

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **STUART Z. LANSON, M.D.**

4 Holder of License No. 7318
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-04-0769A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND ORDER**

(Letter of Reprimand)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting
8 on August 11, 2005. Stuart Z. Lanson, M.D., ("Respondent") appeared before the Board
9 with legal counsel Paul Giancola for a formal interview pursuant to the authority vested in
10 the Board by A.R.S. § 32-1451(H). The Board voted to issue the following findings of
11 fact, conclusions of law and order after due consideration of the facts and law applicable
12 to this matter.

13 **FINDINGS OF FACT**

14
15 1. The Board is the duly constituted authority for the regulation and control of
16 the practice of allopathic medicine in the State of Arizona.

17 2. Respondent is the holder of License No. 7318 for the practice of allopathic
18 medicine in the State of Arizona.

19 3. The Board initiated case number MD-04-0769A after receiving a complaint
20 involving Respondent's care and treatment of a 60 year-old female patient ("ND"). ND
21 presented to Respondent on March 25, 2005 with complaints of recurrent upper
22 respiratory infection, recurrent sinusitis and fatigue. ND related problems with lack of
23 energy and decreased cognitive function, memory and concentration. Respondent
24 reviewed some of ND's old records and noted considerations of chronic fatigue
25 syndrome, fibromyalgia, depression and arthritis of the left hip. On examination
Respondent noted multiple angiomata, swelling of the nasal mucosa, uvula and soft

1 palate, and a positive Romberg sign. Respondent performed a complete history and
2 physical as well as a number of tests, including allergy tests, pulmonary function, blood
3 work and a pulmonary diffusion test.

4 4. Respondent diagnosed ND with vasculitis based on her membrane diffusion
5 abnormality and he also diagnosed immune dysregulation. Respondent recommended
6 ND undergo oxygen therapy for the vasculitis and immunotherapy (presumably for
7 immune dysregulation.) Respondent did not order sedimentation rate ("sed rate"),
8 urinalysis or tissue biopsy – the conventional allopathic workup for vasculitis. All
9 laboratory testing ordered by Respondent was normal and, under allopathic medical
10 standards, ND did not have vasculitis. Respondent submitted ND's chart for review to
11 the peer review program of the American Academy of Environmental Physicians
12 ("Academy"). Academy unanimously endorsed Respondent's diagnosis and treatment as
13 consistent with their standards. Respondent is also licensed as a Homeopathic
14 physician, but the Homeopathy Board determined Respondent was not practicing
15 homeopathy and declined to investigate Respondent.

16 5. Respondent testified he has practiced in Arizona since 1973, first in
17 otolaryngology for twenty years and then in environmental medicine for the past thirteen
18 years. Respondent testified he is board certified in ear, nose and throat through the
19 American Board of Otolaryngology and is board certified by the American Board of
20 Environmental Medicine. Respondent testified that education in the environmental
21 medicine specialty is done through the American Academy of Environmental Medicine
22 and its curriculum is approved by both the American Academy of Family Physicians and
23 the Accreditation Council for Continuing Medical Education. Respondent noted that
24 MICA approves and insures his evaluation and treatment modalities and Medicare pays
25 for the evaluations and treatments. Respondent also noted Medicare has routinely

1 audited him multiple times and he passed the audits. Respondent testified he forwarded
2 ND's records to an internationally recognized expert in environmentally triggered
3 vasculitis and implant sensitivity who provided a detailed letter with supporting literature
4 approving of Respondent's evaluation and treatment plan.

5 6. Respondent testified his workup of ND consisted of a detailed history with
6 collaborative physical findings and pulmonary plyphesmography. Respondent testified he
7 based his diagnosis on information from a textbook in environmental medicine on small
8 vessel vasculitis, articles on environmentally triggered vasculitis, and continuing medical
9 education courses on the subject. Respondent noted vasculitis in ND is an inflammatory
10 condition of the microcirculation or small vessel vasculitis, involving mostly the skin,
11 though he could not rule out segmental or regional involvement. Respondent testified the
12 condition is caused by both immune and non-immune mechanisms, such as chemical
13 exposure and is manifested by the acneform lesions along with a list of signs and
14 symptoms ND gave Respondent when she gave her history – including recurrent edema,
15 recurrent nasal stuffiness, extremity vascular spasm, cold susceptibility, tonsillectomy,
16 increased sense of smell, recurrent myalgias, recurrent sinusitis, recurrent headaches,
17 non-specific colitis, recurrent bronchitis, recurrent arrhythmias, and purple spots on her
18 skin, possibly purpura.

