Dear Dr. Resk:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on Wednesday, December 19, 2001, at 11:30 p.m., at the Clarion Hotel, 3315 Ordway Drive, NW, Roanoke, Virginia. The conference will be conducted pursuant to Sections 54.1-2919, 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code").

An Informal Conference Committee ("Committee"), composed of three members of the Board, will inquire into allegations that you may have violated certain laws governing the practice of osteopathic medicine in Virginia. Specifically, you may have violated Sections 54.1-2403, 54.1-2915.A(1) and (3), as further defined in Section 54.1-2914.A(7), (8), (10), (11), (13) and (14) [formerly Section 54.1-2914.A(9), (10), (12), (13), (15) and (16)] of the Code, and Sections 18 VAC 85-20-30(A), (D) and (E), 18 VAC 85-20-40(A) and (C), 18 VAC 85-20-100 and 18 VAC 85-20-105 of the Virginia Board of Medicine Regulations, in that:

1. On divers occasions, you published, or caused to be published in the Roanoke Times, advertisements that are false, misleading and deceptive, and without containing qualifying statements that there are exceptions to the claims made. Specifically:

a. In the advertisement captioned, "CHELATION POLITICS," you claimed, "Occasionally, some tentacle organization of the establishment tries to convince a medical board to crack down on chelating physicians. Last January it was Nevada; three years ago California. So far, both medical boards have weighed the evidence and chelation prevails. The California State Medical Board ... voted 9 to ZIP in favor of establishing chelation as a recognized treatment for atherosclerosis." However, in his letter dated June 23, 1998, to the Executive Director of the Virginia Board of Medicine, the Supervising Investigator for the Medical Board of California, stated, in reference to this advertisement, "If she [Dr. Resk] is referring to the Medical Board of California as voting this way then this statement is false. The Medical Board of California made no such finding."

The advertisement also claimed that, "Chelation as a non-surgical treatment for hardening of the arteries, has been a political football ever since it was demonstrated to be effective over fifty years ago. The entrenched medical establishment is defensive with respect to its yearly 400,000+..."
angioplasty and by-pass surgeries, and with good reason. Chelation could disastrously cut into the anticipated $274 billion 1998 annual revenue for treating heart disease, saving patients and insurers monster bucks...."

b. In the advertisement captioned, “THE DOCTOR IS IN,” you claimed, “EDTA is used by the carload as a food additive and has been used for decades to prevent drawn blood from clotting. It is relatively non-toxic and risk free, especially when compared with other conventional medical treatments such as coronary artery bypass surgery or angioplasty.”

c. In the advertisement captioned, “PLAYING FOOTSIE,” you claimed, “Some foot pain starts in the feet. Most doesn’t [sic].” The advertisement also stated that, “Your foot hurts, and you go to a foot man. What are the chances that you will end up with ankle surgery? Extremely good. Will that solve the problem? No.... A podiatrist will be happy to do surgery on your foot, but it will never, ever, be the same.”

d. In the advertisement captioned, “Crazy,” you stated, “Think of all the cancer patients out there! Chemotherapy is the mainstay of therapy for many but not all.... Wouldn’t it be worth while to try to build the defense mechanisms while fighting off any kind of cancer? It would not hurt as chemotherapy does. It certainly won’t take your hair or your energy.” The advertisement also stated, “We treat you as a patient not a grand experiment.”

e. In the advertisement captioned, “SITTING PRETTY,” you claimed, “Processed food, devoid of natural fiber, will kill you eventually.”

f. In the advertisement captioned, “RUSH TO JUDGMENT,” you stated, “Anyone presenting with some fuzzily defined mental problems gets labeled ‘Alzheimer’s’ [sic]. Before you accept this trash diagnosis for yourself or a loved one, get a second opinion.”

g. In the advertisement captioned, “REAL MEN ALL GET PROSTATE CANCER,” you claimed that, “Just like death and taxes, you can be sure to get prostate cancer if you live long enough.”

h. In the advertisement captioned, “POPEYE WAS A BLOOMIN’ GENIUS,” you claimed that, “Our very SAD (Standard American Diet) puts us far into the acid range, where we easily slide into problems with diabetes, cardiovascular disease and obesity. High acidity messes up the Krebs cycle that controls how we get energy from food, and makes us resistant to insulin and to the medicines that help normalize insulin levels.”

i. In the advertisement captioned, “JOCK DOC,” you claimed that, “Many injuries that might otherwise be sent to surgery can be resolved without surgery at To Life!”

j. In the advertisement captioned, “GEEK SPEAK,” you claimed that with “counterstrain therapy,” “bones and joints return to their normal locations. Pain stops instantly.”

k. In the advertisement captioned, “PROGESTERONE IS THE PITS,” you stated that, “Popular wisdom says that estrogen alternated with progesterone is less a cancer risk. Not True.... The progesterone actually cranks up the possibility for every other type of cancer, a big net increase.... The whopping protection that estrogen provides against heart disease and osteoporosis more than
makes up for the wee bit of protection progesterone gives the uterine lining, assuming you still have one."

