don't need it. I know, I'm  
22 Herschel K. Mitchell." He's an egomaniac and we  
23 dissociated ourselves with him.

24 He also, by the way, he dissociated -- by  
25 the time we left going from California to New York,

1 would you believe we drove? He had' already been to NYU  
2 to pick up different strains of -- he didn't want to do  
3 it, but he already picked up the other strains to test  
4 it again. The only thing he didn't know how to do is  
5 make those needles which we never told him.

6 By the way, dishonesty in science is a  
7 practice; not a rarity.

8 As my old professor said, "You're no damn  
9 good if you have one idea and that's all you're ever  
10 going to have in life." And Herschel K. Mitchell is a  
11 dud. He's been doing the same thing with Norospra  
12 (phonetic) since 1945. It's almost forty years and  
13 he's gotten nowhere. He's lived by what is known as  
14 the scientific mouth.

15 MR. LaSORTE: Move to strike that whole  
16 soliloquy as being unresponsive.

17 THE WITNESS: What has it got to do with  
18 it? Go ahead. I don't care. I'll respond to  
19 it. I'm not even ashamed of it. I think the man  
20 is nothing but a crook and you can put that in  
21 the record.

22 MR. LaSORTE: Move to strike that, too.

23 THE WITNESS: All right. Let's strike it.

24 MR. MORRISSEY: I asked the question.

25 MR. LaSORTE: I don't think that's what

1           you asked.

2           THE WITNESS: Arguments in science have  
3           gone on for years, eternally.

4           (Discussion off the record.)

5           MR. LaSORTE: Back on the record.

6           MR. MORRISSEY: I think that's all I have.

7           RE CROSS EXAMINATION

8           BY MR. LaSORTE:

9           Q    I've got a couple of questions real  
10           quickly.

11                    Could you explain to the jury, please, what  
12           a double-blind is?

13           A    A double-blind is an experiment in which  
14           usually it includes fifty patients of which twenty-five  
15           get the new experimental drug and twenty-five either  
16           get nothing, placebo, or some other drug that has  
17           proven non-efficacious.

18           Q    Have you performed double-blind experiments  
19           as to your theories on animals?

20           A    On mice,

21           Q    What were the results of those tests?

22           A    Well, I'll tell you what. We eliminated  
23           the placebo effect so that the animals we injected with  
24           the buffer, the tumors grew and the animals we treated,  
25           the tumors regressed.

1 Q And I believe you testified that you will  
2 not perform such a test upon human beings?

3 A I will not participate in that.

4 Q Just one other question.

5 Among the eighteen hundred or so patients  
6 who you've treated, have any of them other than  
7 Mr. Loudon been insured by Prudential?

8 A Yes, sir.

9 Q Do you know how many?

10 A Offhand, no, but they have been paid. One  
11 paid after an institution of a lawsuit. Another one  
12 was paid outright full. Not eighty percent, but total  
13 amounts.

14 Q Okay. And what is her name?

15 A Betty Abernathy.

16 Q Where does she live?

17 A Huntsville, Alabama.

18 Q And was this for an insurance company --

19 A To the tune of six thousand plus.

20 Prudential.

21 Q Prudential Insurance Company paid six  
22 thousand plus?

23 A Yes.

24 Q Was that eighty percent of her bill?

25 A That was total.

1 Q One hundred percent?

2 A That's what she told me.

3 Q How long ago?

4 A She came here in '80. I think she got her  
5 first remittance in '81 and then the final in '82, but  
6 don't hold me to that. This is off the top of my head.

7 Q I understand.

8 Is she presently under your care?

9 A Yes, sir.

10 Q Wasn't there a gentleman from Virginia?

11 A Virginia. Mr. Byers.

12 Q What is his first name?

13 A Lou Byers.

14 Q He was covered by Prudential to the best of  
15 your knowledge?

16 A Covered by Prudential.

17 Q Did they pay?

18 A They paid.

19 MR. LaSORTE: Thank you, sir. That's all.

20 MR. MORRISSEY: I just want to put an  
21 objection as being irrevelant.

22 (Witness excused.)

23 (Thereupon, the foregoing deposition was  
24 concluded at 5:10 o'clock p.m.)

25 (Whereupon, Plaintiff's Composite Exhibit One  
was marked for identification.)

C E R T I F I C A T E

THE STATE OF FLORIDA, )

COUNTY OF PALM BEACH. )

I, KIMBERLY L.P. GARN, Registered  
Professional Reporter and Notary Public, State of  
Florida at Large;

DO HEREBY CERTIFY that the foregoing  
deposition of Dr. Lawrence Burton was taken before me  
in this cause at the time and place and in the presence  
of counsel as shown herein; that before giving his  
deposition said witness was duly sworn by me to testify  
the whole truth; that the foregoing pages are a true  
and correct transcription of the testimony given by  
said witness.

I FURTHER CERTIFY that I am neither  
attorney or counsel for any of the parties, nor am I  
related to or employed by either attorneys or parties  
connected with this action, nor am I financially  
interested in the action.

WITNESS MY HAND AND SEAL this 10th day of  
September, 1983.

*Kimberly L. P. Garn*  
KIMBERLY L.P. GARN, R.P.R. and Notary  
Public, State of Florida at Large.  
My Commission expires:  
May 24, 1987.

1  
2 This is just to advise you that Plaintiff's  
3 Composite Exhibit One for identification,  
4 consisting of five insurance claims and IRC  
5 medical reports, has not been attached to this  
6 deposition. Efforts were made to acquire this  
7 exhibit by the court reporter, but it was never  
8 received.  
9  
10  
11  
12

13 Sept. 16, 1983  
Date

Kimberly Gann  
Kimberly Gann  
Court Reporter