19 7. Respondent testified vasculitis may be the underlying pathology of ND's
20 condition that is responsible for the above listed symptoms, due to increased blood flow
21 and oxygenation of the tissue, creating a dysfunction of organ systems. Respondent
22 testified the recommendations for oxygen and IV nutrient therapy are well-accepted
23 modalities taught in the American Academy of Environmental Medicine's core curriculum
24 and these modalities are approved by MICA and paid for by Medicare and various other
25 health plans. Respondent also noted the Board had dismissed previous complaints for

1 this diagnosis and he used the same modalities in those cases. Respondent testified ND
2 received an appropriate workup, diagnostic workup, and plan and treatment based on the
3 standards of care in his specialty. Respondent also noted his diagnosis is well supported
4 and ND's treatment was never carried out.

5 8. Respondent testified he saw an average of thirty to forty patients per week
6 and most of his patients are referred by other patients and others are referred by other
7 physicians. Respondent testified one to two percent of his patients are diagnosed with
8 vasculitis. Respondent was asked if the American Board of Environmental Medicine is a
9 board recognized by the American Board of Medical Specialties ("ABMS"). Respondent
10 testified it was not, but noted that to be certified by the American Board of Environmental
11 Medicine a physician must be certified by a board that is recognized by ABMS.

12 9. Respondent testified he would not describe himself as an expert in
13 vasculitis, but agreed it was a very serious condition that can be life-threatening.
14 Respondent was asked how he would classify the vasculitides in general. Respondent
15 testified vasculitis has been described involving large, medium and small sized vessels,
16 whether or not there is necrosis, the immunologic basis of vasculitis. Respondent
17 testified that doctors who specialize in environmental medicine realize that many of the
18 small vessel vasculitis, which is what they see clinically, are non-immune related, usually
19 from chemical exposure and the vast majority of patients Respondent sees who have
20 vasculitis have it from chemical exposure. Respondent was asked to list the cardinal
21 features that a standard textbook of medicine would suggest to diagnose small vessel
22 vasculitis. Respondent testified they would usually be petechiae, spontaneous bruising,
23 purpura, hemorrhage, ecchymosis, decreased circulation (where patients have impaired
24 function related to decreased circulation of various organ systems.)
25

1 10. Respondent was asked what diagnostic modality would differentiate
2 vasculitis from other conditions that could produce ND's symptoms and what would a
3 textbook of medicine suggest ought to be done as a basic workup for vasculitis.
4 Respondent testified a biopsy of the lesion, a sed rate, inflammatory markers, various
5 immunologic studies, depending upon the thought of what type of vasculitis it would be.
6 Respondent noted for example, if it were a small vessel vasculitis and cold was related to
7 the trigger, than coagulants would be ordered to see if the patient had that type of
8 problem. Respondent noted there are blood tests, like an anti-neutophilic cytoplasmic
9 antibody, that could be ordered. Respondent was asked if he did a sed rate with ND.
10 Respondent testified he did not. Respondent was asked whether a sed rate was a fairly
11 standard marker for vasculitis. Respondent testified it was, and if he had seen ND in
12 follow-up he would have eventually ordered that test. Respondent noted he routinely
13 ordered sed rates on patients if he is entertaining a vasculitis diagnosis, but he usually
14 sees the patient in follow-up and never had that opportunity with ND.