1. In the advertisement captioned, "10-FINGER ORTHOPOD," you claimed, "The standard orthopedic office will x-ray an injury. If no fracture is evident, you will get a prescription, a bill and a hasty 'Sayonara'. If you are a starting running back you may get the works, otherwise don't hold your breath. Dr. Joan, a 10-finger osteopathic physician and surgeon if there ever was one, is uniquely qualified in orthopedic medicine."

m. In the advertisement captioned, "AN UNCOMPROMISED SECOND OPINION IS A BEAUTIFUL THING," you claimed that, "We never release medical records without written permission from you." However, pursuant to Section 32.1-127.1:03 and Section 8.01-413 of the Code of Virginia (1950), as amended, patient records can be released without the patient’s permission in accordance with a court order or subpoena.

n. In the advertisement captioned, "INFLUENZA DRUG HYPE A CHUCKLE," you claim that the medications Relenza and Tamiflu, which are used to treat the flu, "are sucking up the free press while patients are shelling out the big bucks.... These questionable marvels only work.... The bill: $60 US currency. I'd rather have the flu.... "call To Life! for some real flu medicine."

o. In the advertisement captioned, "ABOUT THAT WART ON YOUR NOSE," you claimed that cosmetic electrosurgery is "a painless, bloodless, controllable method." On or about July 22, 1998, in response to said advertisement, a mother brought her two daughters, Patient A, age 6, and Patient B, age 10, to your office for wart removal. You removed the patients' warts using an Ellman radiosurgical unit. Both patients experienced pain and bleeding during the procedures. In a letter dated July 29, 1998, the mother of the two patients expressed her belief that your advertisement was misleading and misrepresentative of the services you provide.

p. In the advertisement captioned, "IT'S A NEW WORLD TEVYE," you claimed, "There was a time when no one had ever heard of andropause. " "Now even the medical mainstream is beginning to see the benefits of over-the-hill male hormone supplementation."

q. In the advertisement captioned, "GEEK SPEAK," you stated that you are "board certified in Osteopathic Manipulative Therapy...." However, you did not disclose the complete name of the specialty board that conferred the certification.

r. In the advertisement captioned, "SMART STEW," you stated, "No wonder the common treatment regimen is to medicate for 'something.' If you don't improve, it obviously wasn't 'something,' so now you get treated for 'something' else. This is diagnosis by 'treatment.' It is an old method, useful in primitive situations, but hard to justify in the modern clinical setting.... Doing it right requires some extra effort and expense up front, but it can accurately define your problem, so that diagnosis is not a medical lottery and treatment protocols are based on science, not on 'throwing something at it'."

2. On divers occasions, you published, or caused to be published in the Roanoke Times, advertisements that contain claims of superiority. Specifically:

a. In the advertisement captioned, "FLORIDA MOUSE," you claimed that, you had the "warmest doctor-hands ever.... our heated speculum is hands-down the ladies all time favorite. They
exchange horror stories of past icy ones and are often vocal about our compassionate approach to gynecological examination.”

b. In the advertisement captioned, “HUMPTY-DUMPTY DOC,” you claimed, “Dr. Joan, perfectionist that she is, does her own x-ray interpretation, casting, cast-removal, and after-care.... You won’t get a surprise bill from a radiologist you never heard of, but you will get to examine your own ‘before’ and ‘after’ films with the Doctor.... Here’s where those extra 500 hours of musculoskeletal medical school studies pay off for a DO’s patients. Taking care of the associated soft-tissue traumatized by a fracture makes the difference between ‘good enough’ and ‘good as new’.”

c. In the advertisement captioned, “FAMOUS FINGERS FIX SUNDAY TUMMYACHE,” you stated that, “Visceral manipulation applied by a pro is just plain and amazing.... Avoid the ‘pleasures’ of the hospital emergency room.”

3. On or about June 1, 2000, a Department of Health Professions investigator, obtained copies of the records ten (10) of your chelation patients, pulled at random. A review of these records revealed the following deficiencies:

a. On or about September 8, 1998, Patient C presented for an opinion on why he had no energy. The patient suffered from shortness of breath, insulin-dependent diabetes; two (2) past episodes of coughing up blood, open-heart surgery in 1997, and had recently lost his wife. You failed to perform a complete physical examination and to document the patient’s vital signs, to include a blood pressure reading, although the patient had related being on blood pressure medication in the past. In addition, you failed to obtain medical records or other information concerning treatment of the patient from his former treating practitioners. You noted discussing the pros and cons of chelation with the patient, but you failed to document the indication for chelation, anticipated results and the progress of the treatment.

b. On or about August 14, 1998, Patient D, who suffered from non-insulin dependent, diabetes, presented to your office for a consultation on chelation. The patient had a history of hypertension, hypothyroidism and angina pectoris. You failed to perform a complete physical examination and to note the patient’s vital signs, to include a blood pressure reading. Further, you failed to obtain medical records or other information concerning treatment of the patient from her former treating practitioners. You noted discussing the pros and cons of chelation with the patient, and your treatment plan was “Chelation with zinc”; however, you failed to document the indication for chelation and the anticipated results. You subscribed flax-borage oil, zinc and Inositol; however, you failed to note the indication for these supplements, as well as the strength, dosage, and quantity. A “Chelation Progress Chart” in the patient’s record indicates that the patient had chelation approximately nineteen (19) times between on or about August 21, 1998, through February 6, 1999, with two entries for February 6, 1999. At the end of the first chart, there is a notation, “Add Zn & Chromium”; however, there is no other information in the file to explain the same. There are no office notes after August 14, 1998, or documentation as to the indication for chelation treatment and the progress of the treatment.