15 11. Respondent was asked if it would be within the standard of care to order a
16 urinalysis in a patient suspected of having vasculitis, particularly since small vessel
17 vasculitis could produce renal manifestations. Respondent testified it would.
18 Respondent was asked if he considered a biopsy, which is frequently used, to diagnose
19 ND's small vessel vasculitis. Respondent testified he did not and did so only occasionally
20 in patients when he has diagnosed vasculitis. Respondent was asked why he did not
21 consider biopsy in ND. Respondent testified he did not entertain the diagnosis until he
22 got the membrane diffusion capacity and then he never saw ND back in follow-up in order
23 to follow through with ordering laboratory tests. Respondent was asked if the modalities
24 used to diagnose small vessel vasculitis in a standard textbook of medicine would include
25 pulmonary membrane diffusion capacity. Respondent testified they would not.

1 12. Respondent was asked to describe the scientific basis for the pulmonary
2 plyphesmography and membrane diffusion capacity. Respondent testified membrane
3 diffusion capacity measures the gases across the alveolar-capillary membrane and if the
4 lung is normal, then decreased diffusion would indicate endothelial swelling of the
5 capillary. Respondent noted there are studies to show this is the case; for example
6 patients with Raynaud's phenomena will have decreased membrane diffusion.
7 Respondent testified endothelial dysfunction is associated with small vessel vasculitis.
8 Respondent testified he did pulmonary plyphesmography in his office routinely in patients
9 who present with bronchitis and asthma and problems with allergy. Respondent noted
10 the advantage of using that modality or test when seeing patients is that it gives an idea
11 of the endothelial status of the capillaries and the lung, which could reflect what is going
12 on in the rest of the body.

13 13. Respondent was asked if he was speaking about the test as measuring the
14 diffusion of gases across the alveolar-capillary membrane, and, if so, what are the
15 possible reasons why this might be abnormal, other than vasculitis. Respondent testified
16 he was speaking about the test in this way and the other reasons it could be abnormal
17 are emphysema, sarcoidosis, resection of a lung, pulmonary emboli, fibrosis, anemia,
18 congestive heart failure, collagen and vascular disorders and drug therapy. Respondent
19 was asked if, since ND was a smoker, it not be unreasonable that the history of tobacco
20 exposure could also cause an abnormal membrane diffusion capacity. Respondent
21 testified this would not usually happen unless there is pulmonary disease where there is
22 thickening of the alveolar-capillary membrane, if there is fibrosis, interstitial fibrosis. But,
23 with bronchitis the patients that undergo membrane diffusion capacity have normal
24 results.

1 14. Respondent was asked if ND had bronchitis and, if she did, would a history
2 of smoking result in her having a normal or abnormal membrane diffusion capacity.
3 Respondent testified ND did have bronchitis and she would usually not have a membrane
4 diffusion capacity below the eighty percent figure, unless there is scarring or fibrosis in
5 the lung. Respondent was asked what he did to rule out other causes of pulmonary
6 disease or other causes of abnormal membrane diffusion capacity. Respondent testified
7 he only saw ND twice and she did not follow-up, so he never had the opportunity to
8 evaluate her. Respondent was asked about ND's complaint that in two visits she ran up
9 a bill of \$6,000 and whether it was a reasonable approach to order so much testing when
10 the standard of practice would be to start out with some very simple things if he thought
11 ND had vasculitis – such as doing a sed rate or a urinalysis. Respondent testified when
12 he first saw ND his impression was that she had chronic sinusitis and allergic rhinitis and
13 bronchitis, recurrent sinus infections and profound fatigue. Respondent testified the
14 standard of care in environmental medicine when dealing with such a patient is to look for
15 environmental triggers that might be causing the problem.

16 15. Respondent testified that although he mentioned briefly to ND that, based
17 on her history, he thought she had a vasculitis he did not really indicate it in his notes as
18 a diagnosis until after he did the membrane diffusion capacity. Respondent testified the
19 workup on a patient suspected of environmental triggers is to do testing and the expense
20 to ND was based on the allergy testing looking for environmental triggers as the cause of
21 recurrent sinusitis and bronchitis. Respondent testified he performed the allergy testing
22 in his office. Respondent was reminded of his earlier testimony that the membrane
23 diffusion capacity is not a test that would be found in a textbook of medicine as the
24 diagnostic modality of choice for vasculitis and was asked if he was practicing allopathic
25 medicine. Respondent testified he was. Respondent testified he also held a

1 homeopathy license, but what he was doing was not homeopathy. Respondent was
2 asked for a reference to a journal that other allopathic physicians are likely to read that
3 would support the use of pulmonary plyphesmography as the diagnostic modality to
4 diagnose vasculitis. Respondent testified he gave several references on Raynaud's
5 phenomenon and pulmonary diffusion to the Board's investigator. Respondent was
6 asked if ND had Raynaud's phenomenon and he testified she did.

7 16. Respondent was asked the modality of therapy he proposed for ND.
8 Respondent testified he proposed an allergy workup with allergy testing, and then
9 subsequent immunotherapy, along with oxygen therapy and intravenous nutrient therapy.
10 Respondent testified oxygen therapy is a multi-step procedure where the patients breathe
11 oxygen at six liters a minute for two hours, repeatedly over a period of time. Respondent
12 noted studies show that by breathing oxygen patients develop so-called "switch
13 phenomena." Respondent was asked if he had a reference in a peer-review journal
14 commonly read by allopathic physicians that describes this form of therapy and supports
15 it. Respondent testified it is in the textbook of environmental medicine and in the
16 continuing medical education courses given by the Academy. Respondent was asked if,
17 in his experience, it was a common modality employed by allopathic physicians.
18 Respondent testified multi-step oxygen therapy is not, but hyperbaric oxygen, which is a
19 variant of this type of therapy, is.

20 17. Respondent was asked if he could cite to a source other than the textbook
21 of environmental medicine, such as *The New England Journal of Medicine* or *Annals of*
22 *Internal Medicine*. Respondent was unaware of any such source. Respondent was
23 asked if he was practicing alternative complementary medicine. Respondent testified
24 environmental medicine is regarded as allopathic medicine. Respondent was asked what
25 advice he gives patients about the nature of his practice and the nature of the testing and

1 procedures he is going to do. Respondent testified his patients are given total informed
2 consent about his practice and are given information about the modes of evaluation and
3 the types of testing. Respondent testified he discusses with his patients the principles of
4 environmental medicine that environmental physicians are obligated to follow in the work-
5 up and treatment of the patient and that the first principle in environmental medicine is to
6 reduce the total load on the immune system by finding the environmental triggers.
7 Respondent testified he is looking for the cause of the patient's problem and patients are
8 aware the testing is mandatory to determine the environmental triggers that could be
9 causing their problems.

10 18. Respondent also testified another very important principle is the concept of
11 biochemical individuality – a patient may come into the office with fibromyalgia, but may
12 have a different reason for that problem than another person with the same diagnosis.
13 Respondent testified he strives to find the differences in the patients. Respondent
14 testified there are six principles he tries to follow that are described to the patient up front
15 so the patient understands his practice is a little different and not pharmaceutically based.
16 Respondent was asked if he regarded the Mayo Clinic as an authoritative and recognized
17 allopathic diagnostic and treatment center. Respondent testified he did. Respondent
18 was asked how he responded to ND's going to the Mayo Clinic after seeing Respondent
19 and her being diagnosed after an extensive work-up as having fibromyalgia with no
20 evidence of vasculitis. Respondent testified he knew ND had fibromyalgia when she
21 walked into his office and gave him two to three minutes of history and he does not
22 disagree with the Mayo Clinic's diagnosis.

23 19. Respondent testified in environmental medicine physicians try to go further
24 than making diagnosis by trying to find the cause of the patient's complaints.
25 Respondent noted he explained this to ND on her first visit. Respondent testified that if

1 the Board looked closely at the records from the Mayo Clinic it would see in reviewing
2 ND's history, multiple symptoms and signs that are right out of the article he supplied on
3 small vessel vasculitis. Respondent testified ND's overwhelming fatigue is a common
4 finding when grouped with all of ND's other symptoms and yet the CT scan was normal in
5 regard to showing any chronic disease. Respondent testified ND had recurrent acute
6 sinusitis indicating immune dysregulation and she did not have any immunity to fight off
7 infection from her allergy.