c. On or about November 21, 1998, Patient E presented for chelation due to a diagnosis of aluminum toxicity in approximately 1997. The patient related that he had been treated with oral chelation for several months. You failed to perform a complete physical examination and to note the patient’s vital signs to include a blood pressure reading. In addition, other than reviewing hair analysis provided by the patient, you failed to obtain medical records or other information concerning
treatment of the patient from his former treating practitioners. A “Chelation Progress Chart” in the patient’s record indicates that the patient had chelation approximately twenty (20) times between on or about November 21, 1998 and April 14, 1999. However, there are no office notes after November 7, 1998, or documentation as to the progress of the treatment.

d. On or about January 25, 1999, Patient F, who suffered from diabetes and had an angioplasty performed in January 1998, presented for a consultation. The patient presented a chest x-ray, which you noted showed mild cardiac enlargement. You failed to perform a complete physical examination and to note the patient’s vital signs, to include a blood pressure reading. Further, you failed to obtain medical records or other information concerning treatment of the patient from her former treating practitioners. You documented that you discussed the pros and cons of chelation therapy; however, you failed to document the indication for the same. A “Chelation Progress Chart” in the patient’s record indicates that his first chelation therapy was on or about January 23, 1999; however, you documented the initial office visit as being on January 25, 1999; the consent form is also dated January 25, 1999. The progress chart also indicates that the patient had chelation approximately thirty (30) times between on or about January 23, 1999, and May 1, 1999. However, there are no office notes after January 25, 1999, or documentation as to the progress of the treatment.

e. On or about March 12, 1999, Patient G, who had a history of atrial fibrillation and high blood pressure, presented to your office, interested in chelation. You failed to perform a complete physical examination and to note the patient’s vital signs to include, a blood pressure reading. You documented that you discussed the pros and cons of chelation therapy; however, you failed to document the indication for the same. You noted “cancer” in your assessment of the patient; however, cancer is not documented anywhere else in the patient’s record. A “Chelation Progress Chart” in the patient’s record indicates that the patient’s first chelation therapy was on or about March 11, 1999; however, you documented the initial visit as being on March 12, 1999; the consent form is also dated March 12, 1999. The chelation progress chart indicates that the patient had chelation approximately four (4) times between on or about March 11, 1999 and March 22, 1999. However, there are no office notes after March 12, 1999, or documentation as to the progress of the treatment.

f. On or about March 13, 1999, Patient H, who suffered a “slight heart attack” approximately one (1) year prior, and claimed that he had a 90% blockage on the left side of his heart, presented to your office, interested in chelation. You failed to perform a complete physical and to note the patient’s vital signs, to include a blood pressure reading. Further, you failed to obtain medical records or other information concerning treatment of the patient from his former treating practitioners. Your treatment plan included chelation; however, you failed to document the indication for the same. A “Chelation Progress Chart” in the patient’s record indicates that the patient’s first chelation therapy was on or about March 10, 1999. However, the consent form is dated March 12, 1999, and you documented the initial visit as being on March 13, 1999. The chelation progress chart also indicates that the patient had chelation approximately ten (10) times between on or about March 10, 1999, and February 7, 2000. However, there are no office notes after March 13, 1999, or documentation as to the progress of the treatment. Patient H’s record also includes a “Hydrogen Peroxide Progress Chart,” which indicates that he received hydrogen peroxide treatments on four (4) occasions between on or about January 14, 2000, and February 7, 2000. You failed to note the indication for the hydrogen peroxide treatments and to document the progress of said treatments.
g. On or about August 4, 1999, Patient I presented to your office for an examination related to a past cerebrovascular accident and arteriosclerotic heart disease. You failed to perform a complete physical and to note the patient’s vital signs, to include a blood pressure reading. Further, you failed to obtain medical records or other information concerning treatment of the patient from her former treating practitioners. Your treatment plan included chelation; however, you failed to document the indication for the same. A “Chelation Progress Chart” in the patient’s record indicates she had one (1) chelation treatment on August 25, 1999; however, you failed to document the results of the same.

h. On or about July 9, 1999, Patient J presented to your office on a referral from his ophthalmologist for possible hypertension. The patient also complained of stress, allergies and depression and wanted to discuss the possibility of chronic fatigue syndrome. You failed to perform a complete physical and to note the patient’s vital signs, to include a blood pressure reading. Further, you failed to obtain medical records or other information concerning treatment of the patient from his former treating practitioners. Your assessment included hypertension, chronic fatigue syndrome, allergy syndrome, neuritis, fatigue, depression, arteriosclerotic heart disease and statis dermatitis of the legs bilaterally. You treatment plan included performing Spectracell 3000 and Balco tests/profiles; however, you failed to document the indication for the same. Although chelation is not included in your treatment plan, there is a “Chelation Progress Chart” in the patient’s record indicating that he received thirty (30) chelation treatments between on or about July 26, 1999, through November 17, 1999. There are no office notes after August 4, 1999, or documentation as to the progress of the treatment.

i. On or about April 18, 2000, Patient K, who had suffered a cerebrovascular accident in December 1999, and was unable to walk, talk or care for himself was brought to your office by the his brother. The patient wanted chelation treatments, as it was his “last hope therapy.” You failed to obtain medical records or other information concerning treatment of the patient from his former treating practitioners. A “Chelation Progress Chart” in the patient’s record indicates that the patient received chelation treatments approximately six (6) times between on or about April 26, 2000, and June 5, 2000. However, there are no office notes after April 18, 2000, or documentation as to the progress of the treatment.

j. On or about May 3, 2000, Patient L presented to your office “for flushing and clogged arteries as he states.” Although the patient related that he had experienced chest pain three (3) days prior, you failed to perform a complete physical and to note the patient’s vital signs, to include a blood pressure reading. Further, you failed to obtain medical records or other information concerning treatment of the patient from his former treating practitioners. A “Chelation Progress Chart” in the patient’s record indicates that the patient received approximately thirteen (13) treatments between on or about May 5, 2000 and June 13, 2000. However, there are no office notes after May 3, 2000, or documentation as to the progress of the treatment.