8 20. Respondent was asked if vasculitis is an inflammatory process.
9 Respondent testified it was. Respondent was asked if certain laboratory tests will reflect
10 inflammation. Respondent testified they could. Respondent was asked if he ordered the
11 CRP test in the record and whether it was within normal limits. Respondent testified he
12 ordered the test and he believed it was within normal limits. Respondent was asked if he
13 would have expected it to be elevated. Respondent testified when there is an immune
14 vasculitis you usually see an elevated sed rate, but with chemical vasculitis the
15 inflammatory markers are not always apparent. Respondent noted ND worked in the
16 salon industry, had a long history of chemical exposure, and had physical signs of
17 chemical exposure so you may not see inflammatory markers in episodic or recurrent
18 vasculitis. Respondent testified the biggest thing on ND's history was the acneform
19 lesions he never saw and they could be the only finding in cutaneous vasculitis that
20 would be seen in chemically exposed patients.

21 21. Respondent was asked if he based his diagnosis of vasculitis on ND's
22 decreased diffusion. Respondent testified it was an ancillary test and his diagnosis was
23 really based on ND's history. Respondent was asked if he ever considered any reason
24 for the chronic sinusitis other than vasculitis – such as a fungal infection. Respondent
25 testified you see fungal infections in the CT scan as abnormalities, but since he only saw

1 ND twice he never had the opportunity to follow-up and evaluate ND with some of the
2 tests he would normally have liked to have done.

3 22. Respondent was asked if he spoke with ND in reference to the cost of his
4 service. Respondent testified his office manager meets with patients after he sees them
5 to review the costs and patients sign a statement that they are aware of the charges¹.
6 Respondent was asked if he did these extensive tests on every patient who presents for
7 an environmental evaluation. Respondent testified he did not and the reason he did so
8 with ND was because of her pulmonary history – she had a past history of severe
9 bronchitis and respiratory problems and she complained of shortness of breath.

10 23. Respondent was asked why he prepared lipoic acid drops for ND.
11 Respondent testified the drops were to treat fatigue and body pain. Respondent was
12 asked to cite to a common allopathic journal that discusses the efficacy of such treatment
13 for body pain and fatigue. Respondent testified the treatment was recently presented at
14 one of the environmental medicine meetings as a form of treatment; but he could not cite
15 to a common allopathic journal that discussed this treatment. Respondent testified that
16 common allopathic journals do not publish articles discussing using nutrients for treating
17 illnesses.

18 24. The standard of care required Respondent, in diagnosing vasculitis, to
19 employ a standard allopathic approach and standard accepted testing before embarking
20 on a course of unconventional treatments not recognized generally by allopathic
21 practitioners.

22 25. Respondent deviated from the standard of care because he did not employ
23 a standard allopathic approach in diagnosing vasculitis and embarked on a course of
24

25

¹ The Board extensively questioned Respondent about his billing practices, but determined there was not enough evidence to support a finding that Respondent charged or collected an excessive fee.

1 unconventional treatments not generally recognized by allopathic practitioners.

2 26. ND was subject to the potential harm of undergoing unnecessary and
3 unconventional treatment. ND was also subject to potential harm because vasculitis can
4 be life-threatening and, if not treated in the appropriate fashion, the patient can have
5 significant pulmonary, renal or other consequences.

6 **CONCLUSIONS OF LAW**

7 1. The Arizona Medical Board possesses jurisdiction over the subject matter
8 hereof and over Respondent.

9 2. The Board has received substantial evidence supporting the Findings of
10 Fact described above and said findings constitute unprofessional conduct or other
11 grounds for the Board to take disciplinary action.

12 3. The conduct and circumstances described above constitutes unprofessional
13 conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might
14 be harmful or dangerous to the health of the patient or the public.")

15 **ORDER**

16 Based upon the foregoing Findings of Fact and Conclusions of Law, IT IS
17 HEREBY ORDERED that Respondent is issued a Letter of Reprimand for misdiagnosing
18 vasculitis, in part on the basis of unconventional testing, and for recommending
19 unconventional therapy.

20 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

21 Respondent is hereby notified that he has the right to petition for a rehearing or
22 review. The petition for rehearing or review must be filed with the Board's Executive
23 Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The
24 petition for rehearing or review must set forth legally sufficient reasons for granting a
25 rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days

1 after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not
2 filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to
3 Respondent.

4 Respondent is further notified that the filing of a motion for rehearing or review is
5 required to preserve any rights of appeal to the Superior Court.

6 DATED this 13th day of October, 2005.



7 THE ARIZONA MEDICAL BOARD

8 By *Timothy C. Miller*
9
10 TIMOTHY C. MILLER, J.D.
11 Executive Director

12 ORIGINAL of the foregoing filed this
13 13th day of October, 2005 with:

14 Arizona Medical Board
15 9545 East Doubletree Ranch Road
16 Scottsdale, Arizona 85258

17 Executed copy of the foregoing
18 mailed by U.S. Certified Mail this
19 13th day of October, 2005, to:

20 Paul Giancola
21 Snell & Wilmer, LLP
22 One Arizona Center – 400 East Van Buren
23 Phoenix, Arizona 85004-2002

24 Executed copy of the foregoing
25 mailed by U.S. Mail this
13th day of October, 2005, to:

Stuart Z. Lanson, M.D.
Address of Record
Stuart Z. Lanson

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2
3 In the Matter of

4 **STUART Z. LANSON, M.D.**

5 Holder of License No. 7318
6 For the Practice of Allopathic Medicine
7 In the State of Arizona.

Case No. MD-04-0769A

**ORDER DENYING REHEARING
OR REVIEW**

8 At its public meeting on February 8, 2006 the Arizona Medical Board ("Board")
9 considered a Petition for Rehearing or Review filed by Stuart Z. Lanson, M.D.
10 ("Respondent"). Respondent requested the Board conduct a rehearing regarding its
11 October 13, 2005 Findings of Fact, Conclusions of Law and Order for a Letter of
12 Reprimand. The Board voted to deny the Respondent's Petition for Rehearing or Review
13 upon due consideration of the facts and law applicable to this matter.
14

15 **ORDER**

16 IT IS HEREBY ORDERED that:

17 Respondent's Petition for Rehearing or Review is denied. The Board's October 13,
18 2005 Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand is effective
19 and constitutes the Board's final administrative order.

20 **RIGHT TO APPEAL TO SUPERIOR COURT**

21 Respondent is hereby notified that he has exhausted his administrative remedies.
22 Respondent is advised that an appeal to Superior Court in Maricopa County may be taken
23 from this decision pursuant to title 12, chapter 7, article 6.
24
25

1 DATED this 9th day of February, 2006.



ARIZONA MEDICAL BOARD

By *Timothy C. Miller*
TIMOTHY C. MILLER, J.D.
Executive Director

7 ORIGINAL of the foregoing filed this
8 9th day of February, 2006 with:

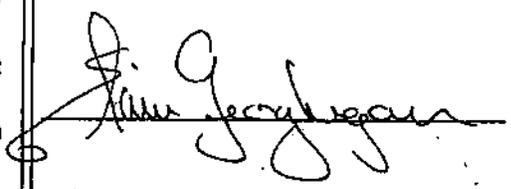
9 The Arizona Medical Board
10 9545 East Doubletree Ranch Road
11 Scottsdale, Arizona 85258

12 Executed copy of the foregoing
13 mailed by U.S. Certified Mail this
14 9th day of February, 2006; to:

15 Paul J. Giancola, Esq.
16 Snell & Wilmer
17 400 E. Van Buren
18 Phoenix, Arizona 85004

19 Stuart Z. Lanson, M.D.
20 Address of Record

21
22
23
24
25

A handwritten signature in black ink, appearing to read "Paul J. Giancola", is written over a horizontal line.