4. You failed to maintain proper boundaries with Patient M in that, between on or about March 15, 1998, through, at least, December 6, 1999, you treated Patient M on an ongoing basis, for a variety of complaints to include: anxiety, hypertension, arteriosclerotic heart disease, chronic head, neck and back pain, migraines, pelvic obliquity, hypoglycemia, zinc deficiency, hormonal imbalance and thyroid imbalance. By your own admission, Patient M is your “significant other,” as well as a contractor/employee of your practice.

5. A review of your record for Patient M revealed numerous discrepancies, and deficiencies. Specifically:
a. Your medication log indicates that, on at least eight (8) occasions between on or about March 15, 1998, and December 6, 1999, Demerol 100mg (meperidine HCL), a Schedule II controlled substance, and Vistaril 50mg (hydroxyzine pamoate), a Schedule VI controlled substance, were signed out for Patient M. However, Patient M’s record does not reflect that said medications were dispensed, administered or prescribed on the dates as listed in the log. Specifically:

<table>
<thead>
<tr>
<th>DATE</th>
<th>Medication log</th>
<th>Medical record for Patient M</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/12/98</td>
<td>Demerol 100mg to Patient DM</td>
<td>No record for 5/12/98</td>
</tr>
<tr>
<td>5/12/98</td>
<td>Vistaril 50mg/1cc to Patient DM</td>
<td>No record for 5/12/98</td>
</tr>
<tr>
<td>5/30/98</td>
<td>Demerol 100mg to Patient DM</td>
<td>No record for 5/30/98</td>
</tr>
<tr>
<td>5/30/98</td>
<td>Vistaril 50mg to Patient DM</td>
<td>No record for 5/30/98</td>
</tr>
<tr>
<td>6/30/98</td>
<td>Demerol 100mg to Patient DM</td>
<td>Not documented in record for 6/18/98</td>
</tr>
<tr>
<td>6/18/98</td>
<td>Vistaril 50mg to Patient DM</td>
<td>Not documented in record for 6/18/98</td>
</tr>
<tr>
<td>6/18/98</td>
<td>Demerol 100mg to Patient DM</td>
<td>Not documented in record for 6/18/98</td>
</tr>
<tr>
<td>6/19/98</td>
<td>Demerol 100mg to Patient DM</td>
<td>No record for 6/19/98</td>
</tr>
<tr>
<td>6/19/98</td>
<td>Vistaril 50mg to Patient DM</td>
<td>No record for 6/19/98</td>
</tr>
<tr>
<td>8/25/98</td>
<td>Demerol 100mg to Patient DM</td>
<td>No record for 8/25/98</td>
</tr>
<tr>
<td>8/25/98</td>
<td>Vistaril 50mg to Patient DM</td>
<td>No record for 8/25/98</td>
</tr>
<tr>
<td>8/6/99</td>
<td>Demerol 100mg to Patient DM</td>
<td>No record for 8/6/99</td>
</tr>
<tr>
<td>8/6/99</td>
<td>Vistaril 50mg to Patient DM</td>
<td>No record for 8/6/99</td>
</tr>
</tbody>
</table>

b. Your medication log indicates that on at least three (3) occasions between on or about March 15, 1998, and December 6, 1999, Vicodin ES (hydrocodone, acetaminophen), a Schedule III controlled substance, was signed out for Patient M; however, the patient’s record does not reflect that said medication was dispensed, administered, or prescribed on those days. Specifically:

<table>
<thead>
<tr>
<th>DATE</th>
<th>Medication log</th>
<th>Medical record for Patient DM</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/2/98</td>
<td>Vicodin ES #100</td>
<td>No record for 12/2/98</td>
</tr>
<tr>
<td>3/1/99</td>
<td>Vicodin ES #100</td>
<td>No record for 3/1/99</td>
</tr>
<tr>
<td>6/10/98</td>
<td>Vicodin ES #100</td>
<td>No record for 6/10/98</td>
</tr>
</tbody>
</table>

c. On or about March 15, 1998, you noted in Patient M’s record under the medication section: “Vicodin ES x 8yr.” without further explanation. On or about October 12, 1998, you noted in the patient’s record, under plan: “Continue with Vicodin ES. Remember to stay ahead of the pain and not behind it.” Between on or about March 15, 1998, and December 6, 1999, you regularly listed Vicodin ES under the medication section of your “SOAP” notes in the patient’s record. However, you failed to note the indication for Vicodin ES and to document the strength, dosage, quantity, and number of refills anywhere in the patient’s record.

d. Throughout the patient’s record, you documented that she suffers from chronic neck and back pain, which you apparently treated with osteopathic manipulation, diathermy and Vicodin ES. However, you failed to adequately manage the patient’s pain in that:

i) You failed to adequately evaluate and document the nature, and intensity of the pain, and the effect of the pain on physical and psychological function.

ii) You failed to document medical indications for the use of pain medication.
iii) You failed to develop and document a comprehensive treatment plan to include objectives used to determine treatment success, such as pain relief and improved physical and psychosocial function.

iv) You failed to refer the patient for additional evaluation and treatment.

e. A review of your records for Patient M revealed that you rarely documented the patient’s vital signs, to include blood pressure readings, although you were treating the patient for hypertension.

f. On or about May 27, 1998, you saw Patient M to discuss her Spectracell 3000 lab results. However, you failed to note the date the test and/or profile was ordered, the indication for the test and/or profile, and the results of the test and/or profile.

g. On or about June 2, 1998, you saw Patient M to discuss the lab results of the “executive profile 1”; however, you failed to note in the record the date the profile was ordered, the indication for the profile, and the results of the profile.

h. On or about June 2, 1998, you noted in Patient M’s record to “continue medications, chelation as prescribed,” although you had not previously documented prescribing chelation for the patient. You failed to note the indication for the chelation, the anticipated results and the progress of the treatment.

i. On or about October 23, 1998, you noted “Chelation run” under “Plan” on your “SOAP” note; however, you failed to note the indication for the chelation, the anticipated results and the progress of the treatment.

j. On or about August 26, 1999, you failed to document any subjective and objective information in the record for Patient M. You noted in the treatment plan “to restart chelation and hydrogen peroxide therapy....” However, you failed to note the indication for said therapies, and the anticipated results of the same. In addition, you had not previously documented prescribing hydrogen peroxide therapy for the patient, and there was no documentation of informed consent for hydrogen peroxide therapy in the patient’s record.

k. A “Chelation Progress Chart,” in your record for Patient M, charts fourteen (14) days between on or about August 20, 1998, and November 12, 1998, on which the patient presumably received chelation therapy. The dates on said chart do not correspond with the office visits documented. In addition, there are three (3) entries for August 26, 1998, of which two are recorded after November 12, 1998. You failed to document the rationale for the chelation therapy/treatment and the results of the same anywhere in the patient’s record. In addition, there is no documentation of informed consent for the chelation therapy/treatment in the patient’s record.

l. On or about June 10, 1998, you saw Patient M to discuss her lab results. You failed to document the date the “Balco lab” test and/or profile was ordered, and the indication for the test and/or profile. In addition, you noted that you had prescribed and dispensed chromium, zinc and magnesium supplements and a Zoloft starter kit; however, you failed to note the indication, strength, dosage and quantity for the same. Under “Follow Up” you noted, “Take care of yourself or suffer the consequences.”
m. A review of Patient M’s record indicates that on two occasions, on or about December 16, 1998, and on or about December 18, 1998, you discussed the same blood count results with the patient; however, your treatment plans for those two dates differ. Specifically:

i) On or about December 16, 1998, you documented in your “SOAP” note, under “Subjective,” that the “patient’s complete blood count is here. Patient called into office.” Under “Objective,” you documented several physical findings, and noted that you discussed with the patient her CBC. You documented an elevated hemoglobin of 15.5 with corresponding elevation of HCT, and that you instructed the patient to change her diet and to exercise more. Under “Plan,” you documented “Eat less protein, cheese. Recheck in several months.”

ii) On or about December 18, 1998, you noted that Patient M “called in for her lab results on a complete blood count and IFG-1 levels.” You documented that the patient’s hemoglobin was elevated to 15.5 with corresponding elevated hematocrit. However, there is no notation regarding the patient’s diet. You noted to “decrease Estrace (estrogen) to 2mg. Recheck complete blood count in several months.” You failed to document the indication for the decrease of the Estrace, as well as the dosage, quantity and number of refills of the same.

n. On or about January 12, 1999, Patient M came to the office to obtain lab results. However, you failed to identify the tests/profiles that were performed, the indication for the same, as well as the results. You noted that you discussed with the patient her anxiety level, pain levels, and blood pressure levels; however, you failed to note those levels in the record.

o. On at least three (3) different occasions between on or about April 27, 1999, and May 28, 1999, you saw Patient M to discuss the lab results of “Spectracell 3000” and/or Balco Laboratories tests and/or profiles. Specifically:

i) On or about April 27, 1999, you noted in the record that the “Spectracell 3000” showed no deficiencies, the patient’s total antioxidant function was average at 60.0 percentile, and that the Balco Laboratories indicated functional deficiency of zinc and chromium. You failed to document the indication for these tests and/or profiles, nor did your treatment plan include investigating the causes of the zinc and chromium deficiencies. You noted that zinc and chromium supplements were dispensed; however, you failed to note the strength, dosage and quantity dispensed.

ii) On or about April 30, 1999, you noted that the “Spectracell 3000” showed no deficiencies, the patient’s total antioxidant function was average at 60.0 percentile, and the Balco Laboratories results indicated a deficiency of “chromium and zinc-chromium at 2SD below normal.” You instructed the patient to continue with “vits and minerals” and to “continue with chromium and zinc—double dosage.” You failed to note the type, strength, dosage, and quantity of said “vits and minerals.” You noted in your follow-up plan: “One year for Spectracell and Balco.”

iii) On or about May 28, 1999, you noted that the Spectracell 3000 indicated a functional “deficiency of zinc and opening easy in and Magnesium insulin interaction.” You noted that the patient’s total antioxidant function was at the desired level at 85.0 percentile.

p. On or about September 14, 1999, you failed to note any subjective and objective information in the record for Patient M.
q. On or about September 8, 1999, you saw Patient M for a recheck of her blood pressure; however, you failed to document the blood pressure reading in the record.

6. From approximately February 10, 1999, through approximately August 3, 1999, you employed Patient N as a receptionist and phlebotomist for your practice, “To Life!” Although you knew or should have known that Patient N was neither a licensed registered nurse nor a licensed practical nurse, you placed two advertisements, captioned, “BREAKFAST CLUB,” and “LOOK UP TO JODIE,” in the Roanoke Times, in which Patient N is referred to as “Nurse Jodie.”

7. You improperly and ineffectively treated Patient N, your employee, who suffered from diabetes, headaches and weekly episodes of projectile vomiting, and had a history of Hodgkin’s lymphoma, in that:

   a. You initially saw Patient N on or about March 18, 1999 for a second opinion regarding treatment of her diabetes. You failed to perform and document an adequate physical examination of the patient, and you failed to obtain medical records or other information concerning treatment of the patient from her former treating practitioners.

   b. On or about March 31, 1999, you saw Patient N to discuss her lab work. You documented that the SMA panel revealed an elevated glucose at 438. You changed her insulin dosage without consulting her physician. In addition, you documented that “the need for Spectracell and Balco were explained” to the patient; however, you failed to document the necessity for the same.

   c. On or about April 7, 1999, after a check of the patient’s urine indicated an abnormally high sugar level, you sent Patient N to the hospital for a “stat” blood sugar. You noted the stat blood sugar was “over 600.” You made diet suggestions to the Patient N and placed her on Buffer PH. You saw Patient N on two more occasions, April 7 and April 13, 1999, and noted that her insulin levels were still not controlled. There are no other office notes documented after April 13, 1999. You discharged Patient N from your practice by letter dated August 3, 1999.

8. From between on or about July 10, 2000, through July 19, 2000, you acted unprofessionally in your interactions with Individual O, whom you hired for the position of phlebotomist, to include berating her and yelling at her in the presence of patients. In addition, you required Individual O to perform duties beyond her scope of practice, education and training. Specifically, you required Individual O to administer infusion therapy to patients, during which you would leave the office for hours at a time, leaving the patients with untrained personnel. Also, you required that Individual O assist you in performing a pap smear, without giving her adequate instruction, and despite her protests that she felt unqualified to do so.

9. You improperly and ineffectively treated Patient P, in that:

   a. Patient P presented to your office on or about March 14, 2000, complaining of increased job stress, and occasional difficulty falling and staying asleep. You noted that the patient took dietary supplements and had requested that you perform laboratory tests in order to determine whether he was “on the right vitamin program.” Although you failed to perform and document a complete physical examination, you assessed the patient as suffering from “multiple vitamin and mineral deficiencies,” without documenting the basis of your assessment. You documented that flax borage oil, “Mag-Tab’s,” maximum multiple vitamins and “Unique E” were dispensed without identifying the reason(s) for their dispensation. In addition, you failed to identify the strength, dosage and quantity of the same.
b. Patient P returned to your office on or about April 12, 2000, to discuss the results of his lab work. You noted that the Balco lab results indicated a functional deficiency of zinc, low potassium and low sodium, and that the Spectracell lab results revealed no functional deficiencies in vitamins or amino acids tested. You also noted that the patient’s “total antioxidant function was average, [in the] 65.6 percentile.” You did not note a calcium deficiency; however, your treatment plan was to “supplement with zinc, calcium and potassium.” You failed to identify the strength, dosage and quantity of the supplements, and your treatment plan did not include investigating the causes of said deficiencies.

c. Prior to his visit on April 12, 2000, Patient P inquired as to the cost of said visit, and was quoted a charge of $60.00. However, you first attempted to charge the patient $150.00 to include the office visit and the supplements you prescribed. When the patient refused to purchase the supplements, he was charged $90.00 for the office visit. In a June 1, 2000, interview with the Department of Health Professions’ investigator, you stated that you provided an “extended office visit” with the patient due to his “plethora” of questions, and you felt that the additional $30.00 you billed was reasonable.

d. By letter dated April 12, 2000, you demanded payment from Patient P for the April 12, 2000 visit, and notified the patient that you were discharging him from your practice. In said letter you used inappropriate and threatening language, to include the following: “If you choose not to pay this office I will personally report your license number and car make to the police for their confiscation as you do not have a valid state license. They would love to sell your vehicle right out from under you.”

10. You engage in expensive and medically unnecessary testing, in that, by your own admission, you obtain two blood and serum profiles on most new patients. Specifically, you use Balco Laboratory, which provides an analysis of patient’s mineral level, and Spectracell, which provides a “survey of vitamins, antioxidants, and essential metabolites.” In your interview of December 2, 1999, with the Department of Health Professions’ investigator, you admitted that the cost of these tests is approximately $860.00.

11. You refused to provide the Department of Health Professions’ investigator with a schedule of your fees as requested on or about June 1, 2000.

The following actions may be taken by this Committee:

1. If a majority of the Committee is of the opinion that a suspension or revocation of your license may be justified, the Committee shall present to the Board in writing its findings, and the Board may proceed with a formal hearing;

2. The Committee may notify you in writing that you are fully exonerated of any charge that might affect your right to practice osteopathic medicine in Virginia;

3. The Committee may reprimand or censure you, or;

4. The Committee may impose a monetary penalty pursuant to Section 54.1-2401 of the Code, or;

5. The Committee may place you on probation for such time as it may designate and direct that during such period you furnish the Committee or its chairman, at such intervals as the
Committee may direct, evidence that you are not practicing in violation of the provisions of Chapter 29, Title 54.1 of the Code, which governs the practice of osteopathic medicine in Virginia.

You have the right to information, which will be relied upon by the Committee in making a decision. Therefore, I enclose a copy of the documents, which will be distributed to the members of the Committee, and will be considered by the Committee when discussing the allegations with you and when deliberating upon your case. Since you have been noticed of an alleged violation of Section 54.1-2914.A(7) [formerly Section 54.1-2914(9)] of the Code, enclosed in these documents are the American Medical Association Principles of Medical Ethics, and Opinions 5.02, 6.05, 8.03, 8.063, 8.08 and 8.14, as well as the American Osteopathic Association’s Code of Ethics. The Committee may consider these opinions and principles when determining whether you have conducted your practice in a manner contrary to the standards of ethics of the practice of osteopathic medicine. These documents are enclosed only with the original notice sent by certified mail, and must be claimed at the post office. I also enclose relevant sections of the Administrative Process Act, which governs proceedings of this nature, as well as laws relating to the practice of osteopathic medicine and other healing arts in Virginia.

Absent good cause shown to support a request for a continuance, the informal conference will be held on December 19, 2001. A request to continue this proceeding must state in detail the reason for the request and must establish good cause. Such request must be made in writing to me at the address listed on this letter and must be received by 5:00 p.m. on November 16, 2001. Only one such motion will be considered. Absent exigent circumstances, such as personal or family illness, a request for a continuance after November 16, 2001, will not be considered.

You may be represented by an attorney at the informal conference. Further, it is your responsibility to provide the enclosed materials to your attorney.

To facilitate this proceeding, you must submit eight (8) copies of any documents you intend for the Committee’s consideration to Renée Dixson, Case Manager, Board of Medicine, Department of Health Professions, 6606 West Broad Street, 4th Floor, Richmond, Virginia 23230-1717, by November 16, 2001. Should you or Senior Adjudication Analyst, Patricia L. Larimer, wish to submit any documents for the Committee’s consideration after November 16, 2001, such documents shall be considered only upon a ruling by the Chair that good cause has been shown for late submission.

Please advise the Board of your intention to be present. Should you fail to appear at the informal conference the Board may proceed to a formal administrative hearing in order to impose sanctions. Should you have any questions regarding this notice, please contact Patricia L. Larimer, Senior Legal Assistant, at (804) 662-7444.

Sincerely,

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine
cc:  Harry C. Beaver, M.D. President, Virginia Board of Medicine  
John W. Hasty, Director, Department of Health Professions  
James L. Banning, Director, Administrative Proceedings Division  
Informal Conference Committee  
Patricia L. Larimer, Senior Adjudication Analyst  
Charles C. Holt Senior Investigator (69343)  
Patricia Fisher, Investigator (69132, 74366, 76992)  
Reneé Dixson, Discipline Case Manager, Board of Medicine  
Carolyn McCracken, Senior Administrative Assistant, Board of Medicine

Enclosures:  
Virginia Code Sections:  
2.2-4019  
2.2-4021  
54.1-2403  
54.1-2914  
54.1-2915  
54.1-2919

Virginia Board of Medicine Regulations  
18 VAC 85-20-30  
18 VAC 85-20-40  
18 VAC 85-20-100  
18 VAC 85-20-105

Informal Conference Package
Map
Attachment I
VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: JOAN M. RESK, D.O.
License No.: 0102-050166

ORDER

In accordance with Sections 54.1-2919, 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), an informal conference was held with Joan Resk, D.O., on March 27, 2002, in Roanoke, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the Informal Conference Committee ("Committee") were: Kenneth J. Walker, M.D., Chairman; Dianne L. Reynolds-Cane, M.D., and J. Kirkwood Allen. Dr. Resk appeared personally and was represented by Paul Beers, Esquire. The purpose of the informal conference was to inquire into allegations that Dr. Resk may have violated certain laws governing the practice of osteopathic medicine in the Commonwealth of Virginia, as set forth in a Notice of Informal Conference dated November 5, 2001.

FINDINGS OF FACT

Now, having properly considered the evidence and statements presented, the Committee makes the following Findings of Fact:

1. On divers occasions, Dr. Resk published, or caused to be published in the Roanoke Times, advertisements that were false, misleading and deceptive, and without containing qualifying statements that there are exceptions to the claims made. Specifically:

   a. In the advertisement captioned, "CHELATION POLITICS," Dr. Resk claimed, "Occasionally, some tentacle organization of the establishment tries to convince a medical board to crack down on chelating physicians. Last January it was Nevada; three years ago California. So far, both medical boards have weighed the evidence and chelation prevails. The California State Medical Board ... voted 9 to ZIP in favor of establishing chelation as a recognized treatment for atherosclerosis." However, in his letter dated June 23,
1998, to the Executive Director of the Virginia Board of Medicine, the Supervising Investigator for the Medical Board of California, stated, in reference to this advertisement, “If she [Dr. Resk] is referring to the Medical Board of California as voting this way then this statement is false. The Medical Board of California made no such finding.”

b. In the advertisement captioned, “PLAYING FOOTSIE,” Dr. Resk claimed, “Some foot pain starts in the feet. Most doesn’t [sic].” The advertisement also stated that, “Your foot hurts, and you go to a foot man. What are the chances that you will end up with ankle surgery? Extremely good. Will that solve the problem? No.... A podiatrist will be happy to do surgery on your foot, but it will never, ever, be the same.”

c. In the advertisement captioned, “SITTING PRETTY,” Dr. Resk claimed, “Processed food, devoid of natural fiber, will kill you eventually.”

d. In the advertisement captioned, “RUSH TO JUDGMENT,” Dr. Resk stated, “Anyone presenting with some fuzzily defined mental problems gets labeled ‘Alzheimer’s’ [sic]. Before you accept this trash diagnosis for yourself or a loved one, get a second opinion.”

e. In the advertisement captioned, “REAL MEN ALL GET PROSTATE CANCER,” Dr. Resk claimed that, “Just like death and taxes, you can be sure to get prostate cancer if you live long enough.”

f. In the advertisement captioned, “PROGESTERONE IS THE PITS,” Dr. Resk stated that, “Popular wisdom says that estrogen alternated with progesterone is less a cancer risk. Not true.... The progesterone actually cranks up the possibility for every other type of cancer, a big net increase.... The whopping protection that estrogen provides against heart disease and osteoporosis more than makes up for the wee bit of protection progesterone gives the uterine lining, assuming you still have one.”

g. In the advertisement captioned, “ABOUT THAT WART ON YOUR NOSE,” Dr. Resk claimed that cosmetic electrosurgery is “a painless, bloodless, controllable method.” On or about July 22, 1998, in response to said advertisement, a mother brought her two daughters, Patient A, age 6, and Patient B, age 10,
to Dr. Resk’s office for wart removal. Dr. Resk removed the patients’ warts using an Ellman radiosurgical unit. Both patients experienced pain and bleeding during the procedures. In a letter dated July 29, 1998, the mother of the two patients expressed her belief that Dr. Resk’s advertisement was misleading and misrepresentative of the services provided by Dr. Resk.

2. From approximately February 10, 1999, through approximately August 3, 1999, Dr. Resk employed Patient N as a receptionist and phlebotomist for her practice, “To Life!” Although Dr. Resk knew or should have known that Patient N was neither a licensed registered nurse nor a licensed practical nurse, she placed two advertisements captioned, “BREAKFAST CLUB,” and “LOOK UP TO JODIE,” in the Roanoke Times, in which Patient N is referred to as “Nurse Jodie.”

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Committee concludes that Dr. Resk has violated Sections 54.1-2403, Section 54.1-2915.A (1), as further defined in Section 54.1-2914.A (11), [formerly Section 54.1-2914.A(13)] of the Code, and Sections 18 VAC 85-20-30 (E) of the Virginia Board of Medicine Regulations.

ORDER

WHEREFORE, based on the above Findings of Fact and Conclusions of Law, it is hereby ORDERED that a MONETARY PENALTY of $1,800.00 is imposed upon Joan M. Resk, D.O. This monetary penalty shall be paid within 45 days of entry of this Order.

It is further ORDERED that within six (6) months of entry of this Order, Dr. Resk shall successfully complete a Category I, AMA approved continuing education (“CE”) course in the area of ethics, which shall be approved in advance of registration by the Executive Director of the Board. Within 21 days of completion of this course, Dr. Resk shall submit a certificate or other evidence satisfactory to the Board of completion of this course.
Violation of this Order may constitute grounds for suspension or revocation of Dr. Resk’s license. In the event that Dr. Resk violates this Order, an administrative proceeding may be convened to determine whether her license shall be revoked.

Pursuant to Section 2.2-4023 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

Upon receipt of evidence that Dr. Resk has complied with the requirements of this Order, this case shall be closed without further proceedings. In the event Dr. Resk fails to comply with the requirements of this Order, in the Board’s discretion, she may be noticed to meet with an informal conference committee.

Pursuant to Section 54.1-2919 of the Code, Dr. Resk may, not later than 5:00 p.m., on May 6, 2002, notify William L. Harp, M.D., Executive Director, Board of Medicine, 6606 West Broad Street, Richmond, Virginia 23230, in writing that she desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated.

Therefore, this Order shall become final on May 6, 2002, unless a request for a formal administrative hearing is received as described above.

FOR THE BOARD

[Signature]
William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

Entered: 4/5/02
COMMONWEALTH of VIRGINIA

Department of Health Professions
6603 West Broad Street, 5th Floor
Richmond, Virginia 23230-1712
February 24, 2003

Joan M. Resk, D.O.
5249 Clearbrook Lane
Roanoke, Virginia  24014-6637

RE: License No.: 0102-050166

Dear Dr. Resk:

The Virginia Board of Medicine ("Board") has received a report from the Compliance Office of the Department of Health Professions regarding your compliance with the Board’s Order entered April 5, 2002. The report indicates that you paid the monetary penalty of $1,800.00 within the required time frame and completed an online education course entitled "Making the Right Choices: The Code of Medical Ethics Online Curriculum, Module 1: Patient Care."

Based on the information received, it has been determined that you have complied with the Board’s Order; therefore, this matter has been closed effective this date.

Pursuant to § 2.2-4023 of the Code of Virginia, a signed copy of this letter shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

Sincerely,

[Signature]

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

cc: Reneé S. Dixson, Discipline Case Manager, Board of Medicine [76992]
Ann Tiller, Compliance Manager
Tamika Hines, Office Manager, Enforcement Division
Patricia Haney, Administrative Assistant